Council, 23 March 2017

Understanding the prevalence of fitness to practise cases about paramedics and social workers in England – interim report

Executive summary and recommendations

Introduction

In 2016 we commissioned a team led by the University of Surrey to undertake research to look at the prevalence of fitness to practise cases about paramedics and social workers in England. The research consists of a literature review; Delphi consultation; interviews and focus groups; and a quantitative and qualitative review of fitness to practise cases in each profession. Stakeholder events will also be held in April 2017 to engage stakeholders with the emerging outcomes of the research. The idea is that the research will help to identify preventative actions that all those involved in practice, education, employment, representation and regulation might take.

The interim report of the research is attached. This includes the full literature review and a description of the findings of the Delphi consultation. The researchers have deliberately avoided beginning to reach conclusions at this stage until the other research components have concluded.

The final report is due in August 2017. The research team are due to present the research to the Council at the September 2017 meeting.

Decision

This paper is for discussion. No decision is required.

Background information

Council, 3 December 2015. Understanding the prevalence of fitness to practise concerns about paramedics and social workers in England.
http://www.hcpc-uk.org/assets/documents/10004E68Enc03-UnderstandingtheprevalenceofFTPcasesaboutparamedicsandSWinEngland.pdf

Resource implications

None as a result of this paper

Financial implications

None as a result of this paper

Appendices

None

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Understanding the prevalence of fitness to practise cases about paramedics and social workers in England

Interim Report

3 March 2017

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Contents

1. Introduction

1.1 This is an interim report on the progress of a research study exploring the reasons behind the disproportionate number of concerns and complaints about paramedics across the UK and social workers in England relative to other HCPC regulated professions. We have not included any analysis, nor drawn any conclusions on the work to date, as this would seem premature given that not all the data has been collected and analysed. The purpose of this report is therefore to describe all the research elements and to provide a detailed account of those elements that have been completed.

1.2 A mixed methods approach is being used to capture the breadth and depth of data necessary to respond to the two primary research questions:

1) Why is there a disproportionate number of fitness to practise concerns raised about (a) social workers and (b) paramedics?

2) What preventative action could be taken to tackle this trend?

1.3 Four research methods are being used to enable a wide range of data to be collected from international experts (via a **Delphi process**), from UK stakeholders involved in the fitness to practise process (via **interviews and focus groups**), and from case analyses (from the HCPC **database**). In April 2017, **meetings with key stakeholders** will be held in order to further identify possible actions on prevention and to inform the recommendations. The Final Report will provide a full analysis and synthesis of the findings from all of these, as well as recommendations emerging from the project.

2. Case Analysis

2.1 Between September 2016 and January 2017, the research team have reviewed case management data on 141 cases referred to HCPC from the two professions. This constitutes 155 of our target of 216 social work cases, and all 47 of our paramedic cases working towards the target of a 10% random sample from cases at each stage in the HCPC process.

3. Interviews

3.1 Between September and January one to one interviews have been conducted with 26 stakeholders drawn from practitioners and service users, professional bodies, universities, unions, and fitness to practise

panel members, lawyers and HCPC case managers. To date, we have conducted 10 interviews with social work practitioners, 11 with paramedics and 4 with experts from professional regulation. These interviews were conducted either over the telephone or face to face. All were recorded and will be transcribed for the purposes of analysis.

3.2 The team will continue to interview individuals from January to March 2017 until the target sample of 30 is reached.

4. Focus Groups

4.1 These will be carried out in the early part of 2017. Meetings are planned in Wales, Scotland and England.

5. Literature review

5.1. Introduction

5.1.1 The HCPC invited the research team to explore the reasons for, and action to prevent, the disproportionate number of fitness to practise cases about paramedics and social workers in England. This was with a view to informing its future work.

5.1.2 The literature reports considerable variation in the ratio of complaints across different health professions. For example, Spittal et.al's recent study in Australia found an average of 6 complaints per 1000 professionals, with higher rates for dentists and doctors (21 per 1000 and 14 per 1000) than for nurses and midwives (2 per 1000) (Spittal et al, 2016). A UK comparison found similar ratios across these professions, with dentists and doctors demonstrating significantly higher rates than other health professions (30 per 1000 and 38 per 1000 respectively) (CESG, 2014). The ratios for HCPC regulated professions are much lower than for doctors and dentists, averaging 6 per 1000 in 2016. However, amongst the 16 HCPC regulated professions, paramedics and social workers consistently represent the highest ratios over time. Last year these ratios were 11 per 1000 and 13 per 1000 (HCPC, 2016) together representing over two thirds of all complaints received).

5.1.3 During the first phase of the project the research team conducted a two-part literature review in order to identify prevalence studies and to explore themes that might relate to paramedics and fitness to practise and social workers and fitness to practise.

5.1.4 Part 1 of the literature review describes the evolution of paramedic practice and the existing data on prevalence of complaints. Seven themes arising from the literature are critically analysed in relation to the research question: complex and challenging work environments; managerial pressure; impact on paramedic well-being; potential for error and reporting challenges; public perceptions and expectations; the nature of paramedic professionalism and professional identity; and changing scope of practice.

5.1.5 Part 2 of the literature review provides background on the development of social work practice and the data on prevalence of complaints. Seven themes, arising from the literature are critically examined in relation to the research question; the nature of social work practice; workplace factors; management of errors and complaints; job stress;

alcohol and drug use; social and emotional vulnerability; and public and media perceptions of social work.

5.2. Methodology

5.2.1 The review included both peer-reviewed and grey literature using systematic searches of electronic databases, web searches, professional body and regulatory body publications and government publications. Searches included but were not limited to CINAHL, Medline, ASSIA and SCOPUS databases.

5.2.2 In searching for both paramedic and social work literature the following search terms were used in line 1: “fitness to practi*” OR “conduct hearing*” OR “disciplinary hearing*” OR “disciplinary action*” OR misconduct OR malpractice OR “professional conduct” OR “professional discipline” OR “professional boundar*” OR professionalism OR “quality assurance” OR complain* OR unethical OR Illegal OR unprofessional. Line 2 of the paramedic literature search consisted of: paramedic OR ems OR emergency medical service OR prehospital OR pre-hospital OR ambulance OR emergency medical technician OR emt. Line 2 of the social work literature search consisted of: “social work*”. Additional criteria were used to narrow down both searches to publications from 2000-2016 and written in English. Please see Appendix A for tables of the search strategies and yields.

5.2.3 At this stage, titles were screened for relevance and the included sources were recorded in the reference management software Mendeley. The paramedic search generated 297 unique entries. Of these, 180 were articles in the US based Emergency Medical Services magazine from the years 2004-2011. The searches brought up a large number of narrative accounts, editorials and ‘thought pieces’ from the grey literature, particularly from the US. The majority of the peer-reviewed papers were qualitative in nature, using ethnographic or other observational methodologies with small sample sizes, or larger scale cross sectional studies using surveys. They included studies carried out in a variety of jurisdictions, including the UK, Ireland, Canada, Norway, Sweden, the US, Australia and New Zealand. They also included studies carried out in a variety of settings, both urban and rural, for example.

5.2.4 The social work database search generated 419 unique entries which passed the initial title screening. Of these, 127 were articles from the UK based Community Care from the years 2006-2011. A further search was carried out on the Community Care website to find relevant articles

from the years 2012-2016, filtering by the tags 'Fitness for practise' and 'Workforce' and identified 122 articles. These were then further assessed for relevance by reading abstracts and then full texts. These texts were largely qualitative in nature.

5.2.5 Please see Appendix B for detailed flow diagrams, which show the selection process of the peer-reviewed and grey literature included in the literature review.

5.2.6 The final list of publications also includes some that were found in the reference lists of the reviewed articles. Appendix C provides details of the sources included in the final review.

5.3. Part 1: Paramedic literature review

Background – the evolution of paramedic practice

5.3.1 The work of paramedics has changed significantly over the last few decades. Until 1960, paramedics in the UK had no nationally recognized qualification (Kilner 2004). Prior to this, they required a full driving license and a certificate in first aid in order to work. Their role was to transfer patients to hospital and offer basic first aid as appropriate. From 1966 onwards, the Ambulance Services Proficiency Certificate was introduced across the UK. This developed into the Institute of Healthcare and Development (IHCD) ambulance technician programme, which was delivered as on the job vocational training. This was the only route to qualification until the mid 1990s. From this time onwards, more and more university programmes have been developed (see https://www.collegeofparamedics.co.uk/how_to_become_a_paramedic) Furber, 2008, Donaghy, 2008).In 2013, the Paramedics Evidence–based Education Project (PEEP) commissioned by the Department of Health in England recommended that there should be greater standardization of education and training for the profession across the UK, leading to an all graduate status by 2019 (Lovegrove & Davis 2013). The PEEP report confirmed the views of many within the paramedic profession that an all graduate status was both desirable and essential for the profession to meet the needs of a 21st century health and care service (Newton 2012). A similar evolution in both practice and education standards has occurred over the same time period in other parts of the globe, such as Canada, US, Australia and New Zealand (Mannon 1992; Metz 1982; Devenish 2014). Paramedics became a regulated profession in the UK in 2000, and the professional body, the British Paramedic Association was formed in 2001. In many

jurisdictions, paramedics work in teams with regulated nurses, doctors and other health and care professionals and alongside emergency care technicians and support workers who are not regulated.

5.3.2 In today's NHS, a paramedic can work in a number of environments – in call centres, in emergency response vehicles attached to acute trusts, rapid response vehicles and in primary care teams working alongside GPs and other health professions. Increasing numbers have extended scopes of practice. These paramedics augment the work of GPs, manage illness at home and prevent admissions to hospital as well as offering specialist support to their colleagues. Throughput of calls to emergency services varies from region to region, depending on population density. In 2013, the East Midlands Ambulance Services NHS Trust covered 5 counties, had a mixed urban and rural population of 4.8 million, and reported answering 616,200 emergency calls in a 12 month period. (Togher et. al, 2014).

5.3.3 Lovegrove and Davis describe the ways in which UK Ambulance Trusts place an ever increasing emphasis on delivering the clinical service rather than the historical transport service of the past (Lovegrove & Davis 2013; SECAMB 2009). This shift requires skills in assessment and referral across a wide range of conditions, including dementia and mental health, stroke, end of life care and a knowledge base that supports paramedics to respond to the needs of socially excluded groups. In addition to paramedics employed in the four National Health Services across the UK, paramedics are also employed by independent health care services and voluntary sector organisations such as St Johns Ambulance.

5.3.4 Not surprisingly, there has been a steady rise in the demand for paramedic services in recent years, and UK governments have responded by increasing the number of commissioned training places year on year. This reached unprecedented levels in 2015/16, when Health Education England's workforce plan proposed a 61% increase in commissioned places for 2016/17 educational intakes.

5.3.5 Devenish (2014) undertook a qualitative study exploring the socialisation of university-qualified paramedics in Australia. He describes the contrast between 'high acuity' jobs involving incidents such as major injuries at road accidents, cardiac arrests, emergency deliveries, and 'low acuity' routine work in which patients are stable, rarely require transfer to hospital and do not require any invasive treatment. Devenish suggests, along with others, that the high acuity jobs are viewed more favourably by paramedics, despite the associated higher levels of stress and fatigue, but are less frequent

occurrences over the course of a typical shift. Within the profession there is what Devenish describes as a 'cultural emphasis' on dealing with high acuity cases, and he compares paramedic practice with Hancock and Kreuger's observations of military life – 95% boredom and 5% terror (Devenish 2014; Reynolds 2004; Wollard 2009; Sofianopoulos et al. 2012).

5.3.6 The political context of health care also has a bearing on the evolution of paramedic practice as it does on all aspects of health and care. For example, several authors (Bevan & Hood 2006; Newdick 2014) refer to the ways in which performance targets and the prevailing focus on measuring effectiveness only in terms of speed of response changed the way in which services were delivered. Newdick (2014) describes how in Mid Staffordshire NHS Trust, fears over breaching waiting time targets led to some Accident and Emergency Patients being made to wait longer than others with less urgent needs. In addition to the external pressures of trust performance targets, ambulance services are described by some authors as having inappropriate outcome measures, with a focus on acute incidents. Togher et al. (2015) called for a widening of the outcome measures of emergency ambulance services relevant to the majority of patients rather than just the minority. Turner et.al (2006) observed that only 2% of patients attended by ambulance services in the UK experienced cardiac arrest, and yet many measures only relate to the management of such patients. This, coupled with the vastly contrasting demands of the job, along a spectrum from treating life threatening conditions at the roadside to operating patient transport and dealing with low risk injuries (Devenish 2014) makes the work of a paramedic very challenging.

The prevalence of fitness to practise complaints

5.3.7 We found very few studies that addressed the specific question of prevalence (% of the population) or incidence (number of new cases during a given period) of complaints about paramedics beyond the data held by the HCPC, suggesting that there is currently a weak evidence base on this topic. We did not find published data on complaints to other agencies such as NHS employers, for example, nor did we find many studies carried out in other jurisdictions. Risavi and colleagues (Risavi et al. 2013) examined complaints in a rural emergency medical care setting in the US. This was a retrospective study involving detailed review of all complaints over a 9 year period, which found only a small number that proceeded to a full investigation, and none which resulted in a suspension or striking off on the basis of a 'clinically related' complaint. They identified 110 complaints from a population of 3,000

paramedics and found an average of 12 complaints per year over the 9 years. Forty five individuals had more than one complaint made against them (classified as 'repeat' complaints) and 40% of complaints were unfounded.

5.3.8 An earlier retrospective study in Denver, US by Colwell, Pons and Pi (2003) examined 286 complaints over a 6 year period between 1993 and 1998. The overall rate of complaints was calculated at 9.3 per 10,000 referrals, with an average of 48 complaints per year. There was no information on the number of repeat complaints, or numbers of unfounded complaints in this sample. It was not possible to compare the prevalence figures between these two studies, as there is no specific information on the size of the paramedic population in the Denver study.

5.3.9 In contrast to the peer reviewed literature searches, the HCPC Fitness to Practise Annual Reports from 2005-2015 provided a rich source of data on the number of cases referred to the regulator. Over the last decade there has been a steady increase in the number of complaints about paramedics referred to the HCPC, rising from 4 per 1000 in 2005 to 11 per 1000 in 2016.

5.3.10 Taking the prevalence data from available sources together, the overall ratio of complaints varied across published studies from 0.9 per 1000 to 36 per 1000 (see Table 1) This ratio is comparable to the range in Spittal et. al's study (2016), a large scale study which found an average of 6 per 1000 across 14 health professions regulated in Australia (not including paramedics). It is the second highest ratio (after social workers) across HCPC regulated professions (HCPC Annual Report, 2016).

Table 1: Summary prevalence data on complaints about paramedics

Data Source	2003	20012	2015/16
Colwell et.al.	0.9:1000		
Risavi et.al.		36:1000	
HCPC			11:1000

Themes from the literature that may impact on complaints and concerns

5.3.11 Seven themes were identified from the literature, which may have a bearing on the research question:

1. Complex and challenging work environments;
2. Managerial pressure;
3. Impact on paramedic well-being;
4. Potential for error and reporting challenges;
5. Public perceptions and expectations;
6. The nature of paramedic professionalism and professional identity; and
7. Expanding scope of practice.

Theme 1 - Complex and challenging work environments

5.3.12 There are a number of accounts of the challenging characteristics of paramedic work environments from different jurisdictions (Mccann et al. 2013; McCann et al. 2015; Jessica L. Paterson et al. 2014; Lu et al. 2013). Lu et al (2013) describe these in the US context as unpredictable, fast paced, typically brief encounters with patients. They are also characterized by team-based approaches to care (paramedics do not typically work alone) coupled with relative isolation in the field, where quick decisions are required. In Australia, several reports note the increase in the numbers of ambulance workers being subject to assault or verbal abuse by intoxicated patients (New South Wales Government 2009). In a Swedish study, 66% reported threats or violence during their work, the most common being threats of physical violence (Petzäll et al. 2011). In a UK ethnographic study, McCann et al (2013) describe some of the encounters which paramedics have with the public:

> *'The alcohol – this is city centre – young people out – on nights you get a lot of this. The worst thing is that they'll call an ambulance and leave us to clear up the vomit and the shit from 'the bus'…nights are very demoralizing. You're threatened. I was on the verge of ****ing killing somebody'* [Field Notes, Researcher B].

> *We receive a radio message to relocate in [district]. We park near the [major road] on an industrial estate near [street]. We talk about Sarah's experience.. she recalls having to go to some rough houses..she tells me she had been assaulted by patients 'a few times' one man had psychosis and wanted to self harm. He had a*

knife and seemed to be on cannabis. Another encounter left a fellow crew member, Chris with blood on his face..the patient had taken ketamine and the crew had to pounce on him to restrain him…Chris got smashed in the face. The first of these two cases went to court, the second did not..Sarah seems sanguine that they are, after all, patients requiring care [Field Notes, Researcher B].

5.3.13 Some studies explore the consequences of these work environments on paramedics. For example, Paterson et al (2014) examined associations between poor sleep quality, fatigue and self-reported safety outcomes in a sample of 556 responses from 30 agencies in the US and found strong correlations on all measures. This is explored in more detail under Theme 3 below.

Theme 2 – Managerial pressure

5.3.14 A number of qualitative studies described the frequent experience of misalignment between 'senior and street level' paramedics. McCann et al's (2013) observational study identified this as a 'strong level of managerial influence' over ambulance work, manifested in remote control via radio communications and electronic position monitoring of vehicles' (p760). They provide reports of senior staff being physically and verbally 'harrying' staff in order to control their work and meet performance targets.

*'We arrive at A and E and I am starting to get really hungry. The patient is wheeled into a bay on arrival and then allocated a bed. We have to search round for a sheet for the bed and a nurse to hand over to. Once we get outside there are three managers shooing people off the site..Anne says she is going to look for sheets, but a manager comes and says we have to leave. I mutter ***ing hell! Under my breath. There is no time to tidy up. Never mind clear or do basic checks. Paramedic Dave says 'these area managers come from the ranks you know, but they forget. They think we're skiving and we cant even get the ambulance checked'.* [Field notes, Researcher C] p761.

5.3.15 This disconnect is reported to have increased in recent years, as Trust performance targets have become the pervasive measure of effectiveness. Despite the appearance of autonomy, ambulance crews are constantly in contact with their control centres, and these become a source of frustration rather than support. In addition, the ways in which changes are communicated to the teams are not always met with approval.

> *'Patient care has gone out the window to be honest. I do the cars (RRVs) as well and one time I had a very sick baby to sort out. He needed the hospital as quick as possible, I could not afford to wait for the ambulance, so I went, I took him in the car. I had the midwife with me. We have to go, but I get slapped on the wrist for this, as were not supposed to take patients in the car. Then I learned the other week that the protocol has changed and we are allowed to. WE get these pink slips, training memos, they go to the station and were supposed to learn about the changes in this way..one copy! Do you think we're really going to read that! After a shift out here, 12 hours, that's if you get off on time – do you really want to go looking for bits of paper to read. You don't see it. You're not informed. It gets lost in the system'* ([Field Notes, Researcher A] p763.

5.3.16 The longitudinal retrospective study in the Netherlands referred to above (van der Ploeg & Kleber 2003) also found a relationship between this disconnect. In their study, lack of social support from supervisors and poor communication were significant predictors of fatigues scores and burnout symptoms in a sample of 123 ambulance personnel working in a variety of settings.

Theme 3 – Impact on paramedic well-being

5.3.17 Given the unpredictable, high risk, volatile work environments and perceptions that there is inadequate support, it is not surprising that there are reports of high numbers of health complaints amongst this professional group. Weaver et al (2012) found 16% of their sample reported experiencing an injury at work during the previous 3 months. Aasa et al (2005) describe a high prevalence of sleep problems, headaches, and stomach symptoms significantly associated with the psychological demands of the work. Worry about work conditions was a risk factor particularly evident amongst ambulance personnel. Higher incidence of psychological symptoms was not always associated with paramedics, however. One study in Norway found that the ambulance workers in their sample did not show higher rates of anxiety or depression compared with rates in the general population. However, they did find higher rates of musculoskeletal pain (Sterud et al. 2006; Sterud et al. 2008), as have similar studies in Australia (Broniecki et al. 2010) and Canada (Coffey et al. 2016).

5.3.18 Sterud et al. (2011) measured emotional exhaustion, job satisfaction, psychological distress and musculoskeletal pain and personality in a sample of ambulance personnel in Norway. They found gender and age differences for musculoskeletal pain, with older women being more likely to experience these symptoms especially when co-occuring with high levels of physical demand and lack of co-worker support. In a US survey of 1,058 paramedics, which explored relationships between reported back pain, job satisfaction, and self reported general health found strong associations between them. Those with poor/fair ratings of general health and low ratings of job satisfaction were more likely to report recent back pain than those with high levels of satisfaction and self-reported good health (Studnek et al. 2010)

5.3.19 There are a number of related studies by Blau exploring the impact of shift work on working lives in emergency care practitioners (Blau, 2011). These studies found correlations between measured sleep patterns and perceived job satisfaction. A later study by Strzemecka et al (2013) surveyed 700 shift workers including paramedics using self-report questionnaires and found that almost half of the respondents reported negative impact of shift work on family life. 66% reported a lack of contact with their families and irregular consumption of meals. A smaller pilot study of 60 paramedics in Australia found two-thirds experienced poor sleep patterns affecting their home and work related activities. 88% of those surveyed felt that fatigue affected their performance at work. The authors concluded that shift work had the potential to influence physiological and psychological health and well being (Sofianopoulos et al. 2011) and needed more widespread investigation. An earlier longitudinal study in the Netherlands measuring fatigue in 123 ambulance workers suggested that one tenth of their sample demonstrated fatigue levels that put them ‘at risk’ for sick leave and work disability (van der Ploeg & Kleber 2003).

5.3.20 Studies of post-traumatic stress amongst paramedics in the UK, Germany and Sweden reveal similar trends (Ravenscroft 1994; Clohessy & Ehlers 1999; Jonsson 2003). An early study of the London Ambulance Service found that 15% of emergency workers reported symptoms that met the threshold for PTSD. Jonsson’s (2003) analysis of data from 362 ambulance crews in Sweden found a similar prevalence figure of 15% who demonstrated symptoms of PTSD. Those experiencing incidents involving fellow

workers or family members appeared to have slightly higher stress reactions.

Theme 4 - Potential for error and reporting challenges

5.3.21 There were a number of studies which explored error reporting in out of hospital care compared with hospital care. There was a suggestion that there were more barriers to reporting in these environments, for example, because there was less of a 'cultural norm' in reporting errors in out of hospital care services than in hospital (Bigham et al. 2012; Vike 2006; Jennings & Stella 2011). Bigham's systematic review of the literature on patient safety in pre-hospital emergency care found a lack of research compared with hospital care, where a broad range of safety themes have been addressed. These include the wide application of surgical safety checklists and bar code scanners on wristbands, as well as multiple examples of methods for encouraging staff to communicate their concerns. There are also reports of organizational and system wide barriers to error reporting, some of which related to the hierarchies within the paramedic services and others to the hierarchies between professions. One study found that paramedics frequently felt blamed for incidents in which other members of the health care team were at fault (Wang et al. 2008). In addition, error reporting was more challenging in environments that required rapid interventions for patients with whom the professional has only had a brief relationship (Lu et al. 2013). Wu's study suggested that there was, in part as a result of these barriers, very little data on the number of out of hospital errors in the US. Paterson's study found that 50% of providers in their study reported one error in their practice in the previous 12 months. Another survey found 40% reported an error or adverse event and 89% reported safety compromising behaviours (Weaver et al. 2012). Wang et al (2008) estimated that in 16 million medical transports in the US annually, there was one lawsuit for every 23,000 emergency medical service encounters (Wang et al. 2008).

Theme 5 - Changing public expectations of emergency services

5.3.22 Ethnographic studies of paramedics on duty during nights provides a graphic illustration of the complexities and challenges of the work (Mccann et al. 2013; McCann et al. 2015). Reports on the increase in admissions via A and E departments in recent years have been widely reported in the media.

5.3.23 In a study of patient experience and views of emergency health care, satisfaction with emergency services was high, but diminished when four or more services had been contacted in a given episode (for example, emergency services, GP services, hospital consultant, social care service) (Knowles et al. 2012). This study also gave a breakdown of the characteristics of those in the sample of 1,000 patients. The authors suggest that longer care pathways may reflect the complexity of a health condition but they may also reflect confusion about where to access appropriate services for particular conditions.

5.3.24 Togher et al (2015) undertook a qualitative study of 22 patients with a wide range of conditions, and 8 carers who were users of three different types of emergency service – call centres, on scene assessment and transport to hospital. They found, not surprisingly, that reassurance was a key outcome for users, and specifically that feeling listened to, being informed, being treated with courtesy and appropriate use of humour all contributed to this. Continuity across transfer points, for example from the call handler to the ambulance, was also seen as important.

Theme 6 - Changing nature of professionalism and professional identity

5.3.25 There were a large number of papers exploring this theme. Several link the issue of professional identity with the changing nature of paramedic practice and rapidly changing roles. For example, Velloso (2014) in Brazil describes a study of emergency care services showing how different members of the team had difficulties differentiating their roles and responsibilities and found these to be a source of tension.

5.3.26 The majority of papers discuss the ‘professionalisation’ of the paramedic profession and its journey from a vocational on the job training to degree level training in a relatively short period of time (Metz 1982; Campeau 2008; Devenish 2014; McCann et al. 2013). Some describe this as ‘professionalization from above’, rather than ‘professionalization from within’ (McClelland 1990; Evetts 2011), largely precipitated by the advent of statutory regulation and the increasing pressure to bring paramedic education and training into universities. Both, it is argued, required a new emphasis on a broader range of skills, new patient pathways and advanced practitioner roles as well as advancing the role and scope of the professional body.

5.3.27 Whilst the literature on professionalism generally is extensive (see, for example, Duchan 2011; Collier 2012; Christmas & Millward 2011; Askham & Chisholm 2006; Levinson et al. 2014), there has been little attention to paramedic professionalism. An exception is O'Meara (2009) who writes of:

> A transition of paramedic care from a single response, deliver first aid and transport model to a more integrated role within the health system […] This transition from strict protocol practice to procedures requiring the paramedic to use knowledge and experience to problem solve and provide solutions is creating a more complex practice for paramedics.

5.3.28 A UK study on professionalism, commissioned by the HCPC (Burford et al. 2014), focused on paramedics as one of three professions. The HCPC study reported the perspectives of paramedic educators and students and referred to professionalism as 'a holistic construct' that develops over time and which is connected with behaviours, attitudes, communication and context.

5.3.29 A study by Brown et al (2005) identified a range of qualities which included: patient advocacy; integrity; self-motivation; empathy; careful delivery of service; respect; time management skills; and teamwork.

5.3.30 A Delphi process, which formed part of a study examining paramedic professionalism, arrived at 21 consensus statements relating to the meaning of 'professionalism'. These included: the ability to make well-informed and accurate clinical decisions; doing the job with sincerity and maintaining professional etiquette and ethics; behaving with integrity; and treating and caring for ALL patients with dignity and respect at all times. The topic area of 'enablers of professionalism in paramedic practice' seems particularly pertinent in relation to fitness to practise. The three levels of the individual (micro-level); the organization (meso-level) and societal/regulatory/political (macro-level) suggest factors that may both enable and inhibit or undermine professionalism. At the individual level, factors such as the paramedics' competence, education, attitudes, values and knowledge reached consensus. At the meso-level, enabling factors that reached consensus include: leadership; teamwork; good management; and the availability of resources reached consensus. At the macro-level, agreed enabling factors included higher educational standards and the contribution of the College of Paramedics (Gallagher, Horsfield, et al. 2016).

5.3.31 The qualitative component of the same study involved interviews with paramedics (Bands 5-7) and paramedic students (Gallagher, Vyvyan, et al. 2016). Factors were again identified, that both enable and inhibit paramedic professionalism. At the micro-level, a participant described how, despite having a code of values:

> *'I find it quite sad when I see people who are supposed to be embodying this not actually giving examples themselves'* (Band 7).

5.3.32 Relating to meso- or organizational factors, a Band 5 paramedic commented:

''I think poor management and poor communication is a huge barrier to professionalism. Where you've got team leaders at the basic level whose clinical knowledge is poor, that doesn't help bolster up the professionalism of people around them, because they don't care. And I think if you don't get care and good management and good professional practice above you, then this is going to affect your professionalism'.

5.3.33 A Band 5 paramedic expressed uncertainty regarding the impact of the regulator (macro-level) as he says:

> 'I'm not sure whether having the registered body helps me to become a professional'.

5.3.34 The qualitative component of this study is small and was conducted in one paramedic NHS Trust so caution needs to be exercised in terms of generalizability.

5.3.35 Overall, the relative lack of peer-reviewed papers in this review contrasts with the large number of articles in the paramedic grey literature on professionalism and what it means to practice. A US paramedic writing in the Emergency Medical Services Magazine (EMS) provides twelve short pieces written over five years on the moral and ethical dilemmas facing paramedics in his jurisdiction, offering advice to his colleagues on topics ranging from how to deal with poorly performing senior colleagues, to anger management and tolerating disrespect and dealing with conflicting views within ambulance teams on the best course of action in an emergency situation and coping with violent patients (Dick, 2004 - 2010). These pieces provide often graphic illustrations of the day-to-day experiences of US paramedics and the challenges of maintaining professionalism in highly charged environments. A newly qualified

paramedic on a night shift struggling with his sense that his team mate 'has the smell of alcohol on his breath;

> '*What can I do? I'm the rookie here, this guy is my field supervisor. He has a fine reputation. If I blow the whistle on him and it turns out he's innocent, nobody will ever want to work with me again'*. (Dick, 2009,p14)

5.3.36 The US based EMS Magazine and EMS World contain many such examples which explore the nature of professionalism in paramedic practice (Page 2016; Touchstone 2010; Gilbert 2012; Smith 2005; Smith 2013). In 2013, an anonymous author wrote a piece entitled 'ten steps to creating safer systems', in which colleagues are exhorted to report mistakes rather than cover them up. '*Reporting errors without fear of individual retribution or punishment lets organisations fix the systemic flaws that led to errors by individuals*' (p33). Perry (2016) also touches on the need to create a 'just culture' across all emergency services in the US in order to encourage greater learning from mistakes, one if the hallmarks of reflective practitioners.

Theme 7 - Expanding scope of practice

5.3.37 Alongside the changes in education and training, (Kilner, 2004, Donaghy, 2008, Lovegrove and Davis 2013), the profession continues to undergo huge changes to the scope of its practice, reflecting the changes in demand from services and successive governments policy directives (Department of Health 2008; Lovegrove & Davis 2013). These changes include the creation of specialist, advanced and consultant paramedic roles, as well as new hybrid roles such as emergency care practitioners. These roles have created higher levels of autonomous practise, allowing practitioners to deliver services in the community with less reliance on their medical colleagues for diagnosis and treatment. This development has played an important role in improving health care at the point of need and reducing unnecessary hospital admissions. The professional body, the British Paramedic Association, now called the College of Paramedics, has played a key role in this, working closely with the Joint Royal Colleges Ambulance Liaison Committee (JRCALC), the Health and Care Professions Council and Health Education England (Donaghy 2016).

5.3.38 There is as yet little published evidence of the impact of these changes in delivery. Mason et al (2007) compared appropriateness, satisfaction and costs of emergency care practitioners (ECPs) in

three areas in England and found that ECPs carried out fewer investigations, provided more treatments and were more likely to discharge patients home compared with 'usual providers' concluding that they were 'no less effective'. ECPs are drawn from paramedics and nurses, practitioners with additional development and extended scopes of practice. They reflect a move towards the creation of more hybrid practitioners with a combination of skills, another example are non-medical endoscopists, drawn mainly from nursing backgrounds who are trained to perform diagnostic procedures once the domain of consultants. Mason and her colleagues went on to publish the results from a cluster randomized controlled trial with patients aged 60 years and over who contacted emergency services about a minor injury or illness (Mason, Knowles, Freeman, & Snooks, 2008). This study found no significant differences between study and control groups, suggesting that these developments have no adverse effects on the delivery of care, and offer significant cost savings for overall health budgets. Donaghy (2008) called for further research, looking at the ways in which higher education is equipping the modern paramedic to work autonomously in the out-of- hospital unscheduled care environment. To date, there have been no studies in the UK context looking at differences between the vocationally trained practitioners and university graduates.

Conclusions

5.3.39 This review did not reveal many studies of prevalence beyond the data published by HCPC on an annual basis. There may be a number of reasons for this. First, research on complaints in the health and care sector overall is a small, albeit growing area of interest, and much of the data that exists is not in the public domain. Second, unlike some of the other health and care professions, paramedics are not regulated in the same way across jurisdictions, or have not been regulated for as long a period of time. Australia, for example, does not currently regulate paramedics, and in the UK paramedics have only been regulated since 2000. Obtaining reliable data from sources other than regulators is a challenge (Spittal et al. 2016).

5.3.40 What the review has revealed is a rich source of studies on the nature of paramedic practice, all of which will inform the analysis and discussion on the second question posed by this study on the preventative actions that might work to reduce the number of complaints about paramedics in the future. In particular, the review

has revealed a rapid expansion in the scope and autonomy of the profession, particularly over the last decade, along with significant increases in the pressures on paramedics and their emergency care colleagues and similar increases in volume and range of services required. It is no longer a 'patient transport' service, but one which delivers a highly variable, often volatile, complex mix of life-threatening emergency and non-emergency responses through a wide variety of channels.

5.3.41 Furthermore, the review has highlighted changes in societal expectations. The public expects consistently rapid response times from highly trained professional staff. Organisationally, research suggests that the relationships between managers and front line staff are not always well designed and delivered, targets are not always appropriate. Where there is poor communication and a lack of mutual trust, either between management and staff or within teams, services can suffer. Several studies suggest that paramedic cultures have a tendency towards under-reporting of errors and the absence of a 'no blame' work environment. There was also evidence to suggest that paramedics demonstrate high levels of reporting of poor health and well being indices, in terms of psychological stress and physical illnesses.

5.3.42 Finally, the review found a (relatively) large number of studies exploring the changing nature of professionalism and professional identity in paramedic practice. These studies explored not only the complex nature of the work but also the ethical dilemmas confronting paramedics on a day-to-day basis, and the ways in which they respond to these dilemmas.

5.4. Part 2: Social work literature review

Background – the nature of social work, its history and the development of professional regulation

5.4.1. Before reporting on the literature review, we will first outline briefly the current nature of social work practice and the history of its development in Britain.

5.4.2. The social work profession works with people experiencing difficulties in their lives, using processes of care, control, empowerment and social support. Core values underpinning the profession include the promotion of social welfare, social justice and human rights. While

social workers work with individuals and groups to improve the circumstances of their lives, they also have an explicit core purpose to work for social change – to challenge inequality and injustice and promote fairness and the social participation of individuals and groups. The global definition of social work is as follows:

'*Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing*.' (International Association of Schools of Social Work and International Federation of Social Workers, 2014)

5.4.3. While social work is recognized internationally at a generic level, it is important to note that the occupation has grown up in very different ways, linked with different welfare systems in various parts of the world, where social workers may have varied roles and the professional title may or may not be protected. The balance between employment in the state, private and third sector also varies enormously across the world, with the USA having a much higher proportion of social workers in private practice than the UK, for example.

5.4.4. In the global North, social work grew out of charitable work in the mid-late nineteenth century, as voluntary bodies with a mission to distribute financial and material resources, encourage self-help and provide moral education to those in poverty became more widespread and organized (Banks, 2004: 28-35; Payne, 2005). Early precursors of social work in Britain are usually identified as the Charity Organisation Society (established in 1869) and the settlement houses, often set up by universities in poor neighbourhoods (starting in East London in 1884). Formal training began in the early twentieth century, with the School of Sociology in London in 1903, amalgamating later into what became the London School of Economics.

5.4.5. Social workers were attached to many of the agencies dealing with social problems, including hospitals and courts. In 1907 the Institute of Hospital Almoners and the Association of Hospital Almoners devised a voluntary professional register, which gave social workers a formal framework of ethics (Mclaughlin, Leigh, & Worsley, 2016). During the second world-war demand for qualified social workers increased and their employment in local authorities began to rise after the establishment of the welfare state in 1948. Following the Report of the

Committee on Local Authority and Allied Personal Social Services (Seebohm Report, 1968), local authority social services departments were set up in the early 1970s. The British Association of Social Workers (BASW) was formed in 1970 as a voluntary membership body, with a code of ethics formulated in 1975. National regulation of professional education programmes was introduced through the Central Council for Education and Training in Social Work (CCETSW) founded in 1971. Until its dissolution in 2001, CCETSW approved educational providers, awarded qualification certificates and held a register of all qualified social workers (although it did not perform any disciplinary functions). This role was taken over by the Social Care Councils in each of the four countries of the UK, which became the statutory regulatory bodies for social workers and social care workers. For the first time, social workers were required formally to apply to be registered, providing evidence of qualifications, declaring physical and mental fitness, criminal convictions or disciplinary proceedings. The statutory body in England was the General Social Care Council (GSCC). These bodies were given the responsibility to refer alleged cases of misconduct to a panel, which then had the power to impose sanctions on individual social workers, including striking someone off the social care register if the complaint was upheld. The national Codes of Practice for Social Care Workers and Employers were published in 2002 and protection of the title of social worker came into force in April 2005. The GSCC was abolished in 2012 when its duties were taken over by the renamed Health and Care Professions Council (HCPC).

5.4.6. The literature makes reference to the ways in which external statutory regulation of the social work profession raised some concerns when it was introduced. Leigh suggested that regulation increased the risk of individual social workers being held accountable for systemic or organisational failings (Leigh, 2013). Likewise, Furness suggested that employers may use this route to resolve matters that they could deal with themselves, without formal investigations (Furness, 2015). McLaughlin argued that there was ‘an inherent imbalance of power in the proceedings, which was weighted heavily towards the GSCC and detrimental to the social workers’ chance of receiving a fair hearing’ (2010 p.311).

Complaints and concerns about social workers in numbers

5.4.7. Reamer (2008), a North American expert on social work ethics, remarked several years ago that there were few studies documenting the extent of professional error in social work, and this seems still to be the case. As with paramedics, the review found a limited number of

studies on prevalence. The data from HCPC shows a steady rise in the number of complaints since 2012, from 9 per 1000 in 2013 to 13 per 1000 in 2016 (HCPC, 2016).

UK-wide regulation of social workers

5.4.8. Social workers in England are regulated by HCPC. Scotland, Wales and Northern Ireland are regulated by three separate regulatory bodies, the Scottish Social Services Council (SSSC) the Northern Ireland Social Care Council (NISCC) and the Care Council for Wales (CCW). These bodies register and regulate the wider social care workforce, which includes social workers. In 2013-14, the ratio of complaints about social workers across the four UK countries varied from 12 per 1000 in England to 11 per 1000 in Wales, 10 per 1000 in Northern Ireland and 22 per 1000 in Scotland. (NISCC, 2015).

5.4.9. The General Social Care Council (2012) provided a report on their learning in the field of social work which provides some useful insights into the referrals and findings of misconduct. In the period between 2004 and 30 September 2011 the GSCC received 4,118 referrals relating to qualified social workers. Amongst the social workers who were referred to the GSCC a statistically significant over-representation was found of male social workers, black social workers, social workers aged between 40-49 (at the time of referral) and social workers who had identified themselves as disabled.

5.4.10 Referrals came from the following sources:

- Employers - 34%
- Self-reporting - 22%
- Service users - 17%
- Members of the public - 13%
- The police - 2%

5.4.11 Only 329 (8%) of the referrals that the GSCC received led to a conduct hearing. Of the cases that were not referred to the conduct committee 54% were closed as the referral did not present specific allegations of misconduct against the registrant, 21% were closed as there was no real prospect of the case securing a finding of misconduct and in 12% of cases the complainant was unwilling or unable to proceed with the complaint and the complaint did not raise public protection concerns.

5.4.12 Misconduct was found in 278 cases (including student social workers) with the outcome of:

- Removal from the register - 42%
- Suspension - 18%
- Admonishment – 37%
- No sanction – 2%

5.4.13 In 69% of cases misconduct was work-related, in 13% a proportion of the misconduct was work-related, and in 18% of cases misconduct occurred in the private lives of the registrant. 265 cases of misconduct by qualified social workers were analysed and it was found that 81% related to some aspect of 'unacceptable behaviour', whilst only 19% related solely to social workers' 'poor practice'. The main types of 'unacceptable behaviour' were dishonesty and misleading behaviour as well as 'inappropriate relationships'. The most common forms of 'poor practice' was poor safeguarding and failing to notify and share information appropriately.

5.4.14 Some interesting patterns were found relating to the gender of registrants sanctioned (Furness, 2015), some of which mirrors the literature from the criminal justice field as well as from other regulators of health professionals. For example, all these contexts reveal a greater proportion of men commit the most serious breaches of misconduct. In the context of social work, the highest number of such cases across both genders related to criminal convictions or cautions, however they differed in the nature of their offences. 54% of criminal convictions for which women were sanctioned were for theft and fraud, in approximately two-thirds of cases this occurred in the private lives of women and involved fraudulent benefit claims and obtaining property by deception (for men two-thirds of such cases occurred in the workplace). 40% of criminal convictions for which men were sanctioned (but no women) were for sexual assault, sexual activity with minors or adult service users, and possessing indecent images of children, in the majority of cases the offences were work-related. The second most significant category of misconduct of female social workers was failing to safeguard service users and others, whereas for male social workers this was for inappropriate behaviour and having inappropriate relationships.

Studies from the USA

5.4.15 There are a number of American studies reported in the literature, however none report specifically on prevalence. It is important to bear in mind that the roles of social workers are different in the USA and their regulation is at state rather than federal level. Boland-Prom (2009) conducted a descriptive study, bringing together the data from the reports of 27 state regulatory boards about their actions against certified and licensed social workers, which includes a total of 874 cases filed during the period 1999 to 2004. Considering the most serious offence in each case, the following categories were most prevalent:

- Dual relationships and boundary violations (23.4%)
- License-related problems (18.2%)
- Criminal behaviour (14.2%)
- Poor standards of care or practice (9.5%)
- Failure to maintain paperwork to professional standards (8.9%)

5.4.16 A further study of US social workers sanctioned by their state regulatory boards included 2,607 cases from 49 states and District of Columbia from the period 2000–2009 (K. Boland-Prom, Johnson, & Gunaganti, 2015). Considering up to four offences for each case (38% of cases related to more than one offence), the following categories were most frequent:

- Record-keeping, confidentiality, consent (24.6%)
- License-related problems (24.5%)
- Dual relationships (18.9%)
- Criminal behaviour (15.5%)
- Poor standards of care (5.6%)

5.4.17 However in both studies the data indicates inconsistencies between states in the types of cases sanctioned and how they were categorised, therefore this may be more reflective of state sanctioning policies, priorities and practices than of unprofessional behaviour per se.

5.4.18 Strom-Gottfried's (2003) study explored the nature and process of complaints filed with NASW (National Association of Social Workers) against its members in the years 1986-1997. A total of 894 cases were reviewed. A significant relationship was found between the type of complainant and whether ethical violations were found, as follows:

- Surrogate (NASW members not party to complaint but made aware of published accounts of violations or licensure board actions) – 77.3% of cases filed
- Self-reporting – 71.4% of cases filed
- Employer or supervisor – 47.5% of cases filed
- Client – 35% of cases filed
- Colleague – 20.4% of cases filed
- Relative of client – 18.6% of cases filed

5.4.19 There was also a significant finding relating to gender: men were overrepresented both in the group that had proceedings and amongst those who were found in breach of ethical standards. Men were the subject of almost half of the cases in which code violations were found despite constituting only 21% of NASW membership. Boundary violations were by far the most common area of complaints, representing 28% of cases.

5.4.20 In another study Strom-Gottfried (2000) analysed 58 NASW complaints made by or against social work students, faculty members and field instructors in the years 1986-1997. Of these

- 14 failed to meet criteria for acceptance
- 10 were withdrawn after acceptance
- 3 closed for other reasons
- 2 resolved through mediation
- 26 went to hearings, of which 14 found violations

5.4.21 The author highlighted the limitations of this dataset: cases were limited to those which concerned NASW members (not all social workers are members) and where the complainant was aware of this as a route of adjudication. Some variability was noted in the responses of different NASW chapters which suggested that they are not consistent in their screening and judgements. Strom-Gottfried concluded that the relatively low number of cases indicated that the NASW adjudication process was not frequently used.

5.4.22 Daley and Doughty's (2006) study compared complaints made against rural and urban social workers based on data from the Texas State Board of Social Worker Examiners (TSBSWE). Despite suggestions that rural social work carries a greater risk of breeches of confidentiality and dual relationships, they found complaint profiles for rural and urban social workers to be similar. In this study ethical allegations regarding poor practice were reported with the greatest frequency in rural areas, which may be explained by the scarcity of rural social workers (fewer per 1000 of population) and poorer availability of supervision and referral resources.

Table 2: summarising the data from social work prevalence studies

Data Source	2007/08	2013-14	2015/16
GSCC	5:1000		
SSSC		22:1000	
NISCC		10:1000	
CCWales		11:1000	
Daley and Doughty?			
HCPC		12:1000	13:1000

Themes from the literature which may impact on complaints and concerns

5.4.23 Seven themes arose from the social work literature, which may have a bearing on the research question:

1. Nature of social work
2. Workplace factors
3. Management of error and complaints
4. Job stress
5. Alcohol and drug use
6. Social and emotional vulnerability
7. Public and media perceptions of social work

Theme 1: Nature of social work: complex decision-making in the context of conflicting values and expectations

5.4.24 A key issue raised in publications on the characteristics of social work is its complex and unpredictable nature. Social workers are routinely required to engage in decision-making in which they balance competing priorities and interests. Summerson Carr (2015) observed that contemporary social work in the United States is largely end-driven and solution-focused and promotes clear professional trajectories towards specific results. However social workers often face problems that cannot be resolved, only 'managed' (Summerson Carr, 2015) and organizational and societal expectations of certainty in social work decision-making are often unrealistic (Burns, 2011).

5.4.25 Following an ethnographic study in an American Supportive Community Housing programme, Summerson Carr (2015) concluded that ethically it is more important that social workers are attentive in their practice rather than being intentionally focused on objectives. Burns (2011), writing from a UK perspective, additionally highlights the importance of reflection in practice that employs a diverse range of concepts and tools. Walter conceptualizes social work as a space of "professional improvisations" (Walter, 2003: 322) which reference familiar categories of knowledge and remake them to respond to needs and advance practice.

5.4.26 Social workers have been subject to increased managerial and political control since the 1990's (Foster & Wilding, 2000) and it is argued that the values of welfare professions are largely at odds with the New Public Management principles introduced at the time and the neo-liberal policies and practices that accompanied them (Bradley, Engelbrecht, & Höjer, 2010; Carey, 2008; Liljegren, 2012). Equally there are tensions experienced between social workers' perspectives on the role of organizational rules and professional discretion in their work. Stewart warns that such conflict is inevitable as in social work 'diverse individuals interpret and internalize professional values' in different ways (Stewart, 2013: 161) and tensions arise between 'technicist approaches' and 'relationship-based approaches' (Ingram, 2013). Attitudes are not simply determined by an individual's organizational or social position (Evans, 2013) but each individual is left to negotiate these themselves.

5.4.27 Ellis (2011) conducted four studies on the use of frontline discretion in Adult Social Care which comprised observation, interviews and analysis of policy and operational documents. Frontline decision making was found to be a dynamic interaction between top-down authority and street-level discretion. It was subject to a varying level of influence from managerialism, professionalism and user empowerment and shaped by the social workers' micro environments of practice. Yet even in settings where professionals could negotiate managerial demands, their practice would reflect a 'hybrid code of ethics forged out of the penetration of professional identity by managerial priorities, albeit in ways that could be squared with traditional social work values' (Ellis, 2011: 240).

5.4.28 Doel et al. report studies that indicate that social workers and social work students resolve moral issues faced in practice based on their personal moral perspectives and that professional socialization and accepted social work ethical practice principles did not significantly influence judgments (Landau, 1999; Asquith and Cheers, 2001 in: Doel et al., 2010). Their own study has found that "The relative absence of grey areas, the shadows, in agency policy documentation about professional conduct is in stark contrast to the reality of every-day practice" (Doel et al., 2010).

5.4.29 Banks examined how personal engagement and professional accountability are negotiated in social work: 'balancing the personal and professional, between closeness and distance, between rationality and emotion' (Banks, 2013: 602). She argued that professional misconduct often relates to situations where this balance is, wilfully or unwittingly, compromised resulting in, for example, either inappropriate

personal engagement with service users or taking an excessively rule-bound approach to dealing with them. Although inappropriate personal engagement is commonly referred to in both data on complaints (see above) and in discussion of establishing and maintaining appropriate professional boundaries, the current dominance of bureaucratic rules is also emphasized in publications (Garboden, 2010; Leigh, 2014).

5.4.30 An independent social work trainer and consultant quoted in a Community Care article emphasized that the Baby P case changed professional judgments on the balance between "common sense" and "tick boxes" in social work: '*the culture within child protection is now so driven by the fear of exposure for incompetence or poor practice, practitioners and their managers have become far more preoccupied with ticking the right boxes and staying close to guidelines*'. (Sue Woolmore quoted in Garboden, 2010)

5.4.31 Leigh recalls a personal experience of risk-averse practice in an agency she worked for and how, as a result, she was prevented from acting in what she believed were the best interests of a child in her initial period of employment there:

5.4.32 It was apparent that in this organization, there was clear conflict between issues of ethical decision-making and defensive practice, issues that have led to a particular doctrine being developed, one which embraced the needs of the practitioner and excluded those of the family. (Leigh, 2014 p. 6)

5.4.33 However, the author acknowledged that, despite best intentions, she and her fellow social workers 'often succumb to the dominant organizational discourse without even realizing it.' (p.7) – a discourse that 'responds to the needs of government, society and the media' (p. 8).

5.4.34 Kirwan and Malaugh argue that, paradoxically, public expectations of social work may increase when professional regulation is introduced, but at the same time social workers 'may become more concerned to closely and demonstrably follow policies and procedures' (Kirwan & Melaugh, 2015 p. 1055), therefore less likely to be responsive and creative in meeting individual needs

5.4.35 Decisions about professional boundaries are found to be particularly ethically complex in social work and related occupations. Shevellar and Barringham (2016) discuss practitioners experiences of negotiating boundaries in community inclusion work in disability and mental health. They highlight the 'messiness' and ambiguity of practice which does

not fit into neat ethical frameworks, leaving workers feeling anxious and challenged in knowing what to do. O'Leary et al. argue that in social work ethical codes professional boundaries are portrayed as professionally determined and 'clear for all to see' (2012: 15). However, the shift in social work ethos towards a relationship-centred approach has made boundaries more permeable and dynamic. This makes them more problematic and difficult to negotiate and the expertise of the social worker is required to co-construct them with service users. There is some evidence that focuses on the quality of relationship between the social worker and service users is significant for intervention outcomes, more so than the model of intervention used (Coady, 1993; Howe, 1998; Lee and Ayon, 2004 in: O'Leary et al., 2012).

5.4.36 Bates et al.'s (2013) study of attitudes in adult safeguarding explored how professionals make judgments about appropriate boundaries. Respondents were asked in a questionnaire how they would behave in circumstances that are not clearly regulated such as: giving and receiving small gifts, lending a book or dvd, accepting a lift or attending the same community activity as service users in their time off. They found that the way professionals approach these issues is an expression of a personal 'boundary attitude', rather than professional views. Professionals' responses indicated two distinct types: the 'permissives' and the ''prohibitives', with people located on a continuum between the two. However, it is highlighted that not much is known about the relationship between personal boundary attitudes and subsequent misconduct. Shevellar and Barringham (2016: 191) provide an interesting Australian perspective, suggesting a number of ways in which workers can be supported to reinterpret their approach to professional boundaries in community work, including:

- Focus on supervision that facilitates challenging and questioning learnt assumptions about the ethics of boundary crossing
- Validation of the ambiguities of effective practice and of the need for—at times— intuition, 'muddling through', trial and error, hunches, common sense, etc.
- Commitment to an open culture in work teams in which workers can feel safe to raise and discuss boundary tensions.
- A willingness by organisations to reimagine an audit culture that is open to debate, acknowledges boundary challenges and reviews codes of conduct, position descriptions, training models, and quality systems accordingly.

- Reshaping the relationship between the community sector and government such that contract processes move beyond a highly individualised, technical, outputs-focused service delivery approach.

5.4.37 Similarly Doel et al.'s (2010) findings suggest that UK social workers would not benefit from further elaboration of codes of practice, but rather from regular, active ethical engagement, for example by openly exploring professional boundary issues in concrete scenarios. This would enable recognition of the limitations of formal codes of practice and engagement with individuals' personal moral codes and belief systems. This corresponds with Banks's broader idea of 'ethics work': 'the effort people put into seeing ethical aspects of situations, developing themselves as good practitioners, working out the right course of action and justifying who they are and what they have done' (Banks, 2013: 600; 2016). This process of practical reasoning requires critical reflexivity on the part of social workers and sensitivity to the 'ethical dimensions' of their practice, highlighted by Clark (2007) as an important moral quality of social workers in professional misconduct cases.

Theme 2: Workplace factors

5.4.38 Research conducted by Guardian Jobs in association with Affinity Workforce collated the views of more than 1,420 social workers. It revealed the extent of pressures experienced daily which were reported through the Guardian Social Care network under the title 'Mission impossible on a daily basis' – a quote from one of the respondents (Murray, 2015). Only a quarter of respondents felt that their workload was manageable and a third that they can focus on what matters. Nearly 80% declared working overtime every day of the week, 86% of which were not being paid for doing so. Most respondents declared they got professional support and opportunities for training, but nearly a quarter were not getting support every month and nearly a quarter said they did not have time to take up any training. The study also revealed a high proportion were required to hot-desk or work remotely.

5.4.39 Adequate support and supervision are recognised as key to delivering high quality services (Kadushin and Harkness, 2002; Rabinowitz, 1987 in: Bradley, Engelbrecht, & Höjer, 2010) and contributing to a social worker's motivation and resilience (Collins, 2007 in: Bradley, Engelbrecht, & Höjer, 2010, Bulbulia and Hanrahan, 2014)). Bradley et al.'s comparative study of the role of supervisors in child welfare settings in South Africa, England and Sweden found that supervision in

England ‘is focused predominantly on an administrative function’ (Bradley et al., 2010: 784) in line with New Public Management Principles and ideas of organisational professionalism, thus neglecting the educative and support functions of supervision. The research also highlighted the inherent tension between managers’ supervisory/support role and their performance management role in their relationship with subordinates, who may find it difficult to report not coping with their cases.

5.4.40 Bates et al. (2009) studied the learning and development needs of newly qualified social workers and found that competencies developed during training did not include enough ‘process skills’ or ‘instrumental skills’. 25% of the newly qualified social workers did not think they were prepared for the assessments, report writing, record keeping, time management and case management which were expected of them in statutory settings.

5.4.41 Clarke’s (2013) paper discusses issues related to the transfer of training into practice in adult social care. The study identified the following work environment factors as a significant influence on the effectiveness of training and likelihood of resulting improvements to practice: the role of the supervisor, lack of time and resources, daily demands of child welfare practice and refusal by supervisors to endorse proposed practice changes (Clarke, 2013). It confirmed that a lack of time to reflect on what has been learnt and try out new skills, as may often be the case in highly pressured environments, means training has little effect (Secker & Hill 2002 in: Clarke, 2013).

Theme 3: Management of error and complaints

5.4.42 Professional management of error is not well researched in social work, however research in the healthcare field provides some useful evidence. It has been found in studies in the USA that appropriate and ethical disclosure and management of error by the care provider makes it more likely that the affected patient and their family will continue to see the practitioner for treatment and less likely that they will report the practitioner or file a lawsuit (Mazor, Simon, and Gurwitz, 2004; Mazor, Simon, Yood, et al., 2004 in: Reamer, 2008). It is therefore likely that service users will be less likely to complain if mistakes are handled sensitively, honestly, responsibly, and forthrightly by social workers and their employers (Reamer, 2008). This view is supported by the experience of a former social worker and author of several independent investigations into formal complaints regarding services for children and adults, expressed in a letter to Community Care:

> '*A theme that has emerged on each occasion without exception is that complainants will tell me that our discussion regarding their circumstances, and why a complaint has been made, is the first time they consider they have found someone who simply listened to them. It is also the case that had complainants felt listened to early on, and some simple solutions explored, a number of formal complaints I have later had to unravel would not have seen the light of day. (…) It seems to me that the challenge in today's professional world is that we risk losing the elegant and powerful simplicities of human compassion, engagement and concern – driven out by attention to process and targets. Let's not forget that these are useful and valid tools for social work but are not ends in themselves*' (Roberts, 2007)

5.4.43 It is possible though that the organisations which employ social workers do not provide an environment which is conducive to acknowledging and openly discussing difficulties and errors. Gibson claims that regulation and inspection frameworks tasked with ensuring that local authorities are providing good services 'strategically use episodic shaming and praising as a mechanism of regulation' (2016 p. 123). Ethnographic research conducted in an English child protection service indicates that 'the experiences of pride, shame, and humiliation were prevalent and significant for both the social workers' and team managers' practice' (Gibson, 2016 p.127). Munro (2011 in: Warner, 2013), in her report following the Child Protection Review, observed that there were high levels of anxiety about blame and a dominance of defensive forms of practice in the child protection system (see also Cooper et al. 2003 in: Parry et al. 2008).

5.4.44 Children were found to be at particular risk of not being heard or given opportunity to seek resolution of issues which mattered to them. Research on children's complaints and advocacy in Wales found that social workers and managers were often ambivalent, if not dismissive, of children's advocacy and had a tendency to resolve complaints as 'issues' without following proper complaint procedures (Parry, Pithouse, Anglim, & Batchelor, 2008). This indicates that complaints from children and young people may actually be underreported.

Theme 4: Job stress

5.4.45 Social work is considered to be an occupation with a high risk of stress and burnout (Moriarty et.al, 2015). Survey data collected in England (Beer, 2016) with a sample of 427 social workers employed across 88 local authorities and in the private and third sector showed that 75% were concerned about burnout, 63% of respondents had difficulties

sleeping, 56% said that they were emotionally exhausted, 15% currently took, or had taken within the past 12 months, anti-depressant medication as a result of their social work role. Only a quarter of these respondents felt their organisations did enough to support them, and only just over half knew where to access support for work-related stress.

5.4.46 A review of literature conducted by Lloyd et al. (2002) found that although there are many job-related factors at play (involvement with resistant service users in emotionally-fraught and complex situations and working in impoverished environments), the most significant contributing factors were organisational: work pressure, work load, low work autonomy, lack of challenge on the job, role ambiguity, low professional self-esteem and poor relationships with supervisors. The review identified supervisory support to be a significant moderating factor.

5.4.47 Wilberforce et al. (2014) identified the Job Demand/Control Model (Karasek, 1979 in: Wilberforce et al., 2014) as a useful theoretical framework for identifying those social workers who are at greatest risk of stress. Job demands refer to 'the degree of mental pressure placed upon individual workers' (excessive workload, tight deadlines, conflicting demands, high levels of responsibility), job control is 'the degree to which an employee can dictate and shape the activities undertaken in their work' and includes decisions about the content of, and approach to, their work and having a choice about the skills they develop and use in their job (Wilberforce et al., 2014: 4). A significant risk of physical and mental health problems is associated with a high level of job demand combined with low job control. This model was applied by the authors in a study of 249 social workers and care managers involved in piloting Individual Budgets and found that workers younger than the sample average, working longer hours, working in large teams and working with older people were significantly more likely to be at risk of high strain i.e. in poorer psychological health. The authors concluded that social workers and care managers did not find greater discretion in decision-making satisfying in itself, however job control was significant in mitigating stress associated with additional job demands. The actual hours worked relative to contracted hours were a strong contributor to job demands.

Theme 5: Alcohol and drug use

5.4.48 Alcohol and drug use are indicated as a way of dealing with stress. In Beer's (2016) study in England 35% of sampled social workers reported using alcohol to cope with work-related stress, with highest usage (39%) in the 40-49 age group. In terms of sector, the highest levels of alcohol consumption were found among those working in learning disability (54.5%) and children's services permanency and transition teams (52.6%). Six percent of respondents reported using drugs (marijuana, ecstacy, cocaine, and codeine) in the past 12 months to cope with work-related stress. Survey data collected from 751 social workers in North Carolina showed 12% were at serious and 25% at moderate risk of alcohol and other drug abuse with many 'remaining in denial' that alcohol and drug use were a 'problem' (Siebert, 2003). Social work literature provides few detailed strategies for interventions with 'troubled colleagues', whereas this study indicated that of those with serious or moderate risk of alcohol and other drug problems, over 30% declared that they had worked when too distressed to be effective and over 30% declared some professional impairment.

Theme 6: Social and emotional vulnerability

5.4.49 Emotional suppression is widely discussed in social work literature in several jurisdictions (Ruch, 2011; Munro, 2011; Morrison, 2007 in: Ingram, 2015) and Ferguson (2005 in: Ingram, 2015) noted that it could have significant impact on the efficacy of decisions and actions in practice. Equally, it was found that individual social and emotional vulnerabilities can be underlying factors in the misconduct of health and care professionals (Katsavdakis, Gabbard, & Athey, 2004). However Ingram's (2015) study found that the emotional content of social work practice is not comfortably explored within the available forums for reflection, supervision and guidance, but was more frequently explored informally through peer support.

Theme 7: Public and media perceptions of social work

5.4.50 Some published papers suggest that social work has been particularly vulnerable to adverse public and media opinion, in part because of the complex and poorly-understood nature of social work practice (Penhale and Young, 2015). Social workers have a dual role; on one hand they serve as gatekeepers in the state system which involves coercion, control and discretion, on the other, they are advocates who endeavour to support and guide their clients (Jessen, 2010). The disjunction and often perceived dominance of the gatekeeper role are likely to

contribute to mistrust and negative attitudes. Trust and recognition from service users could be increased through greater emphasis on the advocacy role of the social worker. This would mean giving service users more opportunities to voice their expectations and, through dialogue, empowering them to become participants in a more responsive service (Lipsky, 1980; Rothstein, 1998 in: Jessen, 2010).

5.4.51 Changing public and media perceptions appears to be a more challenging undertaking. It has been argued that in public perception, social workers operate as

> '*middle class folk devils; either gullible wimps or else storm troopers of the nanny state; either uncaring cold hearted bureaucrats for not intervening in time to protect the victims or else over-zealous do gooding meddlers for intervening groundlessly and invading privacy*' (Cohen, 2002: xv in: Warner, 2013).
>
> Galilee's (2005 in: Moriarty et al., 2010) literature review found that, on one hand, social work is usually of little interest to the media due to its complexity, on the other, social work failures, particularly those involving children, are viewed as newsworthy.

5.4.52 Warner (2013) conducted a qualitative document analysis of press reports about the Baby Peter case that were published during the first week of media coverage in November 2008, following the lifting of reporting restrictions. She found that all accounts shared moral condemnation of social workers:

> '*in its contradictory and confused construction of 'folk devils', the moral panic over Baby P revisits profound unresolved anxieties about the capacity of social work to operate appropriate forms of moral regulation*.' (Warner, 2013: 218-219)

5.4.53 However the reasoning behind this was mixed: some argued that tick-boxes had replaced social workers' common sense, whilst others that professionals had no common sense and were incompetent to begin with, therefore tick-boxes had only become necessary. Similarly, Leigh (2013) observed contradictory headlines - in one newspaper, practitioners were condemned for failing to protect children, and in another instance were accused of being authoritarian for removing children from their parents.

5.4.54 It was found that being appreciated by clients and the wider public is a significant component of social workers' job satisfaction and motivation (Jessen 2010). The stigma and negative public portrayals can be demoralising for social workers who view them as a distortion of the issues they face in their daily work:

> *'Newspapers should stop focusing on social workers when things go wrong but focus on the pressures put on them (…) We are expected to work wonders in a five-day working week with ever-decreasing resources. Why not point out the sacrifices social workers make such as working loads of extra unpaid hours to ensure that the work is completed, doubling up as drivers to collect stranded children from schools and supervising contact when there is a shortage of contact workers – yet still being expected to complete reams and reams of repetitive paperwork well into the night?'* (Guardian Social Lives survey respondent quoted in Murray, 2015)

5.4.55 Community Care retells the story of an agency social worker who was deemed to be experienced and competent, but made a 'stupid mistake' which was then picked up by the press and as a result, the individual was subject to public shaming and abuse. It highlighted the lack of support for agency social workers who find themselves in such a situation and the importance for social workers of belonging to a professional association and trade union to reinforce professional identity and standards of good practice, as well as to access support in cases of complaints.

> '*The biggest lesson I learned was when you're an agency social worker, no-one has a duty of care to you. And I'd never needed to think about that because I never thought I could make such a foolish mistake that would lead to what happened for the whole of the following of that year. (…) so if you make a mistake, you have nowhere to go. I wasn't a member of the British Association of Social Workers (BASW) and I didn't belong to a Union as I had never had that time'* (Stevenson, 2014)

Conclusions

5.4.56 This review did not reveal a strong evidence base on the prevalence of complaints about social workers, indicating a weak evidence base on this topic. However, the review did reveal literature which highlights the difficulties faced by social workers whose job roles are based on contradictory purposes and values (e.g. care and control) and societal ambivalence towards their work with vulnerable and/or dangerous

people (e.g. social workers as ‘bullies’ or ‘wimps’). This feature of social work practice – situated at the heart of a welfare system that is under increasing pressure and whose service users are often branded as ‘skivers’, ‘undeserving’ or ‘troubled’ – may to some extent account for the disproportionately large number of concerns being lodged against social workers by the public. It may also indicate reasons why employers may refer concerns to the regulatory body, as a way of maintaining public credibility, and protecting themselves from blame by ensuring ‘misconduct’ or ‘incompetence’ is seen to be dealt with at an individual level. A tendency towards a blame culture and defensive practice militates against honest relationships between service users, professionals and employers, which might defuse concerns before they escalate to an official level.

5.4.57 Poor conditions in workplaces, high levels of stress and responses to stress (such as alcohol and drug use) as indicated in the literature may also be factors contributing to poor judgement, unethical and incompetent practice. Inadequate supportive supervision (as opposed to performance management), it is claimed, contributes to an environment where errors, omissions and misconduct are not picked up. However, the extent to which improvements in supervision, training, support and workplace culture can either be achieved or make a difference in the current climate of economic austerity is open for debate.

5.4.58 Indeed, a feature not specifically highlighted in this literature review, perhaps because of the specificity of the search terms used, is the impact of austerity on social work and related social care services (Banks, 2011). As demand for services increases, with rising unemployment, benefit cuts and a general trend towards the ‘responsibilisation’ of service users and state withdrawal of services in many areas (Juhila et al., 2017), this may well result in increasing dissatisfaction on the part of service users (or potential service users Penhale and Young, 2015).

5.5. Paramedic literature references

Aasa, U. et al., 2005. Work-related psychosocial factors, worry about work conditions and health complaints among female and male ambulance personnel. *Scandinavian Journal of Caring Sciences*, 19(3), pp.251–258 8p.

Askham, J. & Chisholm, A., 2006. *Patient-centred medical professionalism: Towards an agenda for research and action*, Available at: http://www.picker.org/wp-content/uploads/2014/10/Patient-centred-medical-professionalism....pdf.

Bevan, G. & Hood, C., 2006. Have targets improved performance in the English NHS? *British Medical Journal*, 332, pp.419–422.

Bigham, B. et al., 2012. Patient safety in emergency medical services: a systematic review of the literature. *Prehospital Emergency Care*, 16(1), pp.20–35.

Broniecki, M. et al., 2010. Musculoskeletal disorder prevalence and risk factors in ambulance officers. 23(4), pp.165–174.

Brown, W.E., Margolis, G. & Levine, R., 2005. Peer evaluation of the professional behaviors of emergency medical technicians. 20(2), pp.107–114.

Burford, B. et al., 2014. Professionalism education should reflect reality: findings from three health professions. *Medical education*, 48(4), pp.361–374 14p.

Campeau, A., 2008. Professionalism, why do paramedics require theories of practice? *Journal of Emergency Primary Health Care*, 6(2).

Câncio Velloso, I.S. et al., 2014. Managing the difference: power relationships and professional boundaries in the mobile emergency care service. *Revista de Enfermagem Referência*, 4(2), pp.71–79.

Christmas, S. & Millward, L., 2011. *New Medical Professionalism: A scoping report for the Health Foundation*, London.

Clohessy, S. & Ehlers, A., 1999. PDST symptoms, response to intrusive memories and coping in ambulance service workers. *British Journal of Clinical Psychology*, 38(3), pp.251–265.

Coffey, B. et al., 2016. A physical demands description of paramedic work in Canada. , 53, pp.355–362.

Collier, R., 2012. Professionalism: the historical contract. *Canadian Medical Association Journal*, 184(11), pp.1233–1234.

Colwell, C.B., Pons, P.T. & Pi, R., 2003. Complaints against an EMS system. *The Journal of emergency medicine*, 25(4), pp.403–8. Available at: http://www.ncbi.nlm.nih.gov/pubmed/14654181 [Accessed July 21, 2016].

Department of Health, Pre registration education and funding for paramedics; guidance for SHAs PCTs and Ambulance Trusts. , p.2008.

Devenish, A., 2014. *Experiences in Becoming a Paramedic: A Qualitative Study Examining the Professional Socialisation of University Qualified Paramedics.* Queensland University of Technology.

Dick, T., 2005a. EMS reruns. Fox in the henhouse: when the accused is a caregiver. *Emergency medical services*, 34(7), pp.40–40 1p.

Dick, T., 2009. EMS reruns. What's that smell? *EMS Magazine*, 38(4), pp.14–14 1p.

Dick, T., 2008a. Flexibility: making systems serve people. *EMS Magazine*, 37(11), pp.26–26 1p.

Dick, T., 2006a. Front-line leadership. Leadership tips. Listening later: can some complaints really wait? *Emergency medical services*, 35(11), pp.31–31.

Dick, T., 2004. Professional etiquette: how you show your respect for people. *Emergency medical services*, 33(4), pp.91–96.

Dick, T., 2008b. That whining sound: accept complaints, but expect suggestions. *EMS Magazine*, 37(8), pp.120–120.

Dick, T., 2006b. The lesson. Why do some of us become cynical? *Emergency medical services*, 35(8), p.24.

Dick, T., 2010. Tricks of the trade. Professional etiquette: stuff a pro does. *JEMS: Journal of Emergency Medical Services*, 35(1), pp.32–32.

Dick, T., 2005b. What people say: fielding and responding to customer complaints. *Emergency medical services*, 34(1), pp.52–60.

Dick, T., 2009. What's that smell? Your partner, the drunk. , 38(4), p.14.

Dick, T., 2008. Witch hunt. *EMS magazine*, 37(1), p.101.

Dick, T., 2008c. Witch hunt: supporting caregiver's authority to think. *EMS Magazine*, 37(1), pp.101–101.

Donaghy, J., 2016. Equipping the student for workplace changes in paramedic education. *Journal of Paramedic Practice*, 2(11), pp.524–528.

Donaghy, J., 2008. Higher education for paramedics—why? *Journal of Paramedic Practice*, 1(1), pp.31–35.

Duchan, J., 2011. Emergence of professionalism in late 19th and early 20th

century America. Available at: http://www.acsu.buffalo.edu/~duchan/new_history/hist19c/professionalism.html [Accessed December 14, 2016].

Evetts, J., 2011. Sociological Analysis of Professionalism: Past, Present and Future. *Comparative Sociology*, 10(1), pp.1–37.

Gallagher, A., Horsfield, C., et al., 2016. Experts' perspectives on professionalism in paramedic practice: findings from a Delphi process. *British Paramedic Journal*, 1(2), pp.9–17.

Gallagher, A., Vyvyan, E., et al., 2016. Professionalism in paramedic practice: the views of paramedics and paramedic students. *British Paramedic Journal*,, 1(2), pp.1–8.

Gilbert, S., 2012. How to Respond to Complaints. *EMS World*, 41(11), pp.53–59.

Jennings, P.A. & Stella, J., 2011. Barriers to incident notification in a regional prehospital setting. *Emergency Medicine Journal*, 28(6), pp.526–529.

Jonsson, A., 2003. Post traumatic stress amongst Swedish ambulance personell. *Emergency Medicine Journal*, 20, pp.79–84.

Kilner, T., 2004. Educating the ambulance technician, paramedic, and clinical supervisor: using factor analysis to inform the curriculum. *Emergency Medicine Journal*, 21(3), pp.379–385.

Knowles, E., O'Cathain, A. & Nicholl, J., 2012. Patients' experiences and views of an emergency and urgent care system. *Health Expectations*, 15(1), pp.78–86.

Levinson, W. et al., 2014. *Understanding medical professionalism*, New York: McGraw Hill.

Lovegrove, M. & Davis, J., 2013. *Paramedic Evidence Based Education Project (PEEP) End of Study Report*, Available at: https://www.collegeofparamedics.co.uk/downloads/PEEP-Report.pdf.

Lu, D.W. et al., 2013. Disclosure of Harmful Medical Errors in Out-of-Hospital Care. *Annals of Emergency Medicine*, 61(2), pp.215–221.

Mannon, J., 1992. *Emergency encounters; EMTs and their work.*, Boston: Jones and Bartlett.

Mason, S. et al., 2007. Effectiveness of emergency care practitioners working within existing emergency service models of care. *Emergency Medicine Journal*, 24(4), pp.239–243.

Mason, S. et al., 2008. Safety of paramedics with extended skills. *Academic*

Emergency Medicine , 15(7), pp.607–612.

McCann, L. et al., 2013. Still Blue-Collar after all these Years? An Ethnography of the Professionalization of Emergency Ambulance Work. *Journal of Management Studies*, 50(5), pp.750–776.

McCann, L. et al., 2015. Where Next for the Paramedic Profession? an Ethnography of Work Culture and Occupational Identity. *Emergency Medicine Journal*, 32(5), pp.e6–e7.

McClelland, C.E., 1990. Escape from Freedom? Reflections on German Professionalization 1870-1933. In M. Torstendahl & M. Burrage, eds. *The Formation of Professions: Knowledge, State and Strategy*. London: SAGE, pp. 97–113.

Metz, D.L., 1982. *Running hot: Structure and stress in ambulance work.*, Cambridge: Harper Collins.

New South Wales Government, 2009. *Report on assaults on paramedics*,

Newdick, C., 2014. From Hippocrates to commodities; 3 models of NHS governance. *Medical Law Review*, 22(2), pp.162–179.

Newton, A., 2012. The ambulance service, past present future (Part 1). *Journal of Paramedic Practice*, 4(5).

O'Meara, P., 2009. Paramedics marching toward professionalism. *Journal of Emergency Primary Health Care*, 7(1).

Page, D., 2016. Excrement happens. *EMS World*, August, p.16.

Paterson, J.L., Sofianopoulos, S. & Williams, B., 2014. No Title. *Emergency medicine Australasia : EMA*, 26(2).

Paterson, J.L., Sofianopoulos, S. & Williams, B., 2014. What paramedics think about when they think about fatigue: contributing factors. *Emergency medicine Australasia : EMA*, 26(2), pp.139–44.

Perry, N., 2016. Collaborating on Safety. *EMS World*, August, p.22.

Petzäll, K. et al., 2011. Threats and violence in the Swedish pre-hospital emergency care. , 19(1), pp.5–11.

van der Ploeg, E. & Kleber, R., 2003. Acute and chronic job stressors amongst ambulance personell; predictors of health outcomes. *Occupational and Environmental Medicine*, 60(1), pp.40–46.

Ravenscroft, T., 1994. *Going critical: 1994 survey of occupational stress factors in A and E staff in the London ambulance service.*, London.

Reynolds, L., 2004. Is prehospital care really a profession? *Journal of*

Emergency Primary Health Care, 2(1-2), p.6.

Risavi, B.L., Buzzard, E. & Heile, C.J., 2013. Analysis of complaints in a rural emergency medical service system. *Prehospital & Disaster Medicine*, 28(2), pp.184–186.

SECAMB, 2009. Paramedic skill levels, specialist roles ans timescales; the cornerstone of a high quality ambulance service.

Smith, M., 2005. Beyond the books. Ethics are everything. *Emergency medical services*, 34(10), pp.38–38 1p.

Smith, M., 2013. BEYOND THE BOOKS. Show Me the Professionals. *EMS World*, 42(6), pp.18–18 1p.

Sofianopoulos, S. et al., 2011. The exploration of physical fatigue, sleep and Depression in paramedics: A pilot study. , 9(1).

Sofianopoulos, S., Williams, B. & Archer, F., 2012. Paramedics and the effects of shift work on sleep: a literature review. *Emergency Medicine Journal*, 29(2), pp.152–155.

Spittal, M.J. et al., 2016. Outcomes of notifications to health practitioner boards: a retrospective cohort study. *BMC medicine*, 14(1), p.198.

Sterud, T. et al., 2011. A comparison of general and ambulance specific stressors: predictors of job satisfaction and health problems in a nationwide one-year follow-up study of Norwegian ambulance personnel. *Journal of occupational medicine and toxicology (London, England)*, 6(1), p.10.

Sterud, T. et al., 2008. Suicidal ideation and suicide attempts in a nationwide sample of operational Norwegian ambulance personnel. *Journal of occupational health*, 50(5), pp.406–14.

Sterud, T., Ekeberg, Ø. & Hem, E., 2006. Health status in the ambulance services: A systematic review. , 6.

Strzemecka, J. et al., 2013. The factor harmful to the quality of human life - Shift-work. , 20(2), pp.298–300.

Studnek, J.R. et al., 2010. An assessment of key health indicators among emergency medical services professionals. , 14(1), pp.14–20.

Togher, F.J. et al., 2015. Reassurance as a key outcome valued by emergency ambulance service users: a qualitative interview study. *Health Expectations*, 18(6), pp.2951–2961.

Touchstone, M., 2010. Professional development. Part 2: subordinating your interests. *EMS Magazine*, 39(2), pp.29–30.

Turner, J. et al., 2006. *The costs and benefits of implementing the new Ambulance service response time standards. Report to DH.*,

Vike, G., 2006. Paramedics self reported medication errors. *Prehospital Emergency Care*, 10, pp.457–462.

Wang, H., Fairbanks, R. & Shah, M., 2008. Tort claims and adverse events in emergency medical services. *Annals of Emergency Medicine*, 52, pp.256–262.

Weaver, M.D. et al., 2012. The association between EMS workplace safety culture and safety outcomes. , 16(1), pp.43–52.

Wollard, M., 2009. The Role of the Paramedic Practitioner in the UK. *Journal of Emergency Primary Health Care*, 4(1), pp.1–9.

5.6. Social work literature references

Banks, S. (2004). *Ethics, Accountability and the Social Professions*. Basingstoke: Palgrave Macmillan.

Banks, S. (2011). Ethics in an age of austerity: Social work and the evolving New Public Management. *Journal of Social Intervention: Theory and Practice*, *20*(2), 5–23.

Banks, S. (2013). Negotiating personal engagement and professional accountability: professional wisdom and ethics work. *European Journal of Social Work*, *16*(5), 587–604.

Banks, S. (2016). Everyday ethics in professional life: social work as ethics work. *Ethics and Social Welfare*, *10*(1), 35–52.

Bates, N., Immins, T., Parker, J., Keen, S., Rutter, L., Brown, K., & Zsigo, S. (2009). “Baptism of Fire”: The First Year in the Life of a Newly Qualified Social Worker. *Social Work Education*, *29*(2), 152–170.

Bates, P., Lymbery, M., & Emerson, E. (2013). Exploring boundary attitude. *Journal of Adult Protection*, *15*(1), 26–36.

Beer, O. (2016). *Predictors of and Causes of Stress Among Social Workers: A National Survey*. University of Plymouth.

Boland-Prom, K., Johnson, J., & Gunaganti, G. S. (2015). Sanctioning Patterns of Social Work Licensing Boards, 2000–2009. *Journal of Human Behavior in the Social Environment*, *25*(2), 126–136.

Boland-Prom, K. W. (2009). Results from a national study of social workers sanctioned by state licensing boards. *Social Work*, *54*(4), 351–360.

Bradley, G., Engelbrecht, L., & Höjer, S. (2010). Supervision: A force for change? Three stories told. *International Social Work*, *53*(6), 773–790.

Burns, K. (2011). Professional Decision Making in Social Work Practice. *Child & Family Social Work*, *16*(3), 365–366.

Carey, M. (2008). The quasi-market revolution in the head: ideology, discourse, care management. *Journal of Social Work*, *8*(4), 341–362.

Clark, C. (2007). Professional Responsibility, Misconduct and Practical Reason. *Ethics and Social Welfare*, *1*(1), 56–75.

Clarke, N. (2013). Transfer of training: the missing link in training and the quality of adult social care. *Health & Social Care in the Community*, *21*(1), 15–25.

Daley, M. R., & Doughty, M. O. (2006). Ethics Complaints in Social Work Practice: A Rural-Urban Comparison. *Journal of Social Work Values and Ethics*, *3*(1).

Doel, M., Allmark, P., Conway, P., Cowburn, M., Flynn, M., Nelson, P., & Tod, A. (2010). Professional boundaries: crossing a line or entering the shadows? *British Journal of Social Work*, *40*(6), 1866–1889.

Ellis, K. (2011). "Street-level Bureaucracy" Revisited: The Changing Face of Frontline Discretion in Adult Social Care in England. *Social Policy and Administration*, *45*(3), 221–244.

Evans, T. (2013). Organisational Rules and Discretion in Adult Social Work. *British Journal of Social Work*, *43*(4), 739–758.

Foster, P., & Wilding, P. (2000). Whither welfare professionalism? *Social Policy and Administration*, *34*(2), 143–159.

Furness, S. (2015). Conduct Matters: The Regulation of Social Work in England. *British Journal of Social Work*, *45*(3), 861–879.

Garboden, M. (2010). Lessons of baby P are not being learned, SCR author complains. *Community Care*, (1843).

General Social Care Council. (2012). *Regulating social workers (2001-2012)*. London. Retrieved from http://cdn.basw.co.uk/upload/basw_34828-9.pdf

Gibson, M. (2016). Constructing pride, shame, and humiliation as a mechanism of control: A case study of an English local authority child protection service. *Children and Youth Services Review*, *70*, 120–128.

Ingram, R. (2013). Emotions, social work practice and supervision: an uneasy alliance? *Journal of Social Work Practice*, *27*(1), 5–19.

Ingram, R. (2015). Exploring Emotions within Formal and Informal Forums: Messages from Social Work Practitioners. *British Journal of Social Work*, *45* (3), 896–913.

International Association of Schools of Social Work and International Federation of Social Workers. (2014). Global Definition of Social Work.

Jessen, J. (2010). Trust and recognition: a comparative study of client attitudes and workers' experiences in the welfare services. *European Journal of Social Work,* 13 (3), 301-318.

Juhila, K., Raitakari, S., & Hall, C. (2017). *Responsibilisation at the margins of welfare services*. London: Routledge.

Katsavdakis, K. A., Gabbard, G. O., & Athey, G. I. (2004). Profiles of impaired health professionals. *Bulletin of the Menninger Clinic*, *68*(1), 60–72.

Kirwan, G., & Melaugh, B. (2015). Taking Care: Criticality and Reflexivity in the Context of Social Work Registration. *British Journal of Social Work*, *45*(3), 1050–1059.

Leigh, J. T. (2013). The process of professionalisation: Exploring the identities of child protection social workers. *Journal of Social Work*.

Leigh, J. T. (2016). The story of the ppo queen: The development and acceptance of a spoiled identity in child protection social work. *Child & Family Social Work*, 412-420.

Liljegren, A. (2012). Pragmatic professionalism: micro-level discourse in social work. *European Journal of Social Work*, *15*(3), 295–312.

Lloyd, C., King, R., & Chenoweth, L. (2002). Social work, stress and burnout: A review. *Journal of Mental Health*, *11*(3), 255–265.

McLaughlin, K. (2010). The social worker versus the General Social Care Council: an analysis of care standards tribunal hearings and decisions. *British Journal of Social Work*, *40*(1), 311–327.

Mclaughlin, K., Leigh, J., & Worsley, A. (2016). The State of Regulation in England : From the General Social Care Council to the Health and Care Professions Council. *British Journal of Social Work*, 825–838.

Moriarty, J., Manthorpe, J., Stevens, M., Hussein, S., Sharpe, E., Orme, J., Crisp, B. (2010). A depth of data: research messages on the state of social work education in England. *Research, Policy and Planning*, *28*(1), 29–42.

Moriarty., J, Baginsky., M, Manthorpe., J. (2015) Literature review of roles and issues within the social work profession in England. http://www.professionalstandards.org.uk/docs/default-

source/publications/research-paper/literature-review-roles-and-issues-within-the-social-work-profession-in-england-2015.pdf

Murray, K. (2015). “Mission impossible on a daily basis” – the real effect of spending cuts on social work. *The Guardian Social Care Network*. Retrieved from https://www.theguardian.com/social-care-network/2015/dec/08/mission-impossible-on-a-daily-basis-the-real-effect-of-spending-cuts-on-social-work

O’Leary, P., Tsui, M. S., & Ruch, G. (2013). The boundaries of the social work relationship revisited: Towards a connected, inclusive and dynamic conceptualisation. *British Journal of Social Work*, *43*(1), 135–153.

Parry, O., Pithouse, A., Anglim, C., & Batchelor, C. (2008). “The tip of the ice berg”: children’s complaints and advocacy in Wales -- an insider view from complaints officers. *British Journal of Social Work*, *38*(1), 5–19.

Payne, M. (2005). *The Origins of Social Work*. Basingstoke: Palgrave Macmillan.

Penhale, B., Young (2015) A review of the literature concerning what the public and users of social work think about the conduct and competence of social workers. http://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/what-the-public-think-about-the-conduct-and-competence-of-social-workers-2015.pdf

Reamer, F. G. (2008). Social Workers’ Management of Error: Ethical and Risk Management Issues. *Families in Society: The Journal of Contemporary Social Services*, *89*(1), 61–68.

Roberts, M. G. (2007). Complaints stem from failure to listen...’Complain? Don't bother', 1 November. *Community Care*, (1700).

Seebohm Report. (1968). *Report of the Committee on Local Authority and Allied Personal Social Services*. London.

Shevellar, L., & Barringham, N. (2016). Working in Complexity: Ethics and Boundaries in Community Work and Mental Health. *Australian Social Work*, *69*(2), 181–193.

Siebert, D. C. (2003). Denial of AOD use: An issue for social workers and the profession. *Health and Social Work*, *28*(2), 89–97.

Stevenson, L. (2014). Social worker sanctioned over Facebook posts reflects on feeling abandoned amidst a media storm. *Community Care*.

Stewart, C. (2013). Resolving social work value conflict: Social justice as the primary organizing value for social work. *Journal of Religion & Spirituality in Social Work: Social Thought*, *32*, 160–176.

Strom-Gottfried, K. (2000). Ethical vulnerability in social work education: an analysis of NASW complaints. *Journal of Social Work Education*, *36*(2), 241–252.

Strom-Gottfried, K. (2003). Understanding adjudication: origins, targets, and outcomes of ethics complaints. *Social Work*, *48*(1), 85–94.

Summerson Carr, E. (2015). Occupation bedbugs: Or, the urgency and agency of professional pragmatism, *30*(2), 257–285.

Walter, U. M. (2003). Toward a third space: improvisation and professionalism in social work. *Families in Society*, *84*(3), 317–322.

Warner, J. (2013). Social work, class politics and risk in the moral panic over Baby P. *Health, Risk & Society*, *15*(3), 217–233.

Wilberforce, M., Jacobs, S., Challis, D., Manthorpe, J., Stevens, M., Jasper, R., … Netten, A. (2014). Revisiting the causes of stress in social work: Sources of job demands, control and support in personalised adult social care. *British Journal of Social Work*, *44*(4), 812–830.

6. Delphi Process

6.1. Introduction

6.1.1. The Delphi technique is a well-established research tool and is considered a proactive way of involving stakeholders in the search for responses to complex research questions. The technique has been used previously, in the HCPC context, to explore the use of service users' feedback tools (Chisholm and Sheridan, 2011). It is a process of structured group communication designed to reach reliable group consensus amongst a panel of experts in areas where there is uncertain knowledge. The development of the Delphi method or process dates back to the 1950's and 1960's at the RAND Corporation. Ziglio states that the method was initially used to 'forecast likely inventions, new technologies and the social and economic impact of technological change' (Adler and Ziglio 1996 p.5).

6.1.2. There are two main phases of the Delphi technique: an exploration phase (round 1 where the topic area is explored and open responses invited) and an evaluation phase (rounds 2 and 3 whereby experts' responses are distilled and assessed for agreement and disagreement) (Adler and Ziglio 1996). The Delphi technique is of particular value where there is uncertainty and a commitment to throw light on a complex area drawing on the insights of experts. The benefits or merits of the Delphi technique are identified as:

- Focusing direct attention on the topic under study;
- Providing a structure or framework whereby individuals in different geographical areas and with diverse backgrounds can collaborate in response to a common question or problem;
- Minimising the 'tendency to follow-the-leader' and overcoming communication obstacles and influences from social or professional factors;
- Providing opportunities for all experts to participate and to be involved equally; and
- Producing 'precise documented records of the distillation process through which informed judgment has been achieved' (Ziglio in Adler and Ziglio 1996 p. 22).

6.1.3 Disadvantages of the Delphi technique which have been highlighted (Hnafin 2004) include:

- The anonymity of Panel members may reduce a sense of accountability;
- The quest for consensus may lead to 'a diluted version of best opinion';
- The approach is time-consuming and labour-intensive for panel members and researchers;
- The drop-out rate can be high;
- Selection and recruitment of appropriate Expert Panel members can be challenging; and
- There are methodological issues, for example, during the distillation process), that may undermine study findings.

6.1.4 The Delphi process enables experts, who are geographically dispersed, to participate with relatively little inconvenience and expense in terms of time and finance. The semi-anonymity and remoteness provided by the Delphi approach allows individual opinions to be expressed facilitating progression from individual opinion to group consensus.

6.2. The HCPC Project Delphi Process

6.2.1 In this study, a three-round collaborative Delphi electronic survey design was employed, bringing together a panel of international experts, to respond to the following questions:

1. What, in your opinion, are the reasons for an increasing number of conduct and competence complaints and concerns about health and social care professionals?

1a. Are there any particular reasons that apply to paramedics? Please describe.

1b. Are there any particular reasons that apply to social workers? Please describe.

2. What preventative actions could be taken to respond to the increasing number of conduct and competence complaints and concerns about health and social care professionals?

3. What strategies would you suggest to support health and social care professionals to deliver high quality health and social care?

6.22 The **Round 1** Delphi **questionnaire** invited open text responses to the five questions above. Potential Delphi panel participants were sent a Participant Information Sheet with information about the project (Appendix D). They were also sent an invitation email with the following text:

> We are working on a research project, funded by the UK Health and Care Professions Council, which aims to understand why there is a disproportionate number of concerns/complaints raised to regulators about social workers and paramedics.

6.23 For the **Round 2 questionnaire**, responses to the 5 questions were distilled to statements. The process of distillation and validation involved 3 researchers (AC, AG & MZ) checking and agreeing each of the statements to be included on the Round 2 online questionnaire. The link to the questionnaire was then sent to expert panel members who had agreed to participate in the Delphi process. Panel members were invited to express their level of agreement on a 5-point Likert scale - from 'strongly agree' (1) to 'strongly disagree'(5). There was space for expert panel members to add new statements after each question in Round 2. In the invitation email to the Round 2 questionnaire, participants were provided with the following additional information:

> *By way of background information to the study, we attach a link to the 2015 HCPC Fitness to Pratise report* ***- http://www.hpc-uk.org/assets/documents/10004E22Fitnesstopractiseannualreport2015.pdf*** ***.*** *Pages 11-12 of the report will be of particular interest.*

6.2.4 In **Round 3** the panel had the opportunity to express their level of agreement again in relation to the entire list of statements and to compare their previous responses with the group mean. They also had the opportunity to express their level of agreement with the additional Round 2 statements. At the end of Round 3, statements reaching over 70% agreement (combining 'strongly agree' and 'agree') were considered as consensus statements providing valuable data in response to the 5 question areas [See Appendix E].

6.3. The Expert Delphi panel

6.3.1 Twenty five experts were approached, drawing on international contacts in professional regulation and in paramedic and social work practice, education and research. Those invited were from Canada, Australia, New Zealand, the US and European countries. Experts were identified by the research team and the project Advisory Group. The rationale for countries selected was that they have regulatory processes similar to the UK. Whereas participants in the interviews and focus groups were selected for their UK perspectives, the Delphi panel experts were selected for their international perspectives. It is acknowledged that the practices of social workers and paramedics in these countries may differ from the UK and this needs to be borne in mind as the results are interpreted.

6.3.2 The Round 1 questionnaire was completed by 14 experts; 12 individuals completed the Round 2 questionnaire; and 9 individuals completed the Round 3 questionnaire.

Table 3: areas of expertise and countries of participating expert panel members in each Round.

	Areas of expertise	**Countries**
Round 1 14 experts	Regulation expertise X 5 Social work expertise X 6 Paramedic expertise X 3	New Zealand, Norway, South Africa, Ireland, Australia, USA, Wales (SW), Canada, UK (regulator) and Netherlands.
Round 2 12 experts	Regulation expertise X 4 Social work expertise X 6 Paramedic expertise X 2	New Zealand, Norway, Ireland, Australia, USA, Wales, Canada and Netherlands
Round 3 9 experts	Regulation expertise X 2 Social work expertise X 5 Paramedic expertise X 2	New Zealand, Norway, Ireland, Australia, USA, Wales and Canada.

6.3.3 It should be noted that there were no participants from England represented in the Rounds 2 or 3 questionnaire. This may be of particular relevance to responses relating to social work and needs to be borne in mind as findings are interpreted.

6.4. Overview of the Delphi Questionnaire Findings

Overall Delphi Statements and Themes

6.4.1 Much rich data was generated in response to the five questions and findings are presented in this section. Table 4 below details the number of statements and themes relating to each of the questions.

Table 4: Statements & Themes Questionnaires 2 and 3

QUESTIONS	Number of statements	Statement themes
1. What, in your opinion, are the reasons for an increasing number of conduct and competence complaints and concerns about health and social care professionals?	39 in Round 2 1 statement added in Round 3 23 statements reached 70% consensus	• Public attitudes/ expectations • Pressure on services • Awareness of complaint process • Workforce factors • Media and political factors • Regulatory factors • Nature of practice • Education/training
1a. Are there any particular reasons that apply to paramedics? Please describe.	19 in Round 2 1 statement added in Round 3 9 statements reached 70% consensus	• Public attitudes/ expectations • Pressure on services • Workforce factors • Nature of practice • Education/training
1b.Are there any particular reasons that apply to social workers? Please describe	15 in Round 2 1 statement added in Round 3 0 statements reached 70% consensus	• Awareness of complaints process • Workforce factors • Organisational factors • Nature of practice • Education/training • Regulatory factors
2. What preventative actions could be taken to respond to the increasing number of conduct and competence complaints and concerns about health and social care professionals?	38 in Round 2 7 statements added in Round 38 reached 70% consensus	• Selection & training/education of the workforce • Educate the public/manage expectations • Organisational support • Research to deepen understanding • Regulatory strategies

		• Questioning the increase
3. What strategies would you suggest to support health and social care professionals to deliver high quality health and social care?	46 in Round 2 0 statements added 44 reached 70% consensus	• Staff/training/education and development • Ethics education • Time and space • Organisational factors • Regulatory approaches • A holistic response • Questioning the value of berating professionals re complaints and investigations

6.4.2 The following sub-sections present and discusses the themes arising in the 5 questions

Question 1 - Reasons for an increasing number of conduct and competence complaints and concerns about health and social care professionals

6.4.3 The distillation of the question data resulted in 39 statements which were aligned with 8 themes: public attitudes/expectation; awareness of complaint process; pressure on services; workforce factors; media and political factors; regulatory factors; nature of practice; and questioning the increase (See Appendix F).

6.4.4 Changing public attitudes, access to information, less trust and a decrease in deference are accepted as reasons for the increase in complaints. Related to this is the awareness of the complaints process and the role of the regulator. Limited resources and pressure on services achieved high rates of agreement alongside the complexity and nature of the practice environment and workloads. Responsibility for increasing complaints is attributed to the media (bad press coverage) and also to the heightened role of the regulator. Two statements support scepticism for the increase in complaints (22, 23). Interestingly education/training statements did not reach consensus.

6.4.5 In relation to paramedics specifically, the themes of public attitudes and expectations are strong. The pressured and ‘less than ideal’ aspects of paramedic practice are highlighted as contributing to complaints. One statement relating to training and education achieved consensus with the focus on ‘inter-professional’.

6.4.6 Regarding the particular reasons that apply to social workers - despite the fact that social work is also a pressured practice in contexts of uncertainty and complexity, none of the statements from Round 2 achieved consensus.

6.4.7 Overall, we need to be mindful that there were a small number of participants overall and a significant number of those statements that did not reach consensus had 'no opinion' rather than 'disagree' responses. This was most particularly the case in the profession-specific sections. Whilst the responses are valid and can be said to have reached or not reached the consensus level of 70%, not all participants felt they had the confidence or expertise to comment authoritatively in relation to the profession-specific statements.

Question 2 - Preventative actions could be taken to respond to the increasing number of conduct and competence complaints and concerns

6.4.8 Six themes were identifiable from the Round 2 data relating to preventative action: selection and training and education; educating the public; organisational support; further research; regulatory strategies; and questioning the perceived increase (See Appendix G). Statements relating to training and education were wide-ranging with reference to input relating to teamwork; communication, cultural care, ethics, self-care, empathy and reflection. There was consensus that admission protocols and criteria should be 'rigorous' and that students demonstrating 'unethical behaviour' should be screened out. Complaints data should, 100% of the panel agreed, be 'fed back into the training of practitioners both undergraduate and post-graduate'. The statement that student experiences in practice should be monitored 'to detect where the problems are' indicates the panel's awareness, perhaps, of the significance of organisational context or culture. This is in keeping also with the theme of organisational support and work conditions highlighting the importance of leadership, staff development programmes, peer support and stress management initiatives. Educating the public about channels of complaints and about the nature of the professional role suggests a role for professional bodies. The role of research in identifying and categorising the types of complaint, the roles of different stakeholders (employers, professional organisations and the HCPC) and of link data from different systems is highlighted. Getting better at 'distinguishing between resource availability and practice standards' was allocated to the 'research' theme, however, it can be argued that this is the responsibility of all involved. Eight statements highlight the important

role of the regulator in preventative action. A statement (37) questioning the need for preventative action reached 100% consensus.

Question 3- Strategies to support health and social care professionals to deliver high quality health and social care?

6.4.9 Forty four statements covering 7 themes emerged in response to question 3. The strategies proposed related to staff training in areas that included patient safety, customer relations management, communication, cultural diversity, conflict resolution, emotional resilience and reflection. The fact that 6 statements reached consensus on the theme of 'ethics education' support the importance of this from the perspective of the expert panel. This is also in keeping with consensus statements highlighting the importance of making time and space for reflection. The significance of organizational factors is supported by 13 consensus statements identifying areas such as supportive cultures, networks and managers, the role of chaplaincy, positive management of social media, supervision, values-based leadership and recognition of the relational focus of care work rather than punitive responses focusing on funding. What becomes clear in this section is the need for strategies at 'every level', acknowledged explicitly in consensus statement 44 (see Appendix H below). This is also highlighted in previous work on professionalism that identifies the need for engagement with individuals (micro-level), organisations (meso-level) and the broader societal, political and regulatory context (macro-level). The final statement (46) on Table 5 cautions against any approach that comes across as 'berating' professionals which could have the undesired consequence of defensive practice. This appears to support strategies that celebrate ethical or good care as well as working to reduce unethical practice.

6.5. Conclusions regarding the Delphi process

6.5.1 An extensive range of statements reached consensus in relation to four of the five questions. There was a good deal of common ground in the themes that emerged from the statements. In terms of how the Delphi findings might be interpreted and compared with findings from other project datasets, it may be helpful to categorise findings in terms of different levels of analysis. In the social sciences, cognitive sciences and political science, analysis is organized as three of four levels generally moving from smaller to larger units of analysis. A common categorization is as: micro-level, meso-level and macro-level. Other categorisations are as: individual level; domestic level; systemic level;

and global level (see, for example, Rourke 2005, Jeppersson et al 2011).

6.5.2 For our purposes here, it is proposed that we might focus on the following levels of analysis:

- **Individual level** – selection, training, supervision and development of individuals?
- **Organisational level** – organization factors such as leadership, workload, staff development provision, pressure on services, resource & support?
- **Societal/Political level** – public attitudes and expectations, media & regulatory activities?

6.5.3 Overall, many interesting consensus statements and themes emerged from the Delphi data. However, the number of participants was small and covered a limited range of professional and geographical areas. The strength of the data will be in the triangulation of this data with data from other research methods.

6.6. Delphi references

Adler M. and Ziglio E. (Eds) (1996) *Gazing into the oracle: The Delphi method and its application to social policy and public health (pp. 3—26). London: Jessica Kingsley Publishers.*

Allied Health Solutions (2013) Paramedic Evidence Based Education Project www.hee.nhs.uk/PEEP-Report.pdf

Austin , Z, Moore-Christensen, C, Walsh, J. (2015) Preventing small problems from becoming big problems in health and care. http://www.hcpc-uk.org/publications/research/index.asp?id=1009

Boak, G, Mitchell, L, Moore, D. (2012) Student Fitness to practise and student registration; a literature review. http://www.hcpc-uk.org/assets/documents/10003AFDHPCStudentFtPReportfinal9Feb2012.pdf

Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2). pp. 77-101. ISSN 1478-0887 Available from: http://eprints.uwe.ac.uk/11735

Care Council for Wales (2015) Annual Regulation Report 2015 http://www.ccwales.org.uk/uploads/Council_Members/Council_15.07.15/N._Item_14_Regulation_Annual_Report_2014-2015_15.07.15.pdf

Chisholm, A, Sheldon, H. (2011) Service user feedback tools; an evidence review. http://www.hcpc-uk.org/assets/documents/10003FC9Serviceuserfeedbacktools-anevidencereviewandDelphiconsultationfortheHealthProfessionsCouncil.pdf

Doel, M et.al. (2010) Professional Boundaries; cross a line or entering the shadows. *British Journal of Social Work* 40, 1866-1889.

Donaghy, J. (2011) The student experience of university paramedic education. University of Hertfordshire (unpublished).

General Social Casre Council (2008) Raising Standards. Social Work Conduct in England 2003-2008.

Guthrie, M. (2009) Continuing fitness to pracise; towards an evidence based approach to revalidation. http://www.hcpc-uk.org/assets/documents/10002AAEContinuingfitnesstopractise-Towardsanevidence-basedapproachtorevalidation.pdf

Hanafin S (2004) Review of Literature on the Delphi Technique - http://dcya.gov.ie/documents/publications/Delphi_Technique_A_Literature_Review.pdf

Health Education England (HEE) (2016) Commissioning and investment plan – 2016/17. https://hee.nhs.uk/sites/default/files/documents/HEE%20commissioning%20and%20investment%20plan.pdf

HCPC (2015) Fitness to Practise Annual Report. http://www.hcpc-uk.org/assets/documents/10004E22Fitnesstopractiseannualreport2015.pdf

Jepperson, Ronald and Meyer (2011) Multiple levels of analysis and the Limitations of Methodological Individualisms, *Sociological Theory*, 29 (1): 54-73

Moore, C, Walsh, J Swain, D, Bough, S, Baker, G (2013) Understanding public protection. http://www.hcpc-uk.org/assets/documents/10003FC8Understandingpublicprotection.pdf

Morrow, G, Burford, B, Rothwell, C, Carter, M McLachlan, J, Illing, J (2011) Professionalism in healthcare professionals. http://www.hcpc-uk.org/assets/documents/10003771Professionalisminhealthcareprofessionals.pdf

Northern Ireland Social Care Council Annual Report (2015) , http://www.niscc.info/files/About%20Us/2015%20documents/20151105_Web_NISCC_Annual_Report2014-15_Job91738.pdf

Professional Standards Authority (2015) Rethinking Regulation http://www.professionalstandards.org.uk/docs/default-source/psa-library/rethinking-regulation.pdf?sfvrsn=2

Penhale, B, Young, D. (2015) Public Views of social workers and roles and issues within the profession. http://www.professionalstandards.org.uk/docs/default-source/psa-library/1503-uea-research-views-on-social-worker-conduct-competence.pdf?sfvrsn=0

Redding, S, Nicodemo, C. (2015) The costs of fitness to practise – a study of the Health and Care Professions Council. http://www.hcpc-uk.org/assets/documents/10004BB6Thecostsoffitnesstopractise-astudyoftheHealthandCareProfessionsCouncil.pdf

Rourke, J (2005) Levels of analysis, from *International Politics on the World Stage,* (10th ed.) http://highered.mcgraw-hill.com/sites/0072890363/student_view0/chapter3/)

Scottish Social Care Council Annual Report (2015) www.ssc.uk.com

Ziglio, E. (1996). The Delphi method and its contribution to decision making. In M. Adler & E. Ziglio (Eds.), *Gazing into the oracle: The Delphi method and its application to social policy and public health* (pp. 3—26). London: Jessica Kingsley Publishers.

Appendices

Appendix A – Literature search log

Paramedics

Database/ date	Strategy	Yields
CINAHL 7/07/16 Language: English Date: 2000-2016	**Line 1:** "fitness to practi*" OR "conduct hearing*" OR "disciplinary hearing*" OR "disciplinary action*" OR misconduct OR malpractice OR "professional conduct" OR "professional discipline" OR "professional boundar*" OR professionalism OR "quality assurance" OR complain* OR unethical OR Illegal OR unprofessional **Line 2:** paramedic OR ems OR emergency medical service OR prehospital OR pre-hospital OR ambulance OR emergency medical technician OR emt	679 178 exported as potentially relevant after title/key word screening
Medline 21/07 Language: English Date: 2000-2016	**Line 1:** "fitness to practi*" OR "conduct hearing*" OR "disciplinary hearing*" OR "disciplinary action*" OR misconduct OR malpractice OR "professional conduct" OR "professional discipline" OR "professional boundar*" OR professionalism OR "quality assurance" OR complain* OR unethical OR Illegal OR unprofessional **Line 2:** paramedic OR ems OR emergency medical service OR prehospital OR pre-hospital OR ambulance OR emergency medical technician OR emt	711 45 exported as potentially relevant after title screening, of which 10 were duplicates of existing records
ASSIA 27/07/16 Language: English Date: 2000-2016	**Line 1:** "fitness to practi*" OR "conduct hearing*" OR "disciplinary hearing*" OR "disciplinary action*" OR misconduct OR malpractice OR "professional conduct" OR "professional discipline" OR "professional boundar*" OR professionalism OR "quality assurance" OR complain* OR unethical OR Illegal OR unprofessional **Line 2:** paramedic OR ems OR emergency medical service OR prehospital OR pre-hospital OR ambulance OR emergency medical technician OR emt	4 1 relevant, but duplicate of existing record
SCOPUS	**Line 1:** "fitness to practi*" OR "conduct hearing*" OR "disciplinary hearing*" OR "disciplinary action*" OR misconduct OR malpractice OR "professional conduct" OR	385

27/07/16 Language: English Date: 2000-2016	"professional discipline" OR "professional boundar*" OR professionalism OR "quality assurance" **Line 2:** paramedic OR ems OR emergency medical service OR prehospital OR pre-hospital OR ambulance OR emergency medical technician OR emt	56 exported as potentially relevant after title screening, of which 15 were duplicates of existing records
SCOPUS 27/07/16 Language: English Date: 2000-2016	**Line 1:** complain* OR unethical OR Illegal OR unprofessional **Line 2:** paramedic OR ems OR emergency medical service OR prehospital OR pre-hospital OR ambulance OR emergency medical technician OR emt	268 53 exported as potentially relevant after title screening, of which 7 were duplicates of existing records

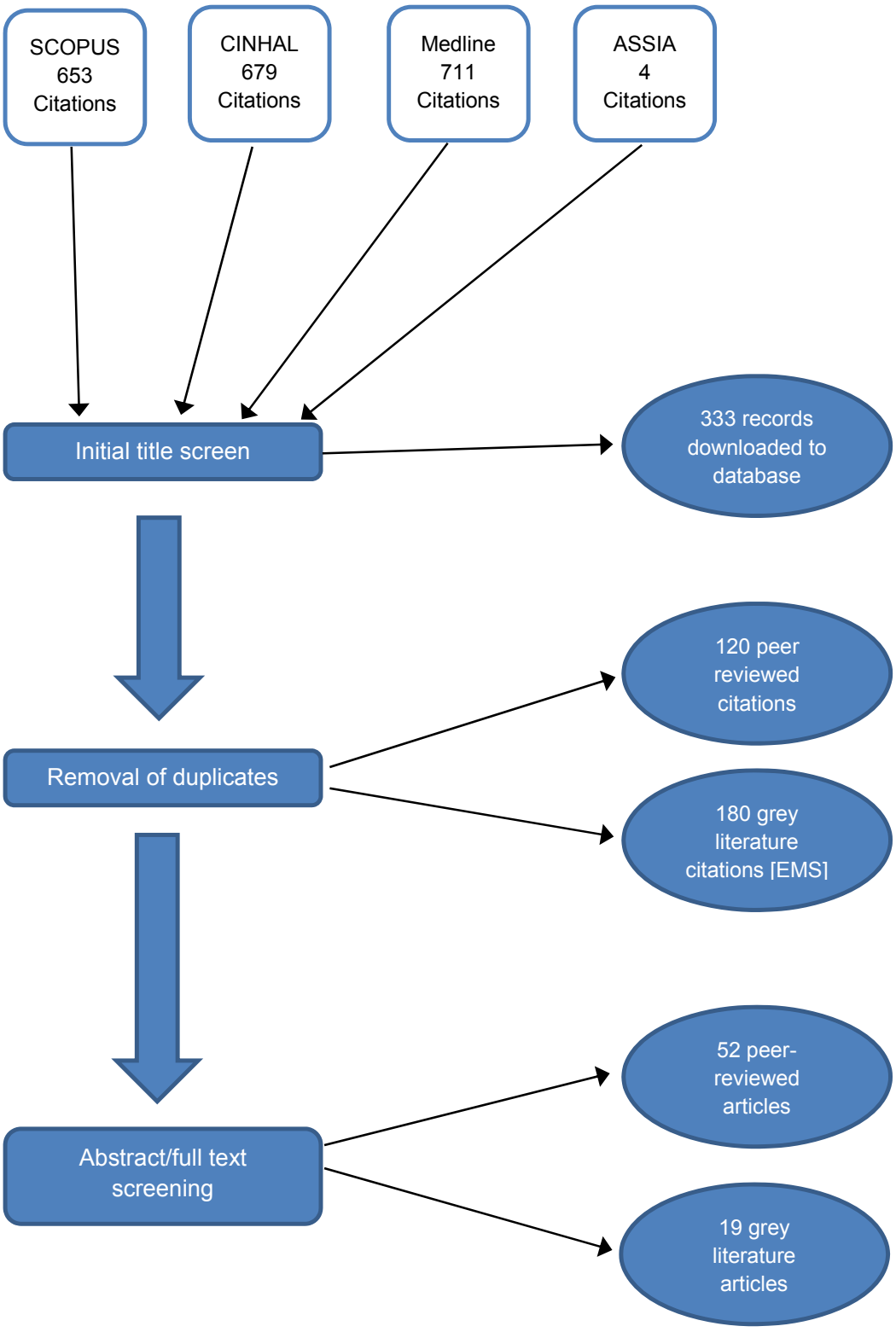
Social Workers

Database	Strategy	Yields
CINAHL 7/07/16 Language: English Date: 2000-2016	**Line 1:** "fitness to practi*" OR "conduct hearing*" OR "disciplinary hearing*" OR "disciplinary action*" OR misconduct OR malpractice OR "professional conduct" OR "professional discipline" OR "professional boundar*" OR professionalism OR "quality assurance" OR complain* OR unethical OR Illegal OR unprofessional **Line 2:** "social work*"	714 254 exported as potentially relevant after title/key word screening
ASSIA 27/07/16 Language: English Date: 2000-2016	**Line 1:** "fitness to practi*" OR "conduct hearing*" OR "disciplinary hearing*" OR "disciplinary action*" OR misconduct OR malpractice OR "professional conduct" OR "professional discipline" OR "professional boundar*" OR professionalism OR "quality assurance" OR complain* OR unethical OR Illegal OR unprofessional **Line 2:** "social work*"	48 30 exported as potentially relevant after title/key word screening, of which 9 were duplicates of existing records

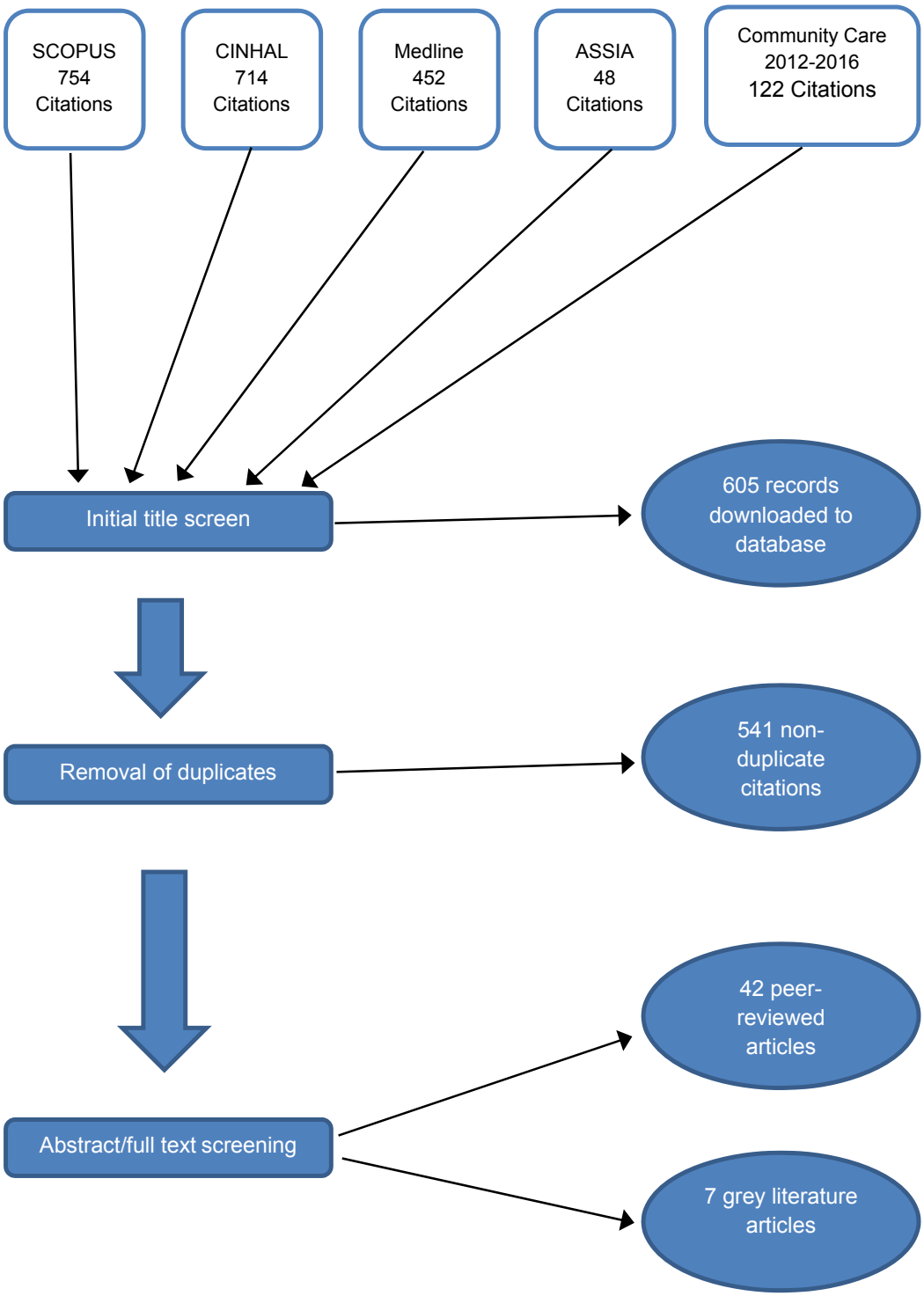
Medline 3/08/16 Language: English Date: 2000-2016	**Line 1:** "fitness to practi*" OR "conduct hearing*" OR "disciplinary hearing*" OR "disciplinary action*" OR misconduct OR malpractice OR "professional conduct" OR "professional discipline" OR "professional boundar*" OR professionalism OR "quality assurance" OR complain* OR unethical OR Illegal OR unprofessional **Line 2:** "social work*"	452 39 exported as potentially relevant after title screening, of which 14 were duplicates of existing records
SCOPUS 3/08/16 Language: English Date: 2000-2016	**Line 1:** "fitness to practi*" OR "conduct hearing*" OR "disciplinary hearing*" OR "disciplinary action*" OR misconduct OR malpractice OR "professional conduct" OR "professional discipline" OR "professional boundar*" OR professionalism OR "quality assurance" **Line 2:** "social work*"	553 109 exported as potentially relevant after title screening, of which 33 were duplicates of existing records
SCOPUS 3/08/16 Language: English Date: 2000-2016	**Line 1:** complain* OR unethical OR Illegal OR unprofessional **Line 2:** "social work*"	201 51 exported as potentially relevant after title screening, of which 8 were duplicates of existing records

Appendix B – Literature review flow diagrams

Paramedics



Social Work


SCOPUS
754
Citations
CINHAL
714
Citations
Medline
452
Citations
ASSIA
48
Citations
Community Care
2012-2016
122 Citations
Initial title screen
605 records downloaded to database
Removal of duplicates
541 non-duplicate citations
Abstract/full text screening
42 peer-reviewed articles
7 grey literature articles

Appendix C – Literature sources

Paramedics

Authors	Title	Date	Journal	Method	Participants	Country	Publication
Aasa et al.	Work-related psychosocial factors, worry about work conditions and health complaints among female and male ambulance personnel.	2005	Scandinavian Journal of Caring Sciences	Survey	1500	Sweden	PR
Aasa et.al	Stress monitoring of ambulance personnel during work and leisure time	2006	In Archives of occupational and environmental health	Observational	26	Sweden	PR
Bevan and Hood	Hitting and missing targets by ambulance services for emergency calls; effects of different systems of performance measurement within the UK	2006	Journal of the Royal Statistical Society	Literature review		UK	PR
Bigham	Patient safety in emergency medical services; a systematic review of the literature	2012	Pre hospital Emergency Care	Systematic review		US	PR

Blau	Exploring the impact of sleep related impairments on the perceived general health and retention intent of an EMS sample	2011	Career Development International	Survey	288	US	PR
Broniecki et al.	Musculoskeletal disorder prevalence and risk factors in ambulance officers	2010	Journal of Back and MSK Medicine			Australia	PR
Burford et al.	Professionalism education should reflect reality: findings from three health professions.	2014	Medical Education	Focus groups	112	UK	PR
Christmas & Millward	New Medical Professionalism: A scoping report for the Health Foundation	2011	The Health Foundation	Policy paper		UK	GL
Clohessy, & Ehlers	PDST symptoms, response to intrusive memories and coping in ambulance service workers.	1999	British Journal of Clinical Psychology	Survey, interviews		UK	GL
Coffey et al.	A physical demands description of paramedic work in Canada	2016		Observational	14	Canada	PR
Colwell et al.	Complaints against an EMS system.	2003	Journal of Emergency Medicine	Retrospective case analysis	286	US	PR

Department of Health	See PEEP report	2008		Policy paper		UK	GL
Dick	• Professional etiquette: how you show your respect for people. • EMS reruns. Fox in the henhouse: when the accused is a caregiver. • What people say: fielding and responding to customer complaints. • Front-line leadership. Leadership tips. Listening later: can some complaints really wait? • The lesson. Why do some of us become cynical? • Flexibility: making systems serve people. • That whining sound: accept complaints, but expect suggestions. • Witch hunt: supporting caregiver's authority to think. • What's that smell? Your partner, the drunk. • Tricks of the trade. Professional etiquette: stuff a pro does.	2004-2010	EMS Magazine	Narrative		US	GL

Fitzgerald	Defining a regulatory framework for paramedics; a discussion paper	2007	Journal of Emergency Primary Health Care	Review		Australia	PR
Gallagher et al.	Experts' perspectives on professionalism in paramedic practice: findings from a Delphi process.	2016	British Paramedic Journal	Delphi	12	UK	PR
Gallagher et al.	Professionalism in paramedic practice: the views of paramedics and paramedic students	2016	British Paramedic Journal	Interviews	16	UK	PR
Gilbert	How to Respond to Complaints.	2012	EMS World	Narrative		US	GL
Harkins	Managing risk in Emergency Care Services	2001	Emergency Medicine Journal	Narrative		US	GL
Heightman	Are foxes gurding your henhouse?	2007	Journal of Emergency Medicine	Narrative		US	GL
Ho	Apathy is not welcome here	2003	Prehospital Emergency Care	Narrative		US	GL

Iacobucci	NHS111 is blamed for the large increase in complaints against ambulance trusts	2014	British Medical Journal	Editorial		UK	PR
Jennings & Stella	Barriers to incident notification in a regional prehospital setting.	2011	Emergency Medicine Journal	Ethnography		Australia	PR
Jonsson	Post traumatic stress amongst Swedish ambulance personell.	2003	Emergency Medicine Journal	Survey	362	Sweden	PR
Kilner	Educating the ambulance technician, paramedic, and clinical supervisor: using factor analysis to inform the curriculum.	2004	Emergency Medicine Journal	Delphi		UK	PR
Knowles et.al.	Patient experiences and views of an emergency and urgent care system	2012	Health Expectations	Survey	1000	UK	PR
Knox	Regulation and registration as drivers for continuous professional competence for Irish prehospital practitioner; a discussion paper	2004	Irish Journal of Medical Science	Literature review		Ireland	PR
Lovegrove, & Davis	*Paramedic Evidence Based Education Project (PEEP) End of Study Report*	2013		Policy paper		UK	GL

Lu et.al.	Disclosure of harmful medical errors in out of hospital care	2013	Annals of Emergency Medicine	Literature review		US	PR
Mason et al.	Effectiveness of emergency care practitioners working within existing emergency service models of care	2007	Emergency Medicine Journal	Observational	524	UK	PR
Mason et al.	Safety of paramedics with extended skills.	2008	Academic Emergency Medicine	Retrospective case analysis	2025	UK	PR
McCann et al.	Where Next for the Paramedic Profession? An Ethnography of Work Culture and Occupational Identity.	2015	Emergency Medicine Journal	Ethnography		UK	PR
McCann et al.	Still blue-collar after all these years? An ethnography of the professionalization of emergency ambulance work,	2013	Journal of Management Studies	Interviews	10	UK	PR
McDonnell	The search and development of professionalism in ‘ambulance’; a multidisciplinary journey	2009	Journal of Emergency Primary Health Care			Australia	PR

Newdick	From Hippocrates to commodities- 3 models of NHS governance	2014	Medical Law Revuew	Narrative		UK	PR
O'Meara	Paramedics marching toward professionalism.	2009	Journal of Emergency Primary Health Care	Narrative		Australia	PR
Page	Excrement happens	2016	EMS World	Narrative		US	GL
Panchal	The impact of professionalism on transfer of care to the Emergency Department	2015	Journal of Emergency Medicine	Observation	1091	US	PR
Paterson	Association between poor sleep fatigues and safety outcomes	2012	Prehospital Emergency Care	Survey	547	US	PR
Paterson	What paramedics think about when they think about fatigue: contributing factors.	2014	Emergency Medicine Australasia	Survey	49	Australia	PR
Perry	Collaborating on Safety	2016	EMS World	Narrative		US	GL
Petzall et.al	Threats and violence in the Swedish pre-hospital emergency care service	2011	International Emergency Nursing	Survey	143	Sweden	PR
Porter	Accepting complaints	2004	EMS			US	GL

Reynolds	Beyond the front line: An intepretative ethnography of an ambulance service.	2008	Ph.D thesis	Ethnographic study		Australia	GL
Risavi	Analysis of complaints in a rural emergency medical service system.	2013	Prehospital and Disaster Medicine	Retrospective case analysis	110	US	PR
Rollert	Coping with violent people	2007	EMS Magazine	Narrative		US	GL
Seddon	Systems thinking In the public sector	2009	Book			UK	
Shojania	Bad apples – time to redefine as a type of system problem?	2013	BMJ Qual & Safety	Narrative		Canada	PR
Sili	Organisational health and quality of life; survey among ambulance nurses in pre hospital emergency care	2011	La Medicina del Lavoro	Survey	411	Italy	PR
Simmonds	Professionalism and care; the daily bread and butter of a paramedic attending patients who fall	2015	Journal of Emergency Medicine	Interview	12	UK	PR
Smith	Beyond the books. It's care with a capital "C."	2005	EMS	Narrative		US	GL

Smith	Beyond the books. Show Me the Professionals.	2013	EMS World	Narrative			GL
Sofianopolous et al.	Paramedics and the effects of shift work on sleep: a literature review.	2012	Journal of Emergency Medicine	Literature review		Australia	PR
Sterud et al.	Health status in the ambulance services: A systematic review.	2006	BMC Health Services Research	Literature review		Norway	PR
Sterud et al.	Suicidal ideation and suicide attempts in a nationwide sample of operational Norwegian ambulance personnel.	2008	Journal of Occupational Health	Survey	1180	Norway	PR
Sterud et al.	A comparison of general and ambulance specific stressors: predictors of job satisfaction and health problems in a nationwide one-year follow-up study of Norwegian ambulance personnel.	2011	Journal of Occupational Medicine and Toxicology	Survey		Norway	PR
Streger	Professionalism	2003	EMS	Narrative		US	GL
Strzemecka	The factor harmful to the quality of human life - Shift-work.	2013	Annals of agricultural and	Survey	700		

			environmental medicine				
Studnek et al.	An assessment of key health indicators among emergency medical services professionals.	2010	Prehospital Emergency Care	Survey	19,960	US	PR
Studnek et al.	Back problems among emergency medical services professionals: the LEADS health and wellness follow-up study.	2010	American Journal of Industrial medicine	Survey	470	US	PR
Togher	Reassurance as a key outcome valued by emergency ambulance service users: a qualitative interview study.	2014	Health Expectations	Interviews	30	UK	PR
Torjesen	BMA and ambulance service call on government to delay roll out of non emergency number 111	2012	British Medical Journal	Narrative		UK	PR
Touchstone	Professional development. Part 2: subordinating your interests.	2010	EMS	Narrative		US	GL
Trede	Becoming professional in the 21st centrury	2011	Journal of Emergency Primary Health Care	Narrative		Australia	PR

Turner et al	The costs and benefits of implementing the new Ambulance service response time standards. Report to DH, University of Sheffield.	2006	DH	Review		UK	GL
Tunaligil	Determinants of general health, work related strain and burnout in public versus private emergency medical technicians in Istanbul	2016	Workplace Health Safety	Survey	824	Turkey	PR
van der Ploeg & Kleber	Acute and chronic job stressors amongst ambulance personell; predictors of health outcomes.	2003	Occupational and Environmental Medicine	Survey	123	Netherlands	PR
Vike	Paramedics self reported medication errors.	2006	Prehospital Emergency Care	Survey		US	PR
Velloso	Mobile Emergency Care services; the work on display	2014	Referencia	Qualitative study	31	Brazil	PR
Wang et al	Tort claims and adverse events in emergency medical services.	2008	Annals of Emergency Medicine	Survey		US	PR

Williams	Is the Australian paramedic discipline a full profession?	2010	Journal of Emergency Primary Health Care	Survey	63	Australia	PR
Williams	Are paramedic students ready to be professional? An international comparison	2015	Journal of Emergency Primary Health Care	Survey	479	NZ/Australia	PR
Wollard	The Role of the Paramedic Practitioner in the UK.	2009	Journal of Emergency Primary Health Care	Review		UK	PR
Zhao	Shift work and work related injuries among health care workers; a systematic review	2010		Systematic review		Australia	PR

Social Work

Author	Title	Date	Journal	Method	Participants	Country	Publication
Banks	Ethics, Accountability and the Social Professions,	2004	Book				
Banks	Ethics in an age of austerity: Social work and the evolving New Public Management	2011	Journal of Social Intervention: Theory and Practice	Narrative		UK	PR
Banks	Negotiating personal engagement and professional accountability: professional wisdom and ethics work.	2013	European Journal of Social Work	Narrative			PR
Banks	Everyday ethics in professional life: social work as ethics work	2016	Ethics and Social Welfare	Narrative			PR
Bates et al.	“Baptism of Fire”: The First Year in the Life of a Newly Qualified Social Worker.	2009	Social Work Education	Survey and Interviews	37	England	PR

Bates et al.	Exploring boundary attitude.	2013	Journal of Adult Protection	Survey and interactive training events	409	UK	PR
Beer	Predictors of and Causes of Stress Among Social Workers: A National Survey.	2016	Thesis publication	Survey and interviews	427	England	GL
Boland-Prom et al.	Sanctioning Patterns of Social Work Licensing Boards, 2000–2009.	2015	Journal of Human Behavior in the Social Environment	Retrospective Case Analysis	2,607	USA	PR
Bradley et al.	Supervision: A force for change? Three stories told.	2010	International Social Work	Narrative		South Africa, England and Sweden	PR
Burns	Professional Decision Making in Social Work Practice.	2011	Child & Family Social Work	Book review			PR
Carey	The quasi-market revolution in the head: ideology, discourse, care management.	2008	Journal of Social Work	Ethnomethodology	44	UK	PR

Clark	Professional Responsibility, Misconduct and Practical Reason	2007	Ethics and Social Welfare	Narrative			
Clarke	Transfer of training: the missing link in training and the quality of adult social care.	2013	Health & Social Care in the Community	Systematic review			PR
Daley & Doughty	Ethics Complaints in Social Work Practice: A Rural-Urban Comparison.	2006	Journal of Social Work Values and Ethics	Retrospective case analysis	594	USA	PR
Doel et al.	Professional boundaries: crossing a line or entering the shadows?	2010	British Journal of Social Work	Survey	504	UK, Ireland, USA, Canada, Australia, New Zealand, South Africa, Sweden, Germany	PR
Ellis	"Street-level Bureaucracy" Revisited: The Changing Face of Frontline Discretion in Adult Social Care in England	2011	Social Policy and Administration	Observation and interviews		UK	PR

Evans	Organisational Rules and Discretion in Adult Social Work.	2013	British Journal of Social Work	Interviews	12	England	PR
Foster & Wilding	Whither welfare professionalism?	2000	Social Policy and Administration	Narrative			PR
Furness	Conduct Matters: The Regulation of Social Work in England.	2015	British Journal of Social Work	Retrospective case analysis	265	England	PR
Garboden	Lessons of baby P are not being learned, SCR author complains.	2010	Community Care	Narrative		England	GL
General Social Care Council	Regulating social workers (2001-2012)	2012	Report			England	GL
Gibson	Constructing pride, shame, and humiliation as a mechanism of control: A case study of an English local authority child protection service.	2016	Children and Youth Services Review	Ethnography	21	England	PR
Ingram	Exploring Emotions within Formal and Informal	2015	British Journal of Social Work	Survey and interviews	112	Scotland	PR

	Forums: Messages from Social Work Practitioners.						
Jessen	Trust and recognition: a comparative study of client attitudes and workers' experiences in the welfare services.	2010	European Journal of Social Work	Survey	1146 professionals and 5442 members of the public	Norway	PR
Juhila, Raitakari, & Hall (eds)	Responsibilisation at the margins of welfare services	2017	Book				
Katsavdakis et al.	Profiles of impaired health professionals.	2004	Bulletin of the Menninger Clinic	Retrospective case analysis	334	USA	GL
Kirwan & Melaugh	Taking Care: Criticality and Reflexivity in the Context of Social Work Registration.	2015	British Journal of Social Work	Retrospective case analysis	72	UK	PR
Leigh	The process of professionalisation: Exploring the identities of child protection social workers.	2013	Journal of Social Work	Interviews	8	UK	PR

Leigh	The story of the ppo queen: The development and acceptance of a spoiled identity in child protection social work.	2014	Child & Family Social Work	Auto-ethnography	1	UK	PR
Liljegren	Pragmatic professionalism: micro-level discourse in social work.	2012	European Journal of Social Work	Individual and focus group interviews	30	Sweden	PR
Lloyd et al.	Social work, stress and burnout: A review.	2002	Journal of Mental Health	Literature review			PR
McLaughlin	The social worker versus the General Social Care Council: an analysis of care standards tribunal hearings and decisions.	2010	British Journal of Social Work	Retrospective case analysis	14	England	PR
Mclaughlin et. al	The State of Regulation in England : From the General Social Care Council to the Health and Care Professions Council.	2016	British Journal of Social Work	Narrative		England	PR
Moriarty et al.	A depth of data: research messages on the state of	2010	Research, Policy and Planning	Multi-method longitudinal study	Includes 25,490 student records, 3,944 survey	England	PR

	social work education in England.				responses, 290 interviews		
Murray	"Mission impossible on a daily basis" – the real effect of spending cuts on social work.	2015	The Guardian Social Care Network	Survey	1,420	UK	GL
O'Leary et al.	The boundaries of the social work relationship revisited: Towards a connected, inclusive and dynamic conceptualisation.	2013	British Journal of Social Work	Narrative			PR
Parry et al.	"The tip of the ice berg": children's complaints and advocacy in Wales -- an insider view from complaints officers.	2008	British Journal of Social Work	Interviews	122	Wales	PR
Payne	The Origins of Social Work	2005	Book				
Reamer	Social Workers' Management of Error: Ethical and Risk Management Issues.	2008	Families in Society: The Journal of	Narrative		USA	PR

			Contemporary Social Services				
Roberts	'Complaints stem from failure to listen...'.	2007	Community Care	Letter		UK	GL
Seebohm Report	Report of the Committee on Local Authority and Allied Personal Social Services	1968					
Shevellar & Barringham	Working in Complexity: Ethics and Boundaries in Community Work and Mental Health.	2016	Australian Social Work	Narrative			PR
Siebert	Denial of AOD use: An issue for social workers and the profession.	2003	Health and Social Work	Survey	751	USA	PR
Stevenson	Social worker sanctioned over Facebook posts reflects on feeling abandoned amidst a media storm.	2014	Community Care.	Narrative			GL
Stewart	Resolving social work value conflict: Social justice as the primary	2013	Journal of Religion & Spirituality in	Narrative			PR

	organizing value for social work.		Social Work: Social Thought				
Strom-Gottfried	Ethical vulnerability in social work education: an analysis of NASW complaints.	2000	Journal of Social Work Education	Retrospective case analysis	894	USA	PR
Strom-Gottfried	Understanding adjudication: origins, targets, and outcomes of ethics complaints.	2003	Social Work	Retrospective case analysis	894	USA	PR
Summerson Carr	Occupation bedbugs: Or, the urgency and agency of professional pragmatism	2015	Cultural Anthropology	Ethnography		USA	PR
Walter	Toward a third space: improvisation and professionalism in social work.	2003	Families in Society	Narrative			PR
Warner	Social work, class politics and risk in the moral panic over Baby P.	2013	Health, Risk & Society	Qualitative documentary analysis	420	UK	PR

Wilberforce et al.	Revisiting the causes of stress in social work: Sources of job demands, control and support in personalised adult social care.	2014	British Journal of Social Work	Survey and interviews	297	England	PR

Appendix D – Delphi Process Participant Information Sheet

Study title: Understanding the prevalence of fitness to practise cases about paramedics and social workers in England

Participant Information Sheet: Delphi Panel

Introduction

We would like to invite you to take part in this research project. This information sheet gives details on why the research is being done and what it will involve for you. Please take the time to read the following information carefully and ask questions about anything you do not understand.

What is the purpose of the study?

This project explores the reasons for, and action to prevent the disproportionate number of fitness to practise cases about paramedics and social workers in England.

The research project uses several research methods to address these issues and includes a literature review, an international Delphi process, in-depth review of 10% of fitness to practise cases in each profession, observation of fitness to practise hearings, 30 in-depth interviews and 6 focus groups with stakeholders from across the UK.

Why have I been invited to take part in the study?

You have been invited to take part in the Delphi Panel because you have been recognised as someone with expertise in the subject area of the study. About 20 participants from around the world will take part in this part of the research.

Do I have to take part?

No, you do not have to participate. There will be no adverse consequences if you decide not to participate or withdraw at a later stage. You can withdraw your participation at any time however it will not be possible to extract your responses as these are anonymised.

What will my involvement require?

If you agree to take part, we will seek your views on three occasions via 3 email questionnaires, between September and November 2016. We estimate that completion of each questionnaire should take approximately 60 minutes.

What will I have to do?

Firstly, we will email you a link to an online survey where you will be asked to confirm your consent to participate in the Delphi Panel and you will be invited to respond to approximately 6 open-ended questions. About 1 month later, you will be sent a link to a second online survey which will ask you to indicate your agreement with statements distilled from all previous responses and you will be given the opportunity to add further statements. Finally, we will ask you to complete a third online survey where you will have the opportunity to express your level of agreement on the entire list of statements. The aim of the process is to arrive at consensus in relation to the question areas.

What will happen to data that I provide?

All the contributions will be analysed by members of the research team.

Please be assured that any information we receive from you will be anonymised. Research data are stored securely for at least 10 years following their last access in line with the University of Surrey policies. Personal data will be handled in accordance with the UK Data Protection Act (1998).

What are the possible disadvantages or risks of taking part?

There are no anticipated risks or disadvantages to taking part in this study. Your expert participation will take some of your valuable time – approximately 3 hours.

What are the possible benefits of taking part?

There may be no direct benefit to you. However, it is hoped that you will gain from the opportunity to engage with questions and responses from other experts. Your expertise and experience will help us explore the reasons for, and action to prevent the disproportionate number of fitness to practise cases about paramedics and social workers in England. The project offers an opportunity to influence the future of practice, education and training and standards for these professions.

What happens when the research study stops?

At the end of the study, a report will be produced and submitted to the Health and Care Professions Council to inform their future work. A summary of findings from the Delphi process will also be made available to Delphi process participants who are happy for us to retain their details for this purpose.

What if there is a problem?

Any complaint or concern about any aspect of the way you have been dealt with during the course of the study will be addressed; please contact Anna van der Gaag, Principal Investigator on a.vandergaag@surrey.ac.uk in the first instance. You may also contact Melaine Coward, Head of School of Health Sciences, University of Surrey on 01483 682507, m.coward@surrey.ac.uk.

Will my taking part in the study be kept confidential?

Yes. Your details will be held in accordance with ethical and legal requirements. Personal data will be handled in accordance with the UK Data Protection Act 1998 so that unauthorised individuals will not have access to them.

Your data will be anonymised and not attributed to individual Delphi panel members. Towards the completion of the Delphi process we will ask if you would like to be named as a Delphi panel member in the final project report. You also have the option of remaining anonymous.

Full contact details of Principal Investigator:

Anna van der Gaag
School of Health Sciences
Faculty of Health and Medical Sciences
University of Surrey
Guildford, Surrey GU2 7TE
Email: a.vandergaag@surrey.ac.uk

Who is organising and funding the research?

This research is organised by the University of Surrey with collaborators from the Universities of Durham, Toronto and Royal Holloway, London. It is funded by the Health and Care Professions Council.

Who has reviewed the project?

This research has been looked at by an independent group of people, called an Ethics Committee, to protect your interests. This study has been reviewed by and received a favourable ethical opinion from University of Surrey Ethics Committee.

Thank you for taking the time to read this Information Sheet.

Appendix E – Delphi Process Summary Table: All statements

Consensus % [statements over 70% highlighted in orange and new statements in yellow) & Mean (Rounds 2 & 3)

Question 1 - . What, in your opinion, are the reasons for an increasing number of conduct and competence complaints and concerns about health and social care professionals?

	Round 3 - % CONSENSUS	MEAN Round 2	MEAN Round 3
Public attitudes/expectations			
1. There are changing attitudes towards what health and social services should deliver to the public and an increasing belief in what the public's rights to help are.	100%	1.7	1.6
2. The public's lack of knowledge of what is feasible or realistic in terms of level of or type of treatment or care.	62.5%	3.0	2.5
3. The increase may be more related to a better-informed public than an increase in misconduct or incompetence of professions.	100%	1.8	1.8
4. There is a reduction in deference to professions by society generally	100%	2.2	1.9
5. The public is more exacting about standards of care and levels of professionalism and not as willing to accept poor communication or below par standards.	100%	1.7	1.6
6. The public has less trust in the infallibility of professional expertise;	100%	2.1	1.9
7. This perhaps reflects a broader shift in social attitudes – a temptation to blame others for	62.5%	2.4	2.4

problems (for example, part of phenomenon that has led to Brexit & Trump).			
8. The public has increased access to information - about legal provisions, services, health indicators etc - and so a more questioning, even challenging, approach is inevitable.	100%	1.9	1.8
9. There is an increasing willingness on the part of members of the public to raise a complaint.	77.5%	2.1	2.0
Awareness of complaint process			
10. There is greater public awareness of how to make a complaint resulting in their filing complaints in increasing numbers.	77.8%	2.0	2.1
11. The public is becoming increasingly more aware of the role of the regulator in receiving complaints.	75%	2.4	2.3
12. Complaints are often made as a precursor to the initiation of court proceedings - it is often considered an inexpensive way of flushing out the case and the details.	25%	3.2	3.0
Pressure on services			
13. Health and social care services are under pressure to deliver 'cost effective' care resulting in hard prioritisation of what type and level of care is delivered.	100%	2.3	1.6
14. Even if better options are available in a given situation, professionals' guidelines dictate them to deliver 'good enough' care, not 'best' care.	50%	3.1	2.8
15. There is a more complex environment within which professionals work which means more can go wrong.	87.5%	2.0	2.1
16. Resources are stretched to the limits following the global economic crisis and many posts are not being filled which puts increased pressure on professionals.	100%	2.1	1.5

17. Professions charged with operating at the juncture between private and public interests are inherently under the spotlight and exposed to a close scrutiny of what might be 'good' behaviour.	75%	2.3	2.0
18. Reduced amount of emotional support from organisations under pressure.	50%	2.3	2.3
19. Professionals are feeling increasing pressure mainly around the lack of support offered at a systems/organisational level.	62.5%	2.3	2.1
20. Many, many complaints/concerns involve apparent poor practice when it is actually the lack of resources (time, supervision, inordinately high workloads) that is as much, if not more, the problem.	75%	2.3	2.1
Workforce factors			
21. Fatigue amongst health care professionals.	62.5%	2.6	2.6
22. Insufficient professional development opportunities offered to staff contributing to increasing fatigue, decreasing employee loyalty and reducing the moral commitment of the health care professionals.	75%	2.5	2.3
23. A disillusioned workforce.	50%	2.4	2.5
24. Pay is not commensurate with work expectations.	37.5%	2.8	2.5
Media & political factors			
25. Bad press coverage - TV and newspapers - may impact on the perception of the services being offered.	75%	1.9	2.0
26. The media is largely responsible for this as is the risk society that has steadily been created over past decades.	75%	2.5	2.4

27. Any actual or perceived number of complaints and concerns is about the wider social and political circumstances and the interrelationship between state and media constructions of risk.	62.5%	2.7	2.1
28. Social media (e.g. twitter and facebook) make it easy for the public to complain and spread stories about poor service.	75%	2.2	1.9
Regulatory factors			
29. Regulator initiatives focused on public outreach, education and communication have informed the public about what they should expect form regulated health and care professionals, and more importantly, what they should do if their expectations are not met.	50%	2.3	2.6
30. There is greater awareness of the regulator and its role.	50%	2.5	2.5
31. There are better system linkages between regulators and other quality assurance mechanisms which means that poor practice is being detected earlier.	62.5%	2.3	2.4
32. Employers and regulatory authorities have taken accountability much more seriously and practitioners are more likely to be reported by colleagues for inappropriate behaviour or conduct that is of concern	87.5%	2.3	1.9
33. In jurisdictions where a registration process has been more recently introduced, this may contribute to heightened awareness of regulatory options for complaints procedures.	62.5%	2.2	2.3
34. From a standards perspective, there is a heightened awareness both within and outside of the professions, in terms of ethics, integrity and appropriate behaviour, and a concomitant emphasis on making complaints/grievance procedures transparently available.	75%	1.9	1.9

35. Maybe we are doing a good job at telling people that they are able to complain, rather than assuming that any increase in the number of complaints indicates a greater level of (e.g.) alleged misbehaviour on the part of the practitioners.	50%	2.1	2.3
Nature of practice			
36. Nature of the work certain groups such as social workers - dealing with tough situations, having to make very tough decisions with unhappy parties no matter what.	75%	1.6	1.9
Education/training			
37. Professional training programs have become less selective at the time of admissions and today's practitioners are, on average, less competent.	0%	3.8	3.9
38. The quality of ethics education is not strong enough.	25%	3.3	3.1
Questioning the increase			
39. I am not convinced that there has been a significant increase in unethical conduct.	87.5%	2.3	2.3
*40. The norms for what we accept as unethical have shifted over time [number change from here]	87.5%		1.9

Question 1A: Are there a ny particular reasons that apply to paramedics? Please describe.

Public attitudes/expectations			
41. If there is a discrepancy between expectations of high level of care (or just a specific, but unnecessary type of care), and what	85.7%	2.3	2.0

the ambulance service or paramedics can or wish to give, there will be a conflict.			
42. A psychological situation which affects paramedics specifically is the 'my home is my castle' situation. From the resident's standpoint, subconsciously, the resident is the king - and therefore also has some kind of right to dominate. So even if one should expect a trained health care professional to be high up in the hierarchy of the local group, this is not always so. If care offered is not aligned with expectations, conflict may arise.	100%	2.9	2.6
43. The public has the expectation when they call an ambulance that they will be taken to hospital and seen by a Doctor. When this does not happen they may feel that they are being denied access to hospital care and vent their frustration at the paramedics.	71.4%	2.1	2.3
44. There is an increased tendency for the public to be aggressive towards paramedics and firemen so complaints may arise from this.	85.7%	2.6	2.9
45. There is a high level of public expectation about the effectiveness of medical/emergency intervention, and less acceptance that people are going to die/be damaged as a result and possibly a greater sense of litigation and individual rights here.	71.4%	2.3	2.3
Pressure on services			
46. There are too few human resources.	42.9%	2.6	2.3
Workforce factors			
47. Paramedicine can attract fast thinking but comparatively low reflective-type individuals. This reactive persona might cause paramedics to be more likely to make decisions that have negative outcomes.	14.3%	3.6	3.3

48. Paramedics not caring for themselves personally, or poorly trained in self-care strategies with evidence of emotional dysregulation.	42.9%	3.0	2.7
49. Lack of clarity to paramedics as to what they can and cannot do, in relation to additional roles.	14.3%	3.2	3.0
50. Expanding scope of practice means paramedics are doing a lot more than they have in the past, with more invasive procedures and access to restricted drugs,	57.2%	2.2	2.3
51. Paramedics work away from communities of other professions who appreciate the strain everyone is under. While supervision may be provided from their own professionals the lack of other health and social care professions working alongside them, could be isolating the cultural behaviour of paramedics.	57.2%	2.3	2.1
Nature of practice			
52. Paramedics work in situations of extremis (at times) and in heightened situations of emotional and physical distress.	85.7%	1.7	1.6
53. The move to treat patients at home and to have on-scene discharge.	57.2%	2.3	2.3
54. As first responders to medical emergencies that can go 'either way', paramedics would be either commended or complained against-depending on the outcome.	57.2%	2.2	2.4
55. Paramedics provide their services in less than ideal circumstances, for example, on the side of the road, in tight spaces in homes, off a cliff or on a beach. By the nature of the calls to emergency services, patients do die or may not have the expected outcome, compared to if the illness had occurred in hospital.	71.5%	2.0	2.0
56. Paramedics may be called out on behalf of others and thus the relationship may not be one	57.2%	2.4	2.3

of a person's own choosing which can lead to contempt.			
57. Paramedics are on the front line of crisis, trauma and emergency services. They are under the watchful eye of a range of people as they go about their jobs. Family and significant others are often involved in emergency situations, and the heightened emotion at times of crisis can result in misperceptions and miscommunication. This can result in complaints.	71.5%	1.9	1.9
58. When patients are acutely sick in the pre-hospital environment, tasks have to be prioritised. This gives priority to medical tasks, instead of good communication with patient, next of kin and members of the public.	56.2%	2.6	2.4
Education/training			
59. Paramedics being educated quite separately from other health and social care professions could add to professional isolation.	57.2%	2.5	2.1
*60. We need more inter-professional training and education	85.7%		1.6

Question 1B: Are there any particular reasons that apply to social workers? Please describe.

Awareness of complaint process			
61. Social workers work with vulnerable client groups who traditionally have not had much of a voice and have tended not to complain. It may be that having a multi-profession regulator makes public education a lot more effective - maybe people know where to go to complain more than they used to, and we may be getting better at making our complaints systems more accessible.	62.5%	2.3	2.4
Workforce factors			

62. Social workers are primarily employed in local authority and do not have the links with other health and social care professions who are dealing with people facing extreme difficulties and are separated from the full involvement of the multi-disciplinary teams.	50%	2.7	2.6
63. While social workers are increasingly part of care teams they often work or interface with clients on their own which can make them more susceptible to complaints which are harder to defend as it often comes down to the clients word or the social workers word.	50%	2.5	2.5
Organisational factors			
64. Professional reflective supervision space is being hijacked by management structures and utilised more as a case management opportunity.	50%	2.3	2.4
65. Organisational factors can exacerbate burnout and secondary traumatic stress and can lead to poor professional performance.	62.5%	2.3	2.0
Nature of practice			
66. Social workers work often at and with the marginalised. They work in situations that are often characterised by fractured families, substance abuse, mental health issues, physical, sexual, emotional abuse and harm. They are part of making and implementing decisions that have the most profound effect on people's lives; lives that are already often dislocated and fractured. Complaints about the social worker are an immediate way of channelling that frustration.	50%	2.1	2.4
67. There is an increased likelihood of 'vulnerability' among the clientele that social workers assist and given the tenuous balance of power that exists between many health and care professionals and their clients, this may increase the chances of conduct or competence complaints	50%	2.2	2.4

68. Social Workers are involved with very challenging family situations on behalf of society often having to make very unpalatable decisions, or in the case of not making those decisions, making very difficult risk assessments about safety of some children. Whatever decisions they make, others are unhappy and will complain.	50%	2.0	2.1
69. The often involuntary nature of the relationship between social workers and clients is a very important feature (with notable exceptions such as in the case of a family wishing to adopt etc.).	50%	1.8	2.3
70. Social workers are often involved in cases where there are other state actors or agencies involved such as the courts. The circumstances are never easy and social workers find themselves part of a complex relationship - for example between parents and children. These relationships are often dislocated and chaotic in nature	50%	1.9	2.1
71. Social workers can and do cause harm to vulnerable people. When complaints are made they are often either on the serious end of the extreme, or the vexatious end.	37.5%	2.9	2.8
72. There are few absolutes and much exercise of judgement, expertise and balancing of risk. All of this occurs under the public spotlight.	62.5%	2.3	2.1
73. Social workers do not appear to have as high a rate of complaints made about them, unless they are involved in statutory child protection work and then they are prime targets.	37.5%	2.6	2.6
Education/training			
74. Social workers are educated away from other health and social care professions. This may prevent collegiality among the professions working with challenging groups.	50%	2.8	2.8

Regulatory factors			
75. The advent of a publicly available Code of Professional Practice, together with the more visible and transparent competence-based nature of social work training at both pre- and post-qualifying levels.	50%	2.8	2.4
*76. Because social workers are not part of health services they could potentially be isolated and unsupported	12.5%		2.9

Question 2: What preventative actions could be taken to respond to th e increasing number of conduct and co mpetence complaints and concerns about health and social care professionals?

Selection and training/education of workforce			
1. Provide education on team work, communication, cultural care and self-care.	100%	1.4	1.4
2. There should be assessment of communication skills both at entry into the professional and as continuing competency assessment as many complaints relate to communication deficits.	87.5%	1.7	1.5
3. Awareness about appropriate levels of empathy and compassion should be explored as part of communication training.	100%	1.7	1.4
4. Make increased efforts to educate health and social care professionals about risks associated with certain practices and behaviours and what is acceptable or may not be helpful.	100%	1.7	1.3
5. Engage more with the student cohort to educate them about the role of the regulator and how to avoid getting into strife.	87.5%	2.4	1.9
6. Providing knowledge and awareness of occupational hazards such as burnout and	100%	1.7	1.4

secondary traumatic stress in itself is a preventative measure.			
7. Target continuing professional development requirements to specific areas of concern in the profession.	75%	1.4	1.8
8. Rigorous admission protocols and criteria at the time of admission to training programmes.	71.4%	2.3	1.7
9. Enhanced pre- and post-registration education on the subjects of professional ethics and risk management. Key topics include ethical decision making; client privacy/confidentiality; informed consent; boundaries and dual relationships; conflicts of interest; documentation; termination of services; consultation; referral; ethical standards associated with professionals' and clients' use of digital technology.	100%	1.9	1.4
10. Ethics should be taught as an inter-professional course so that all health professionals are aware of the codes of ethics and conduct requirements of others.	62.5%	1.8	2.0
11. Codes of ethics needed to be reviewed for currency every three years.	50%	2.3	2.1
12. Professional education has a responsibility to select and screen out students with demonstrated unethical behaviour.	87.5%	2.0	1.6
13. The curriculum needs to emphasise reflective practice.	100%	1.6	1.3
14. Analysis of the data about the nature of the problems identified by the complaints should be fed that back into the training of practitioners - both undergraduate and post-graduate, and to professional associations to better inform the profession about the sorts of matters that are leading to complaints.	100%	1.5	1.6
15. Monitoring student experiences in clinical placements and data from a variety of sources	75%	2.0	2.1

including employers, professional bodies, insurers and third party payers to detect where the problems are.			
Educate the public/Manage expectations			
16. Educate the public about the different channels of complaints and when it is appropriate to make a complaint to the regulator or when it is a complaint against a system.	75%	1.8	2.0
17. Better guidance to the public on airing concerns is needed so that this is more likely to occur at an earlier stage while the situation may be more easily remediable.	75%	2.2	1.8
18. Attempt to target public expectations to emergency medical services, and giving the public alternatives when conditions are non-emergent.	62.5%	1.9	1.9
19. Professional bodies have responsibility for explaining the social work role to the public with the odd 'good news' story occasionally.	87.5%	1.9	1.5
Organisational support/improve work conditions			
20. Provide better organisational support towards each employee, especially support from leadership and coaching programs.	85.8%	1.8	1.7
21. Allow greater flexibility of work place, leave, co-workers, shift cycle & duration.	87.5%	2.2	1.9
22. Create opportunities for peer support and appropriate professional supervision/reflection.	100%	1.4	1.3
23. Employers have workplace responsibility to provide effective supervision and stress management support	87.5%	1.7	1.5
Research to dee pen our understanding of complaints			

24. Categorise the types of complaints so there is a better idea as to what remedial action needs to be taken.	100%	1.7	1.6
25. Identify the specific types of concerns and practice settings - analyse data and look for patterns - what role have employers got in addressing concerns? What role can professional associations and educational bodies play? Is there a specific role for the HCPC Council?	75%	1.8	2.1
26. Spotting trends and potential career flashpoints is important.	62.5%	1.8	2.3
27. We should get better at distinguishing between resource availability and practice standards	87.5%	2.0	1.5
28. Obtain a better understanding required of why patients and fellow professionals do not raise concerns in order to address these reasons.	62.5%	2.2	2.3
29. We need to link data from a variety of systems to detect patterns & deteriorating clinical governance in health and social care services.	75%	1.8	2.1
Regulatory strategies			
30. Appoint an ombudsman to help identify common complaints and allow management the opportunity to develop strategies to reduce these complaints.	87.5%	3.0	2.6
31. Implement solid principles and processes related to Alternate Dispute Resolution- where the client and professional are both engaged in a mediated process to determine what went wrong and what needs to happen to ensure better outcomes going forward.	62.5%	2.3	2.1
32. Regulators should work with paramedics and social workers on such matters as maintaining resilience with multi-professional groups.	87.5%	2.3	1.9

33. Regulators have a role in opening up the discussion with the professionals themselves and invite them to be part of the preventative action. The regulator has a leadership opportunity here in promoting debate and understanding.	100%	1.5	1.6
34. Provision of better guidance to professionals on airing concerns so that this is more likely to occur at an earlier stage while the situation may be more easily remediable.	87.5%	1.8	1.9
35. Develop information materials to support employers and supervisors, professional associations and educators in recognising and responding to areas of concern.	100%	2.1	1.5
36. Publish case studies of disciplinary matters.	87.5%	1.9	1.5
Questioning the increase			
37. Do we need to take preventative action? The increase in complaints and concerns can be seen as a positive thing if poor practice is highlighted and the avenues for the expression of public/service user/ concerns are more visible.	100%	2.1	1.8
38. Service users need to know their rights and have their concerns listened to.	100%	1.6	1.3
*39. Targeted training that focuses on isolated risk avoidance does not instil holistic attitudes and life habits of professional practice	87.5%		1.9
*40. Regulators should be members of the particular profession understanding the work and values and not bureaucrats divorced from front-line practice	50%		2.5
*41. We need better data collection about complaints so all of this can be better understood.	100%		1.3
*42. Categories of complaints should be very specific and not general so data can be interpreted more accurately.	87.5%		1.9

*43. There should be focus on what the registrant is doing to protect themselves from burnout.	87.5%		2.0
*44. Professionals need 'how to look after me' programmes to minimise the risk of disengagement.	87.5%		1.8
*45. Employers should run courses along the lines of 'thank you, let's support you in the next phase of your career'.	75%		2.0

Question 3: What strategies would you suggest to support health and social care professionals to deliver high quality health and social care?

Staff training/education and assessment			
1. Staff should be trained in patient safety issues	87.5%	1.6	1.6
2. Staff should be trained in customer relationship management.	87.5%	2.0	1.6
3. Continuing medical education type programmes can be offered to provide additional training to professionals to reduce the number of complaints (e.g. how to communicate effectively, manage cultural diversity, gender issues, etc.)	100%	1.9	1.6
4. Practitioners need to be equipped with the requisite skills to be able to diffuse conflict situations, for example, being blamed for poor response times.	87.5%	1.7	1.5
5. Rostered time off should be provided for practitioners to undertake targeted training, workshops, retreats etc to focus on growing skills to deliver high quality care.	87.5%	1.8	1.6
6. Continuing professional development (CPD) focussed on area of practice but also elective CPD that gives practitioners the opportunity to expand their training to include training pursuant to alternative future career pathways.	87.5%	2.0	1.8

7. Best practices would suggest training at the under-graduate level be focused less on book knowledge and more on competencies needed to deliver high quality care.	75%	2.3	2.3
8. Exams and assessments at both the entry and on a continuing basis should be done on health and care professionals using competency -based assessments that involve Objective Structured Clinical Examinations using standardized patients	75%	2.6	2.3
9. CPD to value resilience and supports registrants to look at work/life balance - why not have mindfulness training or stress management and relaxation acceptable as part of CPD?	62.5%	2.3	2.1
10. Ensuring that undergraduate and ongoing professional training reflects on the nature of complaints and the hazards associated with this work.	87.5%	1.8	2.0
11. Educators should not assume that concepts such as emotional resilience or work engagement are easily understood concepts that can be taught - a lot of work needs to be done still around understanding these concepts and how they may be fostered and supported. Importantly they need to be looked at in terms of outcomes.	87.5%	1.9	1.9
12. Taking the very real life lessons learned from the complaints made and filtering this back into the professions at undergraduate level and continuous professional development.	100%	1.4	1.6
13. Sound education that covers relational skills and critical reflection, need to be supported by employment environments that provide scope for continuing professional development.	100%	1.7	1.4
14. Practice teachers or assessors working with students during their placements need to feel more able and be more ready to recommend fail	100%	1.8	1.6

outcomes naming their concern in terms of very specific aspects of capability and suitability.			
15. Even in an under resourced system opportunities for reflection are not costly and can bring great value.	100%	1.6	1.3
Ethics education			
16. Empowering professionals to understand the nature of what it means to be an ethical professional rather than someone who must adhere to guidelines. Space needs to be created to explore what this in fact means.	100%	1.5	1.5
17. Instilling value and a sense of self-compassion back into the professionals themselves.	75%	2.0	1.9
18. Ongoing professional development in ethics and professional practice.	100%	1.8	1.5
19. Training in ethical decision making processes.	100%	1.5	1.5
20. In-depth, sustained, rigorous ethics and risk-management education..	87.5%	1.6	1.8
21. It is important to introduce practitioners to key ethics concepts, provide rich examples of complex ethical dilemmas, and discuss ways to manage these dilemmas (applying relevant ethics concepts standards and using practical decision-making protocols).	100%	1.6	1.3
Time and space			
22. Create time and a safe space for discussion.	87.5%	1.8	1.6
23. Make space for reflection and acknowledgement of both strengths and development needs.	87.5%	1.7	1.4
Organisational factors			

24. Be aware of fatigue cultures developing amongst colleagues.	75%	1.9	1.8
25. Health professionals need to feel that they are supported as often the complaints are not related to the individual practitioner's skills and competence but rather broader system and resource constraints. The practitioner is the face of the organisation and often is blamed by the public for general system failures.	75%	1.8	2.3
26. Active and open peer support networks.	100%	1.6	1.6
27. Supportive and accessible managers.	100%	1.4	1.5
28. Organisations must be quick to respond to complaints posted on social media.	87.5%	1.9	1.6
29. Organisations should use social media to share good stories.	75%	1.9	1.8
30. Onsite chaplaincy should be available.	75%	3.3	3.4
31. Better support from colleagues and employers in workplaces, and identifying barriers to this.	87.5%	2.0	1.9
32. Professional supervision for all health and social care workers.	75%	1.8	1.6
33. Implement workload controls.	87.5%	2.1	1.9
34. Pay attention to inter-professional team dynamics and conflict resolution.	75%	1.9	1.8
35. Management in organisations needs to recognise the sensitivities of the relational nature of the work and to support the workers rather than taking on a punitive role because of their funding streams.	87.5%	1.8	1.8
36. Leadership needs to have an emphasis on ethics and values as well as outputs.	87.5%	1.4	1.4

37. Highly trained professionals should work in pairs (e.g. two paramedics on an ambulance instead of one paramedic and one assistant) so they can support each other in decision making and increase patient safety.	50%	2.3	2.3
Regulatory approaches			
38. Regulators should have a humane approach.	100%	1.5	1.3
39. Regulators should emphasise the responsibilities of the employers.	87.5%	1.8	1.4
40. Implement a code of conduct for employers.	87.5%	2.3	1.4
41. Create a greater interface between the systems regulator, the professional bodies (including unions), educators and client/advocate groups.	100%	1.7	1.4
42. While fitness to practise/conduct cases are about individuals, the findings can be utilised to highlight bigger issues. The regulator has a role in appropriately disseminating this information.	87.5%	1.5	1.8
43. There needs to more effective professional publicity regarding complaints/concerns that enables the prospective complainant to identify whether it is the availability (or lack of) resources OR the professional practice in delivering these that is the problem.	75%	2.4	2.0
A holistic response			
44. Interventions are needed at every level - in student selection, undergraduate training, post graduate training and monitoring compliance with professional standards, using data to detect risky practitioners and deteriorating clinical governance, targeting of continuing professional development requirements, revalidation, use of performance assessment powers targeted to at risk groups.	88.8%	1.9	1.7

45. Rather than just targeting individuals, target the systems within which they work - employers, managers, professional bodies, insurers and governments.	77.8%	1.8	2.0
Questioning the strategies			
46. The vast majority of health and social care professionals genuinely deliver services of the very best quality that they can and no amount of berating them with the possibility of complaints or conduct investigations is going to improve this. It's only going to lead to ever more defensive practice.	85.8%	2.5	1.7

Appendix F – Delphi Question 1 – Reasons for increasing number of complaints: Consensus statements

Public attitudes/expectations

1. There are changing attitudes towards what health and social services should deliver to the public and an increasing belief in what the public's rights to help are.	100%
2. The increase may be more related to a better-informed public than an increase in misconduct or incompetence of professions.	100%
3. There is a reduction in deference to professions by society generally	100%
4. The public is more exacting about standards of care and levels of professionalism and not as willing to accept poor communication or below par standards.	100%
5. The public has less trust in the infallibility of professional expertise;	100%
6. The public has increased access to information - about legal provisions, services, health indicators etc - and so a more questioning, even challenging, approach is inevitable.	100%
7. There is an increasing willingness on the part of members of the public to raise a complaint.	77.5%
Awareness of complaint process	
8. There is greater public awareness of how to make a complaint resulting in their filing complaints in increasing numbers.	77.8%
9. The public is becoming increasingly more aware of the role of the regulator in receiving complaints.	75%

Pressure on services

10. Health and social care services are under pressure to deliver 'cost effective' care resulting in hard prioritisation of what type and level of care is delivered.	100%
11. There is a more complex environment within which professionals work which means more can go wrong.	87.5%
12. Resources are stretched to the limits following the global economic crisis and many posts are not being filled which puts increased pressure on professionals.	100%
13. Professions charged with operating at the juncture between private and public interests are inherently under the spotlight and exposed to a close scrutiny of what might be 'good' behaviour.	75%
14. Many, many complaints/concerns involve apparent poor practice when it is actually the lack of resources (time, supervision, inordinately high workloads) that is as much, if not more, the problem.	75%

Workforce factors

15. Insufficient professional development opportunities offered to staff contributing to increasing fatigue, decreasing employee loyalty and reducing the moral commitment of the health care professionals.	75%

Media & political factors

16. Bad press coverage - TV and newspapers - may impact on the perception of the services being offered.	75%
17. The media is largely responsible for this as is the risk society that has steadily been created over past decades.	75%
18. Social media (e.g. twitter and facebook) make it easy for the public to complain and spread stories about poor service.	75%

Regulatory factors

19. Employers and regulatory authorities have taken accountability much more seriously and practitioners are more likely to be reported by colleagues for inappropriate behaviour or conduct that is of concern	87.5%
20. From a standards perspective, there is a heightened awareness both within and outside of the professions, in terms of ethics, integrity and appropriate behaviour, and a concomitant emphasis on making complaints/grievance procedures transparently available.	75%
Nature of practice	
21. Nature of the work certain groups such as social workers - dealing with tough situations, having to make very tough decisions with unhappy parties no matter what.	75%

Questioning the increase

22. I am not convinced that there has been a significant increase in unethical conduct.	87.5%
23. The norms for what we accept as unethical have shifted over time	87.5%

Table 3 – Reasons relating to Paramedic Practice

Public attitudes/expectations	
1. If there is a discrepancy between expectations of high level of care (or just a specific, but unnecessary type of care), and what the ambulance service or paramedics can or wish to give, there will be a conflict.	85.7%

2. A psychological situation which affects paramedics specifically is the 'my home is my castle' situation. From the resident's standpoint, subconsciously, the resident is the king - and therefore also has some kind of right to dominate. So even if one should expect a trained health care professional to be high up in the hierarchy of the local group, this is not always so. If care offered is not aligned with expectations, conflict may arise.	100%
3. The public has the expectation when they call an ambulance that they will be taken to hospital and seen by a Doctor. When this does not happen they may feel that they are being denied access to hospital care and vent their frustration at the paramedics.	71.4%
4. There is an increased tendency for the public to be aggressive towards paramedics and firemen so complaints may arise from this.	85.7%
5. There is a high level of public expectation about the effectiveness of medical/emergency intervention, and less acceptance that people are going to die/be damaged as a result and possibly a greater sense of litigation and individual rights here.	71.4%
Nature of practice	
6. Paramedics work in situations of extremis (at times) and in heightened situations of emotional and physical distress.	85.7%
7. Paramedics provide their services in less than ideal circumstances, for example, on the side of the road, in tight spaces in homes, off a cliff or on a beach. By the nature of the calls to emergency services, patients do die or may not have the expected outcome, compared to if the illness had occurred in hospital.	71.5%
8. Paramedics are on the front line of crisis, trauma and emergency services. They are under the watchful eye of a range of people as they go about their jobs. Family and significant others are often involved in emergency situations, and the heightened emotion at times of crisis can result in misperceptions and miscommunication. This can result in complaints.	71.5%
Education/training	
9. We need more inter-professional training and education	85.7%

Appendix G – Delphi Question 2 – Preventative action

Selection and training/education of workforce	
1. Provide education on team work, communication, cultural care and self-care.	100%
2. There should be assessment of communication skills both at entry into the professional and as continuing competency assessment as many complaints relate to communication deficits.	87.5%
3. Awareness about appropriate levels of empathy and compassion should be explored as part of communication training.	100%
4. Make increased efforts to educate health and social care professionals about risks associated with certain practices and behaviours and what is acceptable or may not be helpful.	100%
5. Engage more with the student cohort to educate them about the role of the regulator and how to avoid getting into strife.	87.5%
6. Providing knowledge and awareness of occupational hazards such as burnout and secondary traumatic stress in itself is a preventative measure.	100%
7. Target continuing professional development requirements to specific areas of concern in the profession.	75%
8. Rigorous admission protocols and criteria at the time of admission to training programmes.	71.4%
9. Enhanced pre- and post-registration education on the subjects of professional ethics and risk management. Key topics include ethical decision making; client privacy/confidentiality; informed consent; boundaries and dual relationships; conflicts of interest; documentation; termination of services; consultation; referral; ethical standards associated with professionals' and clients' use of digital technology.	100%
12. Professional education has a responsibility to select and screen out students with demonstrated unethical behaviour.	87.5%
13. The curriculum needs to emphasise reflective practice.	100%
14. Analysis of the data about the nature of the problems identified by the complaints should be fed that back into the training of practitioners - both undergraduate and post-graduate, and to professional associations to better inform the profession about the sorts of matters that are leading to complaints.	100%
15. Monitoring student experiences in clinical placements and data from a variety of sources including employers, professional bodies, insurers and third party payers to detect where the problems are.	75%
Educate the public/Manage expectations	

16. Educate the public about the different channels of complaints and when it is appropriate to make a complaint to the regulator or when it is a complaint against a system.	75%
17. Better guidance to the public on airing concerns is needed so that this is more likely to occur at an earlier stage while the situation may be more easily remediable.	75%
19. Professional bodies have responsibility for explaining the social work role to the public with the odd 'good news' story occasionally.	87.5%
Organisational support/improve work conditions	
20. Provide better organisational support towards each employee, especially support from leadership and coaching programs.	85.8%
21. Allow greater flexibility of work place, leave, co-workers, shift cycle & duration.	87.5%
22. Create opportunities for peer support and appropriate professional supervision/reflection.	100%
23. Employers have workplace responsibility to provide effective supervision and stress management support	87.5%
Research to deepen our understanding of complaints	
24. Categorise the types of complaints so there is a better idea as to what remedial action needs to be taken.	100%
25. Identify the specific types of concerns and practice settings - analyse data and look for patterns - what role have employers got in addressing concerns? What role can professional associations and educational bodies play? Is there a specific role for the HCPC Council?	75%
27. We should get better at distinguishing between resource availability and practice standards	87.5%
29. We need to link data from a variety of systems to detect patterns & deteriorating clinical governance in health and social care services.	75%
Regulatory strategies	
30. Appoint an ombudsman to help identify common complaints and allow management the opportunity to develop strategies to reduce these complaints.	87.5%
32. Regulators should work with paramedics and social workers on such matters as maintaining resilience with multi-professional groups.	87.5%
33. Regulators have a role in opening up the discussion with the professionals themselves and invite them to be part of the preventative action. The regulator has a leadership opportunity here in promoting debate and understanding.	100%
34. Provision of better guidance to professionals on airing concerns so that this is more likely to occur at an earlier stage while the situation may be more easily remediable.	87.5%

35. Develop information materials to support employers and supervisors, professional associations and educators in recognising and responding to areas of concern.	100%
36. Publish case studies of disciplinary matters.	87.5%
Questioning the increase	
37. Do we need to take preventative action? The increase in complaints and concerns can be seen as a positive thing if poor practice is highlighted and the avenues for the expression of public/service user/ concerns are more visible.	100%
38. Service users need to know their rights and have their concerns listened to.	100%
*39. Targeted training that focuses on isolated risk avoidance does not instil holistic attitudes and life habits of professional practice [Training/education theme]	87.5%
*41. We need better data collection about complaints so all of this can be better understood. [Research theme]	100%
*42. Categories of complaints should be very specific and not general so data can be interpreted more accurately. [Research theme]	87.5%
*43. There should be focus on what the registrant is doing to protect themselves from burnout.[workforce/self-care]	87.5%
*44. Professionals need 'how to look after me' programmes to minimise the risk of disengagement.[employer support/self-care]	87.5%
*45. Employers should run courses along the lines of 'thank you, let's support you in the next phase of your career'.[employer support]	75%

*New statement added in Round 3

Appendix H – Delphi Question 3 – Strategies to support the delivery of high quality care

Staff training/education and assessment	
1. Staff should be trained in patient safety issues	87.5%
2. Staff should be trained in customer relationship management.	87.5%
3. Continuing medical education type programmes can be offered to provide additional training to professionals to reduce the number of complaints (e.g. how to communicate effectively, manage cultural diversity, gender issues, etc.)	100%
4. Practitioners need to be equipped with the requisite skills to be able to diffuse conflict situations, for example, being blamed for poor response times.	87.5%
5. Rostered time off should be provided for practitioners to undertake targeted training, workshops, retreats etc to focus on growing skills to deliver high quality care.	87.5%
6. Continuing professional development (CPD) focused on area of practice but also elective CPD that gives practitioners the opportunity to expand their training to include training pursuant to alternative future career pathways.	87.5%
7. Best practices would suggest training at the under-graduate level be focused less on book knowledge and more on competencies needed to deliver high quality care.	75%
8. Exams and assessments at both the entry and on a continuing basis should be done on health and care professionals using competency -based assessments that involve Objective Structured Clinical Examinations using standardized patients	75%
10. Ensuring that undergraduate and ongoing professional training reflects on the nature of complaints and the hazards associated with this work.	87.5%
11. Educators should not assume that concepts such as emotional resilience or work engagement are easily understood concepts that can be taught - a lot of work needs to be done still around understanding these concepts and how they may be fostered and supported. Importantly they need to be looked at in terms of outcomes.	87.5%
12. Taking the very real life lessons learned from the complaints made and filtering this back into the professions at undergraduate level and continuous professional development.	100%

13. Sound education that covers relational skills and critical reflection, need to be supported by employment environments that provide scope for continuing professional development.	100%
14. Practice teachers or assessors working with students during their placements need to feel more able and be more ready to recommend fail outcomes naming their concern in terms of very specific aspects of capability and suitability.	100%
15. Even in an under resourced system opportunities for reflection are not costly and can bring great value.	100%
Ethics education	
16. Empowering professionals to understand the nature of what it means to be an ethical professional rather than someone who must adhere to guidelines. Space needs to be created to explore what this in fact means.	100%
17. Instilling value and a sense of self-compassion back into the professionals themselves.	75%
18. Ongoing professional development in ethics and professional practice.	100%
19. Training in ethical decision making processes.	100%
20. In-depth, sustained, rigorous ethics and risk-management education..	87.5%
21. It is important to introduce practitioners to key ethics concepts, provide rich examples of complex ethical dilemmas, and discuss ways to manage these dilemmas (applying relevant ethics concepts standards and using practical decision-making protocols).	100%
Time and space	
22. Create time and a safe space for discussion.	87.5%
23. Make space for reflection and acknowledgement of both strengths and development needs.	87.5%
Organisational factors	
24. Be aware of fatigue cultures developing amongst colleagues.	75%
25. Health professionals need to feel that they are supported as often the complaints are not related to the individual practitioner's skills and competence but rather broader system and resource constraints. The practitioner is the face of the organisation and often is blamed by the public for general system failures.	75%
26. Active and open peer support networks.	100%
27. Supportive and accessible managers.	100%
28. Organisations must be quick to respond to complaints posted on social media.	87.5%
29. Organisations should use social media to share good stories.	75%
30. Onsite chaplaincy should be available.	75%

31. Better support from colleagues and employers in workplaces, and identifying barriers to this.	87.5%
32. Professional supervision for all health and social care workers.	75%
33. Implement workload controls.	87.5%
34. Pay attention to inter-professional team dynamics and conflict resolution.	75%
35. Management in organisations needs to recognise the sensitivities of the relational nature of the work and to support the workers rather than taking on a punitive role because of their funding streams.	87.5%
36. Leadership needs to have an emphasis on ethics and values as well as outputs.	87.5%
Regulatory approaches	
38. Regulators should have a humane approach.	100%
39. Regulators should emphasise the responsibilities of the employers.	87.5%
40. Implement a code of conduct for employers.	87.5%
41. Create a greater interface between the systems regulator, the professional bodies (including unions), educators and client/advocate groups.	100%
42. While fitness to practise/conduct cases are about individuals, the findings can be utilised to highlight bigger issues. The regulator has a role in appropriately disseminating this information.	87.5%
43. There needs to more effective professional publicity regarding complaints/concerns that enables the prospective complainant to identify whether it is the availability (or lack of) resources OR the professional practice in delivering these that is the problem.	75%
A holistic response	
44. Interventions are needed at every level - in student selection, undergraduate training, post graduate training and monitoring compliance with professional standards, using data to detect risky practitioners and deteriorating clinical governance, targeting of continuing professional development requirements, revalidation, use of performance assessment powers targeted to at risk groups.	88.8%
45. Rather than just targeting individuals, target the systems within which they work - employers, managers, professional bodies, insurers and governments.	77.8%
Questioning the strategies	
46. The vast majority of health and social care professionals genuinely deliver services of the very best quality that they can and no amount of berating them with the possibility of complaints or conduct investigations is going to improve this. It's only going to lead to ever more defensive practice.	85.8%