Raising Standards in Social Care

Social Care Workers Fitness to Practise Referrals Analysis

1 April 2012 – 31 March 2022

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Index

Introduction

The Northern Ireland Social Care Council (the Social Care Council) is a public body, established by the Department of Health in 2001 to raise standards of practice in social work and social care. The Social Care Council is the regulatory body for the 45,000 people approved to practise social work and social care in Northern Ireland. The Social Care Council's role is to maintain a register of Social Workers and Social Care Workers, to set standards for their conduct and practice and to ensure their continued fitness to practise in their Social Work or Social Care role. This is achieved through partnership working with registrants and stakeholders to develop the workforce, to raise practice standards, to strengthen safeguards; and help improve outcomes for people who use social work and social care services.

This report provides analysis of the 2,755 concerns relating to Social Care Worker's fitness to practise that were referred to the Social Care Council in the 10-year period from 1 April 2012-31 March 2022. It does not include concerns raised in relation to Social Workers or Students. It provides an insight into the type of allegations that were investigated, the service areas where these occurred and the demographic of those whose fitness to practise was assessed against the Social Care Council standards.

Analysis indicates the referral rate of 1% of the registered workforce reflects the broad pattern experienced in Social Care and related services across the UK (*Scottish Social Services Council, Fitness to Practise Statistics, Jan 23*), *(Social Care Wales, Annual Report and Accounts, 21/22),* (*Nursing and Midwifery Council, Annual Report and Accounts, 21/22)*. These relatively low levels of concern about poor social care practice are a positive indicator that working to professional standards is becoming an established element of the induction, management and development of those registered to work in social care.

Referrals were received from a range of stakeholders, with the majority (87%) from social care employers. Members of the public/service users/families submitted 4% of yearly referrals. Although this reflects a small number of referrals, numbering 10-16 per year, it indicates improvement in awareness of raising standards in social care amongst this stakeholder group. As a workforce regulator the Social Care Council would expect social care organisations to refer concerns on behalf of those they provide services for, but it is also important that the public are informed of the role of the Social Care Council and are able to raise concerns independently.

214 of the 2,755 referrals received and assessed by the fitness to practise team were found not to meet the threshold set in the Social Care Council 'Standard of Acceptance'. This accounts for almost 8% of all referrals received in 2012-22. Engagement activity for 2023-24 will provide further support and guidance for employers, registrants and those who receive social care services to ensure they understand the role and scope of the Social Care Council in addressing poor standards of conduct and practice.

The number of reported concerns was observed to be generally proportional to the size of each employment sector, as well as the specific job roles within those sectors. There were minor variations in the proportion of concerns reported by each sector year-on-year, which may indicate some lack of understanding amongst stakeholders about the type of concerns that should be managed by an employer and those that require intervention through fitness to practise processes The Social Care Council will continue to work with employers and leaders in social care, with front-line managers and registrants, with the Regulation and

Quality Improvement Authority and colleagues across health and social care to improve understanding of when concerns should be reported for investigation.

Awareness of what constitutes impaired practice in fitness to practice investigations provides learning to assist social care employers and registered workers in addressing shortfalls in the knowledge, skills and values needed to deliver good quality complex social care,

This report will be shared with social care employers and registrants to raise awareness of how the Social Care Council standards of conduct and practice should be applied in every day practice. Learning from the analysis will be used by the Social Care Council to inform learning and development resources to support registrants and employers in meeting their responsibilities for maintaining the standards expected in social care.

- **Key insights**

- Referral rate of 1% of the workforce, is in keeping with other social care regulatory bodies in the UK.

- The greatest proportion of referrals (87.19%) were made by social care employers

- The proportion of referrals received in relation to job roles is broadly consistent to the composition of the registered workforce in each of the reporting years.

- The greatest proportion of referrals (51%). related to registrants from private sector employments. (Private sector employs the largest proportion of the social care register (44%) at 31 March 2022.)

- The biggest proportion of concerns raised (21%) relate to unsafe and poor practice/ behaviour. Physical abuse (10%). was the second most reported concern.

- From 2018, there is a growing trend in allegations in relation to theft

- Proportionately, more males have a concern raised about their practice than females. (Males made up 15% of the register at 31 March 2022, but they represent 28% of referrals made between 2012-2022.

- A higher proportion of females are referred for theft/alleged theft (89% of all theft referrals).

- The agency sector has a higher prevalence of referring with concerns of theft/alleged theft. The private sector has a higher prevalence of referring with concerns of verbal abuse. The statutory sector has a higher prevalence of referring with concerns of theft/alleged theft. The voluntary sector has a higher prevalence of referring with a concern of professional misconduct.

- A self-referring registrant and member of the public/relative/friend/carer are most likely to raise concern in relation to professional misconduct.

1. Registration and regulation for Social Care

The Social Care Council introduced compulsory registration for those working in social work and social care in Northern Ireland on a phased basis between 2005 and 2017 as set out by Department of Health policy. This approach allowed time for organisations and the workforce to adapt existing work practices to incorporate workforce registration and standards. The Health and Personal Social Services Act (NI) 2001 requires the Social Care Council to maintain the register for these workers, to develop standards for their education and training, to regulate their standards of conduct and practice and to act in cases where standards fall short of what is expected.

Timeline for compulsory registration in Northern Ireland:

- 2004 – Social Work Students
- 2005 - Social Workers
- 2013 – Social Care Managers
- 2013– Adult Residential Care Workers and Residential Child Care Workers
- 2017 – Social Care Workers in Domiciliary Care, Day Care and Supported Living

Social Care Workers now make up 84% of the total register for Social Work and Social Care. The remainder of the register is split between Social Workers (14%) and Social Work Students (2%). Figure 1 below shows growth in the overall register for 2012-22 as the Social Care Council introduced compulsory registration according to job role. Figure 2 shows growth in the Social Care Worker part of the register for 2012-22. The graphs also show the temporary spikes in register numbers in 2020-21 when additional people joined the workforce to provide emergency support for front-line services during the pandemic.

Figure 1: Social Care Council register totals 2021-22

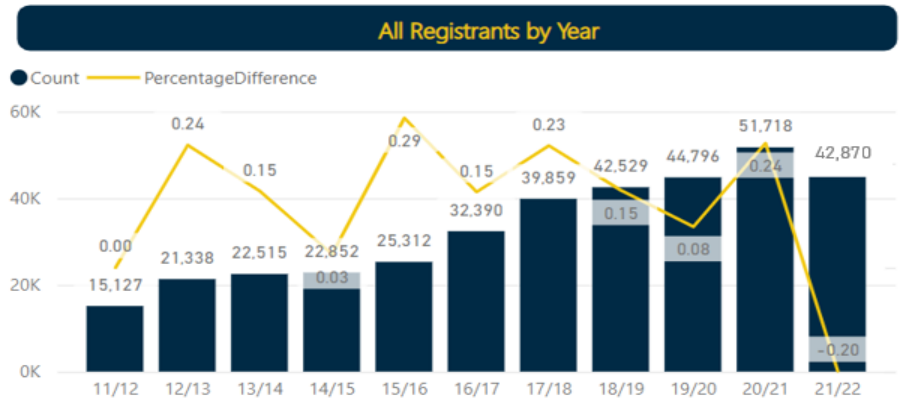
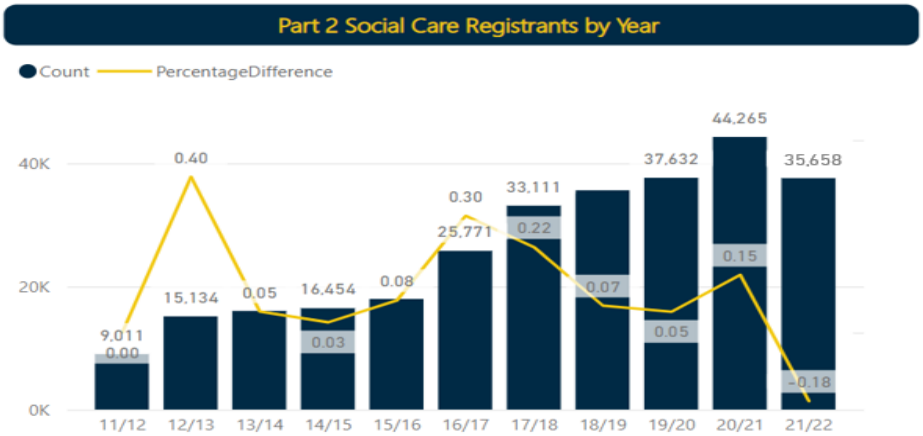


Figure 2: Social Care Council social care worker register totals 2021-22



2. Registration, standards and referrals (2012-22)

The Social Care Council is committed to ensuring that registrants meet the required standards for their good character, conduct and competence necessary to do their job, safely and effectively. As part of their application to join the register, registrants must commit to the Social Care Council standards and to update their learning and development as a condition of their on-going registration. The Social Care Council also has responsibility for publishing standards of conduct and practice for employers and for keeping them under review. Employers are required to provide induction, training and development for their staff to enable to them to maintain their social care registration. The Regulation and Quality Improvement Authority (RQIA) has responsibility for enforcement of Department of Health service standards and will consider compliance with the Social Care Council standards for employers as part of their registration and inspection processes. The Social Care Council and RQIA collaborate to effectively ensure employers adherence to the standards and to share information on adherence to the standards within social care services.

When the Social Care Council registration and regulation functions were first established, registrants were registered and regulated according to the standards set out in the Northern Ireland Social Care Council Code of Practice (2002) and their employers were required to meet the 2002 Code of Practice for Employers. These codes were mirrored by all four regulators of social work and social care across the UK.

Following consultation with stakeholders, the codes of practice were reviewed in Northern Ireland and updated to become the Standards of Conduct and Practice (2015). These new standards provided a broader range of guidance for registrants, employers and the public to ensure a robust and consistent approach to regulating standards in social work and social care. Standards for Social Workers and Social Care Workers were published separately to allow for the inclusion of standards that better reflected the different practices of these two groups of workers. The referrals for 2012-22 which are included in this report have been managed according to both the Codes of Practice (2002) and the Standards of Conduct and Practice for Social Care Workers (2015). A summary of the Standards of Conduct and Practice for Social Care Workers and the Standards of Conduct and Practice for Employers included in Appendices 2 & 3.

3. Fitness to practise model for regulation

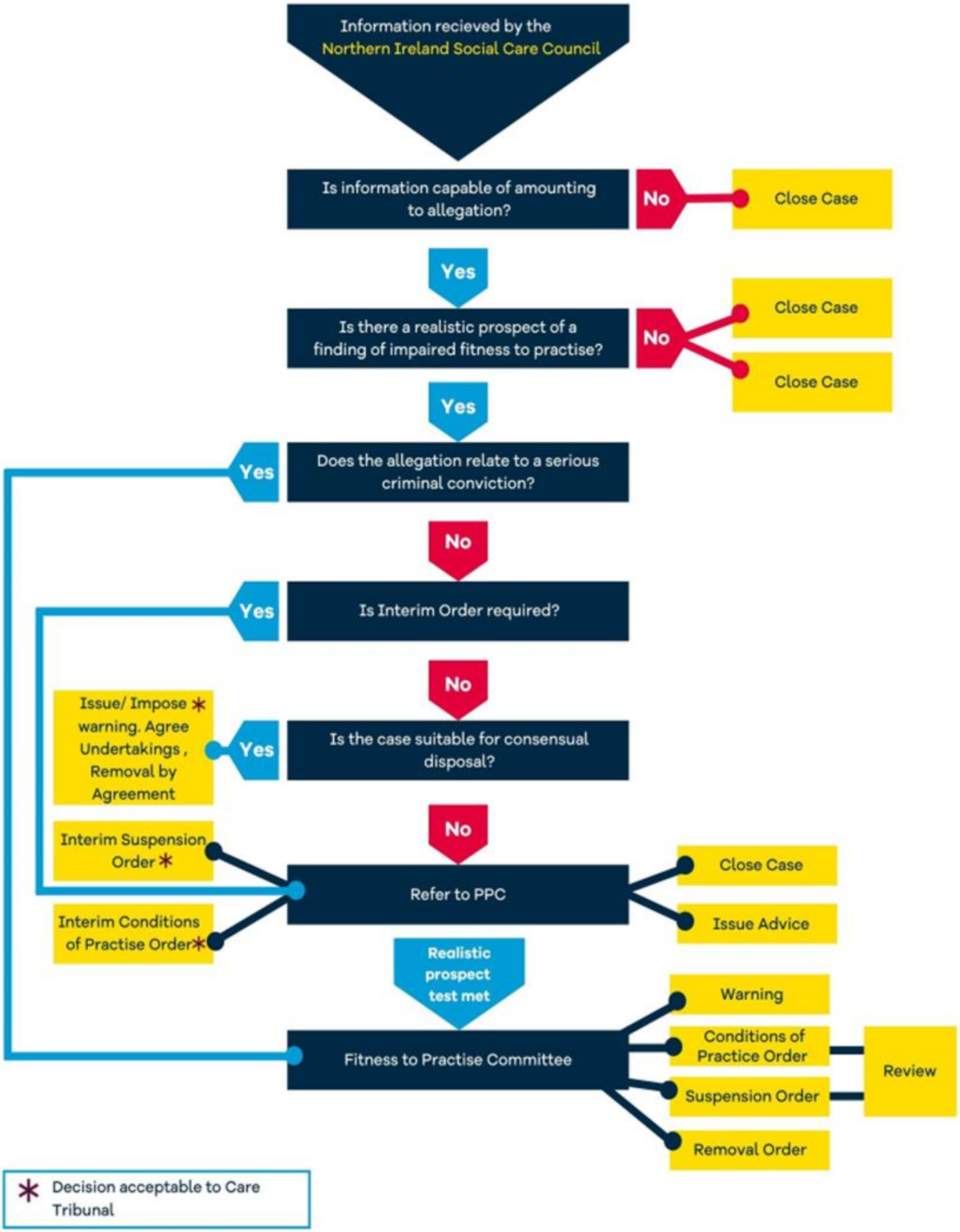
When the regulation of Social Workers and Social Care Workers was first introduced across the UK, complaints about registrants were investigated under a 'misconduct' model, assessing whether an individual had breached their code of practice and applying sanctions as appropriate. This approach limited the opportunity to manage cases in a more agile way, e.g. where an individual's practice may be affected due to health issues, lack of skills, knowledge, understanding of the standards, or work environment issues. Following extensive consultation, the approach to regulation was reviewed and updated in 2016 to a model which centred on assessing the registrant's continued fitness to practise in their role.

The Fitness to Practise model takes account of whether a registrant has the skills, knowledge and character to practise their profession safely and effectively. This approach to regulation provides the option to apply consensually agreed conditions and sanctions that can remediate for lapses in a registrant's practice. It offers the capacity to resolve concerns about practice issues, or health conditions in a fair and appropriate manner. More serious cases continue to be managed through formal Fitness to Practise hearings and committees. The referrals for 2012-22 which are included in this report were managed according to the Fitness to Practise model of regulation from May 2016 onwards.

The Fitness to Practise team assesses all concerns reported to them and follow a series of steps so ensure that all concerns are treated in a robust and appropriate way. The Social Care Council aims to have all referrals risk assessed within three working days of receiving them. High risk concerns are escalated to ensure that risk to the public are minimised. Key stages in the Fitness to Practise processes are outlined in Figure 3 overleaf.

Full copy of the Social Care Council Fitness to Practice Rules (2019) are available at: https://niscc.info/app/uploads/2020/07/20190522_fitness-to-practise-rules-2019.pdf

Figure 3: Stages of handling a Fitness to Practise concern

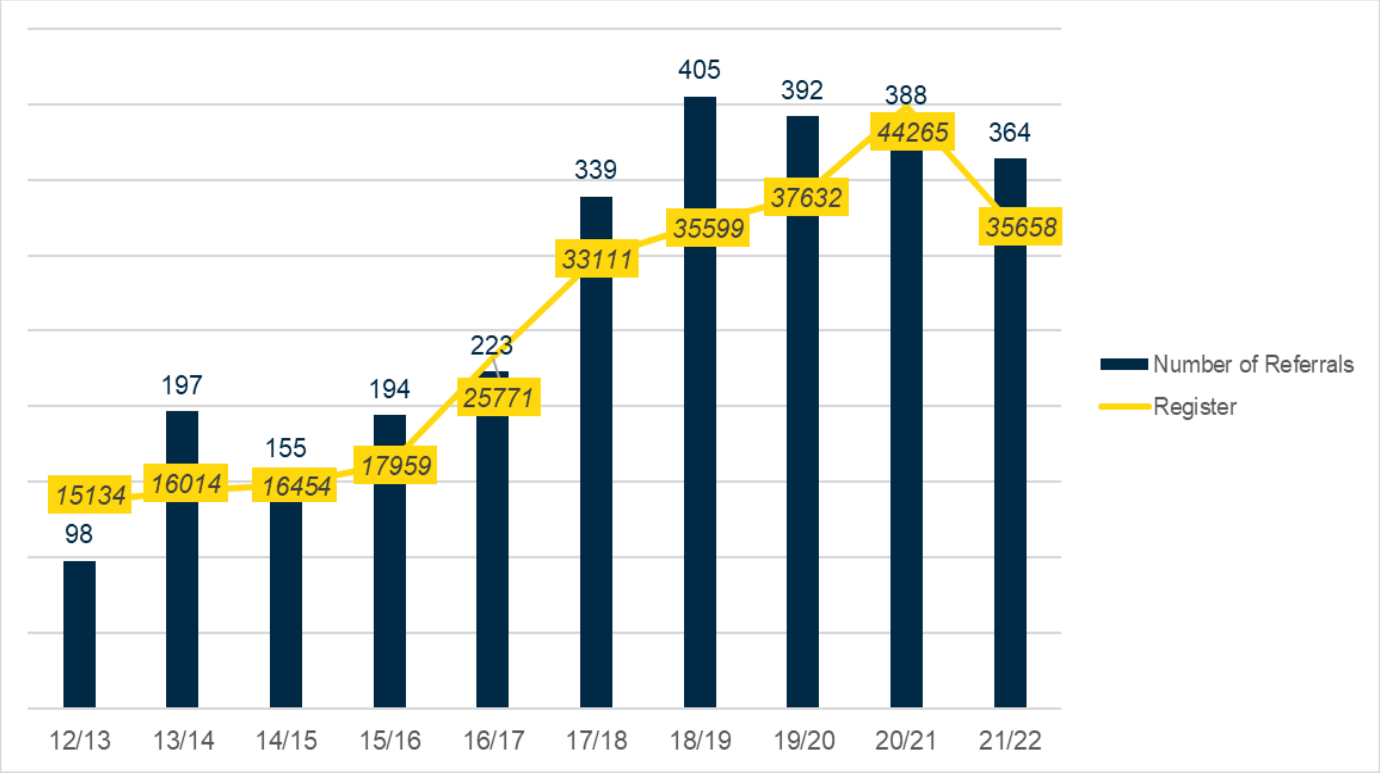


4. Overall trend in referrals (2012–2022)

2,755 concerns about Social Care Worker fitness to practise were referred to the Social Care Council over the 10-year period 2012-22, which corresponds to approximately 1% of the register for Social Care Workers. This referral rate is similar to Social Care Worker referral rates reported by the bodies responsible for regulating Social Care Workers in Scotland and Wales; Scottish Social Services Council (1.13%) (*Scottish Social Services Council, Fitness to Practise Statistics, Jan 23*) and Social Care Wales (0.9%) *(Social Care Wales, Annual Report and Accounts, 21/22)*. There are no arrangements for compulsory registration/regulation of Social Care Workers practising in England, therefore a UK referral rate for social care is not available. UK figures from the Nursing and Midwifery Council show 0.69% referral rates for their registered workforce, a register that includes over 20k nursing colleagues registered to practise in Northern Ireland. (*Nursing and Midwifery Council, Annual Report and Accounts, 21/22)*

Figure 4 below shows the pattern of growth in the social care part of the register with the introduction of compulsory registration and a corresponding increase in the number of referrals to fitness to practise for 2012-22. Two spikes in referrals received can be seen for 2013-14 and 2018-19. These spikes correlate with the periods following completion of compulsory registration for staff groups in 2012 and 2017 and are likely to be a consequence of the involvement of new groups of Social Care Workers. Promotion of registration and the standards may also have heightened employer awareness about reporting possible breaches of the standards. The graph also shows the temporary increase in register numbers in 2020-21 when additional people joined the workforce to provide emergency support for front-line services during the pandemic.

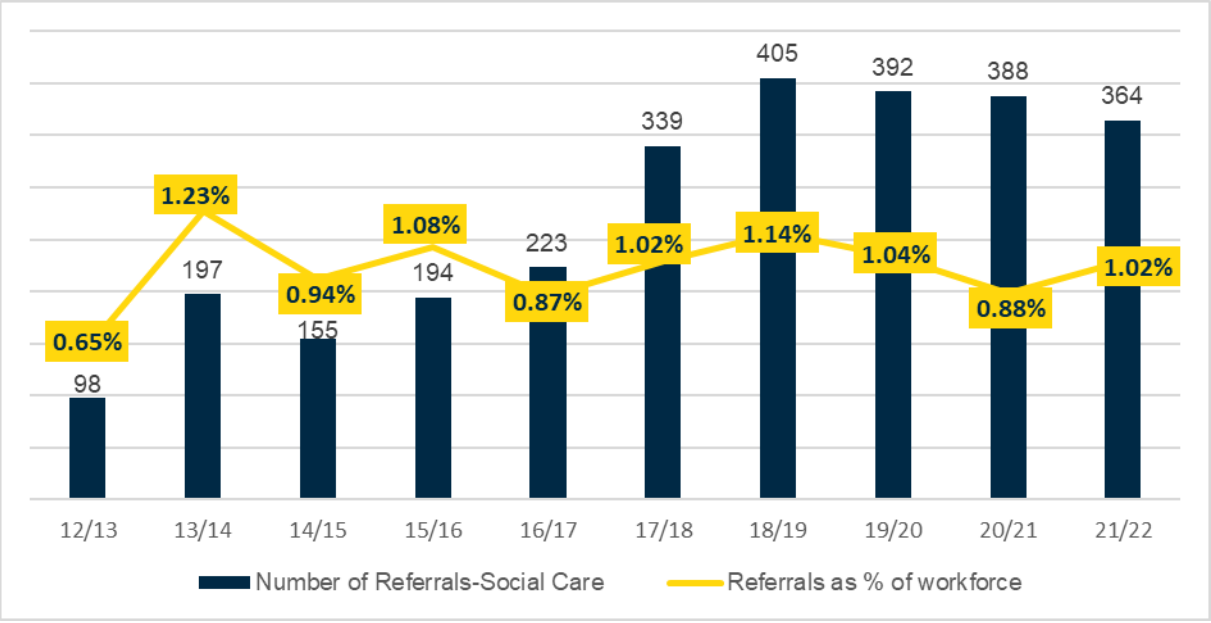
Figure 4: Trend in Social Care Worker referrals compared to social care register numbers (2012-22)



Feedback from the Fitness to Practise team at the time of these peaks commented on lack of employer experience and understanding of the referral process as a contributory factor in the peaks and troughs in reporting concerns. Over-reporting of concerns that were not within the Council's standard of acceptance has also impacted on referral activity at times and as a result, the Fitness to Practise team developed guidance during 2012-2018 to support employers in identifying which concerns should be managed as internal employment issues and which required involvement of the Social Care Council. This included developing guidance on the 'Standard of Acceptance' for fitness to practise issues. Work will continue with employers and leaders in social care, front-line managers and registrants, the Regulation and Quality Improvement Authority and colleagues across health and social care to ensure that everyone is aware of the role of the Social Care Council and when concerns should be reported for investigation. Prior to the pandemic, the engagement activities with employers included sessions on the standards and reporting appropriate concerns. This work was impacted during the peak of the pandemic restrictions, with all activity restricted to online sessions, but resumed in 2022 business year.

Figure 5 below shows the referral rates for Social Care Workers in each of the years between 2012-22. Throughout the period, referral rates for social care remained relatively close to 1% of the number of Social Care Workers on the register. The highest referral rate of 1.23% occurred in 2013-14. This Figure is not unexpected, as it follows completion of compulsory registration for Social Care Workers in adult residential care and nursing home settings in 2012-13. This group are one of the largest groups, making up 39% of the social care register. (15,000 staff, working across over 500 residential facilities). Referral rates returned closer to 1% in the 12 months after this phase of registration, with the next peak of 1.14% occurring in 2018-19. Again, this peak follows completion of compulsory registration for a very large staff group; 14k domiciliary care workers, 2.8k supported living workers and 2.4k day care workers.

Figure 5: Referral rate as % of social care workforce (2012-22)



214 of the 2,755 referrals received and assessed by the fitness to practise team were found not to meet the threshold set in the Social Care Council 'Standard of Acceptance' i.e. they were not within the remit of the fitness to practise rules and processes. This accounts for almost 8% of all referrals received in 2012-22. These non-threshold referrals involved 82 organisations across the four main employment sectors (agency, private, statutory, voluntary). Referrals for each sector were analysed to determine if there was a lack of understanding about fitness to practise which was focused within specific employment sectors or service settings; or if they related to specific practice issues. The rate of occurrence for non-threshold referrals showed little variance between the sectors, with occurrences ranging from 7%-9%. All of these 214 concerns which were assessed by the fitness to practise team as below the threshold for intervention were closed with 'No Further Action'. Guidance was provided for the referrer to explain why the concern could not be pursued through fitness to practise. The registrant involved in each referral was advised that their registration was not affected by the allegation made against them.

5. COVID 19 and fitness to practise referrals

During the early weeks of the pandemic, Fitness to Practise referrals and case management was adapted to facilitate online service delivery within the restrictions imposed. In April and May 2020, there was a 40% decrease in referral rates, largely because Social Care Manager's and Worker's focus was on adapting services to maintain front line care and support in the community and care settings. Referrals dropped to 20 in April 2020 and 27 in May 2020, but then increased to 39 in June 2020 and 52 in July 2020. Referrals during 2020-21 year averaged 37 per month, which was within the anticipated volumes.

Figure 6: COVID related referrals (2020-21)

	Sector Total	Adult Residential Care Worker	Day Care Worker	Domiciliary Care Worker
Agency	1	1	0	0
Private	12	7	2	3
Statutory	1	0	0	1
Voluntary	2	2	0	0
Totals	**16**	**10**	**2**	**4**

COVID appears to have had an almost negligible effect on referrals in terms of being a direct cause of concern about an individual's fitness to practise. There were 16 referrals which were identified as directly related to COVID issues which included: breach of COVID 19 regulations, refusing to care for service users with a COVID 19 diagnosis, false declaration of COVID 19 test, inappropriate use of technology, unsafe practice/behaviour and attending a public place during a period of self-isolation. All of these concerns were assessed by the fitness to practise team and closed at a preliminary stage. Six registrants were issued with letters of advice which included a reminder of the standards of conduct and practice. responsibilities of a registered Social Care Worker. Ten cases required no further action.

6. Referrals and their origin

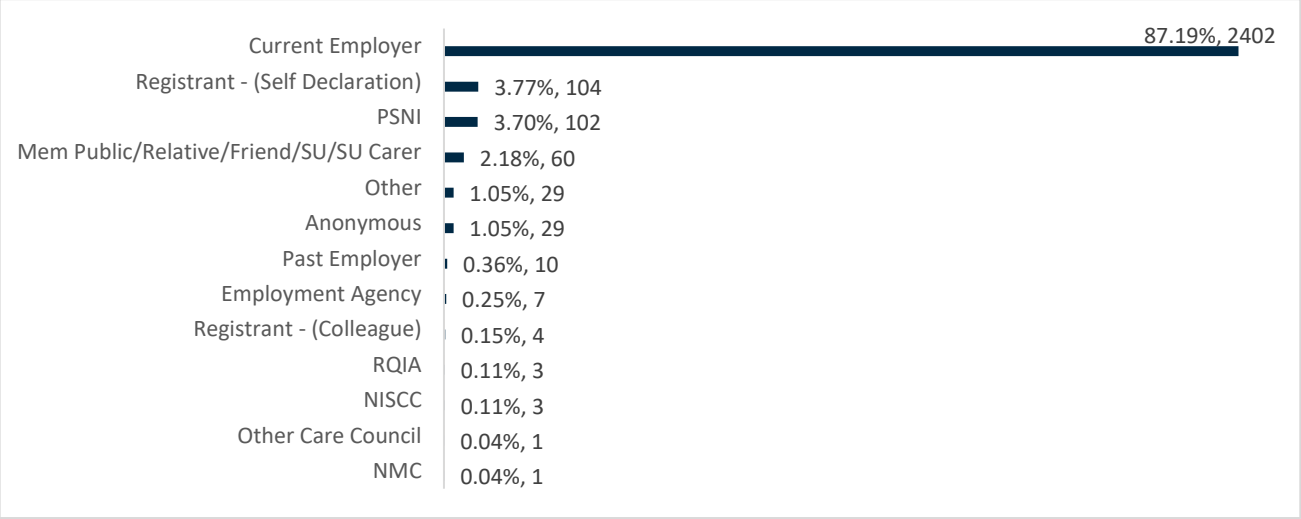
6.1 The people who raised concerns about Social Care Workers

Anyone can report a Fitness to Practise concern if they have information that a person registered with the Social Care Council is not meeting the standards in their conduct or practice. Concerns are received from employers, other health and social care professionals, police, people who use services, their carers and members of the public. In some cases, a registrant will make a declaration to the Social Care Council about issues they have experienced in work, or in their personal life, which may have affected their fitness to practise.

Figure 6 below shows the range of people who referred concerns about Social Care Workers during 2012-22. The most common sources of referrals are current employers, registrant self-declarations and the police. In each of the ten years reviewed, the greatest number of referrals came from current employers who referred 2,402 concerns about Social Care Workers in their work setting. These account for 87.19% of all the referrals in the 10-year period. This strong referral rate from employers reflects the employer fulfilling their obligation to act when a Social Care Worker does not meet the standard expected of them.

It is notable that the next highest referral sources are self-declarations from registrants (104, 3.77%). These referrals can arise when a registrant is applying for periodic renewal of their registration as well when an incident occurs that raises concerns about their own conduct or practice. The PSNI are required to refer cases to the Social Care Council regarding registered workers who are being investigated for alleged criminal behaviour, hence the 102, 3.70% of referrals being received from this source.

Figure 6: People and organisations referring concerns (2012 – 2022)



The number of referrals coming from members of the public/service users/families etc has remained within the top four referral sources for the last five years, accounting for 3%-4% of yearly referrals. Although this reflects a small number of referrals, numbering 10-16 per year, it shows a small positive improvement in awareness about fitness to practise amongst those not directly involved in social care service delivery. The Social Care Council would normally expect social care organisations to refer concerns on behalf of those they provide services for, but it is also important that the public are informed of the role of the Social Care Council and are able to raise concerns independently should they wish. Of note is that the majority

of service user referrals received by the Council (on average 8% per annum) are about social workers. Further details about the origin of referrals by year is available on Appendix 4.

6.2 Referrals received from each employment sector during 2012 – 2022

Between 2012 and 2022, 260 organisations were identified as the employing organisation for the registrants referred to the Social Care Council in relation to fitness to practise concerns (organisations with multiple service settings have been only been counted once). These referrals were sorted into four key employment sectors: agency, private, statutory and voluntary. Figure 7 compares the social care referrals by employment sector for 2012-2022 against the social care register by employment sector at 31 March 2022. To provide a more recent picture of referrals by sector, the Figure also shows the referrals by employment sector for 2021-22. It is recognised that the 10-year period covered by this analysis includes two significant change factors; changes to the register as new groups of Social Care Workers joined the register (2012-2018) and the introduction of emergency registrants to support front line services (2020-21). Figure 8 below provides referral figures by employment sector for April 2018-March 2022 (1549 referrals), covering the lead up to COVID and the transition period after the peak of the pandemic.

Figure 7: Social Care Worker referrals and Social Care employment sector (2012 – 2022)

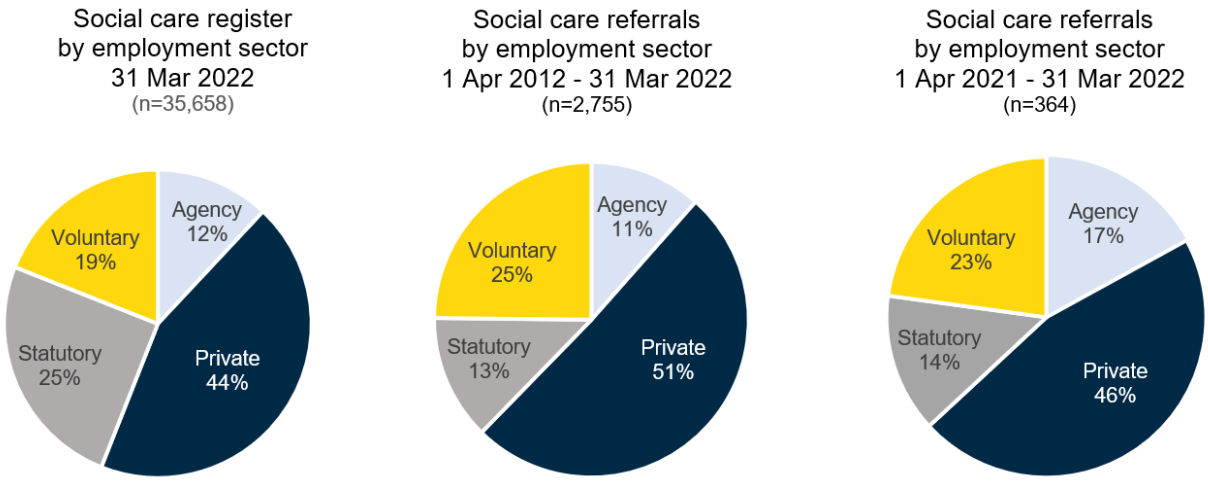


Figure 7 above shows the greatest proportion of referrals throughout the reporting period were related to registrants from private sector employments (51%). This referral rate broadly reflects the position of the private sector as employing the largest proportion of the social care register (44%) at 31 March 2022. Figure 8 below shows the peak in private sector referrals at 55% during 2019-20 and then a downward trend across 2020-22, settling at 46% for 2021-22.

Figure 8: Social Care Worker referrals and social care employment sector (2018 – 2022)

Referrals by Employment Sector	2021-22 (n=364)	2020-21 (n=388)	2019-20 (n=392)	2018-19 (n=405)
Agency	17%	9%	12%	8%
Private	46%	54%	55%	54%
Statutory	14%	18%	15%	14%
Voluntary	23%	19%	18%	24%

Voluntary sector employment made up the second largest proportion of referrals for both periods, ranging from 25% across the 10-year period to 23% of referrals in 2021-22. This referral rate conflicts slightly with the position of the voluntary sector as third largest

employment sector, employing 19% of the registered workforce at 31 March 2022. Figure 8 above shows a drop in voluntary sector referrals to 18% during 2019-2020 and then a return to 2018-19 levels of 23% in 2021-22.

The statutory sector was the second largest employment sector, with 25% of the social care register at 31 March 2022, yet this sector has the second lowest proportion of referrals across the 10-year period with 13% of referrals. Figure 8 shows a temporary increase for statutory sector with 18% of referrals in 2020-21. This referral rate dropped again to 14% during 2021-22, which was the lowest proportion of the four sectors.

As the smallest employment sector (12% of the social care register at 31 March 2022), agency sector showed the greatest variation in proportion of referrals across the period. Agency was the lowest proportion of referrals for 2012-22 at 12%, which broadly reflects the proportion of the social care register employed through recruitment agencies. Figure 8 shows agency as 8% of referrals in 2018-19, increasing to 12% in 2019-20, dropping to 9% in 2020-21 and increasing to 17% in 2021-22. It is not possible to determine if the COVID 19 pandemic caused the variation in referral rates for this smallest sector within social care. Further monitoring will be undertaken to assess the long-term referral rates for agency sector registrants as the workforce settles in this post-COVID period.

6.3 Referrals by job role

Figure 9 below shows the proportion of referrals for each job role during 2012-22. This shows the greatest number of referrals (55%) are related to 1516 people working in adult residential care, with the next largest referral group involving 834 domiciliary care workers (30%). Day care workers at 5% and supported living workers at 3% represent the remaining significant proportion of social care referrals. There is a greater proportion of adult residential care workers in Figure 9 as it represents the 10-year period, compared to Figure 11 as they represented a larger proportion of the workforce between 2012-2017.

Figure 9: Referrals by job role (2012 – 2022)

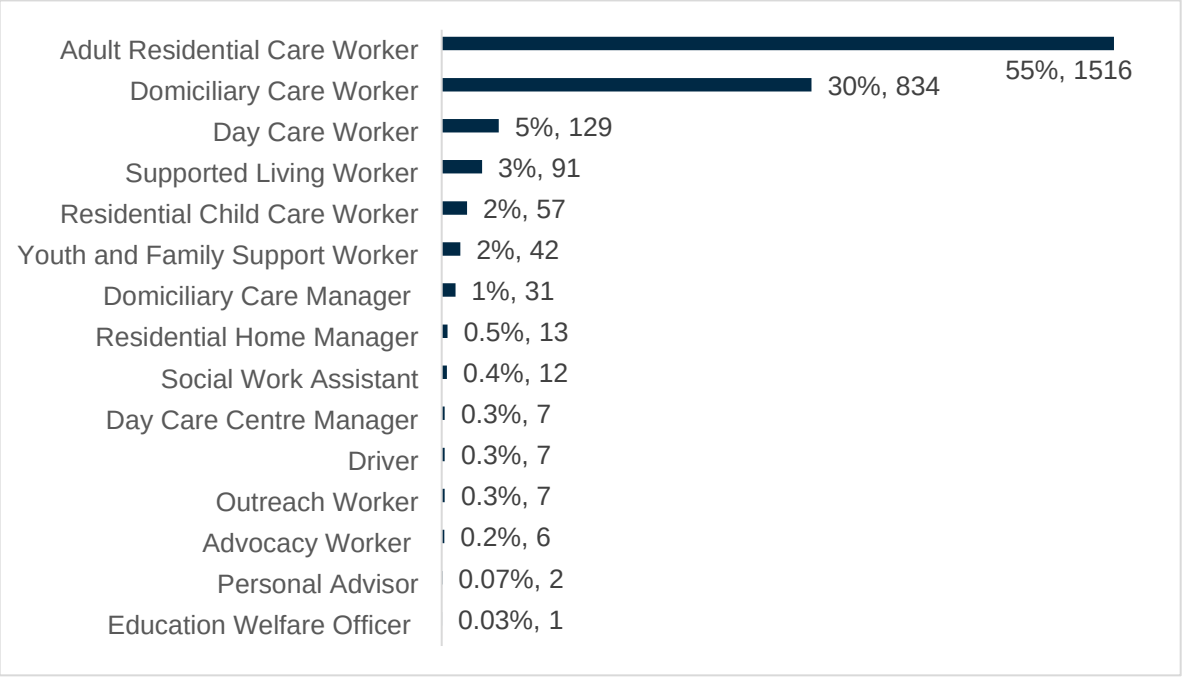


Figure 10 below provides a breakdown of the referrals received for each of the job roles for each year between 2012 – 2022. The addition of workers in domiciliary care, day care and supporting living to the register in 2017, has influenced the increase in referrals rates in respect of these workforce groups.

Figure 10: Referrals by job role per year from 2012 - 2022

Job role	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	Grand Total
Adult Residential Care Worker	69	157	121	144	138	193	177	192	175	150	**1516**
Domiciliary Care Worker	14	27	18	29	56	105	155	136	153	141	**834**
Day Care Worker	1	6	7	6	5	17	30	16	18	23	**129**
Supported Living Worker		1	1		1	7	15	14	21	31	**91**
Residential Child Care Worker	6	1	3	5	8	5	7	10	5	7	**57**
Youth and Family Support Worker	3	2	2	1	6	2	8	8	8	2	**42**
Domiciliary Care Manager	3	1	1	4	3	3	4	6	2	4	**31**
Residential Home Manager			2	2		1	3	3	1	1	**13**
Social Work Assistant				1	2		1	1	3	4	**12**
Day Care Centre Manager		2			2	2		1			**7**
Driver	1					1	1	4			**7**
Outreach Worker				1	1	1	1		2	1	**7**
Advocacy Worker				1	1	1	2	1			**6**
Personal Advisor						1	1				**2**
Education Welfare Officer	1										**1**
Grand Total	98	197	155	194	223	339	405	392	388	364	**2755**

Figure 11 below shows the job roles registered as at 31 Mar 22. Adult residential care workers make up the largest proportion (39.8%) of the register and domiciliary care workers makes up a similar proportion (39.3%). The supported living workers and day care workers represent much less of a proportion of the register at around 6% for each. This shows that the proportion of referrals received in relation to these job roles is broadly consistent to that of the register.

Figure 11: Social Care Register by job role as at 31 Mar 22

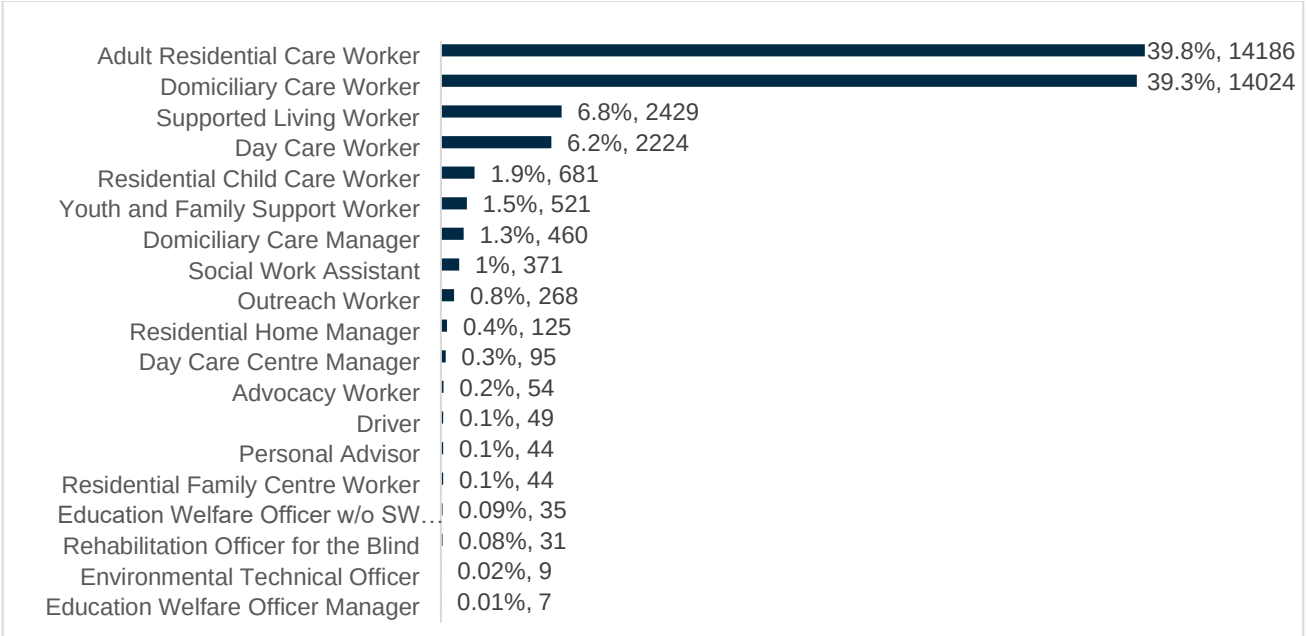
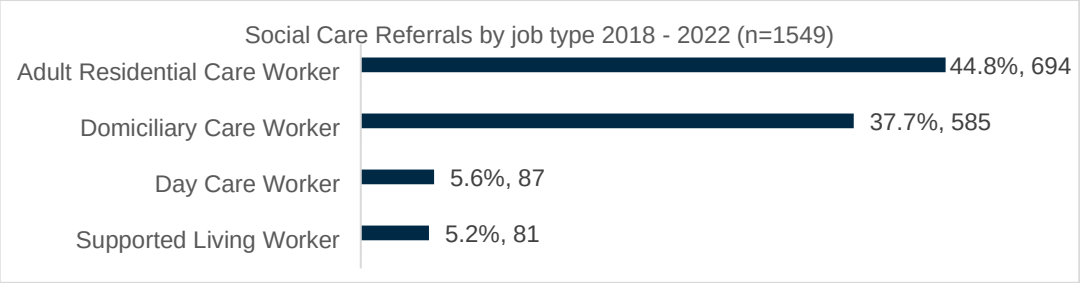


Figure 12 below shows the proportion of referrals in respect of the top 4 job roles referred for 2018-22 and illustrates how the data for 2012-2018 is affected by the timeline for compulsory social care registration which spanned from 2011-2017. Social Care Managers and Adult Residential Care Workers were one of the first groups of Social Care Staff to be included in compulsory registration, becoming part of the registered workforce from 2011 and 2012 onwards, whereas the compulsory registration phase for Social Care Workers in Domiciliary Care, Day Care and Supported Living was not introduced until 2017-18.

Figure 12: Referrals by job role (2018 – 2022)



7. Referrals and Allegations

During 2012 – 2022, concerns referred to the Fitness to Practice team reflected almost 100 different types ranging from 'working whilst claiming sick pay' to 'unsafe and poor practice behaviour.' Detailed below are the definitions of 'unsafe and poor practice', 'professional misconduct' and theft/fraudulent behaviour' as they each cover a range of issues.

Unsafe and Poor Practice

This category defines conduct that fails to adequately or appropriately meet the care needs of the service user and includes behaviour or practice that, whilst not abusive, has the potential to place a service user at risk of harm. The types of allegations that are included in this category are:

- non-compliance with care plans
- failure to respond to instructions of senior or healthcare professionals
- failure to respond to personal care needs or to respond in a timeous manner
- neglectful care
- unsafe moving and handling practice
- rough handling
- leaving call buzzers out of service user's reach

Professional Misconduct

'Professional misconduct' was used prior to 2016 when the 'Codes of Practice (2002)' model was in place. It was used as a 'catch all' category and where there was a variety of allegations within a referral and describes conduct such as:

- Refusing to carry out reasonable instructions/Failure to follow procedures
- Manual handling
- Medication errors
- Verbally abusive/acting aggressively
- Failure to carry out personal care

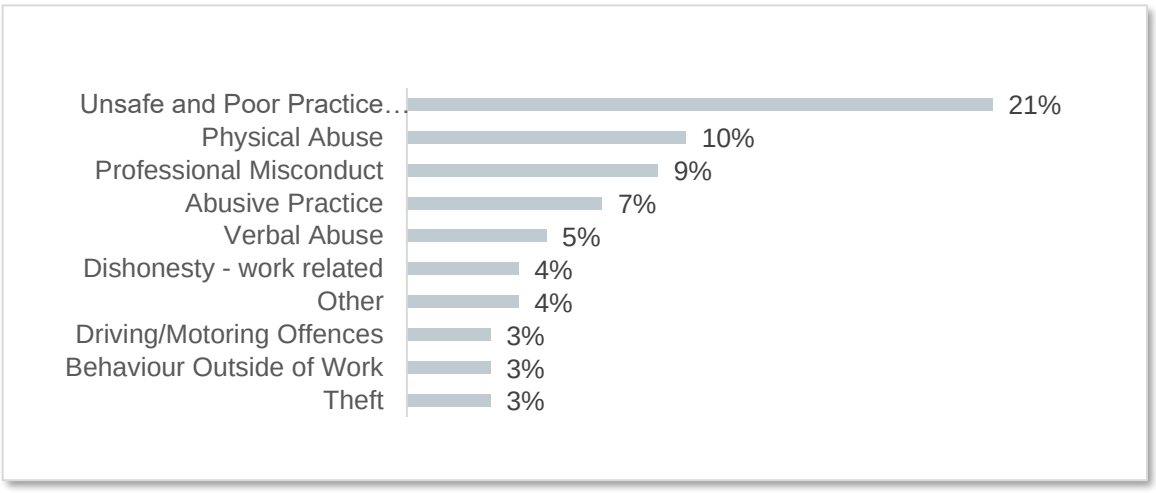
- Use of inappropriate language
- Breach of confidentiality
- Poor and or unsafe practice
- Sleeping on duty
- Poor attitude and behaviour
- Bullying/Harassment

Theft and Fraudulent Behaviour
A number of distinct categories are used to record the range of allegations pertaining to theft and fraud:

- Alleged theft (work related) – where money or property is stolen from a place of employment
- Alleged theft (service user) -where money or property belonging to a service user is stolen
- Alleged theft (outside of work) – where money or property is stolen outside of a work context
- Fraudulent behaviour (fraudulent completion of time sheets, mileage claim forms)

Figure 13 below shows the most commonly reported allegations during this period with 21% of all allegations during 2012 – 2022 related to 'unsafe and poor practice'.

Figure 13: Most commonly reported allegations during 2012 - 2022



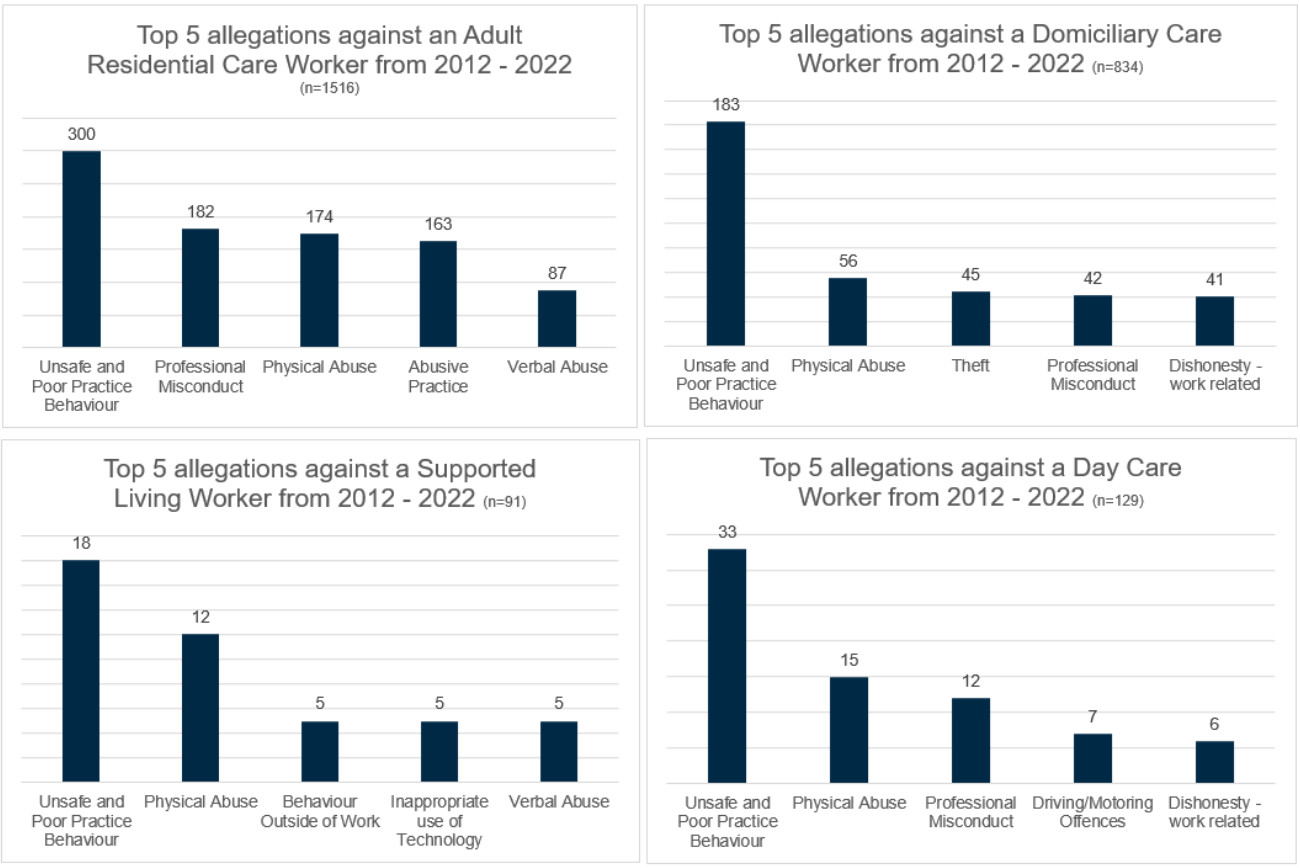
Further drill down of all allegations by year is provided in Appendix 6 and the proportion of allegations for each year is available in Appendix 7.

The top 4 job roles with the most referrals are shown in Figure 14 below and the most commonly cited allegation for each of them is 'unsafe and poor practice behaviour' followed by 'physical abuse'.

In respect of the other allegations, there are some common themes relating to the type of settings where they occur. 'Theft' only occurs in the top 5 allegations made against a domiciliary care worker and this could be due the nature of the environment of care in the home where more personal belongings may be easily accessible or less witnesses to report an incident. The allegation of 'verbal abuse' only occurs in the top 5 allegations against adult residential care workers and supported living workers and this may be attributed to the

residential setting having more people around who could hear and report incidences of verbal abuse occurring.

Figure 14: Allegations for the top 4 job roles



It is evident that allegations of 'unsafe and poor practice behaviour', 'professional misconduct' and 'physical abuse' are the most common and this remains consistent. However, Figure 15 below shows that allegations in respect of theft and financial misconduct are showing the most growth. This is seen more notably occurring from 2018 onwards which could be attributed to the increase in Social Care Workers joining the register, the pandemic and the cost of living crisis. 21/22 has seen a dip in this trend, however this particular type of allegation may continue to feature in the coming years as the cost of living crisis continues.

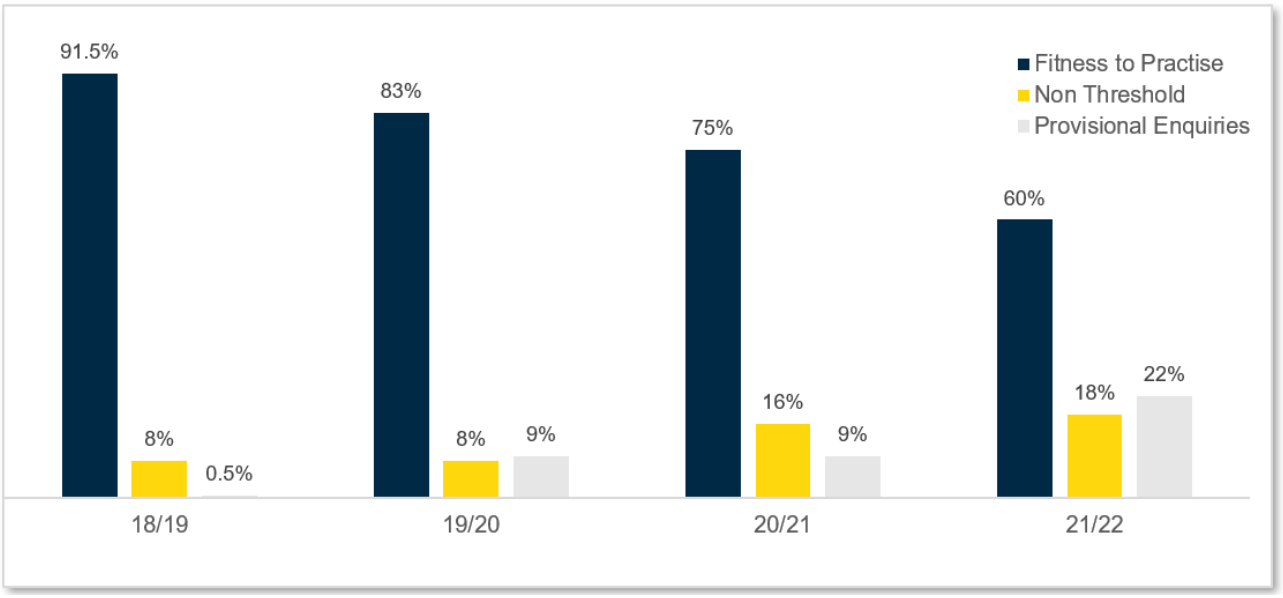
Figure 15: Allegations of theft and financial misconduct

Theft/Financial allegation types	15/16	16/17	17/18	18/19	19/20	20/21	21/22	**Grand Total**
Alleged Theft-From Service User					7	22	12	**41**
Alleged Theft-Work Related						1	1	**2**
Financial Abuse						1		**1**
Financial Misconduct	1	7	6	23	2		1	**40**
Fraudulent mileage claims							1	**1**
Theft		1	4	6	31	17	14	**73**
Grand Total	**1**	**8**	**10**	**29**	**40**	**41**	**29**	**158**

8. Referral outcomes

Once a referral is received, it is categorised into case types. 'Non-threshold' refers to referrals which upon triage, are deemed not to warrant further investigation within fitness to practise processes. 'Provisional Enquiry' refers to where further information is required to determine if a referral meets the Standard of Acceptance. Between 2016 – 2022, the proportion of 'non-threshold' and 'provisional enquiries' collectively **increased** by 40%. This highlights the need both for ongoing engagement with employers to ensure that the Standard of Acceptance is understood and for referral information to include as much detail and supporting documentation as possible to ensure that the triage function can be undertaken effectively and expeditiously. The increase in the percentage of cases screened out at the initial stage perhaps suggests increasing confidence on the part of Council staff in applying referral thresholds and criteria.

Figure 14: Case types during 2018 – 2022 by year



8.1 Sanctions imposed during 2012 – 2022

Cases can be concluded with a range of possible outcomes. 61% of referrals required no further action at triage. An additional 25% required a letter of advice with a reminder of the standards of practice.

An interim suspension order (ISO) is an urgent measure to temporarily suspend the worker from the register while the allegation being made is under investigation. Each ISO applied is unique to the risk identified in the allegation. There were 154 ISOs imposed during 2012-2022 and 31 ISOs in place as at 31 March 2022.

Figure 15 below shows the ISOs imposed for each of the job roles referred and the allegation. 55% of ISOs imposed are for adult residential care workers, with the biggest proportion of them in relation to allegations of physical abuse. The domiciliary care worker represents 32% of ISOs imposed with the biggest proportion of them in relation to physical abuse, dishonesty and theft.

Figure 15: ISOs imposed during 2012-2022 for each job role and the reason

ISO /allegations 2012-2022 (n=145)	Adult Residential Care Worker	Day Care Worker	Domiciliary Care Manager	Domiciliary Care Worker	Residential Child Care Worker	Residential Home Manager	Social Work Assistant	Supported Living Worker	Youth and Family Support Worker	Grand Total
Physical Abuse	24			4				1		29
Dishonesty - work related	8	3		7		1				19
Theft	6	1		7						14
Abusive Practice	9									9
Behaviour Outside of Work	4			4				1		9
Offences against the person	6			2						8
Sexual Misconduct	2	2		3	1					8
Alleged Theft-From Service User	3	1		3						7
Financial Misconduct				7						7
Unsafe and Poor Practice Behaviour	4			2			1			7
Professional Misconduct	3			1					1	5
Verbal Abuse	3			1						4
Other	2			1						3
Behaviour Towards Colleagues				1				1		2
Fraudulent Behaviour			1	1						2
Inappropriate Relationship/Breach of Professional Boundaries				1				1		2
Alcohol/Substance Abuse				1						1
Barred Adults & Children	1									1
Child Protection Concerns	1									1
Dishonesty	1									1
Drugs/Alcohol at Work	1									1
Inappropriate Behaviour towards SU	1									1
Inappropriate Communication (SU)				1						1
Inappropriate use of Technology								1		1
Reporting Failures								1		1
Workforce Regulator			1							1
Grand Total	79	7	2	47	1	1	1	6	1	145

In relation to final order sanctions, 10% (270) were consensually disposed of by the Fitness to Practice Team or required a committee hearing. Figure 16 below shows the largest proportion (57%) of sanctions imposed over the last 10 years were from the committee although this needs to be considered against the context that the Council's powers to agree Consensual Disposals were only introduced in 2016 with the amended legislation. The limited number of sanctions imposed by Committees in 20/21 reflects the temporary suspension of final order hearings due to COVID.

Figure 16: Number sanctions imposed by consensual disposal and committee from referrals received between 2012-2022

Sanctions Imposed by	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	Grand Total
Consensual Disposal				22	14	18	17	20	17	9	**117** (43%)
Fitness to Practise Committee	13	34	17	15	7	18	16	2	20	11	**153** (57%)
Grand Total	**13**	**34**	**17**	**37**	**21**	**36**	**33**	**22**	**37**	**20**	**270**

Figure 17 below shows that consensual disposals were mostly (70%) warnings. The committee sanctions mostly (46%) consisted of a removal order (breakdown in Figure 18)

Figure 17: Proportion of sanctions imposed by consensual disposal or committee

Consensual Disposal Sanctions (n=117)	% of disposal type
Removal by Agreement	15%
Undertakings	15%
Warning	70%

Committee Sanctions (n=153)	% of disposal type
Conditions of practice order	2%
Removed from Register	67%
Suspension Order	14%
Warning	17%

Figure 18 below shows that the biggest proportion of register removals are a result of investigations into concerns around work related dishonesty. Historically, 'work related dishonesty' was used as an overarching category to include allegations such as theft of money from a service user, fraudulent mileage/timesheet claims, falsification of records, identity fraud. This is likely to account for the high percentage of removals falling within this category. These allegations are now identified in their own right.

Figure 18: Register removals and their allegation reasons

Allegations leading to removal from Register (n=102)	% of Removals
Dishonesty - work related	21.5%
Offences against the person	11.7%
Abusive Practice	6.8%
Professional Misconduct	6.8%
Theft	6.8%
Physical Abuse	5.8%
Financial Misconduct	4.9%
Alleged Theft-From Service User	3.9%
Unsafe and Poor Practice Behaviour	3.9%
Alcohol/Substance Abuse	2.9%
Behaviour Outside of Work	2.9%
Dishonesty	2.9%
Fraudulent Behaviour	2.9%
Other	2.9%
Drugs/Alcohol at Work	1.9%
Sexual Misconduct	1.9%
Verbal Abuse	1.9%
Barred Adults & Children	0.9%
Behaviour Towards Colleagues	0.9%
Driving/Motoring Offences	0.9%
Drug Related	0.9%
Inappropriate Relationship/Breach of Professional Boundaries	0.9%
Public Order Offences	0.9%
Workforce Regulator	0.9%

Figure 19 below shows that work-related dishonesty, professional misconduct and abusive practice accounts for the biggest proportion of allegations requiring a sanction imposed by the committee. The majority of sanctions are removal orders.

Figure 19: Committee sanctions between 2012-2022 and allegations

	Sanctions imposed				
Allegations leading to sanctions by Committee 2012 2022	**Conditions of Practice Order**	**Removal from Register**	**Suspension Order**	**Warning/ Admonishment**	**Grand Total**
Dishonesty - work related		22	3	2	27
Professional Misconduct		7	3	8	18
Abusive Practice	1	7	3	4	15
Offences against the person		12	1	2	15
Alcohol/Substance Abuse		3	2	4	9
Physical Abuse	1	6	2		9
Theft		7	1	1	9
Unsafe and Poor Practice Behaviour		4	2		6
Dishonesty		3	2		5
Financial Misconduct		5			5
Alleged Theft-From Service User		4			4
Behaviour Outside of Work		3	1		4
Other		3	1		4
Public Order Offences		1	1	2	4
Fraudulent Behaviour		3			3
Driving/Motoring Offences		1		1	2
Drug Related		1		1	2
Drugs/Alcohol at Work		2			2
Sexual Misconduct		2			2
Verbal Abuse		2			2
Assisting unlawful immigration		0		1	1
Barred Adults & Children		1			1
Behaviour Towards Colleagues		1			1
Emotional Abuse	1	0			1
Inappropriate Relationship/Breach of Professional Boundaries		1			1
Workforce Regulator		1			1
Grand Total	3	102	22	26	153

8.2 Length of time between referral and decision made

Fitness to Practise reports on three KPI's; referrals triaged within 3 working days, conclusion of all ISO hearings within 4 weeks of referral and conclusion of Fitness to Practise cases within 15 months of opening the case. In respect of the length of time between a concern being referred and the case being concluded, this will vary according to complexity and the number of people and agencies involved. As Figure 20 below shows, between 2017-2022 the average/median time to close a case has increased each year. This was most notable during 2020 and 2022. This is attributed to the impact of the COVID-19 pandemic due to a number of factors including the focus on high risk cases by the Council and a commitment by the Council to limit requests for information from employers to enable them to devote their energies to responding to the pandemic. In addition, there were delays in employer investigations and criminal and court processes.

Figure 20: Mean/Median times for case closures

Year	Average (mths)	Median (mths)
2017/18	6.79	4
2018/19	7.21	5
2019/20	9.28	7
2020/21	10.54	8
2021/22	14	11

As at Aug 22 the KPI target for case closure within 15-months was not met, at 69%. However, in addition to the current monitoring systems, the introduction of an 'early alert' system, where cases approaching 15-months are flagged, prompting the respective Officer to assess whether case closure is possible, enabling this target to be met.

Analysis of the Fitness to Practise KPIs between 2017-22, is available at Appendix 10.

9. Profile of Social Care Workers referred to the Social Care Council

9.1 Age analysis of referred individuals

The age profile of referrals ranged from 17-79 with the biggest proportion of referrals overall aged between 40-49. The average age overall during 2012-2022 is 41. The year on year average age of a person referred between 2012-2022 did not deviate by more than 2 years.

Figure 21 below shows the age range profile mostly referred by each of the sectors in comparison to the register. The agency and private sector age group with the most referrals is 20-29. Most referrals received from the statutory and voluntary sector are within the 40-49

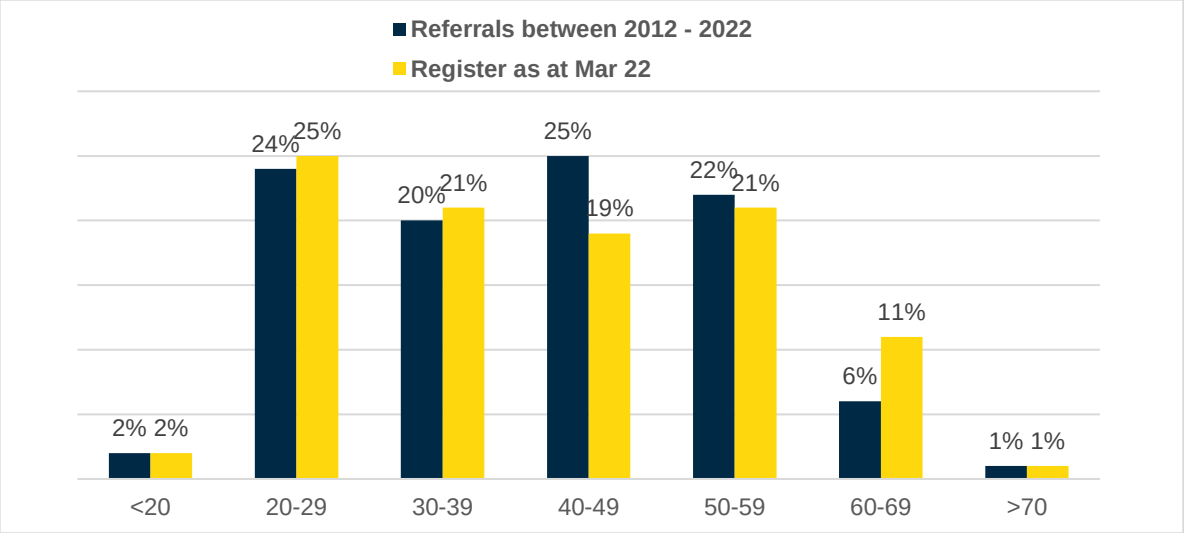
Figure 21: Age groups most referred by each key sector

Sector	Youngest referred	Oldest referred	Age group most referred from the Sector	Age group with most Employees
Agency	18	64	Age 20 - 29	20-29
Private	17	79	Age 20 - 29	20-29
Statutory	20	72	Age 40 - 49	50-59
Voluntary	19	78	Age 40 - 49	30-39

Age Groups of Referrals compared to the Register

Figure 22 below shows the proportion of referrals received during 2012-2022 by age group compared to the proportion of age groups on the register. The number of referrals is broadly proportionate to the register as shown. However, the 40-49 and 50-59 age group has a slightly higher proportion of referrals than on the register.

Figure 22: Proportion of referrals by Age Group referred during 2012 – 2022 compared to the register



9.2 Gender

Figure 23 below shows the gender split for the register as at March 2022 compared to the gender split of all referrals received between 2012-2022. 85% of the register is comprised of females, however, there are proportionately less females referred (72%). Males make up 15% of the register but they represent 28% of referrals which shows that proportionately more males have a concern raised about their practice.

Figure 23: Gender split of individuals referred compared to the Register as at Mar 22

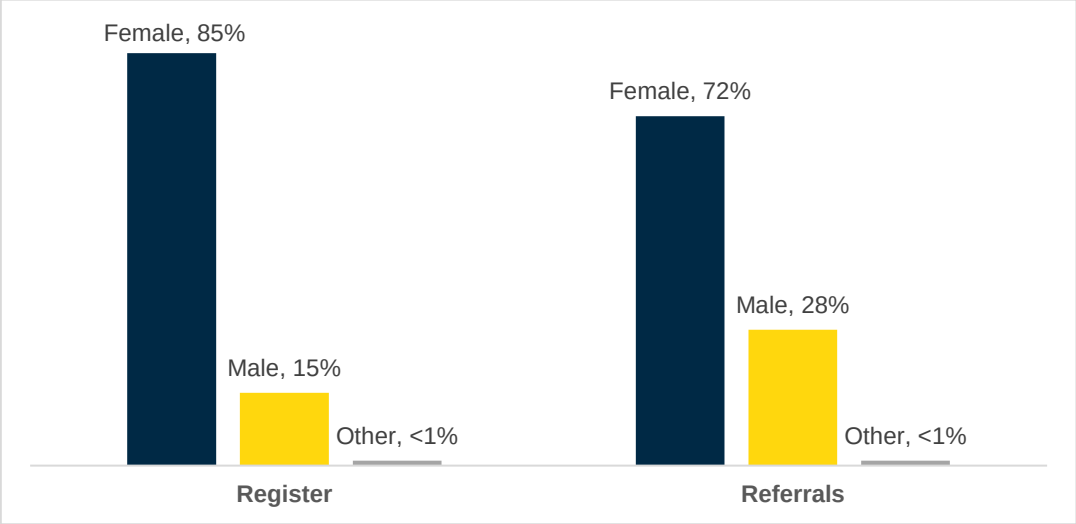


Figure 24 below shows the trend of the gender split of referrals from 2012 to 2022. Females represent the largest proportion of concerns raised at around 73% and this trend remains consistent over the years between 2012 – 2022 and is not expected to change.

Figure 24: Trend of gender split of individuals referred during 2012 - 2022

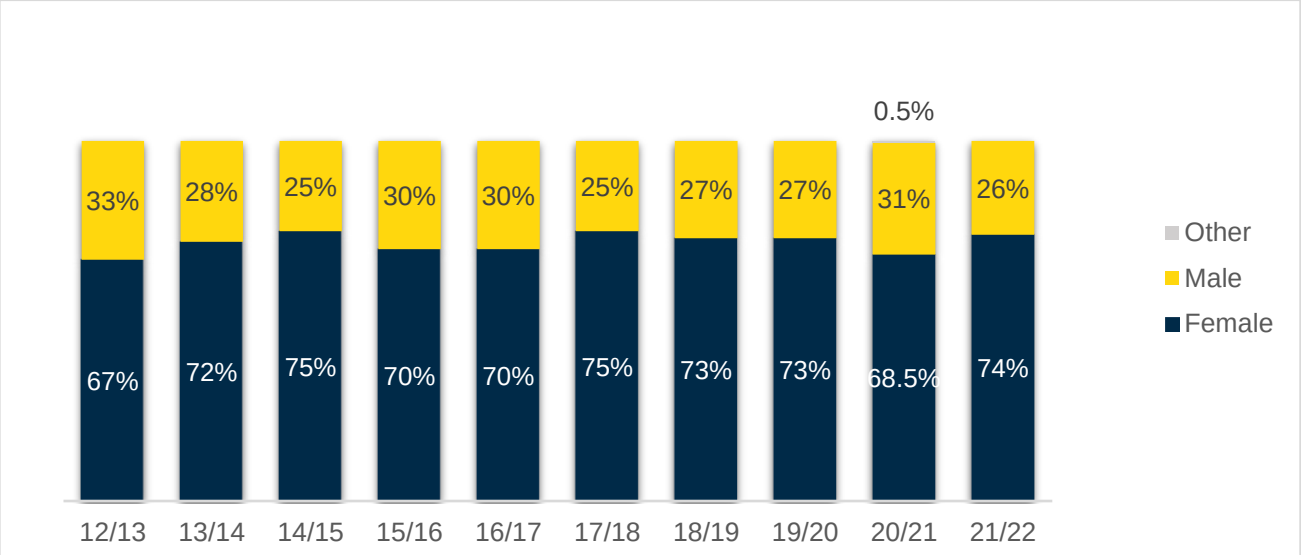


Figure 25 below shows the gender split in respect of the sectors where those who were referred were employed. All the sectors show predominantly more females than males referred which reflects the proportion of referral received overall.

Figure 25: Gender split of referrals from the sectors

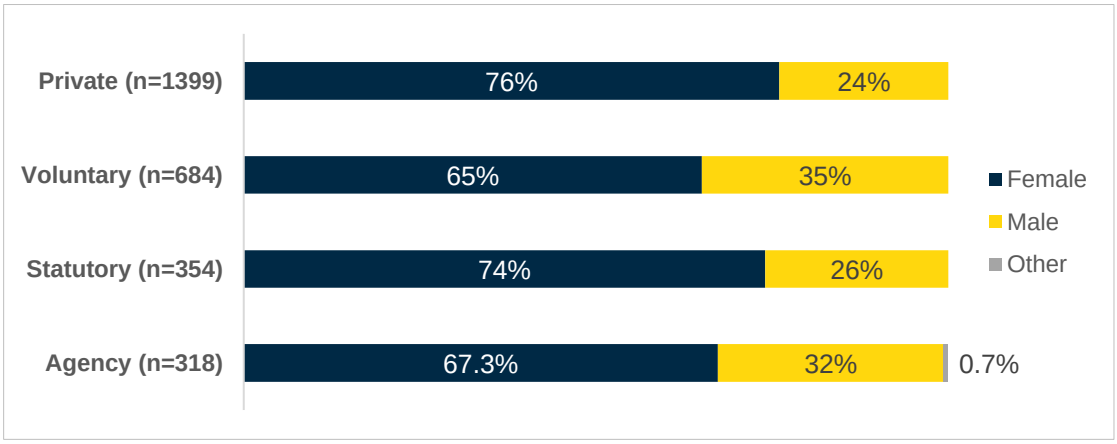


Figure 26 shows the gender split between each of the job roles referred, examined to determine if there were any trends or variances. The adult residential care worker, domiciliary care worker and day care worker gender split is approximately 74% female to 28% male. The supported living worker role shows a lesser proportion of females at 57% compared to 43% of males. The residential child care worker also shows proportionately more males referred at 58% compared to 42% of referrals. The remaining job roles represent a small sample for analysis so the percentage gender split can be skewed.

Figure 26: Gender split of individuals referred between 2012 – 2022 by their job role

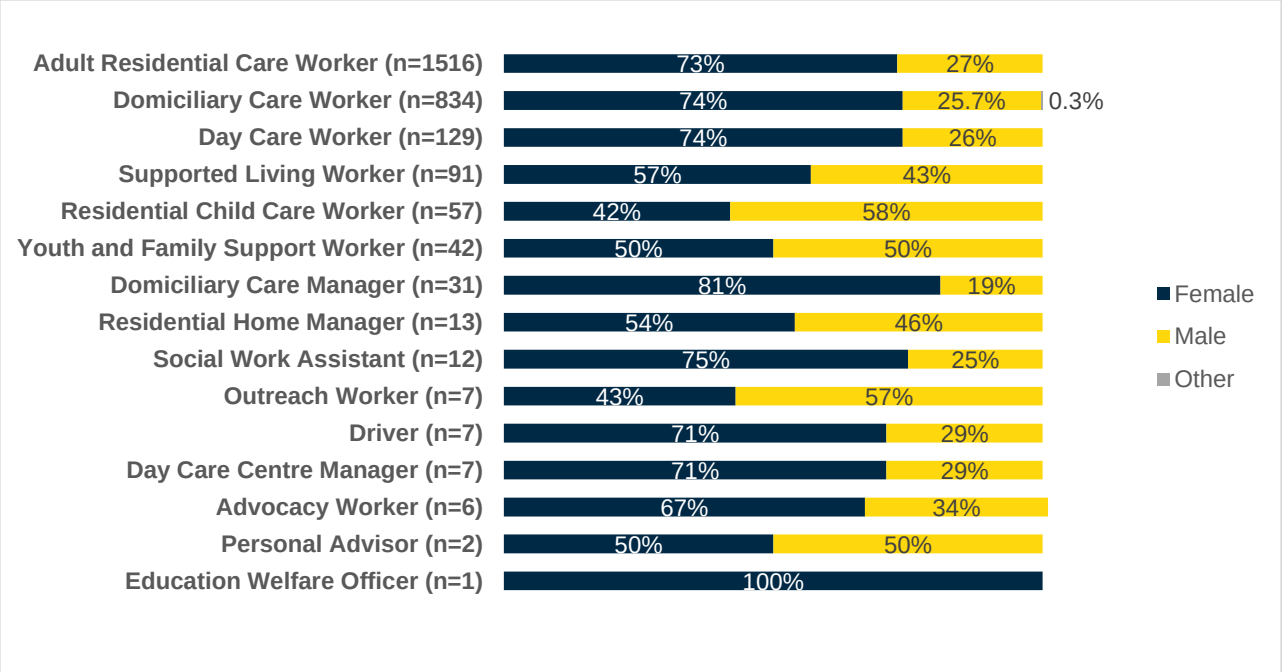


Figure 27 shows the gender split for the most commonly referred job roles compared to the gender split on the register for those jobs. All the roles have a higher proportion of males referred compared to the register so males represent the highest likelihood of referral. This is more acutely evident in the residential child care worker role where males represent 58% of referrals.

Figure 27: Gender split for top referred jobs during 2012 - 2022

Job Title and Gender	Gender split on register	Gender split for referrals
Adult Residential Care Worker		
Female	84%	73%
Male	16%	27%
Day Care Worker		
Female	83%	74%
Male	17%	26%
Domiciliary Care Worker		
Female	92%	74%
Male	8%	26%
Residential Child Care Worker		
Female	68%	42%
Male	32%	58%
Supported Living Worker		
Female	74%	57%
Male	26%	43%

Gender split by age group

Figure 28 below shows the percentage of females across the age groups who had fitness to practise concerns raised against the proportion of females across the age groups on the register. The proportional trend is broadly consistent across the age groups for females.

Figure 28: % Females referred compared to the Register

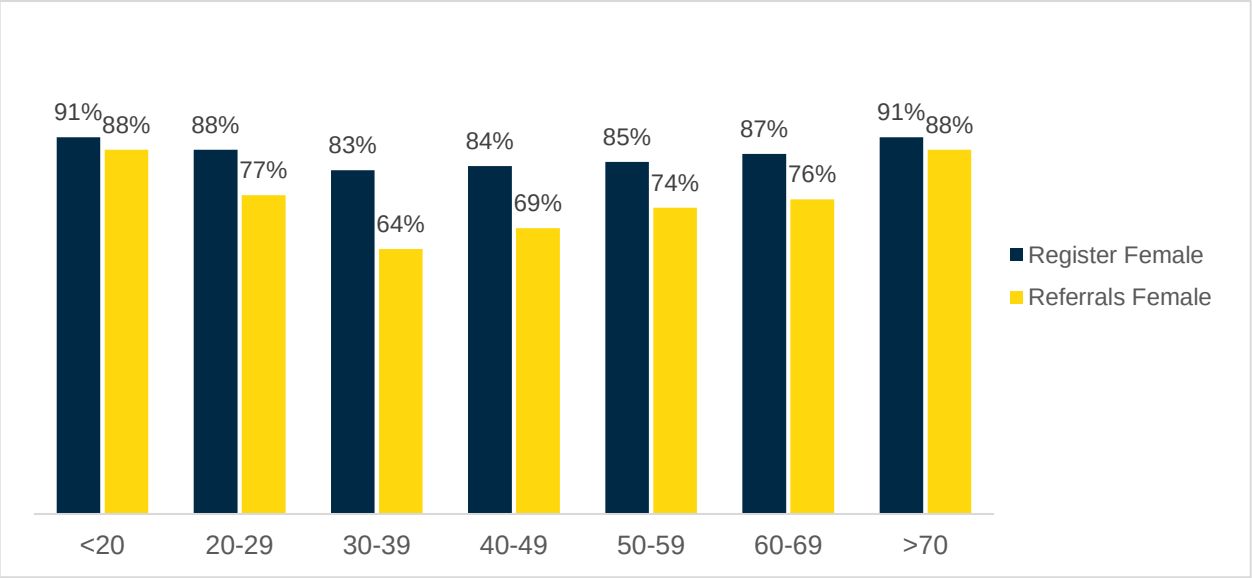
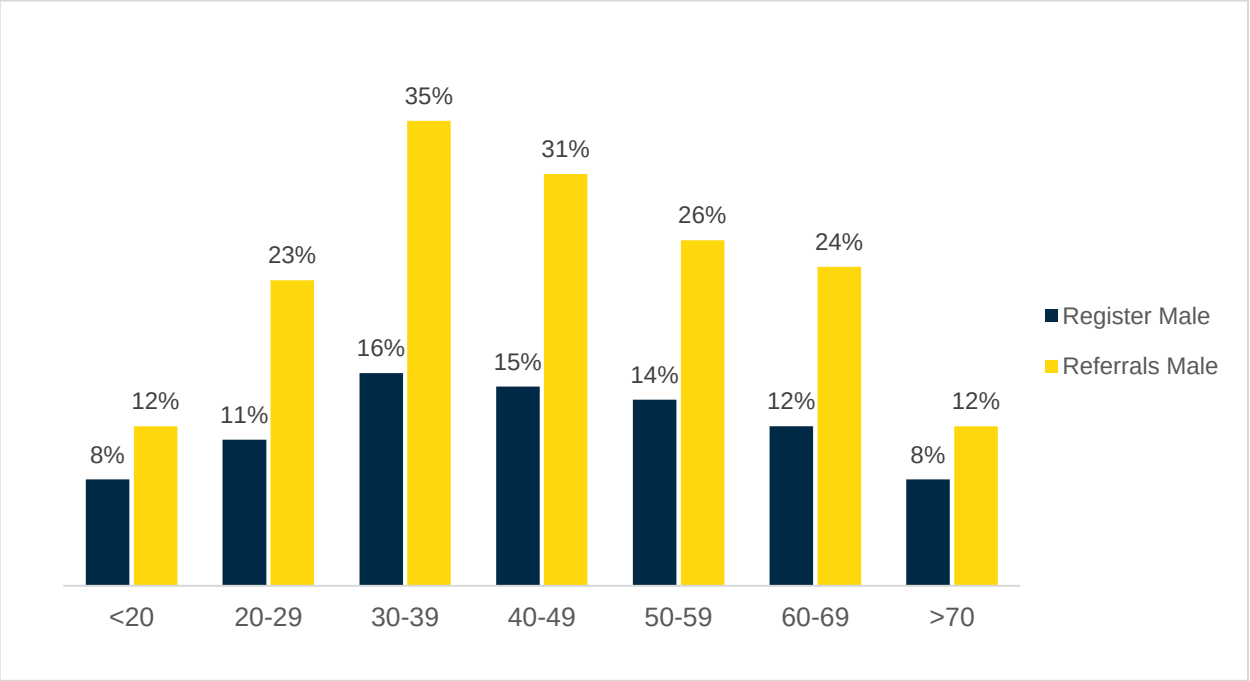


Figure 29 shows the percentage of male across the age groups who had fitness to practise concerns raised against the proportion of males across the age groups on the register. The proportion of males across the age groups differs from that of females in that there are a higher proportion of males referred compared to the males on the register and the age breakdown of age groups is shown below. The greatest difference is seen in the 30-39 age group which indicates that most males are referred within the 30-39 age group.

Figure 29: % Males referred compared to the Register



9.3 Age group and gender split by location

Figure 30 below shows the breakdown of referrals by gender and age group from the employment sectors perspective. Each of the age groups has more females than males across each of the sectors correlating with the register.

Figure 30: Referrals by sector age and gender breakdown

	<20 (n=48)		20-29 (n=662)		30-39 (n=559)		40-49 (n=688)		50-59 (n=610)		60-69 (n=172)		>70 (n=16)	
SECTOR	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**
Private	92%	8%	77%	23%	68%	32%	72%	28%	83%	17%	74%	26%	100%	
Voluntary	75%	25%	72%	28%	62%	38%	64%	36%	62%	38%	74%	26%	67%	33%
Statutory			83%	17%	67%	33%	74%	26%	71%	29%	86%	14%	100%	
Agency	60%	40%	78%	22%	61%	39%	62%	38%	70%	30%	58%	42%		

A detailed analysis of the age group and gender profile of the register in at Appendix 9 and full detail of the breakdown of the age group and gender of the referred job roles at Appendix 8.

10 Referral patterns

The most commonly cited allegations which account for 1540 referrals received (indicated Figure 31-34) during 2012-2022, were analysed to examine if any of the most common referral sources, job roles, sectors or either gender indicated a higher prevalence of any of these more commony cited allegations.

Figure 31 below shows that 1496 referrals citing the most common allegations, were received from the current employer (98%), self-declaring registrant (1%) and the PSNI (1%). Within this sample, the employer is most likely to refer an allegation in relation to verbal abuse. A self referring registrant are most likely to raise concerns of professional misconduct. The PSNI is most likely to refer allegations of physical abuse and theft.

Figure 31: Proportion of the most common sources of referral and the most common allegations during 2012-2022

Most common allegations (n=1496)	**Most common referral sources**		
	Current Employer	Registrant - (Self Declaration)	PSNI
Physical Abuse	96%	0.3%	4%
Professional Misconduct	96%	4%	0%
Theft/alleged theft	93%	3%	4%
Unsafe and Poor Practice Behaviour	99%	1%	0%
Verbal Abuse	100%	0%	0%
Abusive Practice	98%	2%	0%
Proportion of allegations	**98%**	**1%**	**1%**

Figure 32 below shows that 1460 referrals citing the most common allegations, were in respect of Adult Residential Care Workers (64%), Day Care Workers (5%), Domiciliary Care Workers (28%) and Supported Living Workers (3%). Within this sample, the Adult Residential Care Worker is most likely to be referred for concerns related to abusive practice. The Domiciliary Care Worker is most likely to be referred for allegations of theft. The Day Care Worker is most likely to be referred with concerns in relation to physical abuse/theft/alleged theft/unsafe and poor practice behaviour and the Supported Living Worker is most likely to be referred in relation to allegations of physical abuse.

Figure 32: Proportion of most commonly referred job roles and the most common allegations during 2012-2022

Most common allegations (n=1460)	**Most commonly referred job roles**			
	Adult Residential Care Worker	Domiciliary Care Worker	Day Care Worker	Supported Living Worker
Physical Abuse	68%	22%	6%	5%
Professional Misconduct	77%	18%	5%	0.4%
Theft/alleged theft	38%	54%	6%	2%
Unsafe and Poor Practice Behaviour	56%	34%	6%	3%
Verbal Abuse	64%	30%	2%	4%
Abusive Practice	89%	10%	1%	0%
Proportion of allegations	**64%**	**28%**	**5%**	**3%**

Figure 33 below shows the 1540 referrals citing the most common allegations and the proportion of which came from each of the sectors.

The private sector predominantly refers concerns related to verbal abuse and the voluntary sector predominanty refers concerns regarding professional misconduct. The statutory sector and the agency sector predominantly refer concerns related to theft/alleged theft.

Figure 33: Proportion of sector split for the most common allegations during 2012-2022

Most common allegations (n=1540)	**Private**	**Voluntary**	**Statutory**	**Agency**
Physical Abuse	56%	20%	12%	12%
Professional Misconduct	50%	33%	15%	2%
Theft/alleged theft	53%	8%	18%	22%
Unsafe and Poor Practice Behaviour	52%	24%	12%	12%
Verbal Abuse	60%	27%	8%	5%
Abusive Practice	56%	25%	13%	6%
Proportion of allegations	**53%**	**24%**	**13%**	**10%**

Figure 34 below shows the 1540 most common allegations and the proporotion of which were in relation to each gender. Females are predominantly referred for an allegation of theft/alleged theft and males are predominantly referred for physical abuse.

Figure 34: Proportion of gender split for the most common allegations during 2012-2022

Most common allegations (n=1540)	**Female**	**Male**
Physical Abuse	63%	37%
Professional Misconduct	70%	30%
Theft/alleged theft	89%	11%
Unsafe and Poor Practice Behaviour	74%	26%
Verbal Abuse	78%	22%
Abusive Practice	69%	31%
Proportion of allegations	**72%**	**28%**

11 Conclusion

Overall, the report provides valuable insights into the patterns of fitness to practise referrals in the social care sector in Northern Ireland over the past decade. One of the key takeaways is that concerns around fitness to practise were raised for around 1% of the register for Social Care Workers, indicating that the vast majority of workers are meeting the expected standards of practice. However, there were still a significant number of concerns raised, with 2,755 referrals over the 10-year period, and it is important that these are investigated thoroughly to ensure vulnerable individuals receiving social care are protected from harm.

The report highlights that employers raised the majority of concerns, accounting for 87% of all referrals received, which suggests employers are actively monitoring the behaviour of their employees and taking appropriate action when concerns arise. The next highest referral source was self-declarations from registrants, which accounted for 3.77% of referrals, indicating that Social Care Workers are aware of the importance of reporting concerns about their own fitness to practise. The PSNI also made a significant contribution to the referrals, accounting for 3.7% of all referrals, which highlights the importance of collaboration between the social care sector and law enforcement agencies.

It is encouraging to note that the number of referrals coming from members of the public, service users, and families has remained within the top four referral sources for the last five years, accounting for 3%-4% of yearly referrals. This suggests growing awareness among the public about the need to raise standards in social care, which is a positive development.

The report identifies common themes in the concerns raised, with alleged poor standards of work practice, behaviours in the workplace and towards others, inappropriate use of technology, verbal abuse, physical abuse, inappropriate relationships, and behaviour outside of work being the most commonly reported issues. It is essential that Social Care Workers are aware of these issues and receive appropriate training and support to ensure that they are able to meet the expected standards of practice.

The report also reveals that there was a temporary decrease in referral rates in April and May 2020, which can be attributed to the COVID-19 pandemic and the focus on maintaining front line care and support during this time. However, referrals quickly returned to pre-pandemic levels, indicating that the pandemic had a negligible effect on referral rates.

The report highlights the importance of ongoing training and support for Social Care Workers to ensure that they are able to meet the expected standards of practice. Regular analysis of the data will provide opportunity to identify emerging trends and ensure intelligence is fully utilised in informing regulatory improvement and workforce development.

Looking forward

The first Conduct hearing within the Social Care Council took place in 2006. This report has provided a timely opportunity to review our growing evidence base within Conduct/Fitness to Practise as we enter our seventeenth year of operation. Adopting a ten-year lens to our data provides opportunities to develop new learning and insights to better understand the social care workforce we regulate and to support employers and other stakeholders in driving up standards to the ultimate benefit to those individuals and families who receive social care services.

We hope that these findings will be useful to the wide range of stakeholders we work with including the Department of Health, RQIA, social care employers, training providers, in better understanding the nature of the social care workforce and supporting the improvement and transformation agendas.

Going forward, we hope to use these new insights to progress our ‘upstreaming’ agenda by supporting employers to better identify those individuals who are at risk of referral to Fitness to Practise and offering timely supportive and preventative measures to enable them to practise safely and effectively and remain complaint with their Standards.

We also plan to continue to engage with employers to promote better understanding of our referral thresholds and criteria to ensure that only those matters which require regulatory intervention are referred to the Council.

The implementation of a new case management system in 2023/24 will further enhance the Council’s reporting and analysis capability and enable a more drilled down exploration of referral patterns and trends.

In conclusion, it is important to remember that, while our Fitness to Practise function has a critical part to play in our public protection role, fewer than 1% of our registrants come to our attention in this way. It remains a strategic priority of the Council going forward to ensure that the necessary workforce supports are in place to enable the 99% of our registrants who work in very challenging and increasingly complex contexts to continue to deliver a high standard of care.

Appendix 1 – Bibliography

Scottish Social Services Council, Fitness to Practise Statistics (January 2023)

Social Care Wales, Annual Report and Accounts (2021-22)

Nursing and Midwifery Council, Annual Report and Accounts (2021-22)

Regulation and Quality Improvement Authority, Register of Services (2023)

The Northern Ireland Social Care Council (Social Care Worker Prohibition) and Fitness of Workers (Amendment) Regulations (Northrn Ireland) 2017

Appendix 2 – Standards of conduct and practice for social care workers

All Social Care Workers who are registered must follow the Social Care Council's Standards of Conduct and Practice for Social Care Workers. The standards of inform social care workers how they should behave and do their job and explain the skills and information they need to do their job correctly. A summary of the standards for social care workers is below. Full text of these standards is available from the Social Care Council website at: https://niscc.info/app/uploads/2023/03/Social-Care-Workers.pdf

Standards of conduct for Social Care Workers

1. As a Social Care Worker, you must protect the rights and promote the interests and wellbeing of service users and carers.
2. As a Social Care Worker, you must strive to establish and maintain the trust and confidence of service users and carers.
3. As a Social Care Worker, you must promote the autonomy of service users while safeguarding them as far as possible from danger or harm.
4. As a Social Care Worker, you must respect the rights of service users while seeking to ensure that their behaviour does not harm themselves or other people.
5. As a Social Care Worker, you must uphold public trust and confidence in Social Care Services.
6. As a Social Care Worker, you must be accountable for the quality of your work and take responsibility for maintaining and improving your knowledge and skills

Standards of practice for Social Care Workers

1. Understand the main duties and responsibilities of your own role within the context of the organisation in which you work.
2. Be able to communicate effectively.
3. Deliver person-centred care and support which is safe and effective.
4. Support the safeguarding of individuals.
5. Maintain health and safety at work.
6. Develop yourself as a Social Care Worker.

Underpinning values - The following values inform and underpin the standards of conduct and practice:

- Social Care Workers must:
- Respect the rights, dignity and inherent worth of individuals
- Work in a person-centred way
- Treat people respectfully and with compassion
- Support and promote the independence and autonomy of service users
- Act in the best interests of service users and carers
- Uphold and promote equality, diversity and inclusion
- Ensure the care they provide is safe and effective and of a high quality

Appendix 3 – Standards of conduct and practice for employers of social care workers

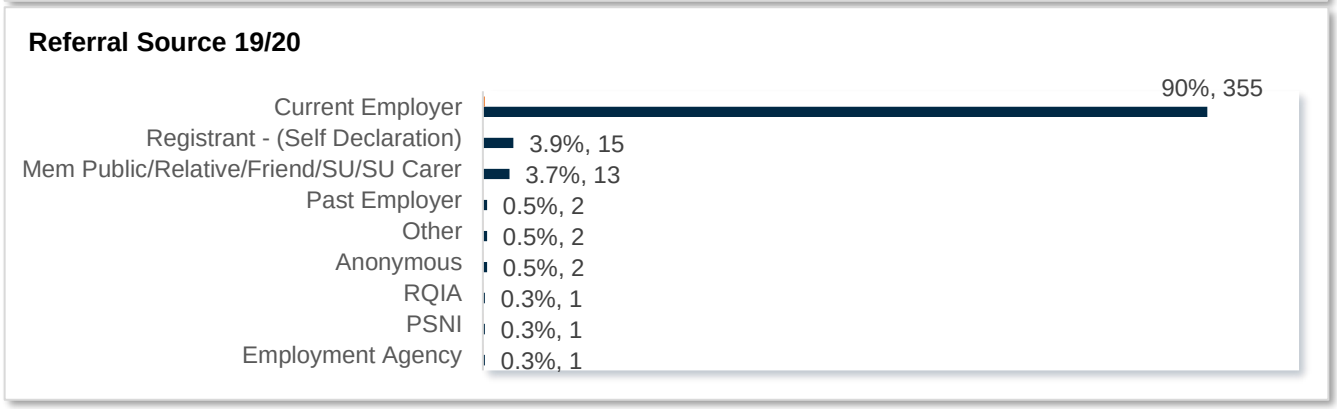
The Standards for Employers describe the responsibilities of employers in supporting and enabling their registered workforce to meet the Standards of Conduct and Practice. The Standards for Employers reflect the provisions within the Standards of Conduct and Practice for Social Workers and Social Care Workers. The Standards for Employers are intended to reflect existing good practice. They are intended to complement rather than replace or duplicate existing employers' policies and form part of the wider package of legislation, requirements and guidance that relate to the employment of staff.

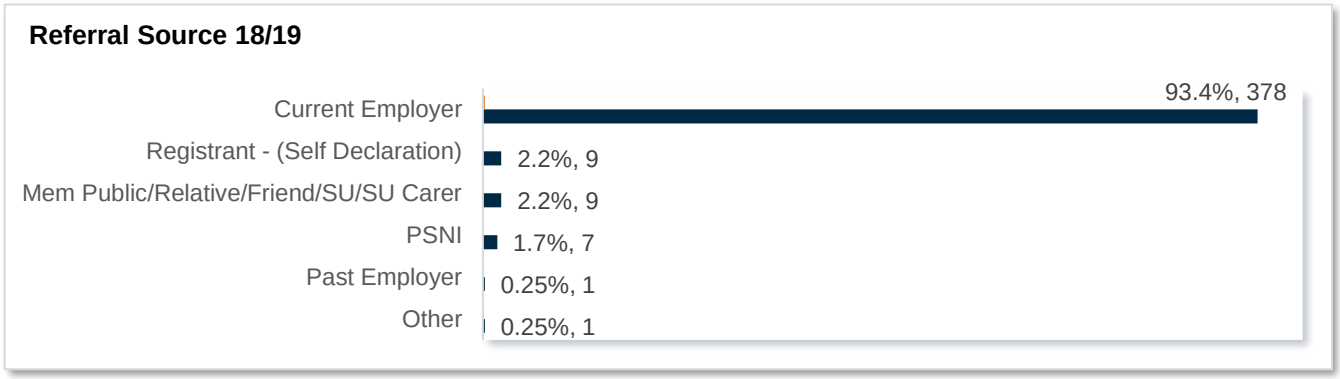
Northern Ireland Social Care Council has responsibility within the legislation for publishing standards for employers and keeping them under review. RQIA has responsibility for enforcement of Department of Health standards and will consider compliance with the Standards for Employers as part of their registration and inspection processes. The Social Care Council and RQIA will collaborate to effectively ensure adherence to the standards for employers and to share information on adherence to the standards within social care services. A summary of the standards for employers of social care workers is below. Full text of these standards is available from the Social Care Council website at: https://niscc.info/app/uploads/2023/03/Standards-of-Conduct-and-Practice-For-Employers.pdf

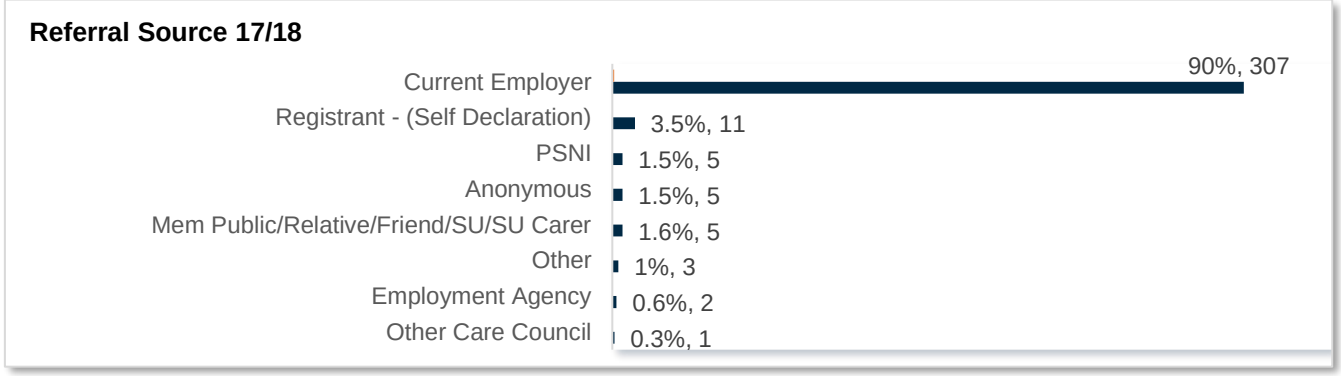
To meet their responsibilities in relation to regulating the social work and social care workforce, employers must:

1. Provide vision and leadership to registrants in line with organisational expectations and governance requirements, to ensure they are enabled to deliver safe, effective and values-led care focused on the needs and experiences of service users;
2. Make sure people are suitable to enter the workforce;
3. Have written policies and processes in place to enable registrants to meet the Social Care Council Standards of Conduct and Practice;
4. Provide learning and development opportunities to enable registrants to strengthen and develop their skills and knowledge;
5. Promote the Social Care Council Standards of Conduct and Practice to registrants, service users and carers and co-operate with Social Care Council proceedings.

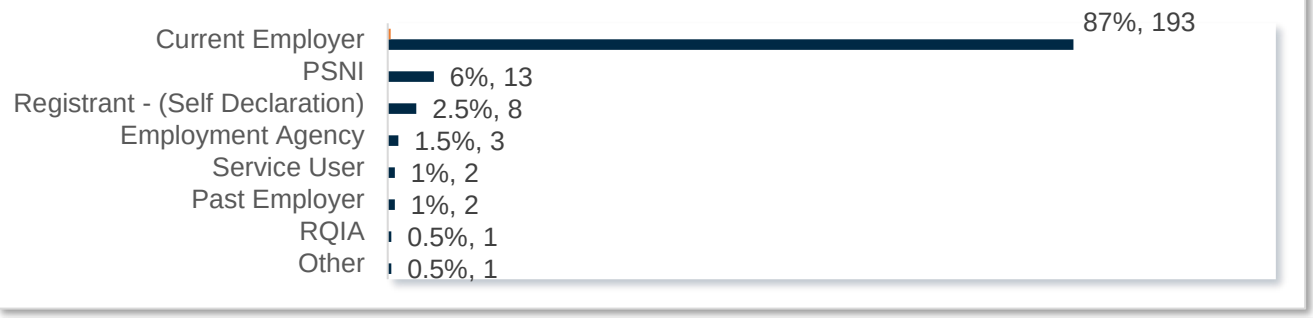
Appendix 4 – Source of referrals by year (2012-22)





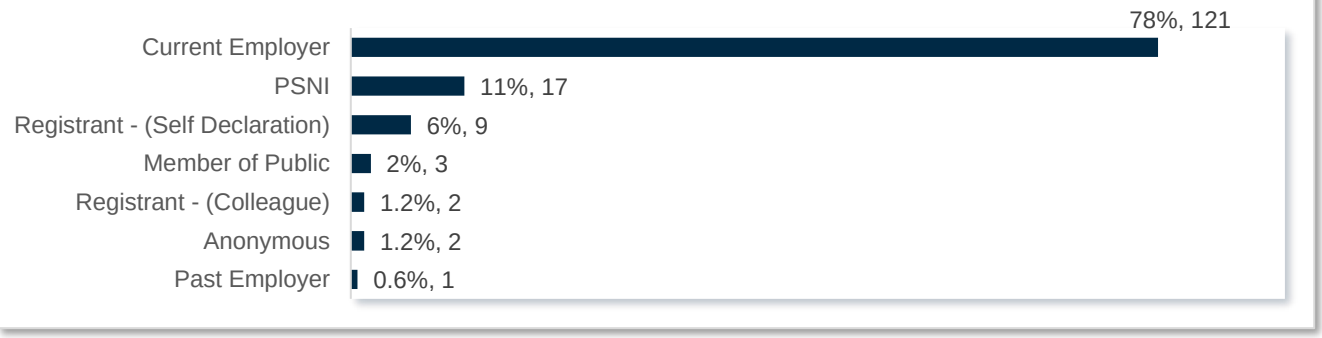


Referral Source 16/17

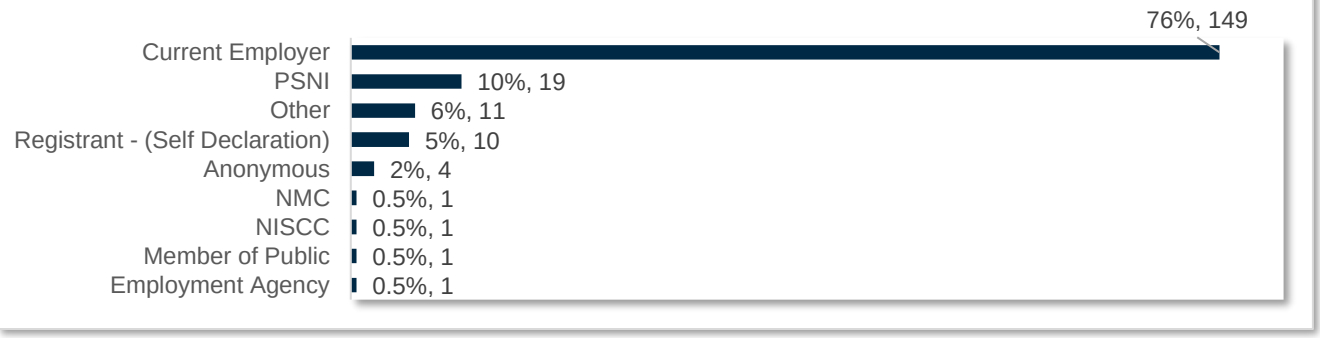


Referral Source 15/16

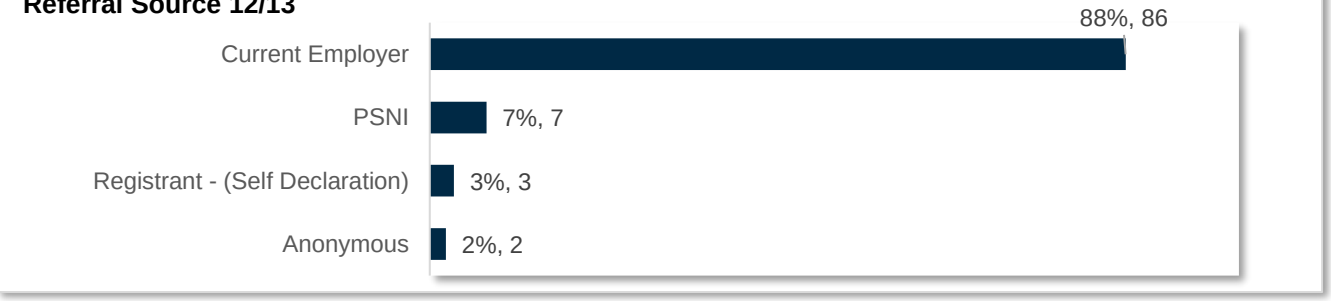
Referral Source 14/15



Referral Source 13/14



Referral Source 12/13



Appendix 5 – Referrals and job role by year (2012-22)

Job Types	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	Grand Total
Adult Residential Care Worker	69	157	121	144	138	193	177	192	175	150	**1516**
Domiciliary Care Worker	14	27	18	29	56	105	155	136	153	141	**834**
Day Care Worker	1	6	7	6	5	17	30	16	18	23	**129**
Supported Living Worker		1	1		1	7	15	14	21	31	**91**
Residential Child Care Worker	6	1	3	5	8	5	7	10	5	7	**57**
Youth and Family Support Worker	3	2	2	1	6	2	8	8	8	2	**42**
Domiciliary Care Manager	3	1	1	4	3	3	4	6	2	4	**31**
Residential Home Manager			2	2		1	3	3	1	1	**13**
Social Work Assistant				1	2		1	1	3	4	**12**
Day Care Centre Manager		2			2	2		1			**7**
Driver	1					1	1	4			**7**
Outreach Worker				1	1	1	1		2	1	**7**
Advocacy Worker				1	1	1	2	1			**6**
Personal Advisor						1	1				**2**
Education Welfare Officer	1										**1**
Grand Total	98	197	155	194	223	339	405	392	388	364	**2755**

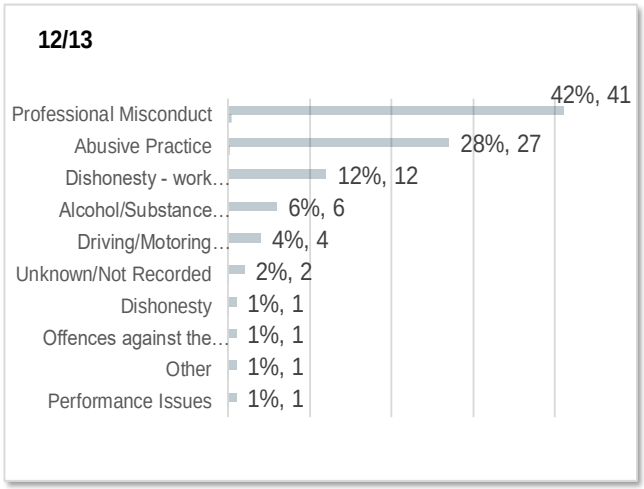
Appendix 6 – Allegations by year (2012-22)

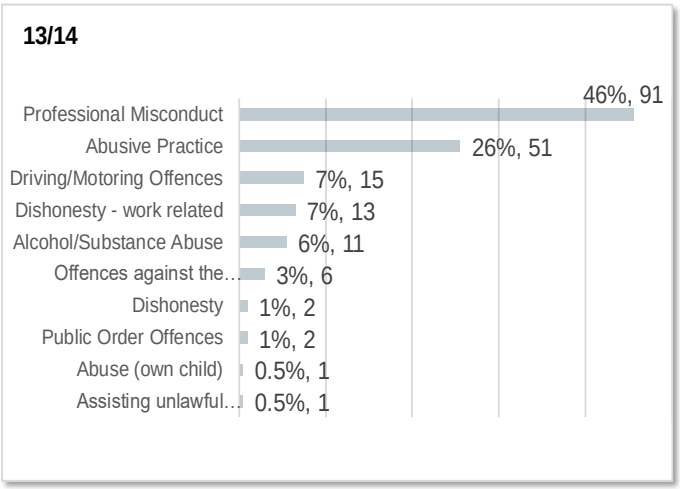
Allegations	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	Total
Unsafe and Poor Practice Behaviour				3	100	126	101	82	87	67	566
Physical Abuse				5	21	37	44	46	56	64	273
Professional Misconduct	41	91	49	72							253
Abusive Practice	27	51	60	55							193
Verbal Abuse				3	17	21	27	32	17	22	139
Dishonesty - work related	12	13	9	11	7	26	30				108
Other	1		4	11	5	18	34	26	1	5	105
Driving/Motoring Offences	4	15	14	11	11	7	5	5	3	6	81
Behaviour Outside of Work					1	6	11	11	29	17	75
Theft					1	4	6	31	17	14	73
Drugs/Alcohol at Work				1	4	15	16	16	10	9	71
Behaviour Towards Colleagues					8	11	12	13	12	14	70
Sleeping on Duty						18	19	7	5	8	57
Inappropriate Relationship/Breach of Professional Boundaries		1		2	3	10	21	7	3	7	54
Sexual Misconduct					6	4	12	10	12	10	54
Inappropriate use of Technology					1	2	12	7	16	12	50
Medication Issues/Errors					8	6	5	9	9	8	45
Offences against the person	1	6	8	6	1	3	4	3	6	7	45
Alleged Theft-From Service User								7	22	12	41
Financial Misconduct				1	7	6	23	2		1	40
Alcohol/Substance Abuse	6	11	3	8	2	1	1	1	2	3	38
Fraudulent Behaviour						3	4	12	10	8	37
Inappropriate Communication (SU)							1	11	12	8	32
Emotional Abuse					5	3	3	8	3	5	27
Policy/Procedure Breach	1				1			7	5	5	19
Reporting Failures - Safeguarding								2	6	11	19
Negligent Care					6	4	6				16
Dishonesty	1	2	4	4	2	2					15
Mental ill Health			1		1	2	1	3	5	2	15
Safeguarding - category not specified								6		6	12
Breach of Confidentiality								2	4	4	10
Drug Related					1	2		2	2	3	10
Public Order Offences	1	2	1		2	2		2			10
Requesting/Accepting Loans								3	1	2	6
Misconduct - not specified							1	2	2		5
Reporting Failures								4	1		5
Unknown/Not Recorded	2	1	1							1	5
Inappropriate Behaviour towards SU									4		4
Absenteeism								1		2	3
Breach of Covid Regulations										3	3
Inappropriate Restraint									3		3
Physical ill Health									1	2	3
Poor Record Keeping								1	2		3
Alleged Theft-Work Related									1	1	2
Animal Cruelty								1	1		2
Barred Adults & Children								2			2
Child Protection Concerns				1						1	2
Dishonesty during employer investigation										2	2

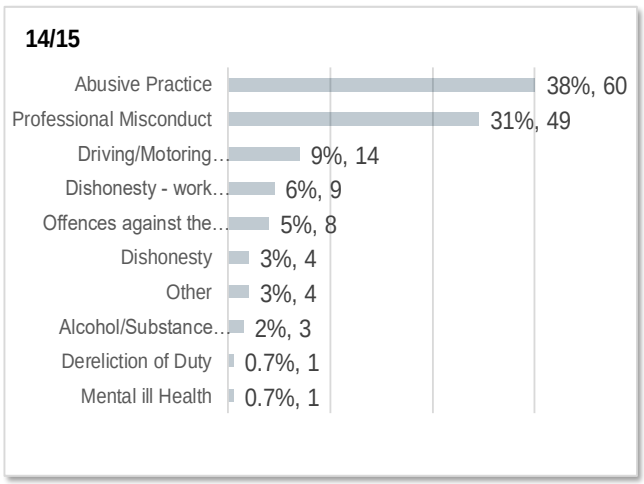
continued overleaf

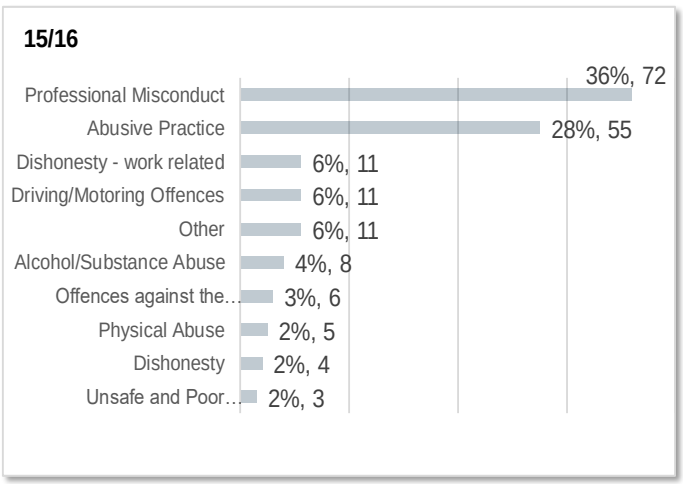
Allegations	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	Total
Poor Managerial Practice								1		1	2
Safeguarding Investigation into sudden death							2				2
Workforce Regulator								1	1		2
Working while not registered									1	1	2
Abuse (own child)		1									1
Abuse of Power							1				1
Alleged physcial abuse (own child)					1						1
Assisting unlawful immigration		1									1
Attending interview whilst on paid period of self-isolation									1		1
Bringing a BB/airsoft gun to work										1	1
Concerns about level of care provided									1		1
Concerns re criminal record held under a second name										1	1
Concerns re service user care provision									1		1
Covid Related - Breach of Covid 19 regulations										1	1
Covid Related - Refusing to care for Covid 19 service users									1		1
Covid Related -False Declaration of Covid test									1		1
Covid Related-Attending a public place during a period of self isolation									1		1
Criminal Damage									1		1
Criminal proceedings-perverting the course of justice					1						1
Cut a SU hair										1	1
Declaration - Offences								1			1
Declaration - Other										1	1
Dereliction of Duty			1								1
Failure to disclose criminal convictions/social services involvement									1		1
Failure to maintain dignity and respect of SU									1		1
Falsifying Employment references										1	1
Financial Abuse									1		1
Fraudulent mileage claims										1	1
Inappropriate use of SU property								1			1
Insubordination								1			1
Making false allegations regarding MOP								1			1
Omitted information on form		1									1
Ongoing Police Investigation									1		1
Performance Issues	1										1
Poor Attendance										1	1
Poor Performance concerns								1			1
Potential Breach of Undertakings										1	1
Refusal to carry out a reasonable work instruction									1		1
Renewed without assessment		1									1
Reporting Failures - Suspended									1		1
Restrictive Practice								1			1
Safeguarding – restrictive practice										1	1
Sexual Abuse									1		1
Subject to ICPO by NMC							1				1
Submitting false personal injury claim in an attempt to defraud employer									1		1
Unknown Working Status							1				1
Witholding information on an application form							1				1
Working whilst claiming stat sick pay									1		1

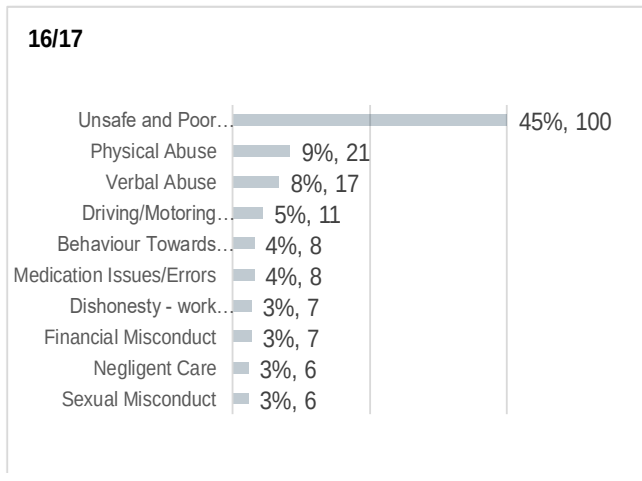
Appendix 7 – Proportion of allegations by year (2012–22)

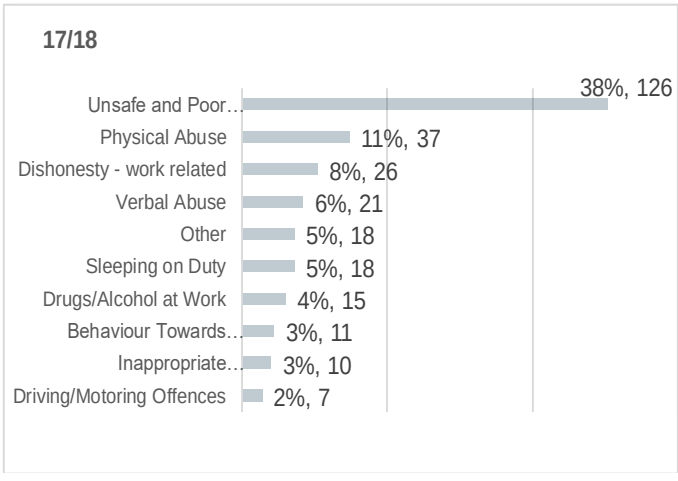


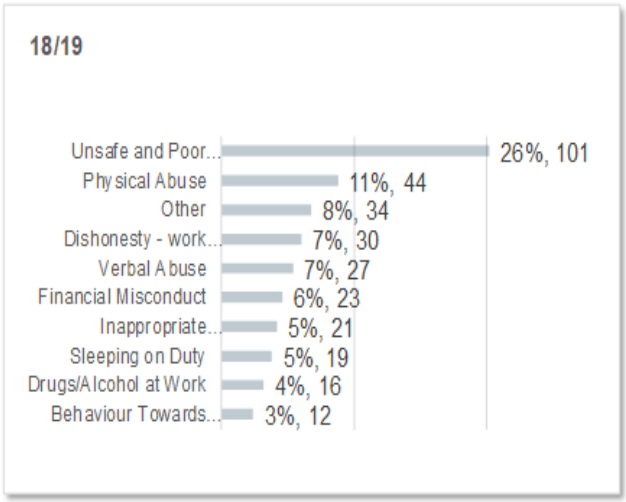


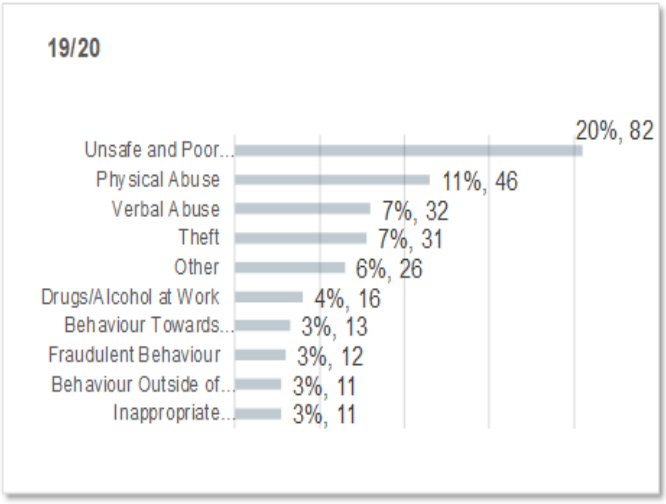


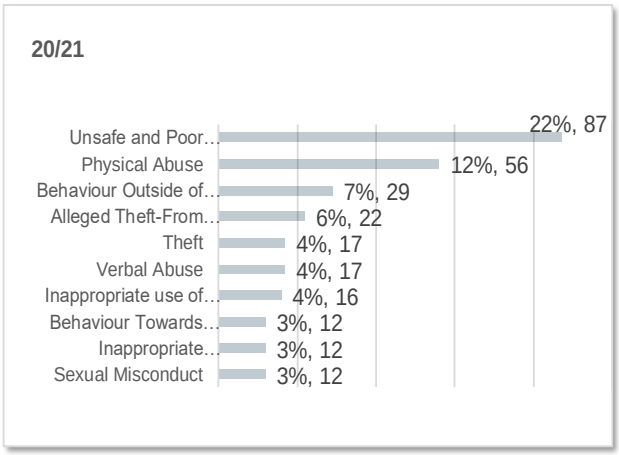


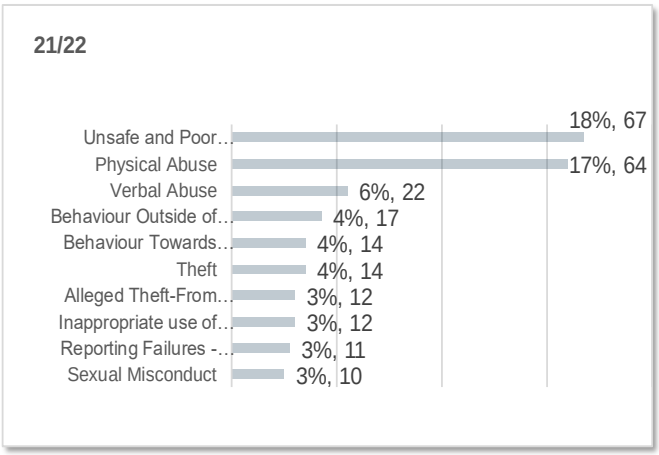





18/19
Unsafe and Poor...
Physical Abuse
Other
Dishonesty - work...
Verbal Abuse
Financial Misconduct
Inappropriate...
Sleeping on Duty
Drugs/Alcohol at Work
Behaviour Towards...
26%, 101
11%, 44
8%, 34
7%, 30
7%, 27
6%, 23
5%, 21
5%, 19
4%, 16
3%, 12


19/20
Unsafe and Poor...
Physical Abuse
Verbal Abuse
Theft
Other
Drugs/Alcohol at Work
Behaviour Towards...
Fraudulent Behaviour
Behaviour Outside of...
Inappropriate...
20%, 82
11%, 46
7%, 32
7%, 31
6%, 26
4%, 16
3%, 13
3%, 12
3%, 11
3%, 11


20/21
Unsafe and Poor...
Physical Abuse
Behaviour Outside of...
Alleged Theft-From...
Theft
Verbal Abuse
Inappropriate use of...
Behaviour Towards...
Inappropriate...
Sexual Misconduct
22%, 87
12%, 56
7%, 29
6%, 22
4%, 17
4%, 17
4%, 16
3%, 12
3%, 12
3%, 12


21/22
Unsafe and Poor...
Physical Abuse
Verbal Abuse
Behaviour Outside of...
Behaviour Towards...
Theft
Alleged Theft-From...
Inappropriate use of...
Reporting Failures -...
Sexual Misconduct
18%, 67
17%, 64
6%, 22
4%, 17
4%, 14
4%, 14
3%, 12
3%, 12
3%, 11
3%, 10

Appendix 8

Age and gender profile of the job roles referred during 2012-2022

	<20 (n=48)		20-29 (n=662)		30-39 (n=559)		40-49 (n=688)		50-59 (n=610)		60-69 (n=172)		>70 (n=16)	
JOB	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**
Adult Residential Care Worker	94%	6%	78%	22%	66%	34%	68%	32%	79%	21%	75%	25%	100%	
Domiciliary Care Worker	85%	15%	76%	24%	70%	30%	76%	24%	73%	27%	76%	24%	83%	17%
Day Care Worker	100%		77%	23%	67%	33%	78%	22%	68%	32%	73%	27%	100%	
Supported Living Worker	33%	67%	77%	23%	38%	62%	42%	58%	64%	36%	67%	33%		
Residential Child Care Worker			50%	50%	44%	56%	43%	57%	42%	58%		100%		
Youth & Family Support Worker			56%	44%	38%	63%	40%	60%	57%	43%	100%			
Domiciliary Care Manager				100%	83%	17%	90%	10%	75%	25%	100%			
Residential Home Manager						100%	67%	33%	25%	75%	100%			
Social Work Assistant			50%	50%	60%	40%	100%		100%					
Outreach Worker			100%		33%	67%		100%	50%	50%				
Driver			100%		100%		100%			100%				
Day Care Centre Manager					100%		67%	33%	100%		100%			100%
Advocacy Worker			67%	33%					67%	33%				
Personal Advisor			100%			100%								
Education Welfare Officer							100%							

Appendix 9

Age and gender of the register of referred job roles

	<20 (n=681)		20-29 (n=8703)		30-39 (n=7552)		40-49 (n=6671)		50-59 (n=7427)		60-69 (n=3969)		>70 (n=477)	
Register of referred jobs 31 Mar 22 (n=35480)	F	M	F	M	F	M	F	M	F	M	F	M	F	M
Adult Residential Care Worker	93%	7%	88%	12%	80%	20%	82%	18%	85%	15%	87%	13%	94%	6%
Domiciliary Care Worker	90%	9%	93%	7%	91%	9%	91%	9%	91%	9%	93%	7%	93%	7%
Day Care Worker	94%	6%	85%	15%	82%	18%	86%	14%	80%	20%	81%	19%	86%	14%
Supported Living Worker	94%	6%	78%	22%	73%	27%	69%	31%	73%	27%	73%	27%	71%	29%
Residential Child Care Worker	100%		74%	26%	70%	30%	70%	30%	64%	36%	61%	39%	83%	17%
Youth & Family Support Worker	100%		85%	15%	76%	24%	79%	21%	63%	37%	83%	17%	100%	
Domiciliary Care Manager			58%	42%	84%	16%	86%	14%	86%	14%	91%	9%	80%	20%
Residential Home Manager			100%		65%	35%	71%	29%	76%	24%	73%	27%	100%	
Social Work Assistant	100%		86%	14%	72%	28%	81%	19%	89%	11%	79%	21%	100%	
Outreach Worker			88%	12%	81%	19%	79%	21%	71%	29%	68%	32%	100%	
Driver			100%		100%		50%	50%	69%	31%	25%	75%		100%
Day Care Centre Manager					100%		88%	12%	72%	28%	85%	15%	67%	33%
Advocacy Worker			86%	14%	69%	31%	63%	37%	92%	8%	60%	40%		
Personal Advisor			100%		83%	17%	71%	29%	83%	17%	67%	33%	100%	
Education Welfare Officer					100%		33%	67%	75%	25%	58%	41%		100%

Appendix 10

Key Performance Indicator – Fitness to Practice Team

Northern Ireland Social Care Council

KEY PERFORMANCE INDICATORS- FITNESS TO PRACTISE

Reporting to Board

Fitness to Practise reports on three KPI's within the performance report submitted to the Board. These are as follows:

1. We will triage all referrals to the FTP Team within 3 working days
2. We will conclude 100% of ISO hearings within 4 weeks of referral
3. We will conclude 90% of FTP cases within 15 months of opening the case

Cumulative Compliance at end of Month Five

At end of month 5 (31/8/22) ,the cumulative compliance rates for triage were 97%. This represented 8 out of a total of 207 cases. All of the outlying cases were triaged within 5 working days as a maximum.

The cumulative compliance rate for ISO's at month 5 was 88%. Given the relatively small number of cases (n=8), this percentage represents only 1 case that exceeded the timeframe. Within the current consideration of risk tolerance, this KPI is likely to be one that could be tolerated by the Board.

In relation to the conclusion of cases within a 15-month time frame, the cumulative compliance level at month 5 is 69%. Even applying the risk tolerance methodology, this level of compliance falls well below the target.

KPI- Fifteen-month case closure compliance

This KPI tends to be an industry target across all health and social care regulators and therefore provides a useful benchmark of performance. The table below charts our compliance with this KPI over the last 5 year period, along with the 7 month and 12 month compliance which are for internal performance management purposes only.

Year	Cumulative compliance - conclude 90% within 15mths of opening case	Cumulative compliance Conclude or refer 80% within 7mths of opening case	Cumulative compliance- conclude or refer 85% within 12 mths of opening case
2017-18	94%	78%	93%
2018-19	94%	79%	90%
2019-20	88%	62%	84%
2020-21	86%	59%	82%
2021-22	73%	48%	68%
Apr 22-Aug 22	69%	57%	64%

It is clear from this table, that we have been on a downward trajectory in relation to all KPI compliance since 2019/20, however performance has particularly dipped in the 2021/22 business year and in the first 5 months of this business year.

Given that the 15-month KPI is reported to the Board, this briefing report will focus on this specific KPI. The table below outlines the number of outlying cases in each business year from 2019-20 and the reasons for non-compliance.

Year	KPI % Compliance	No of non - compliant cases	Reasons for non-compliance
2019/20	88%	35 out of 327 cases	Council Solicitor = 20% Employer Invest = 17% Other = 53%
2020/21	86%	38 out of 293	Council Solicitor = 8% Employer Invest = 42% Other = 50%
2021/22	73%	74 out of 312	Council Solicitor = 5% Employer Invest = 41% Other = 51%
2022/23 (to 31/8/22)	69%	37 out of 128	Council Solicitor = 3% Employer Invest = 32% Other = 65%

Analysis

Cases which are subject to criminal or adult safeguarding investigation processes are excluded from this KPI unless they are compliant.

Current recording of non-compliance reason at the point of case closure includes only three fields -council solicitor, employer investigation or other. We have requested additional drop-down recording capability from the Database Team to allow for more specific reporting. In manually extracting the reasons that fall within the 'other' category from case closure records, these include the following:

- Resident non-engagement with the Council
- Delays in obtaining medical notes/medical reports
- Delays in obtaining medical appointment with Council Medical Officer
- Agreed delays in contacting registrant due to their ill health
- FTP Officer sick leave

The administrative tasks associated with case closure were often not prioritised when caseloads were high which further impacted on compliance.

It is interesting to note the significant increase in employer related delays for the periods 20/21 and 21/22. This coincided with COVID and a decision taken by the Council to focus on high risk cases and to limit requests for information from employers to enable them to focus on dealing with the pandemic. We know from our employer engagement, that many investigative and disciplinary processes were significantly delayed during this time due to competing pressures. To date within the current year, we are seeing a slight reduction in

this figure which is hopefully an indication that the impact of COVID on the workforce has reduced.

Since 2020, we have been heavily reliant on agency staff within the FTP team which has led to a higher turnover of staff. Within 2021/22, we also had two members of staff off on long-term sick leave. We appointed to two permanent positions in August of this year, so now how a full complement of staff in place. This should hopefully lead to improved KPI performance.

Performance Management Measures in Place

There are a number of measures in place within the FTP function to manage and measure KPI performance. These include:

- Review of case progression within 1-1's
- Review of all long running cases (12 months+) at monthly case conferences
- KPI introduced in relation to administrative case closure
- Quarterly review meetings with AD's Governance within the 5 HSCT's
- Regular meetings with DLS
- Monthly update reports obtained from adult safeguarding teams
- Escalation policy in relation to delays in obtaining information from employers or other sources

Going forward, we will maintain all of the above measures. We will additionally introduce an 'early alert' system, where cases approaching the 15-month target are flagged prompting the respective Officer to assess whether case closure is possible enabling the target to be met. The Head of Fitness to Practise will also review the KPI performance in relation to each individual Officer to determine if there are any performance issues which need to be addressed.

[Helen McVicker, Head of Fitness to Practise, 4th October 2022]