Council, 27 March 2014

Review of the standards of conduct, performance and ethics - Research

Executive summary and recommendations

Introduction

We are currently in the process of reviewing the standards of conduct, performance and ethics. We are now approaching the end of the research phase in which we have undertaken a range of internal and external research activities to gather feedback about our existing standards and explore the expectations of stakeholders about health and care professionals.

Attached are two research reports for externally commissioned research with service users and their carers; Connect with service users with aphasia and Shaping Our Lives with social care service users. Also attached is the Executive's analysis of its survey of colleagues from the Fitness to Practise team about the standards.

Decision

The Council is invited to discuss the research reports attached.

Background information

- Paper agreed by Council, 5 July 2012,
  (enclosure 5: www.hcpc-uk.org/aboutus/committees/archive/index.asp?id=608)

Resource implications

None as a result of this paper.

Financial implications

None as a result of this paper.

Appendices

- Appendix 1: Connect research report
- Appendix 2: Shaping Our Lives research report
- Appendix 3: Survey of Fitness to Practise Department analysis

Date of paper

13 March 2014

Connect –The Communication Disability Network
Consultancy on behalf of The Health and Care Professions Council (HCPC)

Introduction

In July 2013 Connect began a 5 month consultancy project commissioned by the Health Care Professions Council (HCPC), to elicit the views of people with aphasia and their carers regarding the HCPC's Standards of conduct, performance and ethics.

Aphasia is a communication disability which results from damage to the communication centres of the brain usually caused by stroke or brain injury. People living with aphasia can experience a range of difficulties with communication from severe difficulties with understanding or producing any spoken or written language, to more mild difficulties perhaps with word finding or understanding complex language. These difficulties can have a profound impact on everyday functioning and can lead to reduced participation in life and isolation. Others with acquired neurological disabilities arising from, for example, Parkinsons Disease, Multiple Sclerosis, Motor Neurone Disease or indeed developmental disabilities may share these experiences and therefore the work described in this report has relevance beyond people living with aphasia.

Connect is a charity for people living with aphasia. It works to improve the lives of people living with aphasia and communication disability by equipping them to reconnect with life. Connect is a collaborative organisation, where people with aphasia lead and shape the work undertaken by the charity. People with aphasia advise on and participate in new projects and opportunities and collaborate in the development of training and publications. Many of Connect's members are extremely involved in raising awareness of aphasia in a variety of ways, and are experienced in consultation and focus group work.

This consultation sought to enable people living with aphasia and their carers to be meaningfully involved in evaluating the standards of conduct, performance and ethics set by HCPC and to provide feedback, based on their own experiences, which may inform changes to the standards.

Aims of the consultation

- To find out what service users with aphasia and their carers expect from their healthcare professionals.
- To find out whether the HCPC standards reflect these expectations.
- To explore whether the standards are accessible to service users with aphasia and their carers.
- To consider what changes might be necessary to the standards as a result.

Process of consultation

Recruitment of Consultation Group Participants

Opportunity to participate in the consultation groups was advertised at the Connect ‘drop in’ session, a weekly conversation and support session at the Connect London centre attended by up to 40 people with aphasia and a few carers. For those people with more severe aphasia, Connect staff were present to explain the project in an accessible way to enable them to understand and become involved if they wished. The people with aphasia attending ‘drop in’ present with a range of severity of aphasia, time post onset, age and ethnicity. The only exclusion criterion was people with cognitive difficulties that would have made processing the complex and abstract content of the consultations impossible.

Involvement in the project was on a voluntary basis and numbers at each focus group showed some variation, with 11 people with aphasia and 4 carers the maximum number at one session. Variable attendance was due to participant availability, (with the last session the least well attended due to having to change the day of the week). However, a core group of participants were clearly engaged and attended each session. In total 24 people with aphasia and relatives took part in the consultation. Participants ranged in time post onset of aphasia from 18 months to 13 years. Participants were of diverse ethnic origin and ranged in age from 23 to 78 years. There were an equal number of male and female participants. Due to the abstract nature of the material presented, most participants who elected to attend and continue with the focus groups had minimal comprehension difficulties; however they did present with a range of spoken and written expressive difficulties, including 4 participants with severe aphasia.

Individual Participants

In order to reach people with aphasia who are not able to or do not access Connect, 4 people with aphasia were interviewed in their own homes. These people were selected because they had received a Connect conversation partner (trained volunteer without aphasia) who had visited them in their homes for 6 months. We thus knew from volunteer feedback that they would be able to take part in the individual face to face interviews. They were 2 women and 2 men also of diverse ethnic background, but older: with ages ranging from 66 to 85. As a group, they had more severe physical disability but milder aphasia. One of this group had previously worked as a stroke unit Charge Nurse, and was particularly engaged with the content.

Facilitators

The Project was led and facilitated by 4 Connect staff: 3 Speech and Language Therapists with specialist aphasia experience, (including the Connect Chief Executive Officer) and 1 project leader with practical experience of aphasia consultation and focus group work. Trained volunteers without aphasia also supported the group consultation sessions.

Content and structure of the group consultations

Each group consultation session lasted for 2 hours and began with an accessible presentation to the whole group by one of the Connect staff, to introduce themes and plans for the session and to provide relevant background information; for example introducing the role of HCPC and the professions it regulates. Further activities, to explore themes in more depth and elicit individual experiences and expectations, were undertaken in smaller groups of 3-4 people with aphasia or carers. Each small group was facilitated by 2 people (either staff or volunteers), trained and experienced in supported conversation, to enable the people with aphasia to tell their stories and give their opinions openly. Resources to support communication exchange were prepared in advance, and included photos, drawings, key words and rating scales related to the HCPC themes.

Four consultation groups took place using progressive themes. The aims of these sessions are set out below:

Consultation Sessions	Themes	Aims of Session
1. July	What is the HCPC?	Introduce HCPC Introduce concept Of professional Standards
	Expectations of professional roles?	Generate expectations of professional people
2. September	Our expectations of healthcare professionals	Generate expectations

		of healthcare professionals
3. October	HCPC Standards How do they compare to our expectations?	Look at and understand the HCPC standards of performance, conduct & ethics Compare them to our expectations Understand and agree changes we might recommend to content
4. November	HCPC Standards: How accessible are they? Summary	Look at how accessible the HCPC standards are for people with aphasia Summarise our recommendations for possible changes to the Standards, both in Content and Accessibility.

Process and structure of the individual consultations

The individual interviews were deliberately carried out late in the process, (after the 3rd consultation group in October 2013) as it was thought that it would be helpful to be able to have the background of the previous consultations to inform the interview questions, and to make the process as concrete as possible for the interviewees. The individuals were shown the same materials as in the group sessions, and the same broad questions were asked of them. (A broad interview topic guide can found in **Appendix 6**). The interviewer (one of the Connect staff team who also one of the group consultation facilitators) carried out the interviews which were audio recorded and then transcribed. Each interview was between 45 minutes and 1 ¼ hours in length. It was more difficult to explain the consultation topics to the individual interviewees as they did not have the benefit of the group context and hearing the views of others. However, the themes they raised reflected the themes from the group consultation, most notably the focus on the *personal* attributes and care of the health care professional. Quotes from individual interviewees are included along with quotes from group members throughout.

Results / themes emerging from the consultation process

The first 2 consultation group sessions focused on developing an understanding of the participants' expectations of health care professionals.

Consultation Session 1

During the first consultation session the group were asked to think about professionals in general, and then drew on their own professional experience. Participants came from a diverse range of professional backgrounds including healthcare, engineering, law, transport and teaching.

As a result, they each brought different focus to the discussion, giving different weight to what they felt was most important. However all participants touched on certain key themes including professionals caring about their work and the people they work with, valuing others and treating people with respect and dignity, having appropriate knowledge and communicating effectively. Other expectations such as dressing appropriately, being organised and being on time were also discussed as important; however the group agreed that this was of differing importance depending on role (see **Appendix 1**).

Consultation Session 2

Discussions during the second session focused particularly on expectations of healthcare professionals, with participants drawing on their own experiences of receiving healthcare. The expectations generated from this session (**Appendix 2**) shared themes with the first session, however the tone differed subtly. Recalling their own experiences of receiving healthcare and their interactions with healthcare professionals produced a list of expectations which demonstrated a greater focus on 'patient' experience and required of professionals a greater emphasis on so-called 'soft skills' including:

Treating people with dignity and respect and caring about them.

> *"Their job is to care about you but they don't always. You're there, but you're not their main reason for existing, they have other things to do."*

> *"Professionalism, empathy, um, consideration, respect."*

> *"Treat patients the way you would have liked to have been treated"*

> *"One, she lacked empathy… although she had confidence, she lacked…"*

Being positive and reassuring and being mindful of people’s emotional state.

> *“She told me it would take at least 2 years for my speech to start to come back, my wife was in tears. 6 months later my speech had come back and I went back to tell her.”*

> *“good at modifying their communication. Taking time, face to face to listen”*

> *“be patient; make them (people with aphasia) feel that they know what they’re saying and that will build up their confidence”*

Examples of stories that appeared to generate particularly **negative emotions** often featured professionals who did not explain or collaborate sufficiently with the individual, or gave negative information in a blunt manner.

> *“And another physio didn’t turn up and I waited and waited and I went to reception desk and said I’m waiting for... and they said he’s not here today and I had an appointment. It was really hard to complain. So I didn’t bother... no explanation... so I gave up.”*

> *“I had a bad experience with a physio... basically they didn’t talk to me properly, they didn’t explain why we have to do this... and basically for me the exercise is very stupid, I didn’t understand why.*
>
> *“And they gave up on me... they sacked me!”*

Consultation Session 3

During the third consultation session the focus group performed a mapping process looking at the common elements between their expectations and the HCPC standards, and whether the HCPC standards reflected their expectations.

Through this process it became clear that there was significant overlap of themes generated by the focus group and the HCPC standards. However the group made specific comments about the thematic grouping of the standards, and suggested alternative wording/emphasis for many of the standards. **Appendix 3** contains the focus group's detailed comments on each HCPC standard, and the key recommendations of the group are summarised at the end of the report.

Following session 3, all material and comments generated by the focus groups (**Appendix 1, 2, 3**) were analysed by Connect staff for common and recurrent themes. 6 key themes emerged.

1. Partnership and mutual respect
2. Knowledge and skills
3. Communication, information and consent
4. Appearance and presentation
5. Honesty, confidentiality and trust
6. Reporting Concerns

Under each theme is a description using the key words and phrases generated by the focus group along with some quotations. (**Appendix 4**)

Consultation Session 4

In the final session the focus group gave feedback on the 6 key themes and descriptions, in terms of both content and accessibility. The group made some amendments to the wording and the ordering of the themes to group them together in a more logical order: firstly how they would like the healthcare professional to treat the individual, followed by themes about knowledge, then appearance and finally, reporting concerns should these standards not be followed.

The group discussed the theme of reporting concerns and whistle blowing in some detail. They felt it was important that an organisation fostered a supportive environment for its healthcare professionals and a protective environment for the public.

In addition to the above themes the focus group discussed 2 guidelines included in the HCPC standards which had not been included in the group’s expectations:

- ‘You should keep accurate records’

- ‘You should deal fairly and safely with the risks of infection’

These themes had not been generated independently by the group, possibly as they feature less prominently in an individual’s experience of healthcare professionals. However the group recognised their importance in good healthcare and therefore felt they should be included in their recommendations.

At the end of the final consultation session, the focus group felt that the 8 standards suggested below accurately reflected all their discussions and were expressed in the appropriate language.

Furthermore, the focus group felt it was important that healthcare professionals ‘signed up’ to these guidelines at the point of qualifying in their respective profession.

Revised standards suggested by the Focus Group

1. Partnership and mutual respect:

- You should treat the people you work with, with respect and dignity.
- You should always be aware of their emotional state and be positive and reassuring.
- You should treat the person not the symptoms, be friendly and value people.
- You should ask the person if there is anyone else they would like to be involved in their healthcare.

2. Providing information, communication and getting consent:

- You need to listen to people and find out their needs and wishes.
- You should give information and explanations in a way the person can understand.
- You should give information at every stage of care to the person and, where appropriate the family.
- Explain things in a straight forward way.
- You should not use jargon or acronyms.
- You should communicate well with other professionals and work as a team.
- After giving information you should ask the person for their agreement for treatment.

3. Honesty, confidentiality and trust:

- You should not abuse your position of power.

- You should be honest and respect people’s confidentiality and privacy.
- You should be reliable and do what you say you will.
- You should be organised and on time.

4. Knowledge and skills:

- You should have the appropriate skills, knowledge and training to do your job.
- You should know your boundaries and check if you don’t know something.
- You should make sure your knowledge is up to date or seek support.

5. Appearance and presentation:

- You should appropriately for your job and have good personal hygiene.
- You should not come to work under the influence of drugs or alcohol.

6. Reporting concerns:

- You should report any concerns about those you work with.

7. You should keep accurate records

8. You should deal safely with the risks of infection

General principles informing the recommendations

- The standards could be reduced in number, and grouped thematically.
- There needs to be particular emphasis on the personal qualities required by health care professionals.
- The standards need to prioritise accessible explanation and information provision.
- The suggested terminology (e.g. person rather than service user) reflects a more collaborative approach.
- The suggested standards are more concrete and specific rather than more abstract and general.
- The standards should be written in clear simple language without the use of jargon and acronyms. This would improve accessibility generally, not just for people with disabilities.

Communication Access

The group felt that as these standards are intended for a number of different groups of people e.g. healthcare professionals and different members of the public it may be useful to have several different versions available, including a straight text version and a more accessible version for people with communication difficulties. For this latter version they recommended:

- Short sentences

- One key idea per sentence
- Straight forward language, avoid abbreviations and jargon
- 14+ size font
- Bolding or underlining of key words
- Use of bullet points to break up long pieces of text
- Use of pictures to illustrate text

An example of one of the standards in this format can be seen in **Appendix 5.**

Summary and Conclusion

The participants who joined the consultation reported enjoying being involved in the process, as was demonstrated by the core group of people who attended every session. They felt it was interesting and important to have some input in shaping standards for healthcare professionals.

Appendix 1

Our Expectations of professionals in general

Dress appropriately for their job

Care about their work

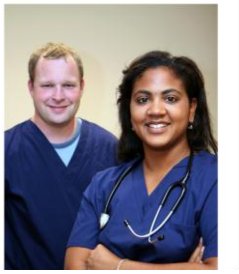
Care about the **people** they work with

Have the **appropriate skills** to do their job

Have the **appropriate knowledge** and **training** to do their job

Be **good communicators**

Treat others with **respect**



Be **Friendly**

Be **fair**

Value other **people**

Be **polite**

Not abuse **power**

Not break the **law**

Listen

Be **on time**

Be **confidential**

Be **honest**

Work **safely**

Be **organised**

Know their **boundaries** and check if they don't know something

Appendix 2

Our expectations of healthcare professionals

Treat people with **dignity**

Treat people with **respect**

Treat the **person not** just the **symptoms**

Respect people’s **privacy/confidentiality**

Be mindful of people’s **emotional state**

Be **positive**

Be **reassuring**

Take time to **listen/find out** person's needs and wishes

Give **time** to each individual

Ensure knowledge is up to date or go and find out. Don't give inaccurate information.

Give **information and explanations** at every stage of care to the person and where appropriate the family

Explain things in a **straight forward way** (not jargon or acronyms)

Where possible have **continuity** of healthcare professional

Be **friendly**

Treat people as **individuals** (do not make assumptions based on age or stereotypes)

Be **punctual**

Be **reliable** and do what they say they will

Communicate with other professionals/work as a team

Be **flexible** and adapt to changing needs of the individual

Appendix 3

Notes from group exercise to map HCPC standards of performance, conduct and ethics to focus group expectations of healthcare professionals

HCPC standard	Focus group expectation/comments
1. You must act in the best interests of service users	The group felt this standard was very general They did not like the terms 'service user' and 'service provider' (too much like 'us' & 'them'), would like something that reflects more of a partnership which may then automatically imply some of our other expectations e.g. respect etc. They liked the words 'people' and 'partner'. It covered all of the group's expectations: - Treat people with **dignity** - Treat people with **Respect** - Treat **the person** not just the **symptoms** - Respect people's **privacy/confidentiality** - Be mindful of **people's** emotional state - Be **positive** - Be **reassuring** - Take time **to listen/find** out person's needs and wishes - Give **time** to each individual - Ensure **knowledge** is **up to date** or go and find out. Don't give inaccurate information. - Give information and explanations at every stage of care to the person and where appropriate the family - Explain things in a straight forward way (no jargon or acronyms) - Be friendly - Treat people as individuals (do not make assumptions based on age or stereotype) - Be punctual - Be reliable and do what they say they will - Communicate with other professionals and work as a team - Be flexible and adapt to the changing needs of the individual
2. You must	The group didn't like the use of the term 'service user'

respect the confidentiality of service users	Alternative suggestions: **Respect people's privacy and confidentiality**
3. You must maintain high standards of personal conduct	To include: - Personal hygiene/dress - Personal conduct – smoking, alcohol, not breaking the law - Meeting expectations of appearance, presentability and behaviour appropriate to your work
4. You must provide to us (and to any other relevant regulators) any important information about your conduct and competence	The group felt this could be represented as a more general standard about reporting misconduct and should reflect an obligation to report misconduct of others as well i.e. whistle blowing An alternative might be: **You must report misconduct, your own or others'.** This might include what would happen if you made a report.
5. You must keep your professional knowledge and skills up to date	The group were happy with this, but might want to include how this is measured?
6. You must act within the limits of your knowledge, skills and experience and, if necessary, refer the matter to another practitioner	The group were happy with this but may wish to alter wording to include **Give clear explanations, if you don't know say so and find out/refer on**
7. You must communicate properly and effectively with service users and other practitioners	The group wished to include: **Give information and explanations at every stage of care to the person and where appropriate their family** **Be friendly and take time with each person**
8. You must	The group had no comment

effectively supervise tasks that you have asked other people to carry out	
9. You must get informed consent to provide care or services (so far as possible)	The group felt this linked to standard 7, that communicating, giving information and explanations was an integral part of getting informed consent. Giving information in an accessible way and then obtaining consent.
10. You must keep accurate records	The group had no comment
11. You must deal fairly and safely with the risks of infection	The group had no comment
12. You must limit your work or stop practicing if your performance or judgment is affected by your health	The group were happy with this, but felt it overlapped with standard 4
13. You must behave with honesty and integrity and make sure that your behaviour does not damage the public's confidence in you or your profession	The group felt that this standard included many of their expectations from lists 1 & 2 and that there was overlap between this and standard 1: - Treat people with **dignity** - Treat people with **Respect** - Respect people's **privacy/confidentiality** - Take time **to listen/find** out person's needs and wishes - Ensure **knowledge** is **up to date** or go and find out. Don't give inaccurate information. - Give information and explanations at every stage of care to the person and where appropriate the family - Explain things in a straight forward way (no jargon or acronyms) - Be punctual - Be reliable and do what they say they will - Dress appropriately - Be fair - Do not abuse power - Do not break the law - Be honest - Work safely

14. You must make sure that any advertising you do is accurate	The group had no comment

Appendix 4: collated material from sessions 1, 2 & 3

1. Partnership and mutual respect:

- You should treat the people you work with, with respect and dignity.
- You should always be aware of their emotional state.
- You should be positive and reassuring.
- You should treat the person not the symptoms.
- You should be friendly and value other people.

> *"Physio was good . . . what made it good was a mutual confidence, they made me feel confident . . . positive"*

> *"The volunteers were the best . . . more interested in me, gave me more time and asked how I was"*

2. Knowledge and Skills

- You should have the appropriate skills, knowledge and training to do your job.
- You should know your boundaries in terms of knowledge.
- You should check if you don't know something.
- You should make sure your knowledge is up to date.

> *"The Royal college of Nursing says you've got to do um….so many hours every 3 years to be kept on the register"*

3. Communication, Information and consent

- You need to listen to people.
- You should find out their needs and wishes.
- You should give information and explanations in a way the person can understand.
- You should give information at every stage of care to the person and, where appropriate the family.
- You should explain things in a straight forward way, with no jargon or acronyms.
- You should communicate well with other professionals and work as part of a team.
- After giving information you should ask the person for their agreement for treatment.

> *"At the beginning of the week you get given your timetable and you didn't have a full week at all . . .supposed to be having a full day of rehab, no one turned up on time . . . waiting . . .waiting . . .waiting . . .no communication, no explanations!"*

> *"If all of them could just talk, communicate and say look I'm sorry about this . . . then that would be better"*

4. Appearance and presentation

- You should dress appropriately for your job.

- You should keep good personal hygiene

> *“The physios came dressed for the job, organised, enthusiastic, brilliant!”*

> *“You can’t come with your hair down there, that’s a no no. Dress code reflects professionalism…and it gives people more confidence*”

5. Honesty, confidentiality and trust

- You should not abuse your position of power.
- You should be honest.
- You should respect people’s confidentiality and privacy.
- You should be reliable and do what you say you will.
- You should be on time or let the person know if you won’t be

> *“I had one SLT who was brilliant, she said she would come and she did!”*

6. Reporting concerns

- You should report concerns about others.
- It is important to maintain standards to protect patients.

Appendix 5. Example of communication accessible standard

Partnership and mutual respect:

You should **treat** the **people** you work with, with **respect** and **dignity**.

You should be aware of their **emotional state**

Be **positive** and **reassuring**

You should treat the **person** not the symptoms,

Be **friendly** and **value** other people.

Appendix 6: Topic Guide for individual interviews

Start with detailed explanation regarding the background to the project. Talk the interviewees through the consultation so far and show them all the accessible resources and power points used to elicit discussion.

1. Can I start by asking you to think about professionals in general (using the sheet of well known professionals). What characteristics might we expect of people doing this job?

2. Can I ask you to think about your own job? What job did you do? What did people expect from you in your role?

3. Now, with your personal experience of having been a patient. What qualities did you expect from the health care professionals looking after you? What was important?

4. Can you think of a health care professional you've met where you didn't have a good experience. Where it was negative? And if so, what made it negative? What was it about them?

5. Can you think of a health care professional where it's been a really good experience? Where they gave you really good care? Why was that? What made them so good?

6. (Showing the Standards of conduct, performance and ethics). What do you think about this as a person with aphasia? How accessible is this? How might you change it?

Appendix 7: Case Study; one of the Focus Group members

One of our focus group members, E, was interviewed in more detail. She is 46 years old, and 2 years post CVA (Cerebral Vascular Accident). We have recorded her direct speech in quotation marks.

‘I asked to get involved. I had just lost my mother and she had a lot of help from health care professionals. I wanted to talk about that. I had my own experience of the world. It seemed like a good opportunity to give back.

I attended all 4 sessions. On the whole it seemed a nice thing to do. Nice to be listened to. It was positive to feel like I had some role to play in talking about health care professionals. I realise a lot of it was not particularly relevant, but there were some things that really were. It was quite interesting. Other people in the group talking about very personal things…quite good. There was one clash between me and C (a relative) but so little, and we got there.

The woman (Anna) was very good at the start but at the time it was difficult to position it, and difficult to maintain momentum of where this was going. It would have been better if it was over 4 weeks not 4 months.

They discussed they’ll use it (*our focus group information*), but not how they will use it. Will they use pictures? It would be nice to see the finished product?’

Service User and Carer Consultation
Review of the Standards of conduct, performance and ethics
Of the Health and Care Professions Council

Shaping Our Lives
November 2013

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Executive summary

In 2013 Shaping Our Lives were commissioned by the Health and Care Professions Council (HCPC) to carry out a consultation with service users and carers to review the HCPC Standards of conduct, performance and ethics.

Shaping Our Lives conducted this qualitative research with 30 solo interviewees and a focus group, all of whom were service users (as defined by Shaping Our Lives) and many of whom were disabled people; some interviewees were carers. The research explored each standard in turn and also asked questions about awareness of the HCPC and the standards generally. We asked the Words and Pictures team at CHANGE to comment on the 14 standards in order to gather feedback from a group of adults with learning disabilities about the accessibility of the language used in the current standards.

Key findings

Interviewees were broadly in agreement with the current standards, and could see that most were relevant.

Most people agreed that the standards are applicable to all 16 types of registrant.

There is low awareness of the HCPC and the standards.

The three standards which deal with ethical behaviour (standards 1, 3 and elements of 13) have a high degree of overlap and need most revision.

Interviewees were keen to map their lived experience of using health and care services to reflect on how the standards were implemented in practice. There was some concern about the difference between the aspiration of the standards and actual delivery within the constraints of time, resources and budgets.

Interviewees had experienced a lack of disability awareness and some discrimination from service providers.

The standards are not accessible to all disabled people. Both the language used and the formats available need addressing.

Recommendations

Shaping Our Lives has made recommendations to inform the planned review of the standards in 2014-15 so that the new standards are fit for purpose from a service user perspective. Shaping Our Lives has also made recommendations about how the HCPC can communicate more successfully with service users. The recommendations are presented under five themes which reflect both the external environment and the issues of particular relevance to service users who are disabled people, and their carers.

- Being in control
- Integration and joint working
- Accessibility
- Considering equality
- Protection of interests

Contents

Appendices

Introduction

Shaping Our Lives has been commissioned by the Health and Care Professions Council (HCPC) to help with a review of the Standards of conduct, performance and ethics (the standards) prior to a public consultation process in 2014/2015. The HCPC is interested in examining how the standards are used, their accessibility to service users and carers and how ethical principles set by the regulator can best be translated into understanding and practice.

This report details the findings from 30 interviews and a focus group with service users (including disabled people) and carers conducted by Shaping Our Lives.

The HCPC is a regulator and its main aim is to protect the public. To do this, it keeps a register of professionals (registrants) who meet the standards for training, professional skills, behaviour and health ('health' here refers to the health of the professional). The standards were first published when the HCPC Register opened in July 2003 and were reviewed in 2008 with some more minor changes in 2012. The list of current standards is shown in Appendix One.

All professionals registered with HCPC will appear on their Register. They must keep to the standards which give levels of expected professional behaviour and provide protection for people using their services. The general public can report concerns about fitness to practise to the HCPC. There are 16 types of professionals on the Register including: chiropodists, hearing aid dispensers and social workers in England (a full list appears in Appendix Two).

The HCPC also publishes standards of proficiency, which are standards used to make sure the professionals they regulate have the knowledge and skills they need to work safely in their field of practice; these standards are not subject to review at this time.

Earlier in 2013 the HCPC commissioned The Focus Group to conduct research exploring registrants and service user views on the content and accessibility of the Standards of conduct, performance and ethics. Their findings have been reported separately but are referred to in this document when relevant.

In 2001 Shaping Our Lives published a Briefing Paper 'Putting The Person First' a result of their role in reviewing the codes of conduct of Social Workers). This is a quote used in that paper, which sums up how service users feel about what matters to them. We feel that this is still as relevant in 2013.

> ‘They value courtesy and respect, being treated as equals, as individuals and as people who make their own decisions; they value [social care] workers who are experienced, well informed and reliable, able to explain things clearly and without condescension, and who ‘really listen’; and they value workers who are able to act effectively and make practical things happen… The way workers behave, and what they do or do not do, makes a big difference to how people feel about themselves and the quality of their lives’.

In this report Shaping Our Lives has occasionally discussed issues that are outside the remit of the research that was commissioned by HCPC. However, we have chosen to include the comments as they were raised by participants. We have highlighted where this occurs.

Definitions

Service users: The definition of 'service user' for the HCPC is someone who uses or is affected by the services of one of their registrants from the 16 professions regulated.

The definition of 'service user' for Shaping Our Lives' is different as detailed below. Service users may also be disabled people, but not necessarily. The term service user generally stretches to a wider group of people and includes homeless people, people with experience of long term care and people with drug and alcohol use issues. Shaping Our Lives sees ' service user' as an active and positive term, which means more than one thing. It is important that 'service user' should always be based on self-identification. But here are some of the things we think it means:

- It means that we are in an unequal and oppressive relationship with the State and society.
- It is about entitlement to receive welfare services. This includes the past when we might have received them and the present. Some people still need to receive services but are no longer entitled to for many different reasons.
- It may mean having to use services for a long time which separate us from other people and which makes people think we are inferior and that there is something wrong with us.
- Being a service user means that we can identify and recognise that we share a lot of experiences with a wide range of other people who use services. This might include, for example, young people with experience of being looked after in care, people with learning difficulties, mental health service users, older people, physically and/or sensory impaired people, people using palliative care services and people with drug and alcohol problems.

This last point about recognising our shared experiences of using services, whoever we are, makes us powerful and gives us a strong voice to improve the services we are given and to give us more control and say over what kind of services we want.

Service users welcome the use of the word 'support' alongside 'care', and sometimes in place of it. People we interviewed are very used to the term service user to refer to them, or people they care for. Some might not like the term but it is widely adopted and understood in this context.

We recognise that the HCPC use the term service user in a wider sense. In this report however we will use the term service user as defined by Shaping Our Lives.

Disabled People: In this report disabled people is used in its broadest sense to include people with physical and sensory impairments, those living with long term conditions and life-threatening illnesses, people with learning disabilities and those living with mental health issues.

Traditionally people have been viewed through a lens of what is wrong with them e.g. they are visually impaired, they are mentally ill, they have an alcohol problem. This is referred to as the medical model. The social model turns the tables and says people are disabled because of the prejudice they face. Using the social model helps identify solutions to the barriers disabled people experience. It encourages the removal of these barriers within society, or the reduction of their effects, rather than trying to fix an individual's impairment or health condition.

The social model is the preferred model for disabled people. It empowers disabled people and encourages society to be more inclusive. Although other people who use social care and support services are not explicitly covered by this model it is a useful reminder to look at all service users in the round, what is really causing the problem in their lives, and not just through a narrow definition of what is 'wrong with them'.

> 'Sometimes personal conduct needs to be less medicalised and more humanised. Meaning that when a disabled person comes into contact with any kind of practitioner there is a tendency to see disability first and not the person.'

Carers: A carer is someone of any age who provides unpaid support to family or friends who could not manage without this help. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems.

Professionals: is a term employed in the context of this report to mean a person providing one of the 16 professions regulated by the HCPC. It is a term used interchangeably with service providers and practitioners. Professionals appearing on the HCPC Register are known as registrants.

The wider context

Obviously since the HCPC last reviewed the standards in 2008 there have been changes to the external environment within which health and care professionals operate, and we have reviewed ones here which are of relevance to service users, particularly disabled people and carers. We are asking how should standards which provide a framework for regulating the conduct, performance and ethics of individual practitioners take account of:

- Equalities and Health legislation, a growing understanding of active participation in health and care services by the end user, in the barriers to accessing new communication technologies,
- a greater public awareness of regulation failures,
- a greater awareness of the role of practitioners in regulation and whistle-blowing.

Choice and control

There has been a growing movement to involve service users as leaders in their own care. One of the interviewees in this review welcomed the HCPC's user involvement:

> 'We have moved to a more collaborative way of dealing with things, rather than them [the HCPC] and us.'

Started by the disabled people's movement in the early 1980s as a campaign for human rights, in more recent years user led service delivery has been adopted by the public sector in recognition that involving people in decisions about their care and support early on can make the key difference to more positive health and quality of life outcomes (Health and Social Care Act, 2012). The Care Quality Commission reports that problems often arise in people's quality of care where there had been a lack of person-centred planning, with little information about people's individual preferences (CQC, 2012). To provide a framework for involvement, the Health and Social Care Act incorporates Public Involvement Duties for Clinical Commissioning Groups and local authorities (via Healthwatch). Do the current standards reflect the 'no decision about us, without us' ethos.

The HCPC and other consumer champions

Patients and other service users are aware of PALs as a well-established means of making a complaint about services received in a health context. Healthwatch is becoming established now and it is planned to grow as a consumer champion. Although beyond the remit of this research, a question for the HCPC is how its profile impacts on service users, how it encourages complaints about the practitioners on its register and how it relates to PALs and Healthwatch.

Integration and joint working

The Department of Health states that improving quality of care is at the heart of the Health and Social Care Act 2012 and that one key means to achieve this is to ensure care is integrated around the needs of patients. The Act seeks to encourage and enable more integration between services.

The benefits to service users are tangible. As Sass and Beresford report states “there is a whole life to be lived and managed – with often far greater consequences than any single clinical encounter or social care appointment can ever address positively.” (User-driven commissioning, Disability Rights UK Shaping Our Lives, 2012). Joint working between agencies is a vital component of enabling service users to keep the whole engine running.

Going forward the HCPC needs to consider how their standards enable joint health and social care working and maintain the best interests of service users.

Provision of good and services within an equalities framework

The Equalities Act 2010 replaced previous legislation such as the Disability Discrimination Act and the Race Relations Act. The Equality Act 2010 legally protects people from discrimination in the workplace and in wider society, such as the provision of goods and services, as those provided by health and social care practitioners. How robust are the current standards in relation to equality of provision and prevention of discrimination?

Online communications: the barriers for disabled people

Another change which needs to be considered is the technological advancements of this century and the benefits and disadvantages they bring to communication between practitioners and service users, and between practitioners.

Because of the rapid growth of new technologies as communication tools, barriers to new technology also have to be recognised by information providers such as the HCPC. Access to the internet as means of receiving information and conducting family life (as defined in the European Convention of Human Rights) is accepted as a norm by many of the UK population and has been the subject of a United Nations report (UN 2011). Increasingly the public, private and voluntary sector use their online portals as their main means of communication. The Office for National Statistics' review of UK internet use shows internet use increasing, however latest published results show 14 per cent of the adult population have never used the internet (ONS, Internet Access Quarterly Update, 2013 Q2). Furthermore individuals with a disability are approximately four times more likely to have never used the Internet than individuals without a disability. This means one third of disabled adults had not used the internet (about 3.8 million people), and disabled adults are over half (54 per cent) of the 7.1 million adults who had never used the Internet.

While this is a situation for national government to address all providers must ensure they communicate with all their audiences in appropriate ways.

Whistleblowing

There is high public awareness that things can go wrong in adult health and social care delivery from the publicity given to both the Winterbourne View and Staffordshire hospitals scandals, and to a less extent recent findings concerning residential homes run by Southern Cross. The role of whistle blowers in this field has greater recognition, and there are service user expectations that they will be 'looked out for' by professionals concerned about the practice of colleagues. Are the current standards robust enough to meet concerns of disabled people and carers?

An ageing population

Finally, the growing and ageing population is only going to increase pressures on social care systems. Three quarters of people aged 65 will need care and support in their later years (Department of Health). Only one third of men (33%) and 15% of women will never need social care (Care Quality Commission). The impact of the ageing population on health and social care services is hard to predict but the number of older people with care needs is expected to rise by more than 60 per cent in the next 20 years (Kings Fund, Time to Think Differently). With an increasing percentage of older people in our population, and a cohort of older people living longer there will be an increased demand for practitioners who currently come under HCPC regulation. A question for the HCPC is, do the standards need be framed or presented differently with this population in mind?

Methodology

In consultation with the HCPC, Shaping Our Lives created a questionnaire which enabled us to explore service users' response to the 14 existing standards and gather their thoughts on the content, format and accessibility of the standards. It should be noted that the participants were not given all the supporting text for each standard because this would have been too long to manage in an interview or focus group. However, the interviewers and facilitators had knowledge of the supporting text and prompts to guide participants to the key issues for each standard.

Between July and September 2013 Shaping Our Lives interviewed 31 individual service users, and held one focus group attended by adult service users. In addition two adults with learning disabilities were interviewed separately with their support worker. All interviewees were asked the same set of questions. The questionnaire is in Appendix Three. Following the interview feedback from two people with learning disabilities, Shaping Our Lives asked for a report on the accessibility of the existing standards from CHANGE www.changepeople.org, experts in the communication needs of adults with learning disabilities. Their report is shown in full in the Findings.

People who were interviewed were diverse in age (the youngest was under 18, the oldest 77), living in a variety of settings with the majority living independently, some with family, and a couple in supported accommodation. A handful (six) declared themselves as carers. Nearly 70 per cent were living with a long term condition or impairment. Shaping Our Lives interviewed more women than men (19 to 16). The ethnic profile of interviews was diverse. Interviewees were asked to self-classify; 17 people declared themselves as white, and 20 as either black, Afro-Caribbean, African, or Asian.

Between them the interviews had used all of the 16 professions required to register with HCPC:
Physiotherapists (nearly 60 per cent of respondents)
Occupational Therapists (over 50 per cent)
Radiographer (just over 50 per cent)
Social Workers in England, Biomedical and Clinical Scientists (all just over 40 per cent)
Dietitians, Hearing Aid Dispensers and Speech Therapists were the least used (by one or two people only).
(This is just a sample of the total 16 registered professions)

For a breakdown of responses to all quantitative questions see Appendix Four. Percentages, where reported, relate to the 31 interview responses. We have provided quotes from interviewees throughout the report, to illustrate a common view or as a useful, if minority, opinion or experience. Although majority views are important and lend weight to a force of feeling on some issues, the lived experience of service users varies because of factors such as condition, care needs, personal circumstances and geography, so in reviewing the findings Shaping Our Lives has taken into account individual views and reported them.

In addition we asked the Words and Pictures team at CHANGE to look at each standard in terms of comprehension. Their response is shown boxed under each standard. The Words to Pictures team met for a full hour and a half session to discuss each of the standards. The Words to Pictures team was made up of eight people with learning disabilities.

Findings

As a general note many of the interviewees spoke from experience of services which are free at the point of delivery and were delivered within the framework of a local health or social care department (also found in The Focus Group research). As such they assumed that practitioners were governed and regulated by their employers.

> ‘I think they [the standards] would be hard to enforce in a private setting as these tend to be sole practitioners. Easier to enforce in an NHS setting.’

A handful had experience of buying their own services, and did then acknowledge that for small or sole practitioners, there must be a form of body which oversaw them.

Standard 1: You must act in the best interests of service users.

The service users agreed that their best interests were important. They had many individual comments on what their best interests were, with some common themes.

Listening to my needs
Dignity
Respect
Recognition of service user as expert in own care

> ‘Understanding that I am the best person that knows me, my capabilities and my body.’

Involving service user in decisions
Professionalism
Not discriminating (giving equal treatment to all)
Choice
Transparency and honesty about outcomes
People first, not problem

A couple of people expressed the important view that cost of treatment should not impact on the best interest decision. A couple of people in the focus group reminded us that professionals and service users do disagree about best interests particularly when what the service user wants is perceived to involve risk.

However this standard proved to be the hardest to get people to comment on initially. The question was met with long pauses, and several ‘what does this standard mean?’

The Words and Pictures team said:
The group were divided about the meaning of this standard. Some of the group thought this could be about the things that you were interested in. Some of the group grasped what this was about. The term ‘best interests’ was misinterpreted by some of the group.

- “Is this about speaking up for somebody in a good way?”
- “Someone wants to help you and be kind to you.”
- “Doing something that is best for me.”
- “Doing something in the right way.”
- “Is this about something you are interested in?”
- “Some people with learning disabilities won’t know what this means.

Standard 2: You must respect the confidentiality of service users.

No interviewees disagreed with this standard. They were asked to explore what confidentiality meant in terms of who information might be shared with. All assumed information would be shared. Many answered it should be, but only on a need to know basis. Several respondents cited their GP as the most obvious person who would be given information about them, with other colleagues of the service provider also frequently mentioned.

Of the individual respondents 16 were not concerned about confidentiality, 11 were concerned but did not give any concrete examples of when breaches of confidentiality had happened to them. There were more concerns about the protection of information generally, and the accessibility of electronic information.

Some respondents thought it was a good thing that useful information could be shared with other parties such as other patients to help with their decision making, or students as study aids.

There were a couple of examples given of where carers and parents of adult service users were given information without consent. The focus group commented on permission to be asked before information is shared, with some in favour. Others pointed out that it could be detrimental to treatment if information was not shared.

The Words and Pictures team said:
Everyone in the group understood what this meant, but accepted that some people with learning disabilities might not understand terms like ‘confidentiality’ and ‘respect’. Volunteers at CHANGE are fairly familiar with these terms due to the nature of the work we do.

- “Confidentiality means that you mustn’t tell anybody else what has been said – it has to be kept private.”
- “Is it about having your own privacy?”
- “It’s about not letting information leak out, keeping it to yourself.”
- “Confidentiality is a long word for some people with learning disabilities to understand – maybe private or privacy would be better.”

Standard 3: You must keep high standards of personal conduct.

We asked what personal conduct meant to the interviewees. There was a lot of overlap with Standard 1. The three most common responses for respondents describing a high standard of personal conduct were:

Respect (cited 9 times)
Integrity (cited 4 times)
Meeting my needs (treating me as an individual) - (cited 4 times)

Other attributes which contribute to a high standard of personal conduct are that the practitioner is:
Motivated
Caring
Puts my best interests first
Transparent in their dealings, discloses information to me
Polite, welcoming and friendly
Well presented – e.g. clean premises and personal appearance
Understands safeguarding.

When asked what they would do if they had a concern about the conduct of someone providing a service, several interviewees said they would simply take the matter up with the provider there and then. At the focus group there was a discussion about first going to speak to the practitioner’s manager rather than contacting the HCPC, as the latter was seen as a very serious course of action that may lead to someone being struck-off or suspended from practise. One person made a suggestion:

> ‘The client should be told how to complain at the initial visit.’

For the handful of interviewees who had experience of paying for services they had a pretty direct method of dealing with their concerns:

> ‘If private contractor would complain directly, as it is my money.’
> And-
>
> ‘Could withdraw from service if I’m paying for it.’

Other interviewees, talking about public services, said they would go to the provider’s manager, with some mentioning a formal written complaint. One person mentioned PALS, and two the HCPC (although three other people said they would report it ‘to the appropriate [professional] body’).

The Words and Pictures team said:
Some of the group struggled with the term ‘personal conduct’ – this had to be explained using easier words. All the group knew what ‘high standards’ meant.

- “What does conduct mean? Is there an easier word for it?”
- “Does conduct mean to be fair and kind to people?”
- “Does conduct mean staying in touch with people?”
- “It makes me think about conducting electricity!”
- “I think this is about attitudes, behaviour and how to respect people.”

Standard 4: You must provide (to us and any other relevant regulators) any important information about your conduct and competence.

There was a discussion in the focus group on how the current stretched resources in social work departments can create an environment where conduct and competence are compromised with some feeling that this standard was not fit for purpose in all situations. There was a question as to what duty of care HCPC has to practitioners whose conduct and competence is challenged.

There was some cynicism in the focus group that asking practitioners to be self-regulating and inform on themselves was the best method to protect service users.

Most individual respondents had nothing to add to this standard but a handful wanted to be sure that it covered issues outside working life, such as any criminal conviction,

A couple of interviewees mentioned the role of other professionals in monitoring their colleagues.

> ‘Should have to provide information about themselves, and if necessary about other practitioners.’

The Words and Pictures team said:
There was a lot in this standard that the group didn’t understand or misinterpreted. The words ‘relevant regulators’, ‘conduct’ and ‘competence’ were hard for most of the group to read and understand.

- “This is not an easy standard to understand, there are a lot of difficult and jargon words used.
- “For me ‘competence’ means how you act and ‘conduct’ is about respecting other people.”
- “This would have to be written in a more accessible way for me to understand what this means, with less jargon.”

Standard 5: You must keep your professional knowledge and skills up to date.

We wanted to know how this standard can be monitored by service users and asked interviewees how they would check that a service provider is giving the latest and best treatments. For several respondents their answer was to look on the internet and educate themselves about latest treatments before going to their appointment. A couple of respondents were confident about their own knowledge, having had their condition since birth.

A handful of respondents cited professionals displaying up to date certificates. Others assumed that there was some process of continual professional development monitored by the HCPC which was connected to registration. Or that the HCPC proactively checked registrants’ qualifications, assuming it was the regulator’s job to keep track of individual registrants.

> ‘Would check out for myself what most up to date treatment is. Would assume legislation and their professional body keeping them up to date.’

Others were more puzzled as to how they would go about this.

> I don’t know! Look on the internet?

The Words and Pictures team said:
The term ‘professional knowledge’ was discussed a lot. Some the group understood what this meant and some didn’t.

- “What does ‘professional knowledge’ mean?
- “‘Professional knowledge’ is about what you’re good at in your job.”
- “I think this standard is about keeping your training skills updated.”

Standard 6: You must act within the limits of your knowledge, skills and experience and, if necessary, refer the matter to another practitioner.

The problem with this standard, expressed by some service users, is that it implies that the service user does not get a choice in whom they are referred to. There was also scepticism, based on personal experience, about how much choice one could be offered within the framework of both geography and cuts to budgets.

> ‘Generally just referred on to someone else, especially in health service. Would expect to have a choice, but geography means that choice is not always available.’

We explored what support or information interviews would need to help them make an informed choice if this happened.

Respondents listed several decision making tools:

- Access to a register of other providers listing their skills and experience.
- To be involved in the decision.
- Trusting reviews from other service users (friends, relations).
- Trusting the judgement of the original provider.

> ‘Expect practitioner to have full knowledge of my condition so they can make proper enquiries on my behalf, and refer me to right person’

The Words and Pictures team said:
This standard was hard for the majority of the group to understand. The terms ‘limits of your knowledge’ and ‘practitioner’ caused some confusion. Only one member of the group said he understood what this was about.

- “I don’t know what this means. ‘Practitioner’ is jargon to me; this would have to be explained.”
- “Is this about acting within your limits?”
- “This standard is quite long and uses a lot of jargon words. I don’t think many people with learning disabilities would know what it meant.”

Standard 7: You must communicate properly and effectively with service users and other practitioners.

We asked what was important about communication for the interviewees. A common theme was provision of information in a way that suited the service user.

> `That they communicate appropriately to the person who needs information e.g. language skills, or large print. The practitioner should know to take communication needs into account.’

Several respondents gave examples of different ways of making sure information was accessible such as large print and easy read.

Several respondents mentioned the additional needs of some disabled people to ensure good communication, with the emphasis on the practitioner having disability awareness.

> ‘If a patient has additional needs in any shape or form, they need to be given time to communicate. Might need easy read or an advocate. The practitioner should welcome that, not be prejudiced.’
>
> ‘Making sure that practitioner understands what to expect from a disabled person on the first visit e.g. be patient, understand the limitations caused by the disability.’

The Equality Act was mentioned as the framework within which communication to service users should be judged. This is because the law covers the provision of goods and services.

One interviewee felt that one of the standards (they did not specify which one) should reference the environment that services are provided in, and specify that the environment had to be accessible to the service user.

The Words and Pictures team said
The majority of the group understood what this standard was about, but there was a lot of discussion about how it could be written more accessibly. Again the term 'practitioners' caused some confusion.

- "This is about how you work with other people."
- "It's about communicating with other people, and how you should do this in a clear way."
- "I don't understand what the term 'practitioners' means".
- "There could be better words than 'effectively' and 'properly', I'm not sure what these mean in this sentence. Maybe communicate 'clearly' would be better".
- Could you say 'other people you work with' instead of 'other practitioners?"

Standard 8: You must effectively supervise tasks that you have asked other people to carry out.

When asked who they think is responsible if someone else is asked to do a task, the majority of respondents initially indicated the person making the request, referring to them as a manager or supervisor. Some said both people would be responsible. However there were questions asked about the supervisory experience of some practitioners, and whether in fact supervise was the correct terminology. How could a practitioner supervise someone if they were not trained, or indeed not from the same discipline? This point was also raised in The Focus Group research.

A couple said it was the responsibility of the referee to make sure the second party had the right skills and experience but not necessarily supervise them.

> 'Responsibility for is a better word than supervised.'

The Words and Pictures team said
Most of the group loosely understood what this meant. Some people struggled with the words ‘effectively’ and ‘supervise’. Some of the group knew what supervise meant through their experience of supervision at CHANGE or on jobs they had done in the past; however, they said not all people with learning disabilities would know what supervise meant.

- “Being supervised means being told what to do.”
- “’Supervised’ means someone that’s your boss.”
- “I was supervised in my old job at B&Q. For me this standard is about being the person that is in charge of watching over the team and checking that things have been done professionally, and you’ve got to say how the people got on.”

Standard 9: You must get informed consent to provide care or services (so far as possible).

We wanted to find out what service users thought this meant, and to unpick what is understood by informed consent. All respondents apart from one were confident they understood the concept of informed consent, and what that meant for them. There were various definitions given:

> ‘It means that they must get my consent, even if my consent is different from those around me, it is for me personally to say what I want.’
>
> Practitioner should have gone through all the options, even procedures that they cannot deliver, and shared this with me.
>
> ‘No good recognising the words, have to understand the meaning and the implication.’
>
> `That we are fully involved in our treatment. We understand what is happening and have the chance to refuse.’

There was some discussion about mental capacity and meaningful consent, and also how informed consent could be applied in an emergency situation.

The Words and Pictures team said
Around half the group were confident that they knew what this standard meant. The concept of ‘informed consent’ is familiar to some of the group, due to consent forms that some of them have had to sign in the past to do with photographs and videos used on CHANGE’s website/social media.

- “I’m not too sure what the word ‘provide’ means in this standard.”
- “Consent is about signing something. Does it mean that you have to sign a form?”
- “It is about signing a document to say that you give your permission to do something?”
- “I think the word ‘permission’ would be better than ‘informed consent’”.

Standard 10: You must keep accurate records.

When asked how important it was to them that accurate records were kept, 67 per cent of respondents said it was extremely important and 27 per cent very important.

Most interviewees said that they would check that their records are accurate by asking to see them. Some talked about being copied into letters between hospital based staff and their GP. One gave a helpful suggestion about having a check list for practitioners of what information should be included on all notes. Another gave an example of being asked to sign and date notes at the end of an appointment.

When asked ‘Would you want to see your own records?’ most respondents said yes. A handful (four people) said no, and three said yes but gave reasons why seeing their own records would not be straightforward.

> ‘There could be distressing information in the records but all records should be shared.’
>
> ‘Although I have been reticent to ask recently in case I am viewed as a difficult patient.’
>
> `Not unless I had a concern about practitioner and accuracy of records.’

The Words and Pictures team said
About half the group was unsure what the word ‘accurate’ meant.

- “This is about keeping something in a file, like your birth certificate.”
- “I think this is about keeping something written up to date – a bit like our supervision notes.”
- “`Accurate records’ means records that are correct. Maybe the word ‘accurate’ could be replaced with a more accessible word, or explained in a different way.”

Standard 11: You must deal fairly and safely with the risks of infection.

No respondents disagreed with this standard; some pointed out how it protected therapists, the service user and then other service users. When we asked service users how they thought the risk of infection should be dealt with there was a great deal of awareness about measures in health environments - most came up with very practical solutions, which were mainly health care related. For example:

> ‘The same way as any health care professional e.g. using gloves, washing hands before and after, making sure equipment is autoclaved, using fresh equipment where appropriate, throwing old equipment away, using new instruments for each patient.’

Some service users wanted transparency about the risks of infection in a particular environment so they could make a decision about using a service. A couple of interviewees reminded us of the onus on service users to declare their infections.

One member of the focus group reminded us that this standard had to apply to practitioners that visited people in their own home. One interviewee pointed out that in managing infection risks practitioners should ensure basic hygiene measures, such as antibacterial gel dispensers, were accessible to all service users.

The Words and Pictures team said
Most of the group had an understanding about what this standard is about. The word ‘fairly’ confused a few people. Most of the group knew this was health related.

- “This is about washing your hands and your body and making sure you are clean.”
- “This could be about using those special sprays so you don’t pass on any germs or infection. Infections make you poorly.”
- “This standard is about keeping safe and looking after yourself.”

Standard 12: You must limit your work or stop practising if your performance or judgement is affected by your health.

The vast majority (90 per cent) agreed with this standard. Additional comments suggested a regular review over a certain age (as with driving licence renewals) or a mandatory retirement age. One respondent reminded us that lifestyle choices had as much impact as health on performance. One commented that unhealthy practitioners were bad role models.

Others looked at the issue from the point of view of practitioners who could be disabled people. They were concerned that practitioners were supported to return to work, one giving the specific example of a practitioner with mental health problems (a fluctuating condition). Another was concerned with practitioner confidentiality:

> ‘I think need to respect that practitioners don’t have to disclose. They are allowed to keep their health condition confidential.’

Three people didn’t agree with the standard. One of those said:

> ‘I don’t think practitioners should be forced to stop because of a health condition. Reasonable adjustments should be made. Can deprive patients of that lived experience of that condition/ impairment which might be useful.’

Someone else agreed with the standard, but made the same point

> ‘Yes, but this is not cut and dried, depends on how performance is affected. E.g. Visually impaired people who are physios.’

Two people pointed out problems with self-assessment

> ‘Self-assessment is not an accurate benchmark. The pressure to continue would override - needs independent judgement. Self-assessment for a sole practitioner – [disclosure] could threaten the therapist’s livelihood.’
>
> ‘Important for professional to recognise a problem, maybe cut down on work. Might need to make decision for them if they are making mistakes.’

It was noted that the standard was all about stopping work, but not enabling a practitioner to come back to work.

The Words and Pictures team said
Some of the group struggled with the concept of this standard and found it hard to relate to. A few of the words in this standard confused people – particularly: ‘practicing’, ‘performance’ and ‘judgement’

- “Does practising mean like a doctor or GP?”
- “For me the words ‘performance’ and ‘judgement’ are jargon. Could there be easier words or an easier way of saying it?”
- “Does judgement mean when you are diagnosed?”

Standard 13: You must behave with honesty and integrity and make sure that your behaviour does not damage the public’s confidence in you or your profession.

Everybody bar one interviewee agreed with this standard and most respondents had nothing further to add. Additional comments people did make related to the importance of being able to trust a professional provider and have confidence in them. Someone reflected it is difficult to separate professional from personal life, so does the standard cover both?

Someone else related this treatment quite specifically, rather than a general characteristic:

> ‘Important to behave like this to ensure confidence of patient. Being up front (honest) even if it is bad news. Best not to hide things.’

One interviewee felt that this was the standard which related most to whistle blowing, and providing protection for the practitioner accordingly.

It was important to note that ‘honesty’ and ‘integrity’ were both qualities listed in response to what was in a service user’s best interests (standard 1) and elements of appropriate personal conduct (standard 3).

The Words and Pictures team said
Again, there were a few words in this sentence which the Words to Pictures team didn’t understand – in particular ‘integrity’.

- “Is this about doing something that damages your image?”
- “I don’t know what ‘integrity’ means, could there be an easier word used?”
- “This is about how you speak to people, I don’t want to offend anyone, so I look for a different way to say things so I don’t damage things for people. I try to be honest.”

Standard 14: You must make sure that any advertising you do is accurate.

Interviewers were asked about what they thought was important when a therapist is advertising a product or service. This gave them the opportunity to expand upon the concept of accuracy and phrases such as honesty, transparency, truthfulness were used, as well as making it clear an alternative product is available.

> ‘I think it is important that they make sure service users know that service/products may or may not be necessary.’
>
> ‘The language/wording should not be medicalised – the language used should be plain English.’

There was a sense of this standard stating the obvious, in that any practitioner advertising inaccurately would be doing something very wrong.

The Words and Pictures team said
Everyone in the group understood this standard. However, a couple of members were unsure what ‘accurate’ meant.

- “It’s about marketing or selling something in a correct way.”
- “Everyone knows what advertising is.”

Knowledge of standards and the HCPC

The majority of interviewees, 60 per cent, had not heard of the standards. Only 30 per cent would have known where to find them (although once the HCPC had been introduced many assumed there would be a website they could find the standards on). Most interviewees, 83 per cent, did not know that the HCPC had a Register of practitioners, although a couple remembered seeing the HCPC referred to on individual therapist's business cards/flyers. Other respondents assumed the practitioners they saw had some sort of regulatory body, even though they could not name it.

The relevance of the standards to all professions

We asked the interviewees if they thought that all these professions can be covered by one set of standards.

70 per cent of individual respondents said that one set of standards could cover all 16 professions.

Some qualifying remarks were made, however, on the lines of having some specific additional standards for individual professions or that not all standards would apply to all professions.

> 'To a large extent yes [covered by one set], but suspect they would need tweaking for some of the professions. Lots of standards are common across most professions but others specific.'
>
> 'Most of these therapists have boards that look at the specifics of that profession.'

The focus group respondents were less convinced than the individual respondents that all the professions can be covered by one set; only two people thought they could with the other six saying no. No actual reasons were given apart from one respondent stating they thought social workers were an exception and should have a different set of standards.

One interviewee reflected on the changing climate of provision:

> 'Atos and Capita are using health practitioners to do assessments. Do these standards apply to those practitioners? Should there be additional standards that apply if working as a sub-contractor outside the NHS?'

Content, Format and Accessibility

There were quite a lot of comments about the language that the standards were written in being a bit challenging, with a simple plea from one interviewee to make them user friendly.

The Word and Picture team comments (in boxes) are very pertinent when considering use of language and how it impacts on the accessibility of the standards for all service users.

One interviewee neatly summarised the comments of several respondents:

> ‘The thing I don’t like about them is that some are relevant to a member of the public or patient and some are relevant to the therapist or professional or the organisation they work for and they’re all bundled together in no particular order. Do people think there might be value in having 5 or 10 relevant to the patient and 5 or 10 relevant to the professional - and then separated in some way?’

Prior to the commencement of the research, Shaping Our Lives raised the point that some standards were more relevant to the professional than to people using a service. As a result, it was agreed that less time would be spent discussing and evaluating 2 of the standards and the interview questions were less detailed accordingly. These were:

Standard 4 states: You must provide (to the HCPC and any other relevant regulators) any important information about your conduct and competence.

Is there anything you would like to add to this?

Standard 13 states: You must behave with honesty and integrity and make sure that your behaviour does not damage the public’s confidence in you or your profession.

i) Do you agree with this? Yes/No
ii) Is there anything you would like to add?

The respondents did not make many comments on either standard, reflecting the assumption by Shaping Our Lives that these were less relevant to people using the services.

In summary, it is suggested that 2 sets of standards would be more appropriate. One that sets out the required standards of conduct, performance and ethics for professionals registered with the HCPC. These would be linked to a second set or ‘charter’ for people using services and would outline what they should expect from a professional.

In some cases the standards were misinterpreted by participants and further guidance was needed to clarify the meaning. Although the supporting text achieves this, more concise standards with short supporting bullet points and accessible language would be preferred.

Participants felt that some of the issues covered in the standards were also met by legislation such as the Equality Act 2010. For example, in the focus group participants commented that accessible premises and communication would be expected as part of the provision of goods and services guidelines.

Several people wanted the HCPC to ensure that all documents that it produces for the public (and practitioners who have access needs) are available in all formats, at the point of service as well as online. Video was also mentioned as a format that is useful.

For people who had checked out the HCPC online (as part of their interview) several reported finding it difficult to locate the standards on the HCPC website.

Conclusions

Overall service users were less interested in the number of, content or wording of the standards as they were in relating how their lived experience reflected the implementation of the standards and whether they guided the practices that they encountered.

A common theme from lived experience was encountering practitioners who had low disability awareness or understanding of disability equality. This was particularly mentioned in relation to communication and provision of accessible premises, but also touched on in relation to the perceived capacity for understanding of some disabled people.

Quite often interviewees would raise issues when discussing a particular standard which are addressed by the HCPC in their commentary on each standard or in other documents on the HCPC website. However these are not immediately accessible to service users.

Understanding existing standards

Most standards were generally understood when reviewed by our 30 interviewees and focus group, and some of them were understood by the Words and Pictures group, but not all. It should be noted that understanding by the respondents had been improved by the rewriting and simplification, in some instances, of the standards by Shaping Our Lives when writing the questionnaire. This understanding was also enhanced from prompts for interviewers and facilitators.

Standard 1 was the standard that most respondents had the least comprehension of; the most common response was a stab at what best interests meant. Given the best interest examples were so diverse the question we asked was to how a standard could meaningfully address best interests. The common theme that emerged was about respect, understanding and behaviours. This standard could be rewritten to provide a useful code of conduct; and consideration given to merging it with standard 3.

Adults with learning disabilities found the standards or the concepts within them more difficult to understand. It was noted by some interviewees from all cohorts that some of the concepts were a bit obtuse.

Relevance of the standards

While nobody questioned the relevance of any standard based on their experience of the health and care system there were some questions about the aspirational nature of some standards when health and care services have to be delivered in real time, with limited resources available. The two standards which were most questioned in this context were standard 6 (referral options) and standard 8 (effective supervision). The only standard which attracted any general comments about relevance was standard 14 because **a)** such matters are covered by another regulator (the Advertising Standards Authority) and **b)** advertising accurately is an example of behaving with honesty and integrity and therefore is covered by at least two other standards.

Service user focus

Given the profile of our respondents, it is not surprising that user involvement, disability awareness and accessibility were recurring themes across the standards. Respondents were answering based on their lived experience of being excluded from decisions about their care, not recognised as experts in their own care and finding services inaccessible to them because of their impairment or condition. It is important that the HCPC recognise the importance of the view through the lens of our service users and their carers.

Additions to the standards

There were no new standards recommended but several suggestions about how individual standards could be improved either by increasing clarity or adding to what was included.   These are referenced in the Findings. Although the research was not tasked with examining the structure and appropriateness of the standards as a tool for both professionals and people who use services, they were comments and doubts that they all worked to meet everyone’s requirements. It was suggested that some standards only applied to one or other of these groups.

Awareness of the HCPC

There was low awareness among service users and carers of the existence of the standards and their purpose, and of the HCPC as a regulatory body. Respondents had some concerns about how they should use the standards and the system for raising a complaint. Low awareness of the HCPC’s existence and role means a route for satisfactory resolution of a problem is not there.

Recommendations

Shaping Our Lives is making these recommendations from the service user and carer perspective to feed into the HCPC review of standards taking place in 2014. These recommendations are a response to the conclusions we have drawn from our findings, and also taken from the thoughtful suggestions made by respondents.

Our overarching recommendation is that in writing the new standards, the HCPC should consider differentiating between which standards relate to the conduct and performance of practitioners within their profession, and those which relate to the conduct of the practitioner in relation to people who use their services, grouping them accordingly.

To accompany the new standards the HCPC should consider publishing a simple check list which provides for service users as customers – a charter of what should/should not happen. This document could be displayed at point of delivery where feasible (we recognise this is not always possible e.g. with paramedics).

We have grouped our other recommendations under five themes, although they do interrelate;

- Being in control
- Integration and joint working
- Accessibility
- Considering equality
- Protection of interests

Being in control

The concept of no decision about us, without us has been a central tenet of the disability movement for many years and is now part of the legislative framework which governs health and social care. Our recommendations are:-

- That the standards are explicit about respecting users as people, valuing them as experts in their own care with the right to make choices about health and social care.

- The standards need to set out good practice in relation to full user involvement in their care and treatment, including access to records; awareness training for all staff; the meeting of needs identified at assessment, with particular attention to people with multiple needs.

- The future process of developing, implementing and monitoring the standards should include full and ongoing user involvement to ensure the maximum effectiveness of the standards and HCPC's role in regulation.

Integration and joint working

- In recognition that integrated services and joint working between professionals gives good outcomes for service users the new standards should reflect and enable this way of working.

Accessibility

These recommendations are for the benefit of service users and practitioners, in recognition that the latter can be excluded by access issues too. Accessibility includes buildings, information provision, attitudes and behaviours.

- The standards should specifically set out what is unacceptable in terms of disability equality and discrimination in the provision of goods and services.

- When writing the new standards the HCPC should use concepts and language that are accessible to practitioners and people using the services.

- When looking at accessibility the HCPC should consider:
  - How easily the public can find the standards and other policies and procedures.
  - Making the standards available at the point of service.
  - What formats the standards (and other documents) are provided in.
  - that information is provided online and offline.

- To take into account that alternative forms and formats of communication are vital for some disabled people in order to access services and information.

- To provide accessible information online and offline.

We note that the HCPC has some documents (available online) already in Easy Read and we would encourage the production of Easy Read versions of all HCPC documentation, as well as providing documents in Word and PDF files, and as BSL videos.

Although this is beyond the scope of the research, we would urge the HCPC to ensure disability awareness and equality training are part of a practitioner's continuing professional development, and, if is not already a condition of registration, to ensure new registrants have had such training.

Protecting services users
Protection includes confidentiality, safeguarding, complaints procedures and actively addressing concerns about practice and behaviours. We recommend:

- That the review of standards concerning information and confidentiality takes account of the increasing use of both electronic communication and storage and the use of portable and mobile devices, recognising both the benefits to service users with different access needs and the consequences to protecting confidentiality.

- To ensure the new standards are explicit about the whistle blowing role of practitioners in protecting vulnerable service users.

- Clarity about what the standards are for and how they can be useful to service users is needed and documentation resulting from a review of this aspect should be readily available to service users.

- That the HCPC promotes itself more widely as a regulatory authority.

- That the HCPC promotes its complaints procedure more widely, with clarity about who to complain to and how.

Healthwatch England has launched a new online tool for people wishing to raise a complaint about a health service and this may present an opportunity to signpost people on action they should take.

Appendices

References

Health and Social Care Act 2012: fact sheets, link to documents online

'State of Care' report, Care Quality Commission 23 November 2012
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Link to survey online

The Kings Fund, Time to Think differently, Ageing Population
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Appendix One

Health and Care Professions Council
Your duties as a registrant

The standards of conduct, performance and ethics you must keep to:

1. You must act in the best interests of service users.

2. You must respect the confidentiality of service users.

3. You must keep high standards of personal conduct.

4. You must provide (to us and any other relevant regulators) any important information about your conduct and competence.

5. You must keep your professional knowledge and skills up to date.

6. You must act within the limits of your knowledge, skills and experience and, if necessary, refer the matter to another practitioner.

7. You must communicate properly and effectively with service users and other practitioners.

8. You must effectively supervise tasks that you have asked other people to carry out.

9. You must get informed consent to provide care or services (so far as possible).

10. You must keep accurate records.

11. You must deal fairly and safely with the risks of infection.

12. You must limit your work or stop practising if your performance or judgement is affected by your health.

13. You must behave with honesty and integrity and make sure that your behaviour does not damage the public’s confidence in you or your profession.

14. You must make sure that any advertising you do is accurate.

Appendix Two
List of registrants

	Service
A	Arts therapists (art, music and drama therapists) - encourage people to express their feelings and emotions through art, such as painting and drawing, music or drama.
B	Biomedical scientists - analyse specimens from patients to provide data to help doctors diagnose and treat disease.
C	Chiropodists and podiatrists - diagnose and treat disorders, diseases and deformities of the feet.
D	Clinical scientists - oversee specialist tests for diagnosing and managing disease. They advise doctors on tests and interpreting data and carry out research to understand diseases.
E	Dietitians (dieticians) - use the science of nutrition to devise eating plans for patients to treat medical conditions. They promote good health by helping to facilitate a positive change in food choices.
F	Hearing aid dispensers - work in private practice to assess, fit and provide aftercare for hearing aids.
G	Occupational therapists - use specific activities to limit the effects of disability and promote independence in all aspects of daily life.
H	Operating department practitioners - participate in the assessment of the patient prior to surgery and provide individualised care.
I	Orthoptists - specialise in diagnosing and treating visual problems involving eye movement and alignment.
J	Paramedic - provide specialist care and treatment to patients who are either acutely ill or injured. They can administer a range of drugs and carry out certain surgical techniques.
K	Physiotherapists - deal with human function and movement and help people to achieve their full physical potential. They use physical approaches to promote, maintain and restore wellbeing.
L	Practitioner psychologists - attempt to understand the role of mental functions in individual and social behaviour.
M	Prosthetists and orthotists - supply prostheses and orthoses to patients. A prosthesis is a device that replaces a missing body part. An orthosis is fitted to an existing body part.
N	Radiographers - plan and deliver treatment using radiation. Diagnostic radiographers produce and interpret high-quality images of the body to diagnose injuries and diseases.
O	Social workers in England - promote social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being.
P	Speech and language therapists - assess, treat and help to prevent speech, language and swallowing difficulties.

Appendix Three

Profile monitoring questions

1. Gender: please type F or M

2. Age:
   Which of the following age groups do you belong to? (please highlight age band or state age)
   Under 18 18 – 24 25 – 34 35 – 44 45 – 54
   55 – 64 65 or over Prefer not to answer

3. Ethnic group (as you would describe yourself)

4. Are you a:

Service user (as in one or more of the services listed below)?	
Do you have a long term health condition or impairment (Disabled person)?	
It would help us if you could briefly state the nature of your condition or impairment	
Carer?	
If a carer, are you caring for someone under 16 years of age?	

I

5. Living arrangement:

Living independently
Living with family (because their support is required)
Supported accommodation
Residential care
Other (please state)

6. Have you used any of the services covered by HCPC?

Survey Questions

Standard 1 states: The provider must act in the best interests of people who use their services.

Q7. This is a question about values. Thinking about your best interests, what would be important to you when using a service?

Standard 2 states: The provider must respect the confidentiality of people who use their service.

Q8.i) Who do you think information might be shared with?

ii) Do you have any concerns about confidentiality?

Standard 3 states: The provider must keep high standards of personal conduct.

Q9 i) In terms of personal conduct, what would you expect from a service provider?

ii) What would you do if you had a concern about the conduct of someone providing a service?

Standard 4 states: The provider must provide (to the HCPC and any other relevant regulators) any important information about their conduct and competence.

Q10. Is there anything you would like to add to this standard?

Standard 5 states: The provider must keep their professional knowledge and skills up to date.

Q11. How would you check that a service provider is giving the latest and best treatments?

Standard 6 states: The provider must act within the limits of their knowledge, skills and experience and, if necessary, refer the matter to another practitioner (service provider).

Q12. What support or information would you need to help you make an informed choice if you were referred to another practitioner by your provider?

Standard 7 states: The provider must communicate properly and effectively with people who use their services and other service providers.

Q13. What is important about communication for you?

Standard 8 states: The provider must effectively supervise tasks that they have asked other people to carry out.

Q14. Who do you think is responsible if someone else is asked to do a task?

Standard 9 states: The provider must get informed consent to provide care or services (as far as possible).

Q15 What do you think this means?

Standard 10 states: The provider must keep accurate records.

Q16. i) Rank how important this is to you (scale: extremely important to not at all)

i) How do you know your records are accurate?

ii) Would you want to see your own records? Yes/No

Standard 11 states: The provider must deal fairly and safely with the risks of infection.
Q17. How do you think the risk of infection should be managed?

Standard 12 states: The provider must limit their work or stop practising if their performance or judgement is affected by their health.
Q18. i) Do you agree with this? Yes/No
ii) Is there anything you would like to add?

Standard 13 states: The provider must behave with honesty and integrity and make sure that their behaviour does not damage the public's confidence in them or their profession.
Q19 i) Do you agree with this? Yes/No
ii) Is there anything you would like to add?

Standard 14 states: The provider must make sure that any advertising they do is accurate.
Q 20. What do you think is important when a service provider advertises a service or a product they sell?

These remaining questions are generals one about the HCPC standards.

21. Did you know these standards existed? Yes/No

22. Do you know where to find the standards? Yes/No

23. Do you know that the HCPC has a Register of service providers that work to these standards? Yes/No

24. Do you think all these professions (the 16 services listed) can be covered by one set of standards? Yes/No

25. Are there any changes or improvements you would suggest to these standards?
    - Content
    - Format
    - Accessibility

Are the standards all relevant to you? Are some not important to people who use services? How should they be made available and in what formats? Should they be organised under sub-headings

Appendix Four

	16. Standard 10	How important is this standard to you?				Would you want to see your own records?	
	Extremely	**Very**	**Quite**	**Not very**	**Not at all**	**Yes**	**No**
Totals	20	8	0	0	0	26	4
%	67%	27%	0%	0%	0%	87%	13%

	18. Standard 12 Do you agree with this standard		19. Standard 13 Do you agree with this standard	
	Yes	**No**	**Yes**	**No**
Totals	27	3	29	1
%	90%	10%	97%	3%

	21. Did you know these standards exist?		22. Do you know where to find these standards?		23. Do you know that the HCPC has a register of service providers that work to these standards?		24. Do you think all these professions can be covered by one set of standards?	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Totals	12	18	9	21	5	25	21	8
%	40%	60%	30%	70%	17%	83%	70%	27%

Fitness to practise survey on the standards of conduct, performance and ethics

Analysis of responses to survey of fitness to practise panel chairs and employees about the standards of conduct performance and ethics

Table of Contents:

1. Introduction

About the survey

1.1 We carried out our internal survey of the Fitness to Practise Department on our standards of conduct, performance and ethics (SCPE) between Monday 4 November 2013 and Friday 13 December 2013. This survey is an important component of the review of our SCPE and will form part of our initial research for this project.

1.2 The survey sought the input of key stakeholders to review our current standards in the context of their use in FTP cases and hearings. It was primarily targeted at panel chairs and case teams, but was also circulated to other members of the FTP department who had relevant experience of the standards in practice.

1.3 We would like to thank all those who took the time to respond to the survey.

About this document

1.4 This document summarises the responses we received to our survey. It starts by explaining how we handled and analysed the responses we received; and provides some overall statistics from the responses. Section three provides a summary of the general themes evident from the responses we received, while section four is structured around the responses we received to specific questions in our survey. The conclusion points to our main findings and areas of possible interest identified within the survey for our review of the standards.

2. Analysing the responses

2.1 Now that the survey has ended, we have analysed all the responses we received from the FTP department.

Method of recording and analysis

2.2 All our respondents used our online survey tool to respond to the survey. They self-selected whether they were a panel chair, case manager, case team manager, hearings officer or other, and, where answered, selected their response to each question (eg yes; no; partly; don’t know).

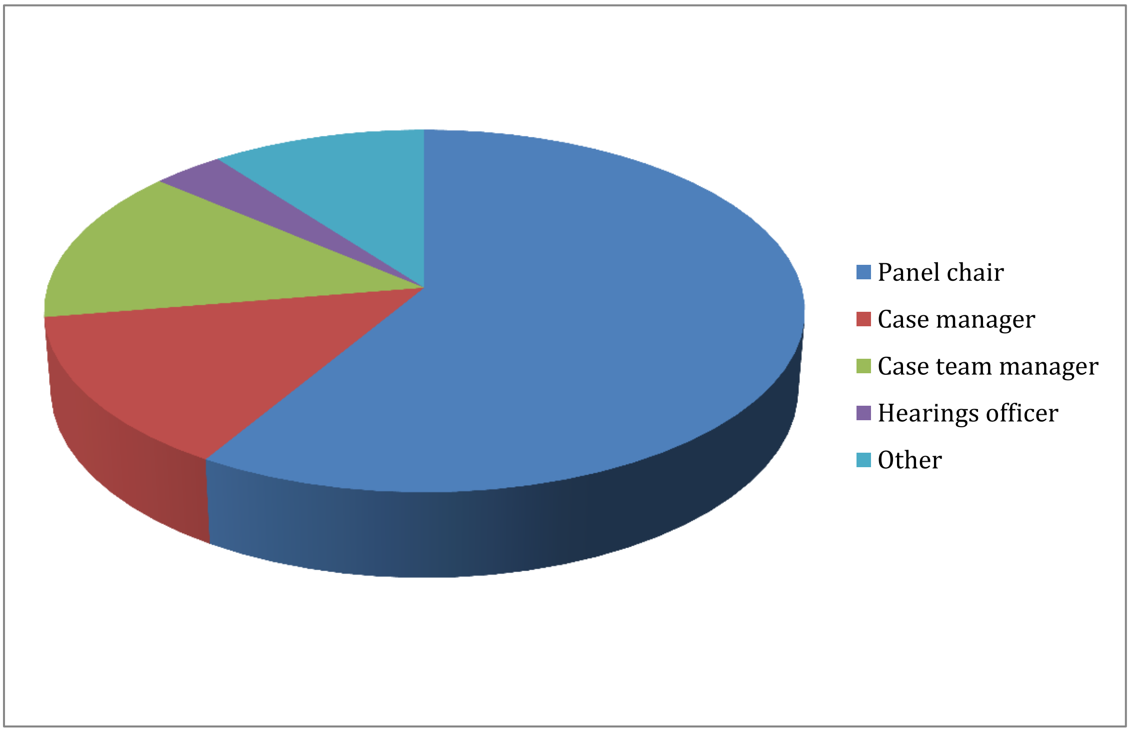
2.3 When deciding what information to include in this document, we assessed the frequency of the comments made and identified themes. This document summarises the common themes across all responses, and indicates the frequency of arguments and comments made by respondents.

Quantitative analysis

2.4 We received 29 responses to our internal survey of the FTP department on our standards. The following is the breakdown of responses by professional category:

- 17 responses were from panel chairs (59%);
- 4 responses were from case managers (14%);
- 4 responses were from case team managers (14%);
- 1 response was from a hearing officer (3%); and
- 3 responses were from respondents who classified themselves as other (10%).

Graph 1 – Breakdown of responses by professional category:



2.5 The table below provides some indicative statistics for the answers to the survey questions. Responses to question five, which asked for any other comments on the standards, are summarised in section four of this paper.

Table 1 – Breakdown of responses to each question

Questions	**Yes**	**No**	**Partly**	**Don't know**
Question 1: Are there any additional standards of conduct, performance and ethics which you think should apply to the registrants on our register?	6 (21%)	17 (61%)	2 (7%)	3 (11%)
Question 2: Are there any standards which you consider are not needed and should be removed?	2 (7%)	23 (79%)	4 (14%)	0 (0%)
Question 3: Are there any standards which you feel should be reworded in some way?	6 (21%)	18 (64%)	3 (11%)	1 (4%)
Question 4: Do you feel that the structure and format of the standards could be revised in any way?	5 (17%)	22 (76%)	1 (3%)	1 (3%)

Table 2 – Breakdown of responses by professional type

	Panel chair				Case manager				Case team manager				Hearings officer				Other			
	Yes	No	Partly	Don’t know	Yes	No	Partly	Don’t Know	Yes	No	Partly	Don’t know	Yes	No	Partly	Don’t Know	Yes	No	Partly	Don’t Know
Question 1	2 (13%)	13 (81%)	1 (6%)	0	1 (25%)	1 (25%)	0	2 (50%)	2 (50%)	2 (50%)	0	0	0	0	0	1 (100%)	1 (33%)	1 (33%)	1 (33%)	0
Question 2	1 (6%)	14 (82%)	2 (12%)	0	0	3 (75%)	1 (25%)	0	0	3 (75%)	1 (25%)	0	0	1 (100%)	0	0	1 (33%)	2 (67%)	0	0
Question 3	5 (31%)	9 (56%)	1 (6%)	1 (6%)	0	3 (75%)	1 (25%)	0	1 (25%)	2 (50%)	1 (25%)	0	0	1 (100%)	0	0	0	3 (100%)	0	0
Question 4	5 (29%)	12 (71%)	0	0	0	2 (50%)	1 (25%)	1 (25%)	0	4 (100%)	0	0	0	1 (100%)	0	0	0	3 (100%)	0	0

- Percentages in the tables above have been rounded to the nearest whole number and therefore may not add up to 100 per cent.
- Question 5 asked respondents to make any additional comments about their experience of using the standards of conduct, performance and ethics in fitness to practise hearings. This question did not require ‘yes’ or ‘no’ answers, and as such it has not been included in the above table but a summary to these responses can be found in section four of this document.

3. Summary of responses

3.1 The following is a summary of the comments we received together with the main identified themes.

Inclusion of additional standards

3.2 21 per cent of respondents considered that additional standards should apply to the professionals on our Register. Respondents who supported this view sought additional standards in a number of areas.

- Additional guidance and/or reference to social media and networking.
- Extending a duty of candour to all our registrants.
- Strengthening the requirements for registrants to assist with investigations.
- An onus for registrants to charge a fair and reasonable amount for services provided.
- A specific requirement which outlines a registrant's responsibility to handle and deal with mistakes.

Removal of standards

3.3 Only seven per cent of respondents identified standards which they considered were no longer needed and/or should be removed. The standard which generated most comment here was standard eleven "You must deal fairly and safely with the risks of infection." This was not surprising as this standard is not directly applicable to all the professions we regulate, for example, social workers in England. One respondent provided a helpful suggestion for broadening the standard to make it more applicable to all our registrants: "you must provide a safe service".

Structure of standards

3.4 A number of respondents detailed various comments and suggestions for improving the structure and content of the standards. The various suggestions included:

- shortening and subdividing the standards to make them easier to read and more comprehensible;
- providing additional numbering;
- being consistent in format and style;
- adopting a more thematic approach and restructuring the standards under same; and
- continuing use of the Plain English (PE) Campaign to edit the standards for plain English.

Amending the scope of individual standards

3.5 A few registrants recommended widening the scope of some standards to strengthen the requirements and responsibilities of registrants. These included:

- introducing a specific requirement in standard four for registrants to be watchful of the conduct of others in order to strengthen the “whistleblower” requirements;
- extending the cooperation requirements for registrants beyond formal investigations and inquiries;
- strengthening the requirements for the disclosure of health related issues by registrants; and
- reaffirming the importance of the maintenance of professional boundaries.

Areas for providing further clarity

3.6 Respondents specified the following areas where further clarity could be provided in the revised standards.

- The requirements for registrants to declare historic convictions and cautions under the revised Rehabilitation of Offenders Act (Exemptions) Order 1975.
- Qualifying some standards to make them more relevant and pertinent to health and care professionals.
- Providing more prescriptive detail on record keeping.
- Strengthening the accountability requirements of registrants in managerial positions with regard to the delegation of duties.

4. Comments in response to specific questions

4.1 This section contains comments made in response to specific questions in the survey.

1) Are there any additional standards of conduct, performance and ethics which you think should apply to the registrants on our Register?

4.2 The vast majority of respondents (61 per cent) believed that no additional standards were required. This view was particularly strong amongst panel chairs with 81 per cent of those surveyed indicating that no additional standards were required.

4.3 The majority of respondents, who commented on this question, were satisfied with the existing standards and their content. The reasons for this included

- their comprehensiveness;
- the standards were sufficient, clearly written and easily applied in practice;
- the absence of negative comments from registrant panel members; and
- the fact that the majority of respondents did not suggest additional standards.

4.4 However, a number of respondents did suggest further standards. A few respondents commented that the revised standards should refer to the internet, social media and/or networking. There was a disparity of views on this point though. Two respondents stated that issues over the use of social media occur very regularly in FTP cases and that such cases are rising. One of these respondents commented that there is no particular guidance in relation to this issue from us. They acknowledged the difficulty in setting down detailed standards in our revised SCPE, but suggested that some general guidance might be useful. The second respondent commented that this issue could be tackled by changing the standard on confidentiality to include relevant information on the responsible use of internet and/or social media sites. These changes could include specifying ways that registrants could breach confidentiality including through use of social media.

4.5 Individual respondents raised a number of other issues which have been detailed below.

- The standards should refer to charging a fair and reasonable amount for the services provided by our registrants.
- The standards should include a specific requirement for registrants to assist with voluntary investigations, for example, where a colleague is being investigated, and referenced the Nursing and Midwifery Council's (NMC) code as a case in point.
- We should extend the duty of candour (contained in the Francis Report) beyond organisations to our own registrants and adopt these recommendations in full.
- The revised SCPE should include an explicit standard on how registrants behave if they make a mistake. One respondent suggested the following wording for a new standard: "If you make a mistake, acknowledge and report what you have done, and take steps as quickly as possible to put it right."

2) Are there any standards which you consider are not needed and should be removed?

4.6 The vast majority of respondents (79 per cent) believed that there were no standards which were no longer needed and/or should be removed, with 82 per cent of panel chairs expressing this view.

4.7 However, a number of other respondents disagreed with this assessment. These respondents outlined a number of recommendations which included:

- combining standards which covered similar areas or content;
- observing that some standards were not directly applicable to all our registrants;
- noting that some standards do not appear frequently in FTP cases; and
- seeking clarity on the standards which overlap with our standards of proficiency (SOPs).

4.8 A few respondents commented on standard eleven “You must deal fairly and safely with the risks of infection.” One respondent commented that this standard was not applicable to all our professions. Whereas another respondent suggested rewording the standard in order to broaden its scope to cover all our professions: “You must provide a safe service.” Finally, a third respondent argued that this standard does not appear frequently with regard to FTP and there may be a case for incorporating it into other standards.

4.9 One respondent recommended combining standards three and thirteen (due to their similarity) into a new standard. They suggested the following wording: “to maintain high standards of personal and professional conduct, acting always with integrity and propriety”.

4.10 Individual respondents identified a few standards which they argued were not applicable to all our professions and were rarely referred to in FTP. These included:

- standard eight “You must effectively supervise tasks that you have asked other people to carry out”; and
- standard 14 “You must make sure that any advertising you do is accurate.”

4.11 One respondent sought greater clarity with regard to the “performance” aspects of the standards and how these overlapped with the SOPs. This respondent identified the following standards in particular – 5, 7, 10 and 11.

3) Are there any standards which you feel should be reworded in some way?

4.12 The majority of respondents (64 per cent) felt that there were no standards which should be reworded. However, only 56 per cent of panel chairs indicated that the standards should not be reworded in some way.

4.13 A number of respondents suggested alternative wording for some of our standards. The reasons included:

- providing more detailed guidance on our requirements and expectations;
- widening and/or narrowing the scope of some standards;
- suggesting changes to the structure; and

- qualifying some standards to make them more pertinent to health and care professionals.

4.14 A few respondents commented on standard four “You must provide (to us and any other relevant regulators) any important information about your conduct and competence.” One respondent referred to the content of the first paragraph of this standard which requires our registrants to also disclose information with regard to “…other registrants and health and care professionals you work with”. This respondent claimed that the current standard limits this requirement to cooperating with investigations and/or formal enquiries into the conduct of others. They suggested a specific requirement for registrants to be watchful about the conduct and competence of others and claimed that due to the absence of the above this important “whistleblower” element was “lost”.

4.15 Two respondents suggested widening standard four to include disclosures over health including if a registrant is no longer able to practise due to their health. One of these respondents also suggested the following wording: “you must provide (to us and any other relevant regulators) any important information about your conduct, health and competence”. Whereas, another respondent suggested rewording standard four to reflect the recent revisions to the Rehabilitation of Offenders Act 1974 (Exemptions) Order 1975 in relation to the disclosure of historic cautions and convictions. This respondent acknowledged that the list currently provided in the standards is not a full list, but suggested that such an amendment would provide clarity to what registrants were and were not required to disclose to us.

4.16 Two respondents commented on standard ten “You must keep accurate records.” One respondent suggested rewording the standard to the following: “You must keep full and accurate records.” This respondent observed that although such records may accurately record the interaction of service users they may not fully record the care, advice or service provided by the registrant. Whereas, the second respondent sought more prescriptive detail in this standard. This included an onus on registrants to provide clear and concise record keeping in order to enable another practitioner to understand and continue with a course of treatment for a service user should the original registrant be unable to continue their treatment.

4.17 Two respondents commented on the general structure of our existing standards. One respondent observed that our standards were very lengthy and contained a lot of paragraphs. However, they argued that registrants don’t always fully understand the detail contained in the standards. This respondent indicated their support for a shorter and easier to follow structure. Whereas a second respondent proposed sub-dividing the standards in order to make them more comprehensible when quoting them in FTP decisions.

4.18 One respondent commented on standard eight “You must effectively supervise tasks that you have asked other people to carry out.” This respondent suggested including additional guidance where a registrant delegates another individual to provide care or services to a service user on their behalf: “Whenever you give tasks to another person to carry out on your behalf, you must be sure that they have the knowledge, skills, experience, *resources and support* (suggested addition in italics) to carry out the tasks safely and effectively." This respondent argued that the above amendment would require registrants in a managerial or supervisory role to exercise that role responsibly, with a primary focus on the quality of the service provided to the service user.

4.19 One respondent argued that standard 13 "You must behave with honesty and integrity and make sure that your behaviour does not damage the public's confidence in you or your profession", should be narrowed in scope to simply require registrants to act with honesty and integrity. They argued that this requirement was important enough to stand alone and that the second part of the standard should be attached to standard three.

4.20 One respondent commented that standard one "You must act in the best interests of service users", should include an additional requirement for registrants to respect professional boundaries. They recommended the following addition: "Must always respect professional boundaries".

4.21 One respondent commented that standard three "You must keep high standards of personal conduct", should have increased emphasis on the maintenance of professional conduct especially for health and care professionals. This respondent suggested the inclusion of the following: "As a health care professional your behaviour and actions may be judged more critically than others".

4) Do you feel that the structure and format of the standards could be revised in any way?

4.22 The majority of respondents (76 per cent) were happy with the current structure and format of the standards. This point was evident amongst panel chairs with 71 per cent indicating their satisfaction with the status quo.

4.23 Some of the respondents who provided detailed comments with their answers were generally supportive of the existing structure and format of the standards. These respondents noted that the standards were:

- regularly reviewed, revised and updated;
- concise;
- helpful;
- clear; and
- easy to follow.

4.24 However, there was not universal satisfaction among respondents about the structure and format of the standards. Two respondents commented on the structure of the standards and also outlined areas for improvement which have been listed below.

- Numbering each paragraph and subsection to make the standards easier to refer to.
- Revising use of dash indents and/or paragraph length within the standards for consistency.
- Including use of bullet points for emphasis.
- Making the text neater and easier to read.

- Restructuring the standards under six main paragraphs with the various standards grouped under these paragraphs (similar to the former GSCC's code).

4.25 With regard to the latter point (restructuring the standards), this respondent observed that standards five and six and standards three and thirteen cover similar areas and could be amalgamated. This respondent argued that less and more focused paragraphs would help registrants to understand the standards better.

5) We would welcome any additional comments that you would like to make about your experience of using the standards of conduct, performance and ethics in fitness to practise hearings?

4.26 The majority of respondents who had additional comments on our standards were generally supportive of the current structure and content of the standards.

4.27 One respondent commented that the current standards were thoroughly fit for purpose and required no revision. This respondent observed that the standards are worded in such a way that they are capable of covering all relevant misconduct and competency issues for registrants. This respondent with significant experience of chairing FTP hearings commented that they never had to stretch the interpretation of the standards in order to make appropriate decisions.

4.28 Another respondent was very supportive of the universality of our SCPE across all of the professions we regulate with regard to forming a core set of ethics which are fundamental to professional behaviour. This respondent supported not having separate SCPE for the individual professions that we regulate.

4.29 Respondents regularly utilised our standards in a number of ways in FTP hearings. One respondent found them to be very helpful in highlighting a registrant's failings in written decisions. However, another respondent observed that the extent to which the standards are referenced by us in bringing a case to a FTP hearing does vary. This respondent argued that although the standards are a key consideration in assessing a registrant's fitness to practise they are not given sufficient emphasis in the case summary and may not appear in the notice of allegation. Finally, a third respondent observed that a great deal of importance is placed by panels on a registrant's ability to understand their failures and their impact on service users.

4.30 Two respondents acknowledged some difficulties with the standards. One respondent observed that although some standards are used to judge certain matters; they can be interpreted in different ways. Another respondent observed that at a particular hearing it is sometimes difficult to identify which standard applies to the particular allegation. This respondent commented that some panels have an over reliance on the summary of the standards instead of referring to them in detail. They argued that this can result in a lack of focus on the principles and the actions which demonstrate compliance with an individual standard. This respondent welcomed the fact that our standards had been approved by the Plain English (PE) Campaign, and suggested that this continue.

Although they did propose that the PE campaign should look not just at individual paragraphs but at the overall impact and comprehension of the standards for our registrants and to compare this against other regulators’ standards.

5. Conclusion

5.1 The following section sets out our initial response to the range of comments we have received for our survey.

5.2 We have carefully considered the comments received and have identified the following areas which may merit further consideration as part of our review of the standards.

- Use of the internet and social media.
- Guidance around making, acting and acknowledging mistakes.
- Incorporating any relevant recommendations from the Francis report which could include strengthening the “whistleblower” requirements.
- Strengthening the delegation requirements for those registrants in a managerial position.
- Reviewing the wording around standard eleven “You must deal fairly and safely with the risks of infection”, to make it more applicable to all our registrants.
- Adopting a more thematic approach and possibly combining some of our existing standards which have similar content.
- Improving the structure and layout of the document to enhance its accessibility for both our registrants and other stakeholders.

5.3 With regard to the provision of further guidance on the requirement for registrants to disclose historic cautions and convictions under the revised Rehabilitation of Offenders Act 1974 (Exemptions) Order 1975, this will be addressed in the updated guidance on health and character.