Health Professions Council – 9 February 2012

Professionalism in nursing, midwifery and the allied health professions in Scotland

Executive summary and recommendations

Introduction
Following the publication in 2010 of the "Healthcare Quality Strategy for NHSScotland" which held a vision of a "world class healthcare system", the Chief Nursing Officer of the Scottish Government, Ros Moore, and the NMAHP (Nursing, Midwifery and Allied Health Professions) Coordinating Council commissioned a report on professionalism as they agreed that it was a good opportunity "to consider how we could re-energise the concept."

As Council members are aware, the Chair of HPC, Dr Anna van der Gaag, was appointed to the working group which was chaired by a lay member, Dr Frances Dow, former Vice Principal at the University of Edinburgh. The working group was tasked with exploring the issue of professionalism and the focus was on the NMAHP workforce, although not exclusively, and it was carried out in parallel to the ongoing work in this area within Scottish medicine.

The working group formulated a series of recommendations which are summarised on pages 31-33 of the report. The Coordinating Council have considered the report and further work on implementing the recommendations is under development

Decision
Council is requested to discuss the report.

Background information
None

Resource implications
None

Financial implications
None

Background papers
None

Appendices
None

Date of paper
27 January 2012

Professionalism in nursing, midwifery and the allied health professions in Scotland: a report to the Coordinating Council for the NMAHP Contribution to the Healthcare Quality Strategy for NHSScotland

January 2012

Contents

Foreword by the Chief Nursing Officer

Although the landscape of health care has changed beyond recognition over the last 30 years, the importance of professionalism has remained constant in the minds of patients, the public and healthcare professionals.

I see professionalism as the “value-added” factor that enhances the quality of care and the contribution of practitioners. It implies a commitment to vocation and to public interest and presumes adherence to a set of values that are owned and understood by all. Professionalism provides nurses, midwives and allied health professionals (NMAHPs), and patients, service users and carers, with much needed continuity in the face of an ever-changing system and an “internal compass” to guide them in challenging circumstances.

One might assume from objective health data that professionalism is thriving in Scotland. However, with numerous formal and informal reports highlighting examples of “unprofessional” behaviour and workforce surveys referring to low morale among NMAHPs, this cannot be assumed.

Despite this, I do not subscribe to the view currently expressed through the media that we are witnessing a fundamental crisis of professionalism, particularly in nursing, and that a return to the ethos and structures that dominated in the past is necessary. The reality is that while evidence of unprofessional behaviour in healthcare undoubtedly exists, there are far greater examples of excellence in service delivery. From a personal perspective, I see evidence of professionalism everywhere I go.

I do believe, however, that it is now time to look at professionalism afresh and ensure that it reflects today’s realities rather than those of the past. Professionalism must speak to a multigenerational audience and act as a driving force for quality. We must ask whether professionalism goes beyond regulation, competence and compliance and question whether it is the vital spark that can motivate staff to work with pride and passion and do the right thing every time. We also have to ensure that NHS boards and their leaders and managers play their part in creating a culture in which professionalism can thrive.

The publication in 2010 of the *Healthcare Quality Strategy for NHSScotland,* with its vision of a world class healthcare system, offered a timely opportunity to undertake a review of professionalism and to consider how we could re-energise the concept.

It is important to say at the outset that it is neither my intention nor that of the NMAHP community to lay claim to the notion of professionalism. The Chief Medical Officer for Scotland is leading a workstream promoting professionalism and excellence in Scottish medicine, and related work is also being taken forward to progress the quality strategy. Professional and regulatory organisations continue to promote professionalism through their work and to embed its values in everyday practice.

Professionalism is seen by the NMAHP community as an inclusive and potentially unifying force, particularly as we progress to an integrated health and social care system. Although this report is targeted primarily at NMAHPs, it is clear from discussions with a wide range of stakeholders that the interdependencies highlighted within mean that it will have much wider applicability.

I wish to offer my sincere thanks, and express my great admiration, to all members of the working group for the effort and expertise they have brought to their task of producing the report. My particular thanks go to Dr Frances Dow, who has chaired the group with skill, tact, humour and the great insight that her experience in academia and public service brings. They have delivered, I believe, a landmark report that sets the direction of travel for recognising, promoting and, most importantly, practising the principles of professionalism within healthcare services.

Ros Moore
Chief Nursing Officer and Director for Patients, Public and the Health Professions, Scottish Government

1. Introduction

This report was commissioned by the Chief Nursing Officer of the Scottish Government and the NMAHP Coordinating Council as part of wider *NMAHP Contribution to the Quality Strategy* programme. It was supported by the Scottish Government Chief Health Professions Officer and chief nursing officers in the three other countries of the United Kingdom.

The report seeks to explore the complex issue of professionalism and is focused primarily, but not exclusively, on the NMAHP workforce in NHSScotland. It was produced by a working group of experts in the field of health and social care and representatives of the Scottish and UK governments, professional bodies, regulators, academics and lay members, and chaired by Dr Frances Dow, a lay member. Terms of reference and membership of the group can be found at Annex 1.

The working group recognised that services are delivered by multidisciplinary and multi-agency teams and that professionalism is equally relevant to the wider healthcare workforce, including support workers and, in the future, to the social care workforce. Drawing on a wide range of sources, the group took account of patients' and carers' perspectives gained from the *Better Together*[1] programme and the diverse experiences of individual members of the multi-professional working group. Views of participants at the 2011 National Regulatory Conference were also incorporated.

This work parallels work in relation to the medical profession[2] that has been progressing since the 2009 Scottish Medical and Scientific Advisory Committee report to the Chief Medical Officer.[3] They are complementary in that each recognises the values necessary to underpin the moral contract between the healthcare professions and society and seeks to promote the concept of professionalism in everyday practice.

Overview

The report:

- offers an overview of professionalism within modern healthcare settings
- explores perceptions of what professionalism looks like
- suggests ways of facilitating and developing professionalism within health service organisations
- provides options for its recognition and measurement.

[1] Better Together programme.
http://www.bettertogetherscotland.com/bettertogetherscotland/CCC_FirstPage.jsp
[2] Royal College of Physicians (2005). Doctors in society: Medical professionalism in a changing world. Report of a Working party of the Royal College of Physicians of London. www.rcplondon.ac.uk
[3] Scottish Government (2009). Promoting Professionalism and Excellence in Scottish Medicine: A Report from the Scottish Medical and Scientific Advisory Committee.
http://www.scotland.gov.uk/Publications/2009/06/12150150/0

It sets out:

- the changing context in which professionalism operates (Chapter 2)
- the positive behaviours and principles associated with professionalism (Chapter 2)
- factors that may enable and inhibit professionalism (Chapter 3)
- possible means by which professionalism may be measured (Chapter 4)
- recommendations for action for the NMAHP Quality Coordinating Council and the UK chief nursing officers to consider within their jurisdictions (Chapter 5)
- what will happen with the report (Chapter 6).

Why professionalism, and why today?

The context in which NMAHP practice takes place has changed profoundly over the last 30 years. Changing social attitudes and advances in science and technology have increased the public's knowledge and, consequently, their expectations. Care contexts are much more diverse and, in some cases, virtual as the balance of care inexorably shifts from acute inpatient activity to settings close to where people live. Professional and occupational roles have also changed along with the shape and size of the healthcare workforce, with conventional professional and organisational boundaries increasingly becoming blurred or erased. Traditional public service and professional values now exist alongside a strong business ethos, and greater transparency and accountability at all levels of the system means there is greater scrutiny on performance and outcomes.

The need to match increasing demand for healthcare with the finite resources available is creating an even more dramatic shift in the approach to healthcare delivery. In Scotland, this has contributed to the development of an ethos of mutuality and shared responsibility for health and health services involving the NHS and local communities, a planned move to health and social care integration, a shift of resources towards health prevention in all its forms and a drive to reduce unnecessary variation, harm and waste in the system through innovation and improvement.

Participative patients and service users

The public, patients and service users are now much more active participants in healthcare than in previous times. Examples can be seen in the degree of patient and public involvement in volunteering, board elections and "expert patient" programmes throughout the country. Access to performance and health data is also unprecedented, as is access to the knowledge traditionally "owned" by healthcare professionals. People expect the same sort of service from the NHS that they get in other areas of their life in which their needs are considered paramount and their responses personalised.

The policy drive is to shift from approaches that focus on deficits and gaps to those that value assets and personal capacity building, with people as co-producers of their health and care. By focusing on the outcomes people want to achieve in terms of their health and well-being, people can be empowered to take control of their lives and to build the foundation for lasting and sustainable change in their communities. This requires a shift in the balance of power from health service-controlled to person-owned care (a practical example of this is person-owned and controlled health

records) and a development in professional skills from narrowly defined functions to more encompassing roles that enable and facilitate health and well-being.

The challenge of social media

As we move through the decade, it seems certain that elements of healthcare will increasingly be delivered through electronic means. The IT and digital revolution has already had a significant impact on the context in which NMAHPs operate, however growing reliance on social media (such as Skype™, Facebook and Twitter) will further increase the complexity. Social media represents much more than a tool for communication. It changes how people work and interact, how relationships are formed and how people complain, celebrate, discover and create. It does so on people's own terms and, as such, cannot be controlled.

Currently, examples of the use of social media in healthcare include NHS 24, NHS Education for Scotland and the Scottish National Blood Transfusion Service, however most NHS boards are exploring its potential as a means of providing information and posting messages. National work on staff governance issues is also likely to consider and address the challenges posed by social media. Its use goes beyond the world of work, of course, and its potential to conflate the personal with the professional is fast becoming apparent. NMAHPs, patients and service users are empowered to use social media; this needs to be encouraged and promoted in a responsible and secure way, with the personal and professional implications made clear.

Generating pride and passion through professionalism

Although there may not be a robust empirical base to demonstrate a direct link between pride, passion and professionalism and the importance of these factors in delivering quality, an initial review of the "grey" literature reveals a wealth of evidence from many different professions and groups showing that the link is present at practitioner level. Reports of severe system failures[4,5] in care settings show that "unprofessional behaviour" does exist and that levels of morale and job satisfaction among NMAHPs vary. It is therefore essential to consider how pride and passion can be generated, sustained and harnessed, particularly in difficult circumstances.

Setting the direction

Irrespective of the changing nature of healthcare and the complexity of the context in which it operates, NHS staff, patients, service users and the general public still place a high premium on the notion of professionalism, the ethos of trust it represents, the degree of accountability it confers, and the role it plays as a driver of quality and the benchmark for the attitudes, actions, behaviours expected from all.

To remain relevant, any modern and pragmatic description of professionalism must articulate the intention to shift from the traditional 20th Century model of healthcare towards a model that reflects the complex and challenging realities set out above.

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[4] Independent inquiry into care provided by Mid-Staffordshire NHS Foundation Trust January 2005 – March 2009 Vol 1. Chaired by Robert Francis QC.
http://www.midstaffsinquiry.com/assets/docs/Inquiry_Report-Vol1.pdf

[5] Care Quality Commission review of Castlebeck Group Services.
http://www.cqc.org.uk/sites/default/files/media/documents/20110726_castlebeck_summary.doc

This includes the intention to provide person-centred care, do “with” rather than “to” patients and service users and reject paternalistic notions of “the professional knows best” in favour of a greater emphasis on relationship-based care, mutuality, partnership working and shared decision-making. It also means ensuring that advocacy is in place for those who need it (or is available when required) so that the right balance between autonomy, empowerment and risk is maintained.

In addition to respecting the law and practitioners’ individual rights, contemporary professionalism places the interests of the public, patients and servicer users above practitioners’ self-interest, their political, cultural or religious beliefs, and any professional or occupational allegiances. Part of this, but by no means the only part, is the will and determination to challenge poor practice and to tackle safety issues. Few would argue that public confidence has been severely dented by recent severe system failures in care settings, the failure to tackle problems within teams and the propensity of leaders and managers to focus on objective data and performance at the expense of quality and people.

Consequently, this is an opportune time to provide a contemporary vision of professionalism for NMAHPs and support workers, with associated principles and behaviours that are clear to all. This aims to help restore the confidence in (and of) the healthcare workforce that has arguably been diminished as a result of negative publicity and adverse media coverage Closely aligned with the aspirations of the *Healthcare Quality Strategy for NHSScotland* for the consistent delivery of care that is safe, effective and person-centred, the focus for professionalism should be on the following priorities:

1. improving patients’, carers’ and service users’ experiences through professionalism
2. looking at opportunities to kindle a sense of pride and passion in those who are part of, support or have recently joined the NMAHP professions.

Every opportunity should be taken to embed contemporary professionalism in everyday practice and to instil and encourage professionalism in others. Identifying where professionalism is not apparent and taking appropriate action is therefore essential. Although organisational policy and procedures support staff to challenge and report poor practice and raise safety concerns, their translation into practice is inconsistent and organisational responses to expressions of concern is variable. NHS boards may consider undertaking further work on this with the royal colleges, partnership forums and regulators, who may also wish to take this opportunity to review their guidance.

This report posits that awareness of professionalism among healthcare staff should be promoted through selection, induction and ongoing performance review processes (to reinforce the central role of professionalism in healthcare practice) and professional behaviours and values should be recognised and reinforced in day-to-day practice and within workplace cultures. It also identifies environmental and organisational factors that impact on the projection and demonstration of professional behaviours, highlights the importance of team and organisational culture as a major influence in promoting professionalism, and recognises the role of strong and effective leadership and the impact of positive role-modelling, each of which will

go a long way to supporting the delivery of professionalism across the healthcare workforce. To that end, the behaviours and actions of board executives, professional leaders and managers are central.

2. Understanding and demonstrating professionalism

A Dignified Revolution (ADR), a voluntary movement set up to promote and improve care for older people in hospitals in the UK, urges healthcare professionals to reflect on the following Mumbai hospital motto adapted from a quotation from Mahatma Gandhi:

> *"A patient is the most important person in our hospital. He is not an interruption to our work; he is the purpose of it. He is not an outsider in our hospital; he is a part of it. We are not doing a favour by serving him; he is doing us a favour by giving us an opportunity to do so."*[6]

To ADR and many other groups promoting patients' and service users' interests, this presents the benchmark – and the challenge – that health services must aspire to meet.

All healthcare staff, including NMAHPs, who are highly committed to the ethos of professionalism strive to reflect this within the delivery of person-centred, safe and effective care and make a significant contribution to the three quality ambitions for NHSScotland. Underpinning the quality ambitions are the "7Cs" that articulate what people have said are important to them:

- **caring** and **compassionate** health services
- **collaborating** with patients and everyone working for and with NHSScotland
- providing a **clean and safe** care environment
- improved access and **continuity** of care
- **confidence** and trust in healthcare services
- delivering **clinical** excellence

The issue

> *"Public confidence in a profession is sustained when its expectations are – or are perceived to be – in harmony with professional culture and actual performance. On the other hand, public confidence is undermined when a significant gap appears between general expectation and performance."*[7]

Most people who use health services will say that they have had positive experiences,[8] and most staff are seen to demonstrate caring and professional behaviours. The fact that a noticeable proportion are reported not to demonstrate caring and professional behaviours cannot, however, be ignored. It is clear that in some instances, there is a gap between the behaviours expected of staff and those displayed to patients and service users. Attempts to address this include a renewed interest in self-regulation against recognised statutory codes of conduct, performance and ethics and the implementation of mandatory standards and codes

[6] http://dignifiedrevolution.org.uk/about-us/background-information.html
[7] Sir Donald Irvine (2003). The Doctors' Tale: Professionalism and public trust. Radcliffe Publishing Ltd.
[8] Better Together programme. www.bettertogetherscotland.com

for healthcare support workers issued as a Direction from Scottish Ministers in 2010.[9]

Reports from bodies such as the Scottish Public Services Ombudsman (SPSO) and the Mental Welfare Commission for Scotland (MWCS) and findings from professional regulators' fitness to practise hearings reflect the trends in dissatisfaction among the public regarding professional behaviours and attitudes. SPSO investigations[10] reveal:

> *"... an attitude – both personal and institutional – which fails to recognise the humanity and individuality of the people concerned and to respond to them with sensitivity, compassion and professionalism".*

A common subject of complaint in these investigations, reflected also in evidence from the UK professional regulators,[11] involves patients, service users, families and carers describing an NHS that is process-driven and bureaucratic rather than efficient and person-centred. Issues highlighted in complaints include lack of information and failure to promote autonomy and involvement, leading to people feeling helpless and powerless rather than empowered and in control. Cultures are also highlighted, with a lack of clear values leading to local cultures that can be hierarchical, or even bullying. Poor communication, poor attitudes and poor behaviours underpin many of the complaints.

Some health and social care staff may believe these failings relate to other people's practice rather than their own. When they reflect on their practice in an insightful and meaningful way, however, they are often able to identify instances in which their verbal communication and non-verbal behaviours have been inadequate and where the quality of their care has not been of the required standard. They may also be able to recognise the impact of small gestures or relatively insignificant interactions on patients', service users' and colleagues' perceptions and experiences, and may be able to recall occasions when their actions have been less than satisfactory.

Articulating professionalism

Although healthcare professionals and support staff perceive behaving in a professional way as a central facet of their role, they may find it difficult to articulate exactly what professionalism means and what it looks like in everyday practice.

Professionalism within the context of healthcare delivery should therefore be accepted as a fluid construct. It is dynamic, socially constructed and multi-faceted and is applicable to all staff who work as part of the healthcare team regardless of their role, status, title or designation. As was noted by a study of paramedic, occupational therapy and podiatry students and educators commissioned by the

[9] www.workinginhealth.com/standards/healthcaresupportworkers
[10] Scottish Public Safety Ombudsman. Annual Report 2010-2011
http://www.spso.org.uk/media-centre/annual-reports/2010-2011-annual-report
[11] NMC annual Fitness to Practise reports
http://www.nmc-uk.org/About-us/Statistics/Statistics-about-fitness-to-practise-hearings/
HPC annual Fitness to Practise reports
http://www.hpc-uk.org/publications/reports/

Health Professions Council (HPC) as part of a wider research programme exploring aspects of professional practice:[12]

> *"Professionalism ... was not seen as a static well-defined concept, but rather was felt to be constructed in specific interactions. Consequently, definitions of professionalism were fluid, changing dynamically with changing context."*

Consistently high levels of professionalism are important to patients and service users. Research has shown that what they understand as professionalism has always been valued and, indeed, is expected. For them, professionalism seems to incorporate a range of attributes and characteristics that include technical competence, appearance, image, confidence level, empathy, compassion, understanding, patience, manners, verbal and non-verbal communication, an anti-discriminatory and non-judgemental attitude, and appropriate physical contact. Absence of, or inconsistency in, the projection and manifestation of these characteristics underpins many of the complaints patients, service users and carers make about care.[13]

Healthcare workers also identify professional behaviour as a key element of good practice. In the HPC study into perceptions of professionalism, good clinical care or "doing the job well" included interacting and communicating in ways that were appropriate to patients and service users. Being self-aware and adhering to codes and protocols were also considered to be "professional behaviours", with professional self-awareness identified as influencing participants' desire to keep up to date and to maintain high standards of care.

Finding ways of projecting professionalism in practice is therefore desirable for both users and providers of care, with a greater focus on relationship-based care, mutuality and partnership working ("doing with" rather than "doing to" patients and colleagues) and with an emphasis on the "how" as well as the "what" of care delivery.

Literature, codes and standards across the healthcare workforce define some of the characteristics that underpin professional behaviour. Self-awareness, understanding and managing "self" in the work context, reflective practice, technical competence and a clear professional identity are identified as essential elements of professional and inter-professional practice. Maintaining professional boundaries when engaging with patients and service users in highly emotional contexts is also recognised as important, while not losing the essential elements of a caring relationship.

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[12] Morrow G, Burford B, Rothwell C, Carter M, McLachlan J, Illing J (2011). Professionalism and conscientiousness in healthcare professionals. Final report for Study 1 – Perceptions of Professionalism. Medical Education Research Group, School of Medicine and Health, Durham University, 21 April 2011 p22

[13] Parliamentary and Health Service Ombudsman. Care and Compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people. February 2011 http://www.ombudsman.org.uk/__data/assets/pdf_file/0016/7216/Care-and-Compassion-PHSO-0114web.pdf

The HPC study of perceptions of professionalism[14] found that interpretations of "professionalism" encompassed many and varied aspects of behaviour, communication and appearance. The study included the following summary of "what professionalism looks like".

- Professionalism has a basis in individual characteristics and values, but is also largely defined by context. Its definition varies with a number of factors, including organisational support, the workplace, the expectations of others and the specifics of each patient/service user encounter.
- The personal characteristics underlying professionalism may develop early in life as well as through education and work experience, but role-modelling is also important in developing the necessary awareness of appropriate action in different contexts.
- Views of professionalism did not diverge widely, regardless of professional group, training route or status as student or educator. All saw the interaction of person and context and the importance of "situational judgement" ("the ability to judge circumstances in order to identify the most appropriate way of acting/responding/communicating in a particular context, whilst still following a code of conduct") [15] as the key to "professional behaviour".
- Professionalism may be better regarded as a metaskill comprising situational awareness and contextual judgement that allows individuals to draw on the communication, technical and practical skills appropriate for a given professional scenario. The true skill of professionalism may be not so much in knowing what to do, but when to do it.

If healthcare staff are to display the behaviours, attitudes and values that are the core of quality health care and to develop respectful and effective relationships with patients, service users, carers and fellow professionals across many organisational boundaries, the underpinning principles that will support these desired characteristics need to be clearly laid out. There is a strong argument in favour of a single set of shared behaviours and values to focus the efforts of all staff.

Consequently, the working group has opted in this report to consider Stern's principles[16] as a useful starting point. Stern's principles provide a foundation from which a wider consideration and development of a pragmatic expression of professionalism can be progressed. This does not imply that Stern's principles should be universally adopted or, indeed, that they should be adopted in their entirety, but rather that they provide a foundation from which a wider consideration of the principles of professionalism can be launched. The group could equally have chosen another source as a starting point, such as the insightful practice model: the main priority was to identify a model that assisted understanding of the concept of professionalism and acknowledged the challenges that need to be addressed around, for example, dignity, respect, compassion, empathy, honour, integrity and acting in the best interests of patients and service users.

[14] Morrow G, Burford B, Rothwell C, Carter M, McLachlan J, Illing J (2011) Professionalism in healthcare professionals. www.hpc-uk.org/publications/research
[15] Morrow G, Burford B, Rothwell C, Carter M, McLachlan J, Illing J (2011). Perceptions of professionalism in healthcare professionals www.hpc-uk.org /publications/research
[16] Stern DT (2006). Measuring medical professionalism. Oxford University Press.

Stern identifies **four principles** as encompassing the notion of professionalism. Although valuable, these principles are considered by some to be subject to individual and cultural interpretation and are therefore limited in their application. Accordingly, they are outlined below alongside contextualised definitions and related concepts developed by working group members with a view to illustrating their applicability in a practical setting (Table 1).

Table 1. Stern's principles, contextualised definitions and related concepts

Stern's principle	Contextualised definition	Related concepts
Excellence	Demonstrating practice that is distinctive, meritorious and of high quality	1. Commitment to competence 2. Commitment to exceeding standards (in education and practice) 3. Understanding of ethical principles and values 4. Knowledge of legal boundaries (and practice) 5. Communication skills
Accountability	Demonstrating an ethos of being answerable for all actions and omissions, whether to service users, peers, employers, standard-setting/regulatory bodies or oneself.	1. Professional:patient contract (including acknowledgement of unequal "power" relationship) 2. Professional:social contract 3. Self-regulation (including standard setting, managing conflicts of interest, duty, acceptance of service provision, responsibility)
Humanism	Demonstrating humanity in everyday practice.	1. Respect (and dignity) 2. Compassion 3. Empathy 4. Honour 5. Integrity
Altruism	Demonstrating regard for service-users and colleagues and ensuring that self-interest does not influence actions or omissions.	1. Opposite of self-interest 2. Acting in the best interests of patients

There may be value in disseminating a vision for professionalism, with further exploration of its application in a changing healthcare world.

Recommendation 1. Develop and publish a vision for the delivery of professionalism in the changing healthcare context and test with a range of stakeholders.

Projecting professionalism

As previously alluded to, all healthcare staff, including support staff, are expected to demonstrate behaviours that support optimal care, project confidence and competence, and provide reassurance to all who come into contact with service providers. There is also increasingly a suggestion that staff should empower, enable and support service users to be in control, be suitably informed and take ownership of their care. This begins with the positive presentation of self, meaning strict compliance with national uniform policy or professional dress code where appropriate, clearly displayed identification and clean, tidy and modest appearance.

Professionalism, however, is about much more than appearance. Projecting the concept of professionalism requires recognition that care is not restricted to external technical tasks (the "what" of care delivery) but is also, importantly, about internal

human qualities (the “how” of care delivery). This starts from the first moment of contact with patients or carers who, by virtue of the fact that they are having to access health services, are liable to be anxious and in need of a kind, courteous, reassuring and comforting response.

Professionalism is understood to be driven by internal drivers such as personal values, attributes and a sense of personal responsibility: these personal attributes are considered core to professionalism,[17] and several studies[18] have illustrated the ways in which they influence how practitioners behave towards one another and towards patients. They are influenced by organisational values and are supported by external drivers such as environmental and cultural influences, engaged leadership and facilitation of learning, and through feedback from patients, carers, service users and colleagues. Empathy is not the same as sympathy, and being able to put oneself in the patient’s, service user’s or carer’s position can be a hugely impactful reflective approach.

Activities associated with reflective practice are key influences on professionalism. Regular reflection on practice is recognised as a way of developing and improving performance[19] and practitioners who regularly review and adapt their practice accordingly are more likely to be receptive to new developments in their field and new ways of working. They are also more likely to be responsive to feedback and more willing to adapt and change their practices and behaviours. The desire for self-development and the motivation to keep up to date is recognised as an important influence on professionalism in practice.

The imminent review of the Staff Governance Standard[20] is likely to focus not only on the rights of staff (as is the current focus) but also on their responsibilities, mirroring the approach taken in the forthcoming Patient Charter of Rights and responsibilities introduced in the Patient Rights (Scotland) Act 2011. This work provides an opportunity to ensure that the requirement of professionalism is explicitly stated within the standard.

Recommendation 2. Incorporate professionalism within all staff governance and employment activity.

The cost of professionalism

There are enormous advantages and privileges for healthcare staff in being recognised as professional, but with these come responsibilities. Those who behave according to the principles of professionalism are required to devote a measure of

[17] Stern DT (2006). Measuring medical professionalism. Oxford University Press.
[18] Royal College of Physicians (2005). Doctors in society: Medical professionalism in a changing world. Report of a Working party of the Royal College of Physicians of London. www.rcplondon.ac.uk
[19] Schön D (1983). The Reflective Practitioner, How Professionals Think In Action. Basic Books.
Bolton G (2001). Reflective practice: writing and professional development. Paul Chapman Publishing Ltd.
Sharp C (2005). The improvement of public sector delivery: supporting evidence based practise through action research. Scottish Executive Social Research.
Bergman D, Arnetz B, Walstrom R, Sandhal C (2007). Effects of dialogue groups on physicians’ work environment. Journal of Health Organisation and Management 21(1);27-38.
Thistlethwaite J, Spencer J (2008). Professionalism in Medicine. Oxford Radcliffe Publishing.
[20] http://www.staffgovernance.scot.nhs.uk/what-is-staff-governance/staff-governance-standard/

their own time to developing their knowledge and skills and need to accept that the public, employers and, where appropriate, professional regulators expect them to uphold the principles of professionalism and display good character at all times, even when not "on duty".

Providing empathic, personal and respectful care also carries a price. The concept of "emotional labour" conveys the practical manifestations of this price and describes some of the challenges that healthcare staff face on a daily basis. Emotional labour is described as hard skilled work and is "*an integral yet often unrecognised part of employment that involves contact with people*".[21]

Early indicators of the emotional and psychological effects of caring may often be seen by colleagues but may not be acknowledged, leaving staff feeling lonely, unsupported and under stress. This can exact a heavy personal toll on staff as individuals, causing physical and mental health problems and deterioration in professional standards, performance and behaviour. It could also lead to them leaving the job or the profession. This negative spiral of events can be arrested if the emotional and psychological impacts are recognised and acknowledged and appropriate support is offered.

A study focusing on compassionate care within inpatient settings[22] identified "caring conversations" as an enabling influence for compassionate care and a means of providing support to staff. Caring conversations involve staff, patients, service users and carers "discussing, sharing, debating and learning" about how care is provided. The approach fits with relationship-centred care and draws on the collective wisdom of the team.

A similar approach to providing support to offset the emotional cost of professional healthcare practice is that of Schwartz Center Rounds®[23]. These have been recommended by the King's Fund[24] as a viable and effective means of counteracting stress in healthcare staff, reinforcing positive professional principles of empathy and compassion and building positive team cultures. The technique involves supportive, facilitated groups in which staff are encouraged to explore their feelings in relation to their contributions to the care of individual patients and service users; participants ask questions, share experiences and reflect on the challenges of care. If applied appropriately, this can result in practitioners gaining insight into their own practice, behaviours and attitudes and those of others – in effect, learning to see themselves as others see them.

Participants involved in research on Schwartz Center Rounds® in the United States reported that their ability to provide compassionate care improved and they felt better

[21] Gray B (2009). The emotional labour of nursing – Defining and managing emotions in nursing work. Nurse Education Today 29(2):168-175
Gray B, Smith P. (2009). Emotional labour and the clinical settings of nursing care: The perspectives of nurses in East London. Nurse Education in Practice 9(4):253-261
[22] Edinburgh Napier University and NHS Lothian (2012). Leadership in Compassionate Care Programme Final Report.
[23] http://www.theschwartzcenter.org/
[24] Machell S, Gough P, Steward K (2009). From Ward to Board: identifying good practices in the business of caring. The King's Fund, London.

supported in caring for patients. A pilot evaluation study in the UK[25] found that similarities between the UK pilot sites and the United States were more marked than any differences.

Mechanisms such as these above should be investigated and adopted to enable staff to deal with the emotional and psychological impacts of healthcare practice. Failure to do so may impact significantly on the ability of individual practitioners to continue to function in a professional way.

Recommendation 3. Introduce supportive mechanisms to enable staff to deal with the emotional and psychological impacts of health care.

[25] Goodrich J (2011). Schwartz Center® rounds. An evaluation of the UK pilots. The King's Fund, London. http://www.kingsfund.org.uk/current_projects/point_of_care/schwartz_center_rounds/schwartz_center.html

3. Facilitating professionalism

This chapter explores the key influences and contexts in which professionalism can thrive, recognising that the particular influence of a culture, system, framework, standard or patient encounter will vary. Strong leadership, committed organisational support, empowered staff, partnership working and a commitment to securing patient/service user feedback to inform activity are among the positive influences on professionalism observed in the work environment: these may have the greatest potential for revitalising professionalism among healthcare staff in the future.

Standards for professional practice

(This subsection focuses specifically on NMAHPs, rather than the wider healthcare workforce).

Regulatory body standards of practice are set by UK-wide regulators such as the Nursing and Midwifery Council (NMC) and the HPC. They describe how professionals are expected to behave towards patients, service users and colleagues in the practice of their profession and are considered key to safeguarding the health and well-being of the public and protecting their interests. They determine personal responsibilities for all individuals who are governed by the standards to ensure they act by them but also reflect wider organisational responsibilities to ensure that individuals are supported to meet the standards.

Regulators have robust legal powers to take action against those who do not adhere to their standards, including removal or suspension from the register and restrictions on practice. Behaviours that could lead to the regulator taking action against professionals relate to practice and conduct and include financial exploitation of a vulnerable patient or service user, conducting an inappropriate relationship with a patient or service user, and serious or persistent failure to meet a standard of competence. Further examples are set out in annual fitness to practise reports such as those from the NMC[26] and HPC (see Annex 2).[27] These incidences occur in a very small minority of health professionals but have a profound effect on both the individuals concerned and levels of public confidence in the professions.

A range of contracts, guidelines, standards, protocols and codes has been developed for NMAHPs in Scotland and across the UK. These include professional and regulatory body standards, the Royal College of Nursing's *Principles of Nursing Practice,*[28] national guidance developed at government level and local standards, and procedures and protocols at NHS board level. As has already been mentioned, Scotland also has a mandatory code of conduct for healthcare support workers with induction standards for those entering the workforce and a code of practice for employers .[29]

[26] http://www.official-documents.gov.uk/document/other/9780108510717/9780108510717.pdf
[27] http://www.hpc-uk.org/assets/documents/10003700FTPannualreport2011.pdf
[28] Royal College of Nursing (2011). The principles of nursing practice. www.rcn.org.uk/development/practice/principles
[29] www.workinginhealth.com/standards/healthcaresupportworkers

These standards and codes provide the parameters within which NMAHPs and support workers must practise and are positive drivers of service excellence. Failure to act in accordance with them may result in practice or actions that not only put patients, service users and possibly colleagues at risk, but also place practitioners at risk of disciplinary action from their employer, sanction by their regulator and, in extreme cases, prosecution under the legal process.

Environmental/cultural influences

Different organisational and professional systems and frameworks interact with, and potentially shape and sustain, professionalism. Facilitating professionalism can therefore be explored on a number of levels.

Establishing a culture that values all contributions will help to maintain feelings of pride and motivation in staff. Recognising that all staff make an essential contribution to an individual's experience of healthcare can help to build a team ethos and equitable work culture. If the workforce does not feel engaged or valued, this can affect motivation, culture, attitudes and behaviours and could impact on manifestations of professionalism. Work being taken forward in Scotland on shared governance recognises the importance of this.

In addition to the national codes and standards developed by government departments, regulatory bodies and professional associations discussed above, a range of workplace drivers also influence professionalism. These include:

- clinical governance
- care governance
- staff governance
- professional leadership and career frameworks
- general management frameworks
- partnership-working frameworks
- individual performance management frameworks
- education, training and personal development planning frameworks.

Team cultures and norms exert a significant influence, positively or negatively, on the ability of individual staff to adopt and embed professionalism within their practice. A positive team culture will nurture professionalism, whilst a negative culture, in which innovation is stifled, care approaches are not person-centred and development and learning are not ingrained, may mitigate against the development of professional behaviour, particularly in less experienced team members. A key element in facilitating professionalism within services is therefore to identify where team cultures are hindering professional behaviour and take action to nurture more positive approaches. The aim must be to create consistency in approach to professionalism across teams by raising the bar for those who are not functioning in accordance with the principles of professionalism, rather than lowering it for those who are. It is therefore important to be clear about expectations of team cultures and define what is non-negotiable.

Recommendation 4. Implement measures to enable a professional culture to flourish across NHSScotland.

Support and review mechanisms

The NMAHP workforce has a strong culture of mutual support that includes the provision of mentorship, preceptorship, coaching, personal development planning and review and clinical supervision. For instance:

- students access mentorship from experienced staff in clinical placements
- new registrants undertaking the Flying Start NHS®[30] programme commonly benefit from mentorship from a more experienced colleague
- healthcare support workers undertaking mandatory induction and assessment of compliance with the code of conduct receive support and review of progress against the required standards
- practitioners in many services, particularly midwifery, mental health and learning disabilities, engage in forms of clinical supervision with peers
- senior staff often organise individual mentoring and coaching schemes to support their personal and professional development
- all NHSScotland staff have access to annual personal development planning and performance review as part of their employment contract.

Clinical supervision is seen as integral to lifelong learning and is an important part of clinical governance and improving standards of care. It is described as a range of processes centred on enabling practitioners to reflect on their practice, identify possible solutions to problems and improve standards. All profession-specific regulatory and professional bodies promote clinical supervision as a means of supporting practitioners to work effectively and to enable professional and personal development. Midwives are distinct in that they have a separate statutory requirement to access supervision, given the more autonomous nature of their practice.

There is, however, significant variation across the country in terms of opportunities for staff to access support schemes such as these. They are nevertheless important in relation to promoting professionalism and could usefully be organised around the underpinning principles of professionalism; these would serve as benchmarks for personal development planning and performance review with a view to identifying ongoing development needs.

Recommendation 5. Develop existing support measures to facilitate and embed professionalism across NHSScotland.

One of the aims of the NHS Knowledge and Skills Framework (KSF) is to provide a fair and objective basis for review and development for staff employed in the NHS. The KSF is primarily focused on knowledge and skills, although the addition of a professionalism strand into the personal development planning and review process would appear attractive. There is a need to consider how this could be achieved and integrated into current processes without creating an unnecessary and overly bureaucratic burden.

Recommendation 6. Incorporate the requirements of professionalism within personal development planning and review processes.

[30] http://www.flyingstart.scot.nhs.uk/

Recruitment and selection

Healthcare organisations' mechanisms for recruitment and selection at all levels should be sensitive to the key underpinning characteristics of professionalism and should be capable of identifying these in potential recruits, both within written and online submissions and in interview and assessment processes. Similar considerations should govern processes for recruitment and selection to education and training programmes.

Potential applicants should be made clearly and explicitly aware of what is expected from those who are recruited. The aim is to ensure that, as far as is possible, an "upstream" approach to embedding professionalism in the workforce is adopted by service and education providers, with the aspiration of avoiding problems "downstream". This reflects a proactive approach to promoting professionalism.

Recommendation 7. Explore and implement mechanisms for selection and recruitment that incorporate the requirements of professionalism.

Leadership and role modelling

It is acknowledged that individual healthcare workers have responsibility for demonstrating the values and behaviours commensurate with professionalism, however leadership is a key influence on their ability to adopt professional behaviours. The Chief Nursing Officer for Scotland has introduced a model of shared governance across NHSScotland to support a dynamic staff−leader partnership that promotes collaboration, shared decision making and accountability for improving quality of care, safety and enhancing work life.

Leaders at all levels in organisations, throughout practice, management and education areas, nurture engagement through which the meaning of professionalism can be revitalised. Alimo-Metcalfe's Model of Engaging Leadership[31] is an example of a model that may have relevance here; it identifies 14 dimensions that may support leaders in this endeavour (Table 3).

Table 3. Model of Engaging Leadership

Engaging with individuals • showing genuine concern • being accessible • enabling • encouraging questioning	**Engaging the organisation** • supporting a developmental culture • inspiring others • focusing team effort • being decisive
Engaging the stakeholders – moving forward together • building shared vision • networking • resolving complex issues • facilitating change sensitively	**Personal qualities and values** • being honest and consistent • acting with integrity

[31] Alimo-Metcalfe B (2008). Building leadership capacity through engaging leadership. Selected Reports from the 12th World HR Congress, London. http://acripnacional.org/BLC.pdf

The NHSScotland *Delivering Quality Through Leadership* strategy,[32] which includes an appendix detailing "leadership qualities and behaviours", will also support leaders to project professionalism within their organisations.

Styles of leadership have been shown to be an important factor in improving staff motivation, job satisfaction and commitment, and reducing work-related stress. As highlighted by the King's Fund,[33] leaders play a key role in role-modelling professional behaviours. Professionalism in action can be demonstrated by leaders who "walk the talk" and are visible role models, inspiring those who work alongside them. This is at the heart of the *Leading Better Care*[34] programme.

The impact of poor or weak leadership and management has been highlighted in recent reports into severe system failures in care settings.[35,36] These reports reveal a consistent pattern of leaders and managers failing to: provide training for staff; ensure adequate staffing levels; provide effective supervision of staff; ensure effective care planning; respond to and learn from serious incidents; notify relevant authorities of safeguarding incidents; and involve people in decisions about their own care. Where leadership fails in such ways, it makes it more difficult for professional behaviours to be adopted and embedded within clinical practice.

Positive leadership and instilling a sense of responsibility and accountability in all staff will assist in building a sense of team contribution and will promote the principles of professionalism. Leaders can:

- ensure that individual personal development plans within their services are influenced by the principles of professionalism, and that individual and team objectives instil a sense of collective contribution to achieving excellence
- establish a culture that values all contributions and promotes feelings of pride and motivation in staff
- celebrate achievements and success
- ensure that agreed performance management processes are used to identify and assist those who do not display the behaviours of professionalism.

These factors, and many more related to leadership, can affect culture, attitudes and performance among the workforce and impact on the development of professional behaviours.

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[32] Scottish Government (2009). Delivering Quality Through Leadership: NHSScotland Leadership Development Strategy
http://www.scotland.gov.uk/Publications/2009/10/29131424/13

[33] Machell S, Gough P, Steward K (2009). From Ward to Board : identifying good practices in the business of caring. The King's Fund, London

[34] Scottish Government (2008). Leading better care: Results of the Senior Charge Nurse Review and Clinical Quality Indicators Project conducted by the Scottish Government and professional advisers.
http://www.scotland.gov.uk/Publications/2008/05/30104057/0

[35] Independent inquiry into care provided by Mid-Staffordshire NHS Foundation Trust January 2005 – March 2009 Vol 1. Chaired by Robert Francis QC.
http://www.midstaffsinquiry.com/assets/docs/Inquiry_Report-Vol1.pdf

[36] Care Quality Commission review of Castlebeck Group Services.
http://www.cqc.org.uk/sites/default/files/media/documents/20110726_castlebeck_summary.doc

Recommendation 8. Promote positive role modelling and leadership across NHSScotland as a means of promoting professionalism.

Education, training and learning from others

There is broad agreement across the healthcare sector that personal responsibility for learning and a commitment to lifelong learning are core aspects of professionalism. Continuing professional development (CPD) is fundamental to the development of NMAHPs and all healthcare staff and is a mechanism through which high-quality care is identified, maintained and developed.[37] Organisations should aim to support and reinforce individuals' commitment to lifelong learning and ensure the provision of ongoing CPD opportunities that focus on issues of conduct as well as knowledge, competence and skill to support their development. This need not necessarily come at financial cost, as development opportunities can be secured through workplace and exchange activities.

Recommendation 9. Reinforce personal responsibility for lifelong learning as part of professionalism, facilitated by organisational support.

Recommendation 10. Focus NHSScotland learning and development activity on issues of conduct as well as knowledge, competence and skill.

Research with doctors in the United States[38] found that those who did not display professional behaviour or fulfil course responsibilities during their pre-registration education were far more likely to subsequently be subject to disciplinary action by a state medical board. The correlation was particularly strong for repeated instances of certain behaviour such as unreliable attendance at a clinic, not following up on activities related to patient care and repeated instances of diminished capacity for self-improvement, such as failure to accept constructive criticism, argumentativeness and displaying poor attitudes. It is not unreasonable to assume that these findings could extend across other health professions. This is currently being investigated by researchers at Durham University.

Pre- and post-registration education and training programmes provide opportunities for students to explore the concept of professionalism for their practice. Studies have shown that clinical role models can have a significant impact on how professionalism is perceived by students. The concept of professionalism needs to be embedded in such programmes, including undergraduate and postgraduate curricula, with support provided to mentors to promote awareness of its principles among students and other learners.

Regulators work with education institutions to ensure that students understand the significance of professionalism to practice. Demonstrating the importance of professional values and the principles embodied in regulatory standards will help

[37] Joint Position statement on continuing professional development for health and social care practitioners
http://www.cot.co.uk/cpd/joint-statement-cpd

[38] Papadakis MA, Arnold GK, Blank LL, Holmboe BS, Lipner RS (2008). Performance during internal medicine residency training and subsequent disciplinary action by state licensing boards. Annals of Internal Medicine 148:869-876

students and other learners to carry these values and principles through into their clinical practice.

Recommendation 11. Incorporate professionalism as a central concept within all training and education programmes, including undergraduate and postgraduate curricula.

There has been a strong evidence base since the 1980s showing the positive correlation between the learning environment and the clinical environment.[39] A good place for learners has been shown to be a good place for patients, service users and staff. The Profile of Learning Achievements in Care Environments (PLACE) project[40] demonstrated that the relational aspect of care is central to the experience of teaching, learning and communication and, ultimately, to the quality of care delivered to patients and service users, and job satisfaction for staff. Equally important is the learning that takes place among peer groups, whether formally through conferences, journal clubs, action learning sets and peer review processes, or informally through day-to-day role modelling and feedback.

Learning from patients and service users is another key influence on the development and maintenance of professionalism. Learning can arise through compliments and complaints from patients, service evaluation feedback, public meetings, service user involvement in student education and training, and from research into patients' views. The *Better Together*[41] programme is a positive example of how patients' expectations and experiences can influence professionals at many different levels and in a variety of contexts. Patient and service user feedback can be undertaken through formal and informal activity and should be perceived as a key driver of change.

Promoting and communicating professionalism

The aim of this work is to embed professionalism in the everyday practice of all members of the NMAHP and wider healthcare workforce in Scotland. The dialogue about how professionalism is promoted and communicated is therefore an important consideration.

As this report has described, professionalism runs as a thread through mandatory codes and standards and most local and national policy and strategy in Scotland, including the *Healthcare Quality Strategy for NHSScotland*[42] and mandatory standards and codes for healthcare support workers.[43] It also features as a central tenet of clinical and operational standards and is increasingly recognised as a key quality indicator. However, the task of revitalising professionalism within the conduct, performance and ethical underpinnings of the healthcare workforce will be greatly

[39] Alexander MA (1983). Learning to Nurse: Integrating theory and practice. Edinburgh, Churchill Livingstone Publishers.
Fretwell JE (1982) Ward Teaching and learning. London, Royal College of Nursing.
[40] Brown J, Robb Y, Duffy K, Lowndes A (2010). Enhancing Learning in Care Settings: the Profile of Learning Achievements in Care Environments (PLACE) Project. Emerald Group Publishing Ltd.
[41] Better Together programme. www.bettertogetherscotland.com
[42] Scottish Government (2010). NHSScotland Quality Strategy - putting people at the heart of our NHS. http://www.scotland.gov.uk/Publications/2010/05/10102307/0
[43] www.workinginhealth.com/standards/healthcaresupportworkers

assisted if the concept is promoted and communicated in a clear and meaningful way.

This is a challenging undertaking that requires more than the production of leaflets and other written materials. It calls for a multi-faceted approach that will address different communication needs and different levels of motivation to ensure that the key messages reach their intended audiences (managers, educators, practitioners, patients, service users and the general public). Various forms of research, including that related to psychology and educational experience, can show the complexity of behavioural change and the influence of attitude and motivational factors. Such research should be used to support any promotional work that may be taken forward.

Recommendation 12. Secure all relevant research input into any promotional and communications work.

This report has been developed to *inform* the NMAHP Co-ordinating Council: further work is now needed to develop resources on professionalism to *engage* the NMAHP and wider healthcare workforce and to *reassure* the public.

4. Measuring professionalism

A subgroup of the working group, including academics from Dundee, Durham, Edinburgh Napier and Stirling universities, reviewed and explored the literature on mechanisms to recognise and measure manifestations of professionalism and professional behaviours. The subgroup identified an array of potentially suitable measurement tools (proxy measures) that might be appropriate to measure professionalism and to identify development needs. Essentially focused on behaviours, relationships, practice, context and culture, the tools cover diverse approaches that may facilitate quality improvement through professionalism. This chapter provides a brief summary of some of the key findings from the research: the complete research report can be accessed at http://www.knowledge.scot.nhs.uk/qualitycouncils/support-workstreams/professionalism-(and-regulation).aspx.

Characteristics such as “care” and “compassion” are top priorities for health service users and are key to the professional principles that guide NMAHPs. Many of the caring and enabling behaviours are those which define “professional” behaviours, and their presence can be measured. The Care Governance Measurement Framework[44] proposes a range of measures including variables that describe caring and enabling behaviours, their interrelationships and influences, and their impact on staff and patient experiences and outcomes.

Informatics principles should also assist in ensuring that data collected are fit for purpose, cost-effective and are used to drive quality improvement. Key principles include the reporting of data in real time (or near real time) to enable those who are accountable for the delivery of care to make informed decisions that promote and sustain quality patient care.

Potential tools

It is important to emphasise that no one tool or approach will suffice: one size does not fit all.[45] It will be for individual organisations to determine the most appropriate tools to apply in specific contexts and to provide feedback to staff accordingly.

Collated views of co-workers: multi-source feedback

Multi-source feedback (MSF) involves collecting data from different sources – peers, clinical supervisors, non-clinical staff – to develop a broad indicator of practice patterns.[46] One of the aims of MSF is to raise self-awareness of performance. It also seeks to encourage improvement and utilise feedback from both clinical and non-clinical peers[47]. The ECO model (emotions, content, outcomes) is a three-step

[44] http://www.knowledge.scot.nhs.uk/qualitycouncils/support-workstreams/care-governance-measurement-and-ehealth.aspx

[45] Schuwirth LWT, van der Vleuten C (2004). Changing education, changing assessment, changing research. Medical Education 38:805-812

[46] Lockyer J (2003). Multi-source feedback in the assessment of physician competencies. Journal of Continuing Education in the Health Professions 23(1): 4-12

[47] Murphy DJ, Bruce DA, Mercer SW, Eva KW (2009). The reliability of workplace-based assessment in postgraduate medical education and training: a national evaluation in general practice in the United Kingdom. Advances in Health Science Education 14: 219-232. http://dx.doi.org/10.1007/s10459-008-9104-8

process developed from the counselling literature to facilitate feedback acceptance and use in MSF.[48] Those who have used the model have found it useful and simple: it engages participants to reflect upon their feedback and performance and explore emotions, and clarifying content appeared integral to accepting and using the feedback. Using the ECO model to engage individuals in feedback discussions may prove useful in the future.

Patient opinion/satisfaction
Patient and service user satisfaction questionnaires can be another useful source of feedback for professionals.[49] The Consultation and Relational Empathy (CARE)[50] questionnaire focuses on relationship empathy as perceived by patients within healthcare consultations. The CARE measure has been validated with doctors, and the *Healthcare Quality Strategy for NHSScotland*[51] is committed to pursuing its introduction in all clinical appraisals and with other healthcare professionals.[52]

*Conscientiousness inde*x
The trait of "conscientiousness" can be measured objectively and has been shown to be an effective predictor of workplace performance in a number of settings. Data on undergraduate medical student performance on routine tasks show that the "conscientiousness index" data correlated positively with staff and peer understandings of professionalism.[53] This work has been independently replicated elsewhere and is currently being explored for use in a number of postgraduate settings, including those for AHPs. A conscientiousness index is inexpensive to calculate and is reliable and objective. While it does not capture all elements of professionalism, it may reflect a significant part. There is potential for the conscientiousness index to be used with other healthcare groups.

Measurement of insightful practice
Measurement of insightful practice is a new concept that is being tested in the Tayside In-Practice Portfolio (TIPP) study.[54] The method focuses on encouraging productive reflection (engagement and insight) and necessary action (lifelong learning and response to audit).

External and objective feedback based on patient care governance outcomes
Data on patient outcomes relevant to specific roles have been used within the NHS to promote quality improvement. These data could be developed to feed back to different professional groups on their personal and team performance.

Sargeant J, Mann K, Ferrier S (2005). Making available a mentoring service to support physician feedback, reflection, learning and change, can increase acceptance and use of feedback; Medical Education 39:497-504

[48] Sargeant J, McNaughton E, Mercer S, Murphy DJ, Sullivan P, Bruce DA (2011). Providing feedback: Exploring a model (Emotion, Content, Outcomes) for facilitating multisource feedback. Med Teacher 33(9): 774-779

[49] Chisholm, A Sheldon H (2011). Service user feedback tools: An evidence review and Delphi consultation. www.hpc-uk.org/publications/reports

[50] http://www.gla.ac.uk/departments/generalpracticeprimarycare/research/caremeasure/

[51] http://www.scotland.gov.uk/Publications/2010/05/10102307/0

[52] http://www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf p26

[53] McLachlan JC (2010). Measuring conscientiousness and professionalism in undergraduate medical students. The Clinical Teacher 7:37-40

[54] Murphy D, Guthrie B, Sullivan F, Mercer S, Russell A, Bruce D. BMJ Quality and Safety 2011 (manuscript under review).

Personal qualities assessments
The revised NEO Personality Inventory (NEO-P-IR) is an internationally recognised instrument to measure personality. It is a 240-item measure of a five-factor model – extraversion, agreeableness, conscientiousness, neuroticism, and openness to experience – that measures six sub-domains across each of these personality factors, including leadership, decision-making and stress management.[55]

Independent measurement of the professional (such as situational judgement tests)
Situational judgement tests (SJTs) are used to assess performance in solving problems in the workplace. They usually present users with hypothetical and challenging scenarios they might face in the work environment, offering different approaches they may want to take to solve the problem (generally in multiple-choice format). SJTs have been described as valid and reliable tools with which to select professionals within organisations[56] and have been used to reduce the number of applicants taken forward to more resource-intensive selection processes. This suggests that they may be effective as a filter in recruitment and appraisal processes.

Internal self-assessment of the team by its members
Questionnaires may be used to capture the perceptions of team members, allowing sharing of views and identification of opportunities to develop team cultures and improve quality.

External independent assessment of the team by others
Questionnaires completed by those working with the team and those experiencing care could be developed to provide feedback on culture.

A feedback exercise [link to full measurement report] shows that tools perceived as likely to demonstrate a strong breadth of performance as potential formats of measurement include:

- patient opinion/satisfaction questionnaires
- situational judgement tests
- external objective feedback on patient care outcomes (governance)
- team questionnaires on culture.

There are other potential methods of testing that were not included in the research, such as observation processes like the Workplace Culture Critical Analysis Tool (WCCAT),[57] which supports continuous quality improvement and provides real-time

[55] McCrae RR, John OP (1992). An Introduction to the Five-Factor Model and Its Applications. Journal of Personality 60:175–215
McCrae RR, Costa PT Jr. Del Pilar GH, Rolland JP, Parker WD (1998). Cross-Cultural assessment of the Five-Factor Model: The Revised NEO Personality Inventory. Journal of Cross-Cultural Psychology 29: 171
[56] McDaniel MA, Morgeson FP, Finnegan EB, Campion MA, Braverman EP (2001). Use of situational judgment tests to predict job performance: A clarification of the literature. Journal of Applied Psychology; 86:730-740
[57] McCormack B, Henderson E, Wilson V, Wright J (2009). Making practice visible: The Workplace Culture Critical Analysis Tool (WCCAT) Practice Development in Health Care Vol 8, Issue 1 pp28–43. Article first published online: 22 Jan 2009 DOI: 10.1002/pdh.273

feedback on quality interactions and culture. Observational and simulation processes were also not tested.

Making choices

The real test of any successful measure of professionalism is whether it supports the workforce to achieve improved patient, service user and carer experiences and outcomes. Successful implementation should reassure the public and help deliver the *Healthcare Quality Strategy for NHSScotland*[58] quality ambitions.

Means of enabling individuals and teams to consider their professionalism need to be flexible and practical. When making choices on tools, it will be important to consider if they adequately cover necessary professional attributes, include a measure(s) of patient/service user feedback and are endorsed through personal development planning/review mechanisms.

The inclusion of patient/service user opinion offers challenges. Assuring anonymity will be important if valid feedback is to be captured, and this has been successfully achieved with the CARE process with patients.[59] Team questionnaires are potentially more difficult, but improved technology and better web access should make it possible to feed back increasingly sophisticated information to teams on measurable patient outcomes.

The working group's suggestions on possible tools for measuring professionalism in the NMAHP workforce are shown in Table 4. Consideration needs to be given to the infrastructure required to train and support a range of people to use the tools and give the necessary feedback as part of the improvement cycle.

Table 4. Working group's suggestions on possible tools for measuring professionalism in the NMAHP workforce

NMAHP group	Suggested tools
Pre-registration students	Situational judgement tests Personal qualities assessments Conscientiousness index
Newly qualified practitioners	Conscientiousness index Situational judgement tests Observation of practice and clinical skills
Established practitioners	Conscientiousness index Peer feedback (such as MSF) Patient feedback (such as CARE) Team (culture) questionnaires (possibly based on care

[58] http://www.scotland.gov.uk/Publications/2010/05/10102307/0

[59] Mercer SW, Hatch D, Murray A, Murphy DJ, Eva KW (2008). Capturing patients' views on communication with Anaesthetists: the CARE Measure, Clinical Governance 13(2):128-137.
Mercer SW, Murphy DJ. Validity and reliability of the CARE Measure in secondary care (2008). (Manuscript CG401) Clinical Governance; 2008: 13(4):269-283.
Mercer SW, Fung CSC, Chan FWK, Wong FYY, Wong SYS, Murphy D J (2011). The Chinese version of the CARE Measure reliably differentiates between doctors in primary care: a cross-sectional study in Hong Kong. BMC Family Practice; 12:43
Murphy DJ, Bruce DA, Mercer SW, Eva KW (2009). The reliability of workplace-based assessment in postgraduate medical education and training: a national evaluation in general practice in the United Kingdom. Advances in Health Science Education; 14: 219-232.
http://dx.doi.org/10.1007/s10459-008-9104-8

	governance) Observation of practice and clinical skills
Support workers	Peer feedback (such as MSF) Patient feedback (such as CARE) Team (culture) questionnaires (possibly based on care governance) Observation of practice and clinical skills Personal qualities assessments
Managers	Peer feedback (such as MSF) Patient feedback (such as CARE) Team (culture) questionnaires (possibly based on care governance)

Recommendation 13. Ensure that information-gathering and measurement tools are appropriate to needs and are endorsed and facilitated through systems such as personal development planning and review processes.

In summary:

- there is no single measurement tool that can be relied upon to measure professionalism, given the diverse nature of the concept and the multiple roles in which high standards are important
- there is a need for a range of tools to meet local circumstances and needs
- there is a need to explore the validation of approved team (cultural) measures
- measurement of outcomes should be linked to professionalism to ensure that any implemented process is successful
- any adopted system(s) will need to align with the Scottish Government's Quality Measurement Framework
- current work on care governance may produce useful cultural measures of professionalism.

5. Recommendations

Professional values and behaviours are expected of all those with whom patients and service-users come into contact, as is adherence to existing standards and, where relevant, codes of conduct, performance and ethics within regulatory frameworks. While the recommendations in the report are intended primarily for the NMAHP community, it is anticipated that the related principles will have relevance to, and will resonate with, all healthcare staff and will serve to unite the wider workforce.

The following recommendations are presented for consideration and action by the Coordinating Council.

There may be value in disseminating a vision for professionalism, with further exploration of its application in a changing healthcare world.

Recommendation 1. Develop and publish a vision for the delivery of professionalism in the changing healthcare context and test with a range of stakeholders.

The imminent review of the Staff Governance Standard is likely to focus not only on the rights of staff (as is the current focus), but also on their responsibilities. There is an opportunity here to ensure that the requirement of professionalism is explicitly stated within the standard.

Recommendation 2. Incorporate professionalism within all staff governance and employment activity.

There is a personal cost to professionalism, and it is important that organisations seek to assuage any potential negative effects through appropriate support and promotion of professionalism among the workforce. Supportive mechanisms should be investigated, assessed and introduced to enable staff to deal with the emotional and psychological impacts of healthcare practice. Failure to do so may have significant impacts on the ability of individual practitioners to continue to function in a professional way.

Recommendation 3. Introduce supportive mechanisms to enable staff to deal with the emotional and psychological impacts of health care.

A key element in facilitating professionalism within services is to identify where team cultures are hindering professional behaviour and taking action to nurture more positive approaches. The aim must be to create consistency in approach to professionalism across teams by raising the bar for those who are not functioning in accordance with the principles of professionalism, rather than lowering it for those who are.

Recommendation 4. Implement measures to enable a professional culture to flourish across NHSScotland.

The NMAHP workforce has a strong culture of mutual support that includes the provision of mentorship, preceptorship, coaching, personal development planning and review, opportunities for reflective practice and clinical supervision, although

there is significant variation across the country in terms of opportunities for staff to access support schemes such as these. They are nevertheless important in relation to promoting professionalism and could usefully be organised around the underpinning principles of professionalism; these would serve as benchmarks for personal development planning and performance review with a view to identifying ongoing development needs.

Recommendation 5. Develop existing support measures to facilitate and embed professionalism across NHSScotland.

The addition of a professionalism strand into the personal development planning and review process would appear attractive. There is a need to consider how this could be achieved and integrated into current processes without creating an unnecessary and overly bureaucratic burden.

Recommendation 6. Incorporate the requirements of professionalism within personal development planning and review processes.

Healthcare organisations' mechanisms for recruitment and selection at all levels should be sensitive to the key underpinning characteristics of professionalism and should be capable of identifying these in potential recruits, both within written and online submissions and in interview and assessment processes. Similar considerations should govern processes for recruitment and selection to education and training programmes.

Recommendation 7. Explore and implement mechanisms for selection and recruitment that incorporate the requirements of professionalism.

Professional leadership and role modelling is a key influence on the adoption of professional behaviours. Positive leadership and instilling a sense of responsibility and accountability in all staff will assist in building a sense of team contribution and will promote the principles of professionalism.

Recommendation 8. Promote positive role modelling and leadership across NHSScotland as a means of enhancing professionalism.

There is broad agreement across the healthcare sector that personal responsibility for learning and a commitment to lifelong learning are core aspects of professionalism. Organisations should aim to reinforce individuals' commitment to lifelong learning and ensure the provision of ongoing CPD opportunities to support their professional development.

Recommendation 9. Reinforce personal responsibility for lifelong learning as part of professionalism, facilitated by organisational support.

Recommendation 10. Focus NHSScotland learning and development activity on issues of conduct as well as knowledge, competence and skill.

Pre- and post-registration education and training programmes provide opportunities for students to explore the concept of professionalism for their practice. The concept of professionalism needs to be embedded in education programmes, including undergraduate and postgraduate curricula, with support provided to mentors to promote awareness of its principles among students and other learners.

Recommendation 11. Incorporate professionalism as a central concept within all training and education programmes, including undergraduate and postgraduate curricula.

Promoting professionalism requires a multi-faceted approach that will address different communication needs and different levels of motivation to ensure that the key messages reach their intended audiences (managers, educators, practitioners and the public). Various forms of research, including that related to psychology and educational experience, can show the complexity of behavioural change and the influence of attitude and motivational factors. Such research should be used to support any promotional work that may be taken forward.

Recommendation 12. Secure all relevant research input into any promotional and communications work.

A subgroup of the working group identified an array of potentially suitable measurement tools (proxy measures) that might be appropriate to measure professionalism and to identify development needs. Essentially focused on behaviours, relationships, practice, context and culture, the tools cover diverse approaches to facilitating quality improvement through professionalism. When making choices on tools, it will be important to consider if they adequately cover necessary professional attributes, include a measure(s) of patient/servicer user feedback, and are endorsed through personal development planning/appraisal mechanisms. Consideration also needs to be given to the infrastructure required to train and support a range of people to use the tools and give the necessary feedback as part of the improvement cycle.

Recommendation 13. Ensure that information-gathering and measurement tools are appropriate to needs and are endorsed and facilitated through systems such as personal development planning and review processes.

6. Conclusion

Don Berwick, writing for an audience of general practitioners, observed that today's healthcare workforce must "*embrace the authority and autonomy of patients"* and become much more focused on cooperation, teamwork, inquiry and dialogue than previous generations were required to do.[60] This call for an adjustment to the central components of professionalism reflects the context and cultural sensitivity of the concept itself, and the need to evolve and reflect external expectations as well as internal drivers.

Professionalism is widely accepted as a central element of health care, but it is a complex and multifaceted concept that is often difficult to define. Consequently, it is frequently described in terms of its absence and the negative values, behaviours and relationships that are demonstrated when things have gone wrong. The emphasis should therefore shift to reinforcing the positive and professional behaviours that are expected of staff and to articulating how they can be motivated and supported to enact the quality agenda.

Professionalism is learned in many ways and in many contexts – the internal and external drivers interact with and reinforce one another and may exert differing degrees of influence at different stages in a practitioner's or support worker's career. As has been observed elsewhere in this report, the particular influence of a culture, system, framework, standard or patient/service user encounter will vary depending upon circumstances.

A collective desire to reinvigorate professionalism in Scotland's NMAHP and wider healthcare workforce is likely to come from a combined will to effect change and to see it sustained over time for the benefit of patients and service users. National standards and codes and quality education and training are important to achieving this, but it is individual self-regulation along with organisational support, and shared and consistent leadership and role modelling, that may carry the greatest potential for revitalising professionalism in Scotland in the 21st Century.

Next steps

In Scotland, this report will be presented to the Coordinating Council for the *NMAHP Contribution to the Healthcare Quality Strategy*, which is chaired by the Chief Nursing Officer. It is anticipated that the Council will consider the recommendations and advise on their practical application to NMAHPs and that the Scottish Government's Quality Alliance Board infrastructure action group on workforce issues will consider their applicability to the wider health and social care workforce. In England, Wales and Northern Ireland, it is anticipated that the chief nursing and allied health professions' officers will consider the report and its potential application to NMAHPS and the wider healthcare workforce in their jurisdictions.

[60] Berwick D (2009). The epitaph of profession. British Journal of General Practice 59(559):128-131.

Annex 1

Workstream terms of reference

The aim of this workstream is to facilitate the development of the necessary requirements to make professionalism a delivery reality within the context of the Healthcare Quality Strategy.

The objectives of this workstream are to:

- develop a pragmatic expression of key features of professionalism, building on existing literature, such as Stern's principles, as a model to assist understanding and communication
- inform and oversee the development of methodologies that will assist with the assessment (self or otherwise) of professionalism within the NMAHP professions in NHSScotland with the aim of confirming and revitalising the concept
- consider the relevance of its findings to the wider healthcare workforce in NHSScotland
- make recommendations to (and if appropriate compile a report for) the NMAHP Coordinating Council.

Specific foci of the group's work will be on the following.

1. The individual health care 'worker', not the profession as a group. The individual might not be a member of a 'profession'; our aim is to support professional values, attitudes and behaviours in the individual, irrespective of whether the individual belongs to a recognised healthcare profession or works in a healthcare support role.
2. The context of relationships – practitioner:patient; practitioner:team members; practitioner:wider organisation/context, including with families/carers/visitors, NHS volunteers and other partners in third sector or local authority.
3. The impact of culture on the system and on the individual's outward manifestation of professionalism.
4. The concept of 'caring for' and 'caring about' and the duty of care to oneself as a professional as well as to others.
5. The place of role models, mentoring and 'self learning' in developing professionalism.
6. The patient's perspective and the importance of person-centredness as an aspect of professionalism. There needs to be a major emphasis here on respect and dignity which are vitally important to patients.
7. The role of insightful refection and structured constructive feedback and its impact on practice.
8. Whether there are validated measures that could be used as a proxy for 'professionalism'.
9. Articulating all work with existing (or developing) governance frameworks and taking the opportunity to influence any revisions of national policy, eg PIN (Partnership Information Network) policies.
10. Considering UK, and other related, evidence-based work that focuses on the concept and measurement of professionalism relevant to the UK/Scottish context.
11. Reinforcing *Revitalisation* and *Actualisation* as keywords in any communications.

Working group membership

NAME	DESIGNATION
Dr Frances Dow	Chair (lay member)
Dorothy Armstrong	Nurse Adviser, Scottish Public Services Ombudsman and Programme Director NHS Education for Scotland
Gerry Bolger	Independent Adviser on Quality, Measurement and Outcomes, Imperial College Healthcare, London representing the Department of Health
Cathy Cairns	Assistant Director, Scotland and Northern Ireland Affairs, Nursing and Midwifery Council
Audrey Cowie	Professional Adviser - Regulation and Workforce Standards, Scottish Government, then External Adviser from September 2011. Workstream lead until August 2011.
Andy Crawford	Head of Clinical Governance, NHS Greater Glasgow & Clyde
Lilian D'Arcy	Lay member
John Davidson	Head of Staff Governance, Health Workforce Directorate, Scottish Government
Geraldine Doherty	Registrar, Scottish Social Services Council
Debbie Donald	Associate Director of Workforce Planning, NHS Tayside and Action Officer for Health Care Support Workers
Dr Mairghread Ellis	Lecturer in Podiatry, Queen Margaret University, Edinburgh
Kath Fairgrieve	Director of Allied Health Professions, NHS Tayside representing Scotland's Allied Health Professions Directors
Vicki Finlay	Professional Officer, Nursing Workforce, Policy and Practice, Department of Health, London
Kathryn Fodey	Nursing Officer, Education and Regulation, Personal Social Services Northern Ireland (PSSNI)
David Forbes	Officer, UNISON representing Scottish Workforce and Staff Governance Committee
Ellen Hudson	Associate Director, Royal College of Nursing (Scotland)
Professor Melanie Jasper	Head of School, University of Swansea, representing CNO Welsh Assembly Government
Dr Aileen Keel	Deputy Chief Medical Officer, Scottish Government
Professor John McLachlan	Associate Dean of Undergraduate Medicine, University of Durham
Jenny McNicol	Lead Midwives Group, Scotland
Eileen Moir	Nurse Director, Healthcare Improvement Scotland
Dr Douglas Murphy	Senior Clinical Research Fellow, University of Dundee
Rose Ann O'Shea	Professional Adviser for Regulation and Workforce Standards, Scottish Government
Denise Richards	Nursing Officer, Education and Regulation, Welsh Assembly Government
Carol Sinclair	Better Together Programme Director, Scottish Government
Gillian Smith	Director for Scotland, Royal College of Midwives
Dr Stephen Smith	Lead Nurse/Senior Lecturer, Edinburgh Napier University
Claire Tester	Senior Strategic Lead for Quality in NHSScotland, Healthcare Planning Division, Scottish Government
Dr Anna van der Gaag	Chair, Health Professions Council
Rhoda Walker	Nurse Director, NHS Orkney representing Scottish Executive Nurse Directors Group (SEND)
Professor Brian Williams	Director, NMAHP Research Unit, University of Stirling
Karen Wilson	Deputy Chief Nursing Officer, Scottish Government
Paul Wilson	Nurse Director, NHS Lanarkshire and Chair, Scottish Executive Nurse Directors Group (SEND)
Helen Whyley	Nursing Officer, Education and Regulation, Welsh Assembly Government

Annex 2

Examples of behaviours that could lead to regulators taking action against professionals

Examples include professionals who:

- were dishonest, committed fraud or abused someone's trust;
- exploited a vulnerable person;
- failed to respect service users' rights to make choices about their own care;
- have health problems which they have not dealt with, and which may affect the safety of service users;
- hid mistakes or tried to block our investigation;
- had an improper relationship with a service user;
- carried out reckless or deliberately harmful acts;
- seriously or persistently failed to meet standards;
- were involved in sexual misconduct or indecency (including any involvement in child pornography);
- have a substance abuse or misuse problem;
- have been violent or displayed threatening behaviour; or
- carried out other, equally serious, activities which affect public confidence in the profession.[61]

[61] http://www.hpc-uk.org/assets/documents/10003700FTPannualreport2011.pdf