THE INDICATIVE SANCTIONS POLICY – THE PUBLIC'S VIEW

Research report prepared for the Health and Care Professions Council by GfK UK

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1 Executive summary of key findings

1.1 Background

The Health and Care Professions Council (hereafter, HCPC) is an independent professional regulator set up to protect the public. Set up in 2002, the HCPC regulates 16 professions[1].

Where there are concerns that a registrant's fitness to practise is impaired, this is investigated by the HCPC. Practice Committee panels consider fitness to practise cases. The HCPC's **Indicative Sanctions Policy[2]** sets out the principles that panels should consider when deciding what, if any, sanction should be applied. The Indicative Sanctions Policy is now being reviewed and research amongst the public was required as a key part of this process.

1.1.1 Research objectives

The over-arching aim of the research was to explore the public's view on the principles that under-pin the Indicative Sanctions Policy, specifically focusing on general public views towards:

- The range of sanctions available, and which are felt to be most appropriate for the most serious cases.
- The role of insight, remorse, apology and remediation and views regarding the importance placed on these when determining sanction/s.
- The principle of proportionality.
- Content relating to equality and diversity.

1.2 Research approach

The research used a qualitative method, which involved eight mini-group discussions and eight in-depth interviews. The qualitative approach enabled the research team to fully

[1] Arts therapists, biomedical scientists, chiropodists/ podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/ orthotists, radiographers, social workers in England, speech and language therapists.

[2] http://hpc-uk.org/publications/policy/index.asp?id=80

explore how participants considered and reacted to the principles under-pinning the Indicative Sanctions Policy.

The sample was made up of eight mini-group discussions and eight in-depth interviews. These were split across all four countries of the United Kingdom. Fieldwork was carried out between 25 September and 3 October 2017.

To support the GfK research team in understanding the way in which the Indicative Sanctions Policy is used in real life the team carried out three telephone interviews with members of the HCPC Tribunal Advisory Committee (TAC).

A discussion guide was designed using two key techniques to engage participants in the topic:

1. Information stimulus designed to explain to participants: the role of the HCPC; the health and care professionals regulated by the HCPC; the types of cases that go to a fitness to practise panel; the sanctions available to panels; the make-up of the panel.
2. Case studies based on real life examples of fitness to practise cases.

1.3 Setting the context

Across the research, none of the participants had heard of the HCPC. As participants received information about the HCPC during the research session, they were interested to know more, and recognised the value of the HCPC.

As discussions about fitness to practise cases developed, participants recalled media stories that had tackled similar themes. These media stories promoted both positive and negative views of health professionals (including those who are and are not regulated by the HCPC).

It was clear that personal experience and values played a role in shaping any reaction to cases and the sanctions imposed. Overall views towards fitness to practise cases were also affected by individual participants' outlook on wrongdoings and outcomes. These differences in outlook did not tend to result in major differences in opinion throughout the research, but were reflected in situations where some participants were slightly more or less lenient towards cases. Across the research, very few differences emerged based on demographic profile of the participant.

1.4 Types of cases heard at fitness to practise hearings

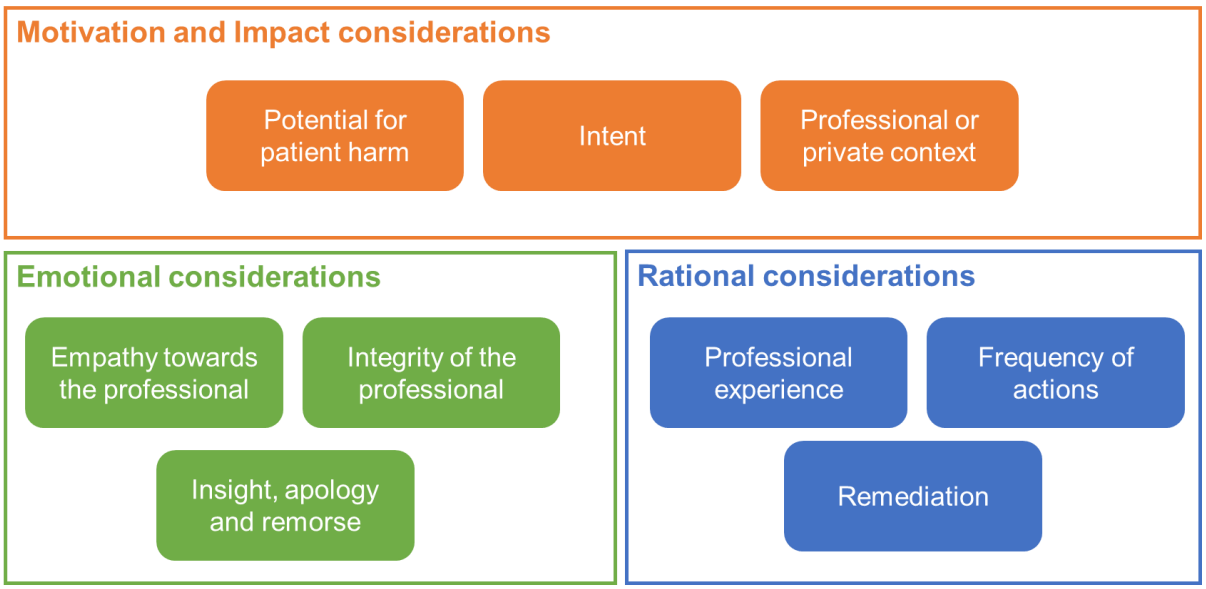
Participants were provided with a list of the types of cases heard by a fitness to practise panel. There was strong agreement that the most serious cases included child pornography, sexual misconduct and violence or abuse. In addition to these most severe cases, participants tended to feel most strongly, where cases involved breach of trust between the patient and the professional. Breach of trust was considered most serious where linked to dishonesty. Here, the intent behind the breach in trust caused most concern. Further to this, it was agreed that deliberate exploitation of a vulnerable person compounded the severity of a case.

1.5 Range of sanctions available to panels

Participants were shown a list of typical sanctions available to the panel. Participants felt that sanctions should be tailored and chosen to reflect each individual case. However, there were some broad areas where they felt there was a clear match between case type and sanction imposed. This included a direct link between the most serious cases and the most severe sanctions, and a link between retraining as a sanction for cases that involved incompetence.

1.6 Mitigating and aggravating factors

Across the research, participants cited a range of mitigating and aggravating factors they anticipated would be taken into account when panels were deciding the appropriate sanction for any case. The mitigating and aggravating factors generated fell into three broad groups of considerations:



1.6.1 Motivation and Impact considerations

The factors within the group of considerations were considered the most serious across the research. Participants strongly felt that the degree of patient impact should be a key factor considered by the panel to determine potential risk in the professional continuing to practice. They also reacted more strongly to cases where they felt that the professional's behaviour had been planned and intentional. The context of the behaviour was also taken into account, with participants noting that actions that happened within the workplace, or had a direct link to working duties were more serious.

Where a combination of these aggravating factors was found, participants envisaged that the case would be very serious indeed.

1.6.2 Emotional considerations

Whilst participants often responded emotionally to cases, there were mixed views regarding the role that these more emotional factors should play in reaching a decision about imposing a sanction. This was particularly the case when participants reflected that these aggravating and mitigating factors were not measurable, and were therefore subjective.

Participants often considered the justification for a behaviour provided by a professional and expressed some tolerance for situations where they could understand this rationale.

Another key emotional factor taken into account across the research was the integrity of the professional. This was clearly of importance to participants who talked about the following aspects of a professional's behaviour:

- Honesty
- Professionalism
- Attending the hearing

Insight, apology, remorse and remediation were all factors that generated debate across the research sessions. Participants reflected that insight, apology, remorse and remediation were closely linked, and it was difficult to isolate the specificities of each. Whilst there was an expectation that a professional would demonstrate at least one of these as a natural response to having done something wrong there was skepticism about the authenticity of this type of response from the professional. Many participants placed a greater emphasis on the role of remediation as an action that could be more easily measured.

1.6.3 Rational considerations

Rational considerations were identified as key aggravating or mitigating factors that were measurable. With this in mind, it was clear that participants felt that they could be confidently used by the panel to help guide their decision-making process.

Participants agreed that remediation involved taking steps to rectify a behaviour, going beyond insight and remorse to provide evidence that the professional was keen to remedy their deficiencies. Participants specifically felt that proactive remediation was a strong mitigating factor. They felt that if the professional had personally sought remediation or was proactively suggesting a course of remediation, this demonstrated insight and a desire to return to practice. Despite strong positive views towards remediation, there were concerns that remediation could be carried out without genuine insight as a way to simply lessen any sanction the panel might impose. With this in mind participants agreed that the panel could look across insight, apology, remorse and remediation to help determine which professionals were genuine

Other rational considerations included:

- Frequency of actions: participants felt that frequent actions suggested a lack of insight from the professional and risk of repeat behaviour.

- Professional experience: participants tended to be more lenient towards junior, younger or less experienced professionals where the case involved incompetency.

1.7 Views on the principles of proportionality

Most participants struggled to imagine how panels might go about actually deciding on a sanction. They were aware that there were many factors to be taken into account and anticipated that this was a very difficult process and decision to reach. Across the research five key principles emerged as important to participants:

1. Unbiased decision-making

Participants felt that it was crucial that the panel think open-mindedly and from a neutral viewpoint.

2. Making fair and appropriate decisions

Views regarding fair and appropriate decisions focused on the importance of tailoring sanctions and outcomes to fit each case rather than imposing a 'blanket approach'. Participants felt that making fair decisions needed to balance the public and the professional viewpoint but tended to think first and foremost about the severity of the case and what would need to be put in place to protect the public from harm as well as ensure public trust and confidence in the profession. Participants also considered the importance of allowing the professional to continue, or be supported back to practice where appropriate.

3. Protecting the public from harm

Participants interpreted achieving public protection to mean safeguarding against the same thing happening again. They felt that this should be at the heart of panel decision-making.

4. Ensuring the public can trust/ have confidence in the profession

Participants strongly agreed that it was important that the public could be confident in the profession and this was often interpreted as being able to trust the profession. This was particularly important for cases involving patient harm and cases that impacted public opinion.

5. Thinking about the rights of the professional

Participants agreed that the balance of decision-making should heavily focus on protecting the public from harm and ensuring trust between patients and professionals. However, they also considered the rights of the professional focusing on two key aspects:

- Whether cases that involved incidents outside of the working environment and entirely unrelated to working duties should go before a panel.
- The importance of ensuring that professionals can access support where needed regardless of sanction imposed.

1.8 Equality and diversity

Participants agreed that all professionals should be treated equally and fairly. Participants were specifically asked for their views on how differences in cultural backgrounds could be taken into account. There was strong agreement that any professionals regulated by the HCPC should be practising to the same professional standards regardless of their cultural background.

When prompted, participants recognised that people with different cultural norms and backgrounds may express themselves differently. There were different levels of tolerance towards the differences that cultural norms may present. Overall it was agreed that despite differences in cultural expression it should still be possible for a professional to demonstrate honesty, integrity and remediation, and anticipated that these factors would remain important across cultures.

Some felt that the panel itself should be diverse to reflect the diversity of health and care professions. It was also suggested that the panel be carefully chosen to include those with experience that would support them in making fair and appropriate decisions such as those with ‘life experience’.

2 Background

The Health and Care Professions Council (hereafter, HCPC) is an independent professional regulator set up to protect the public. The HCPC set and maintain standards which cover education and training, behaviour, professional skills and health; approve and monitor educational programmes which lead to registration; maintain a register of people that successfully pass those programmes; and take action if a registrant's fitness to practise falls below HCPC standards. The HCPC was set up in 2002 and regulates 16 professions[3].

Where there are concerns that a registrant's fitness to practise is impaired, this is investigated by the HCPC. Concerns may be raised by members of the public, employers, the police or other health and care professionals. The approach to investigation is both risk-based and proportionate ensuring best use of HCPC resources in protecting the public.

2.1 The Indicative Sanctions Policy

Practice Committee panels consider fitness to practise cases. The HCPC's **Indicative Sanctions Policy[4]** sets out the principles that panels should consider when deciding what, if any, sanction should be applied. The role of the policy is to ensure that decisions are fair, consistent and transparent.

Panels make independent decisions, but the policy, whose use is supported by case law, is a guide to those independent decisions and details:

- The purpose of sanctions
- Proportionality
- Insight and remorse
- Procedure
- Sanctions
- Interim orders

[3] Arts therapists, biomedical scientists, chiropodists/ podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/ orthotists, radiographers, social workers in England, speech and language therapists.

[4] http://hpc-uk.org/publications/policy/index.asp?id=80

- Multiple sanctions

The Indicative Sanctions Policy is now being reviewed and research amongst the public was required as a key part of this process.

2.2 Objectives

The over-arching aim of the research was to explore the public's view on the principles that under-pin the Indicative Sanctions Policy, specifically focusing on general public views towards:

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- The principle of proportionality.
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3 Research approach

3.1 Method

The research used a qualitative method, which involved eight mini-group discussions and eight in-depth interviews. The qualitative approach enabled the research team to fully explore how participants considered and reacted to the principles under-pinning the Indicative Sanctions Policy. The qualitative nature of the research allowed for both spontaneous and prompted views to be gathered, providing researchers with detailed insight into participants priorities and considerations when reflecting on the decision making process the panels follow when determining sanctions.

The research used a mix of qualitative methods tailored to gather feedback from a broad range of members of the general public:

- Mini-group discussions provided an open forum where participants shared their views with each other. The discursive nature of a group setting was ideal for gathering nuanced feedback about the principles under-pinning the Indicative Sanctions Policy. The mini-group discussions lasted two hours each.

- In-depth interviews provided a private forum for discussion where the participant's individual point of view was explored in depth. The private nature of an interview meant participants were comfortable in revealing views that they may have otherwise felt uncomfortable expressing in a group of peers. A one-to-one environment was also chosen as an appropriate method for those who were more likely to have frequent interaction with healthcare professionals. This enabled the research team to tailor the session to any individual sensitivities or views. In-depth interviews lasted 1 hour each.

3.2 Sample

The sample was made up of eight mini-group discussions and eight in-depth interviews. These were split across all four countries of the United Kingdom including:

- England: London
- Wales: Cardiff
- Scotland: Glasgow
- Northern Ireland: Belfast

Fieldwork was carried out between 25 September and 3 October 2017.

3.2.1 Mini-group discussions

The focus groups lasted two hours and included five or six participants in each group. The table below gives an overview of the sample.

Location	**Mini-groups**	
London	Mini-group 1 • 18-24 years • C2DE • None to have children	Mini-group 2 • 40-59 years • BC1 • At least 4 to have children living at home
Belfast	Mini-group 3 • 60+ years • BC1	Mini-group 4 • 25-39 years • C2DE

	• None to have children living at home • At least 2 x to have a long-term condition	• At least 4 to have children living at home
Cardiff	Mini-group 5 • 25-39 years • BC1 • At least 4 to have children living at home	Mini-group 6 • 40-59 years • C2DE • At least 4 to have children living at home
Glasgow	Mini-group 7 • 60+ years • C2DE • None to have children living at home • At least 2 x to have a long-term condition	Mini-group 8 • 18-24 years • BC1 • None to have children

Groups were stratified on the basis of demographic characteristics and healthcare use and experience to ensure positive group dynamics and to enable the research team to identify any differences in views on this basis. Accurate recruitment was facilitated by a recruitment screening questionnaire that included a list of questions to ask any potential participants to ensure they met the profile required.

Demographic characteristics:

- Age. Stratification by four age bands: 18-24 years; 25-39 years; 40-59 years; and 60+ years.
- Socio-economic group. Socio-economic group is determined by the job role of the chief income earner in the household. Groups were stratified into two bands: BC1 and C2DE.
- Presence of children. Quotas were set to ensure inclusion of some people with children in the relevant age bands.

- Caring for others. Eight participants across the research self-identified as informal carers.
- Gender. Each group included a mix of male and female participants.
- Ethnicity. This was representative of the local area in each location.

Healthcare use and experience:

- To ensure the research included those with more recent experience of healthcare services, at least one participant in each group had either personally used a healthcare service, or had a close family member or friend that had used a healthcare service.
- The recruitment screening process was designed to exclude those who had made a complaint about a healthcare professional to reflect that those who had made a complaint may have a different view or different levels of knowledge regarding fitness to practise.

3.2.2 In-depth interviews

We carried out eight in-depth interviews across the research locations. The overall sample breakdown was:

Depth	**Profile**	
1	75+ years old with a long term condition	• To include: o 4 x male o 4 x female • Spread of socio-economic group • Spread across the research locations
2	75+ years old with a long term condition	
3	Under 75 years old with a long term condition	
4	Under 75 years old with a long term condition	
5	With a sensory impairment	
6	With a sensory impairment	
7	With a mental health condition	

8	With a mental health condition	

3.3 Discussion guide design

A discussion guide was designed to enable research participants to think about and discuss the under-lying principles of the Indicative Sanctions Policy as detailed in the research objectives.

3.3.1 Shaping the discussion guide

To support the GfK research team in understanding the way in which the Indicative Sanctions Policy is used in real life the team carried out three telephone interviews with members of the HCPC Tribunal Advisory Committee (TAC).

These interviews provided the research team with valuable insight into the ways in which the policy is used which gave the research team a sound context for the research with the general public.

These interviews also provided opportunity for the GfK research team to gather from members of TAC their views regarding the research objectives, and key areas where they particularly valued general public feedback. TAC members agreed that the research objectives covered key areas for exploration with the general public and identified some detailed areas within these areas for specific coverage in the research sessions:

- Views on mitigating and aggravating factors to enable the HCPC to consider whether these should be included in the Indicative Sanctions Policy.
- Ways in which insight, apology and remorse are distinguished.
- Views on the inclusion of equality and diversity guidance and how cultural factors should be taken into account.
- Views on any specific cases that have an obvious link to a sanction. They felt that this would support the HCPC in deciding whether example scenarios could be included in the Indicative Sanctions Policy.

3.3.2 Discussion guide techniques

Two key techniques were used within the discussion guide to enable research participants to both engage in the topic under discussion, and consider their views.

Information stimulus

Stimulus materials were designed to clearly explain to participants key information:

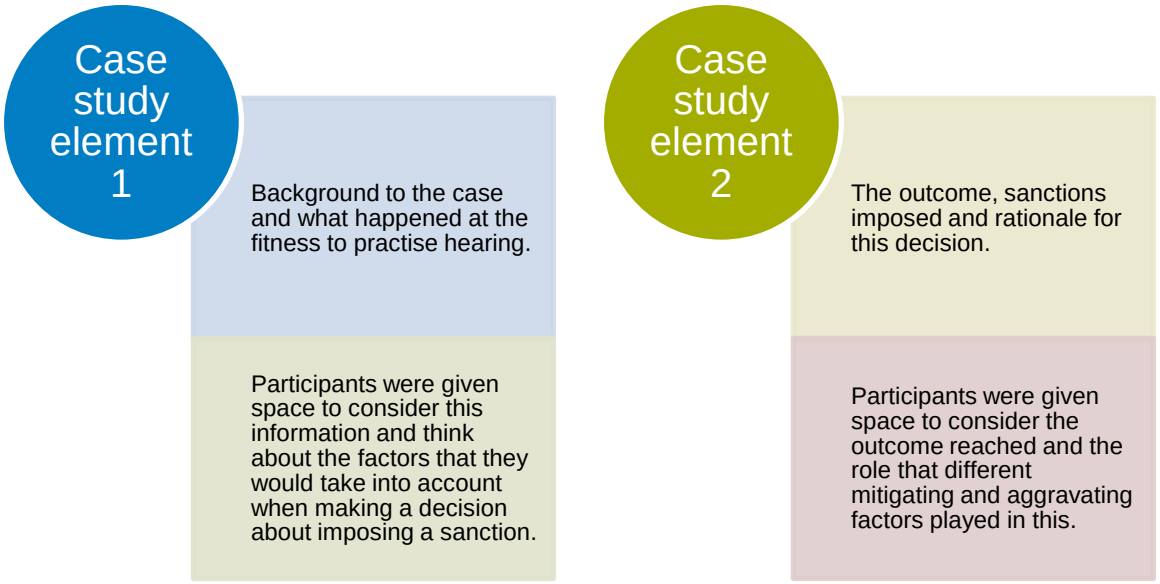
- the role of the HCPC;
- the health and care professionals regulated by the HCPC;
- the types of cases that go to a fitness to practise panel;
- the sanctions available to panels;
- the make-up of the panel.

This information was designed to use a mix of written information in plain English, and video content (from the HCPC YouTube channel) to maximise engagement. This information was intended to give a concentrated mini-briefing to participants to set the background to the discussion.

Case studies

Case studies were included to help participants base their discussions and considerations of the principles under-lying the Indicative Sanctions Policy in real life examples. Case study examples were taken from the HCPC website[5], and are based on real decisions made for real life cases. The information provided to participants for each case study was streamlined and tweaked to provide something that was: easy to read; digestible; and provided in plain English. Information for each case study was broken down into two elements:

[5] http://hpc-uk.org/complaints/casestudies/



Detailed consideration of case studies in turn gave participants space to consider the principles under-lying the Indicative Sanctions Policy. Participants initially discussed principles at a spontaneous level whilst considering the case studies but were then also prompted to directly consider the principles as outlined in the research objectives.

The first few research sessions cemented the fact that basing discussion in real life case studies was crucial to generating meaningful discussion and debate amongst participants. With this in mind, the discussion guide was tweaked to give greater focus on discussing the case studies, and further case studies were added to give a good range of cases for debate.

The discussion guide, stimulus information and case studies are provided in the appendix.

3.4 Strengths and limitations of the research

A qualitative approach was employed to explore how people considered and reacted to the principles under-pinning the Indicative Sanctions Policy. This allowed researchers to gather rich insights, which were increased by using a blend of mini-group discussions and in-depth interviews.

The key strength of a qualitative approach is that it enables researchers to gather spontaneous attitudes and insights, as well as highly nuanced feedback about the research objectives. Whilst qualitative discussions follow a clear structure, they emphasise

the role of the participant in leading and driving the conversation through allowing them to answer in their own words and leading to responses that are full of rich insights. Participants are not limited in the way they answer the questions by being required to choose from multiple-choice answers as they would in a quantitative study.

The main limitation to using a qualitative research approach is that it emphasises self-expression and insight over numerical outcomes and so relies on detailed discussion with relatively small sample sizes. Whilst we included people from a wide range of backgrounds and with a variety of demographic characteristics, the overall sample size means it is not statistically representative. The findings in this report focus on participant views and opinions; the findings do not attempt to quantify these.

3.5 Reporting conventions

Please note the following reporting conventions.

- The Health and Care Professions Council is abbreviated to 'HCPC' throughout the report.
- Quotes from participants are italicised and provided in boxes.
- Where participant views are best demonstrated by summarising their reaction to case studies shown during the research, these are included in case study boxes. These case study boxes include a short summary sentence describing the case in question, and the full case study detail is provided in the appendix.

4 Setting the context

4.1 Awareness of the HCPC

Across the research, none of the participants had heard of the HCPC. A couple were familiar with the role of regulatory bodies either through work, or after reading or seeing relevant news articles.

> *"A regulator imposes regulations on groups to make sure they are operating within best practise." (Cardiff group, 25-39 years, BC1)*

However, for most this topic and concept was new information. As participants received information across the research session, they recognised the value of the HCPC, and were interested to know about the work of the organisation.

> *"I don't want this person or a social worker [found to have done something wrong] working for a private company just moving to another company. The same thing could happen elsewhere if they just leave quietly. So it's good there's an overall body looking at this." (Cardiff group, 25-39 years, BC1)*

4.2 Public access to fitness to practise outcomes

There was some debate about whether the public had access to information about cases and sanctions imposed on professionals. No participants were aware of any published information.

> *"Can you see if any of these people, like can you go online somewhere and see if anyone had a caution against them?" (London group, 40-59 years, BC1)*

Some queried whether HCPC did not publish information to protect the professionals.

> *"In a way it is like protecting them because nobody else knows what they have got apart from HCPC." (London group, 18-24 years, C2DE)*

Across the research, it was clear that participants were interested to know about any published information.

4.3 Drawing on examples in the media

As discussions about fitness to practise cases developed during the research sessions, participants recalled media stories that had tackled similar themes.

Some of these media stories focused on concerns and cases regarding healthcare professionals. Whilst these stories were often regarding healthcare professionals not regulated by the HCPC, they often promoted a cynical view of healthcare professionals.

> *"I've read in the paper about people in care homes who tend to either steal off the person or things like that." (London depth, male, 75+ years, long-term condition)*
>
> *"You hear about fraud cases and people going into homes to help old people and that kind of stuff." (Glasgow group, 60+ years, C2DE)*

Whilst other media stories had encouraged participants to consider resourcing issues faced by healthcare professionals.

> *"I feel sorry for social workers though, they are under an awful lot of strain. Not in all cases – but somebody carries the can. They don't have enough funding or resources so mistakes are going to happen." (Glasgow depth, female, hearing impairment)*

4.4 Participant experience and outlook

Across the research it was clear that personal experience and values played a role in shaping any reaction to cases heard by fitness to practise panels, and the decision making process in hearing these and determining a sanction.

Some participants talked about personal experiences of issues with healthcare professionals including those regulated by the HCPC. These experiences had encouraged participants to consider what happens when there are issues with health and care professionals. However, it should be noted that these participants did not have any greater knowledge of the HCPC when compared to other participants.

> *"People are going to seek alternate care or even go overseas you know. I know what a lot of people did with dentists, when they started implementing changes in dental health care. I know a lot of people were going over to Europe and getting their teeth done." (London depth, female, mental health condition)*

"It's very complicated all this really. I had two GPs, who were alcoholics, once an alcoholic always an alcoholic. One of them was struck off which I think was right but you could suspend someone if they are willing to get help then they would have to prove after a certain period, probably a few years, that they could do their job." (Belfast depth, female, 75+ years, long-term condition).

Overall views towards fitness to practise cases were also affected by individual participants' outlook on wrongdoings and outcomes. Some participants reflected that they had limited tolerance for wrongdoings.

"They have to think about protecting the public you see…don't forget when somebody commits an offence once, nine out of ten times they do it again." (London depth, female, 75+ years, long-term condition)

"If you've done something wrong you're out. Don't have the attitude of saying 'oh we'll give you another chance'." (London depth, male, 75+ years, long-term condition)

Others were more lenient in their outlook.

"There is a level of forgiveness in society to move on." (London group, 40-59 years, BC1)

These differences in outlook did not tend to result in major differences in opinion throughout the research, but were reflected in situations where some participants were slightly more or less lenient towards cases.

Across the research, very few differences emerged based on demographic profile of the participant. Where these differences were observed, they are noted.

5 Types of cases heard at fitness to practise hearings

Participants were provided with a list of the types of cases heard by a fitness to practise panel:

The types of cases that HCPC look into include cases where the professional:

- Was dishonest
- Committed fraud
- Abused someone's trust
- Exploited a vulnerable person
- Did not respect a patient's rights to make choices about their own care
- Had/ has health problems which they did not deal with and which could affect the safety of patients
- Hid mistakes
- Had an improper relationship with a patient
- Carried out reckless or deliberately harmful acts
- Seriously failed to meet standards of their profession
- Persistently failed to meet standards of their profession
- Has been involved in sexual misconduct or indecency
- Has been involved in child pornography
- Has been violent
- Has shown threatening behaviour
- Has carried out a serious activity that would affect public confidence in the profession

Participants agreed that all of these cases were serious.

"They're all pretty serious in my opinion if you're working in the care profession." (London depth, male, long-term condition)

"They're all serious aren't they?" (London depth, female, mental health condition)

There was strong agreement that the most serious cases included child pornography, sexual misconduct and violence or abuse.

"Pornography is the one that jumps at me. It goes without saying you know." (London group, 40-59 years, BC1)

"Physical and mental abuse." (Glasgow depth, male, mental health condition)

In addition to these most severe cases, participants tended to feel most strongly, where cases involved **breach of trust** between the patient and the professional.

They noted that it was crucial that the public could trust professionals, and therefore the abuse of trust in these cases was a key concern.

"They are all pretty serious…you are breaking the person's trust." (Belfast group, 60+ years, BC1)

Being able to trust healthcare professionals to support patients in receiving, accessing and making the right healthcare decisions was considered key.

"People want to know that they're putting their health into somebody else's hands. And they want to know that they're getting the best treatment that's possible for them." (London depth, female, mental health condition)

Breach of trust was deemed most serious where linked to **dishonesty**. Here, the **intent** behind the breach in trust caused most concern for participants.

"If it is corruption or if it is stuff that they have lied about then I think that is a bit more serious because that is showing a character flaw." (London depth, male, visual impairment)

"Deliberate is more calculated whereas if you make a mistake…

…mistakes can happen."

(London group, 40-59 years, BC1)

Views regarding intent are further discussed in section 6.1.2.

Overall, views regarding severity of cases were consistent across participants. However, younger participants were most likely to spontaneously raise concerns around security of personal information and note that misuse of this would impact on trust in the professional.

"Things usually to do with healthcare are confidential. So if it has been exploited then that person might feel like they've been violated in terms of privacy." (London group, 18-24 years, C2DE)

Older participants were most likely to spontaneously mention misdiagnosis. Some had direct experience of this within their family and again felt that it damaged the trust between patients and professionals.

5.1 Vulnerability

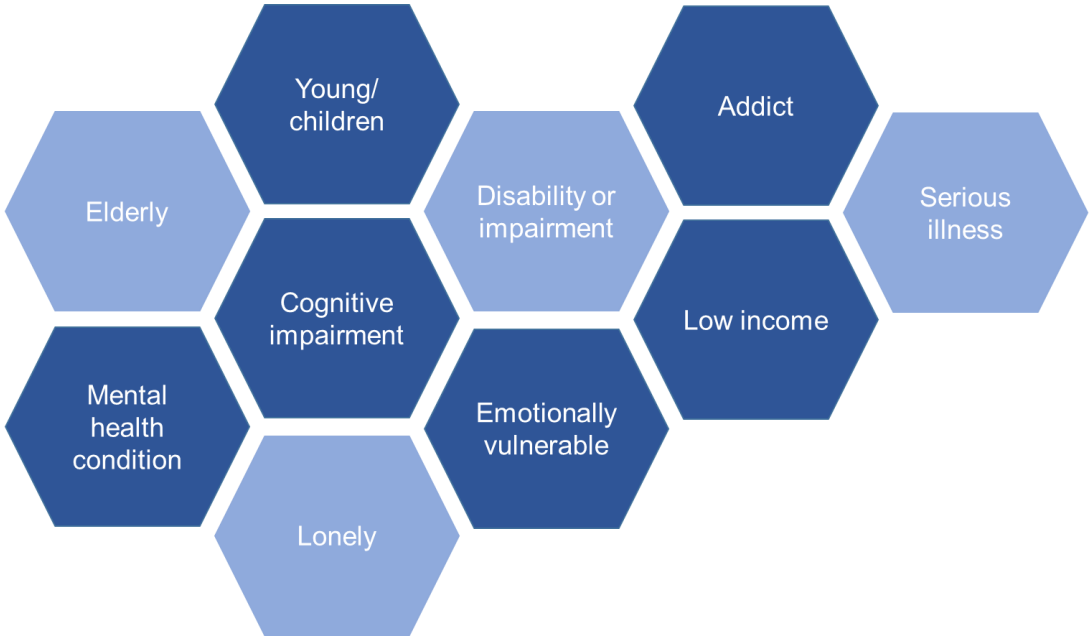
Exploiting a vulnerable person consistently emerged as one of the more serious types of case listed.

> *"Exploiting a vulnerable person, I think that's got to be one of the big ones." (London depth, male, long-term condition)*

Some participants noted that anybody could be vulnerable when seeking help from a healthcare professional because they were placing their trust in the healthcare professional.

> *"Anybody can be vulnerable, anybody. Even me. I mean it's how you trust people." (London depth, male, long-term condition)*

However most thought about the following groups when thinking about vulnerable people:



Participants agreed that deliberate exploitation of a vulnerable person was particularly concerning and compounded the severity of the case in question.

> *"I think it's worse if a professional takes advantage of a vulnerable person as they know the situation and are doing it anyway." (Glasgow group, 18-24 years, BC1)*

"I think it makes a difference if the person is vulnerable. To exploit – they know these people are weak and I think that's horrible." (Glasgow depth, female, hearing impairment)

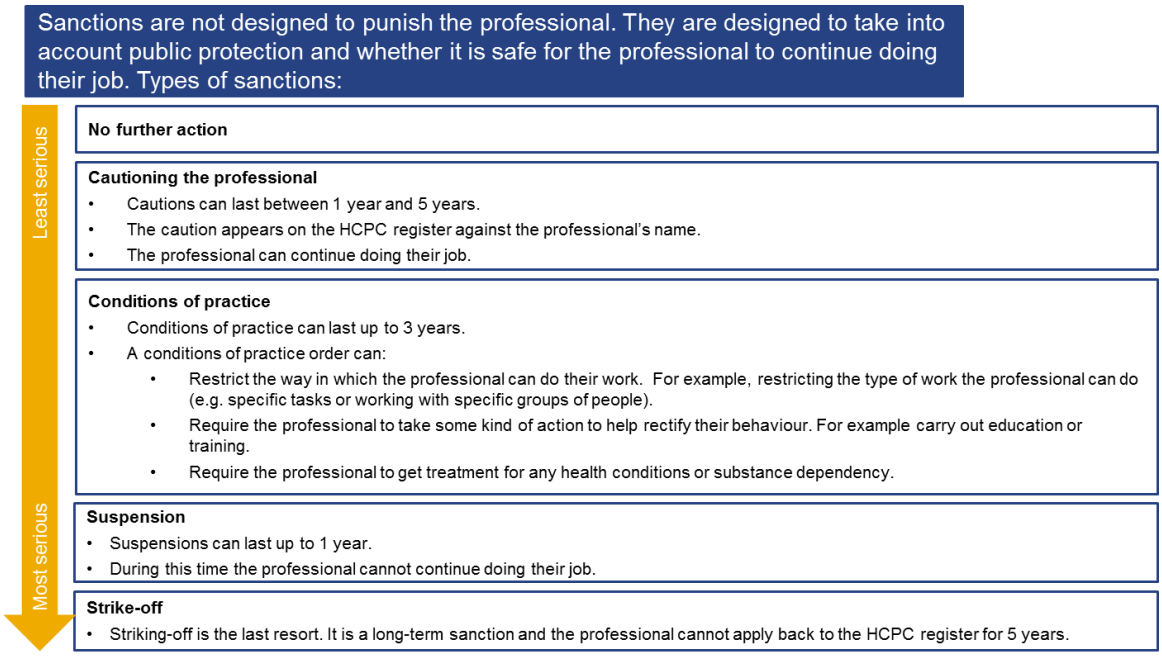
Again, the key focus for participants was the professionals' abuse of trust.

"I guess it is a bigger breach of trust." (London depth, male, visual impairment)

"I think like vulnerable people that go to these kinds of people for that support and if you are abusing that, then it's not fair." (London group, 18-24 years, C2DE)

6 Range of sanctions available to panels

Participants were shown a list of typical sanctions available to the panel:



Participants agreed that there needed to be a range of sanctions available to the panel to reflect different types of cases, the severity of different cases and the specific circumstances relating to each case they reviewed.

> *"It depends how serious it is in the first place. Maybe theft or sexual abuse are different levels." (Glasgow group, 60+ years, C2DE)*
>
> *"Sanctions should depend on how long this has been going on, how experienced they are, how serious the case is." (Belfast depth, female, 75+ years, long-term condition)*

Whilst participants felt that sanctions should be tailored and chosen to reflect each individual case, there were some broad areas where they felt there was a clear match between case type and sanction imposed.

The first obvious area for participants focused on the most serious and severe cases. Being struck off the HCPC register was considered the appropriate sanction for cases that involved child pornography, sexual misconduct, abuse and violent behaviour towards a patient.

"I think sexual misconduct, child porn, threatening behaviour, violent misconduct – anything that would hurt someone, should be instant dismissal." (Glasgow depth, female, hearing impairment)

"If you are violent to a patient, there's no comeback from that. You shouldn't be working with the public if you are violent." (Cardiff group, 25-39 years, BC1)

"Child pornography…there is no fixing that. You can go on as many courses as you want but there is no fixing that." (London group, 40-59 years, BC1)

There was very little discussion around any mitigating factors that might change the sanction imposed for these types of cases. Participants struggled to identify any factors that could mitigate the serious nature of these cases.

The second obvious area for participants were cases where re-training was considered appropriate. Re-training was cited as the obvious sanction for cases of incompetence.

"I think it is also important for them if an incidence has occurred maybe to go back, retrain, bring their qualifications up to date and then show that he has done that…

…that would give you a little bit more confidence…that would give the public a little bit more confidence." (London group, 40-59 years, BC1)

However, there were mixed views about whether this training should be put in place as a condition of practice, or for completion during suspension. Some anticipated that training during a suspension would give the professional opportunity to demonstrate their keenness to return to work. Training during suspension was typically preferred by participants who felt less comfortable with the professional practising if there were clear areas requiring remediation. However others were more comfortable with the idea of training taking place as a condition of practice, with these participants noting that the professional could still carry out some tasks.

6.1 Queries about how sanctions are implemented

Participants had a number of queries about the implementation of sanctions.

For **cautions**, participants queried whether the professional would be monitored during this time. They anticipated that this would be the case.

"They can get cautioned for up to 5 years, does that mean they are actually keeping an eye on them? That's what I'd expect." (Glasgow group, 18-24 years, BC1)

When the sanction imposed was a **suspension**, participants were keen to know if the professional would be paid during this time – there was an expectation that they would not.

Participants anticipated that conditions of practice be put in place to support professionals in returning to work following a suspension.

"After the suspension when they go back I'd want those things [conditions of practice] to be implemented as well." (London depth, male, long-term condition)

"I wouldn't re-employ someone after they've been suspended for a year without some sort of rehab or some sort of training to help why they were suspended. So even though it says suspension i would have thought there would have been some training involved." (Cardiff group, 25-39 years, BC1)

Participants were often surprised that professionals could return to the profession after five years following being struck-off. Whilst many envisaged that in reality, few would seek to return, some felt that this sanction should be a lifetime sanction[6]. This view was strongly linked to participants anticipating that the most serious and severe of cases would result in being struck-off.

"If they're struck off they should be struck off. They don't come back." (Cardiff group, 40-59 years, C2DE)

"If it is something involving child pornography and it happened twenty years ago it should never be wiped off." (London group, 40-59 years, BC1)

There were also some queries regarding whether a health and care professional who was struck-off could re-train to a health profession regulated by a different regulator.

[6] It should be noted that there are stringent HCPC processes for considering any restoration applications as outlined here: http://www.hcpc-uk.co.uk/assets/documents/100047E5PN-Restoration(May2014review).pdf

Participants thought that it would be important that regulatory bodies worked together to share this type of information.

Participants also queried how collated information about fitness to practise hearings was used by the HCPC. There was widespread agreement across the research that panels should also be thinking about any indication of wider systemic issues at play and whether changes were needed at an organisational level.

> *"I feel like it seems to be the more senior members of staff are the ones that are having these issues so maybe they have got way too complacent thinking that they know everything in the workplace so are letting these things slide." (London group, 18-24 years, C2DE)*
>
> *"If it is happening often then obviously there is something wrong with the procedures before they get there so they need to look back at that and see how they can adjust that to support them." (London group, 18-24 years, C2DE)*

Participants were keen to know that more broadly patterns in cases were being monitored and looked into.

6.2 Level of agreement with panel imposed sanctions

Across the research, in most instances participants agreed with the sanctions that the panel had put in place for the case studies shown during the research sessions. Participants were keen to note that the decision-making process undertaken by panels appeared to be complex and many commented that they personally would not feel confident in determining sanctions without meeting the professional in question or learning much more detail about the cases under discussion[7].

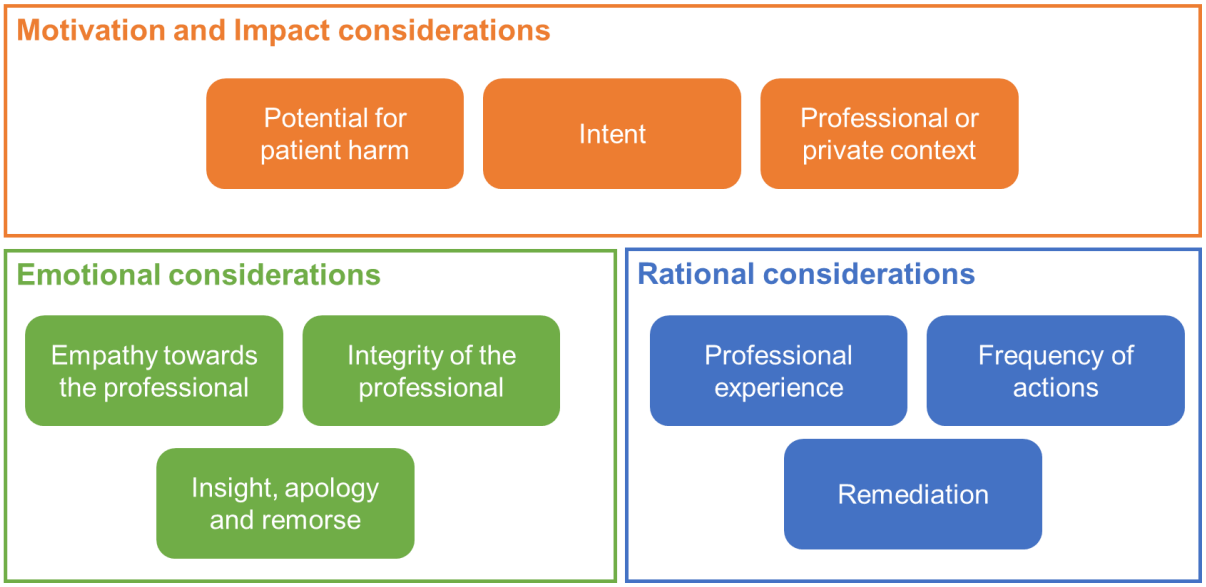
7 Mitigating and aggravating factors

Across the research, participants cited a range of mitigating and aggravating factors they anticipated would be taken into account when panels were deciding the appropriate sanction for any case. Consideration of these different factors further cemented

[7] It should be noted that panels would have detailed case information for each case, and professionals are invited to attend the hearing although are not obliged to attend.

participants' belief that each case heard by a fitness to practise panel should be treated individually.

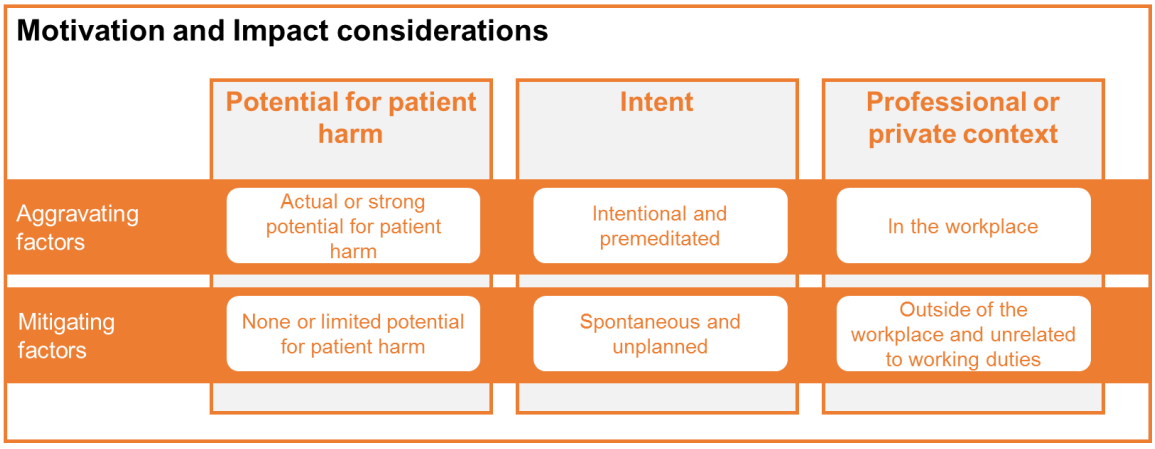
The mitigating and aggravating factors generated fell into three broad groups of considerations:



Each of these groups of considerations is discussed in the remainder of this chapter.

7.1 Motivation and Impact considerations

The diagram below shows the key aggravating and mitigating factors within this group of considerations.



The aggravating factors within the group of considerations were felt to be the most serious aggravating factors across the research. Where a combination of these aggravating factors

were found, participants envisaged that the case would be very serious indeed. For example, if a case was found to be intentional, resulted in actual patient harm and to have taken place in the workplace, participants often struggled to see how any mitigating factors could reduce the severity of what had happened.

7.1.1 Potential for patient harm

Impact on patient was of key importance for participants.

Participants tended to think about two aspects of patient impact as discussed below.

1. Was a patient harmed?

Participants agreed that negative impact on a patient was an aggravating factor for any case. Whilst participants were clear that imposing sanctions was not intended to act as punishment, they strongly felt that the degree of patient impact should be a key factor considered by the panel in considering any risk in the professional continuing to practice.

> *"Even though what we might think being dishonest is not that bad, it's how it has affected the patient. Something that could otherwise be quite minor could be huge in its effect on a patient." (Cardiff group, 25-39 years, BC1)*

This was particularly the case for cases where the patient involved was vulnerable.

> *"But if somebody had done something to children it would be very hard to get mitigation in there." (Glasgow group, 60+ years, C2DE)*
>
> *"Committed fraud seems so-so but if you're talking about a 90 year old patient with dementia and you take their credit cards, that's terrible." (Cardiff group, 25-39 years, BC1)*

2. Was there potential for patient harm?

Even where a case did not involve actual harm to a patient, participants considered whether there had been any risk of harm. Where this was the case, this acted as an aggravating factor, with participants questioning whether this professional was safe to continue practising.

Example: Case study 5 – Biomedical scientist who failed to report to a Consultant abnormalities in blood samples that indicated possible acute leukemia

Whilst this case study did not report any harm to patients, participants were concerned that the potential for serious patient harm had been present in the professional's behaviour. This acted as an aggravating factor for participants, who felt that this case was serious.

"It is like a massive impact on that person's life and it could be between life and death and that was in his hands." (London group, 18-24 years, C2DE)

Example: Case study 6 – Radiographer carrying out screening procedures without being registered to do so with the Care Quality Commission

Whilst this case study did not report any harm to patients, participants were concerned that the professional had knowingly carried out screening procedures without the required registration. This acted as an aggravating factor for participants who felt that the professional's lack of registration could have led to patient harm, and could happen again.

"My concern is he is going to do this again because he is clearly not bothered about patient safety." (London depth, male, visual impairment)

7.1.2 Intent

Participants reacted more strongly about cases where they felt the professional's action had been intentional and planned. Deliberate and premeditated behaviour was clearly an aggravating factor whilst no intent suggested that the action was a mistake, and therefore potentially less concerning.

Some participants considered cases where a professional may carry out a serious action (e.g. violence) as a reaction to a situation (e.g. self-defence). In these situations, participants felt that it would be important for the panel to take into account the circumstances, considering whether the action was spontaneous and reactive rather than premeditated.

"It is really difficult [to decide what sanction should be imposed for]…being violent, that could be a suspension, but…say he got punched on a night out and then you know, he stuck up for himself." (London group, 40-59 years, BC1)

7.1.3 Professional or private context

Whether a case under investigation had taken place at work or outside of work emerged as an important factor for consideration amongst participants. There was agreement that if the professional's actions took place outside of work, and was unrelated to their employment then it was likely to lessen the severity of the case.

Example: Case study 1 – Operating Department Practitioner convicted for driving a car under the influence of alcohol following a family celebration

Participants felt that the conviction for drink driving had occurred outside of the working environment, and had not affected the professional's ability to do their job. Further details of the case detailed that the professional had self-reported the incident to the HCPC, had shown remorse, completed a drink driving course and provided character references that their behaviour had been out of character. With these additional factors in mind, participants felt the fact that this had happened outside of work made it something related to private life rather than working life.

"I think it sounds like he just made a human error unrelated to his job. I don't think there should be further action." (Glasgow group, 18-24 years, BC1)

There was some debate regarding the line between private life and professional life and the point at which the HCPC should take action. Most participants agreed that if the incident took place outside of work, did not harm anybody, did not directly relate to working duties and did not suggest a wider or deeper concern then no action was needed.

"I agree with the panel that unless his job involved driving, like being an ambulance driver, then his offence was unrelated to his job duties. Even though he made a bad decision in his personal life – I don't think that had anything to do with this…I don't understand why the council has the right to condone or to determine what happens in his personal life. If

he shows up to work with shaky hands because he's drinking every day then that is affecting his on the job performance and that should be questioned. But what happens outside… I'm not minimising the danger of drink driving." (Cardiff group, 25-39 years, BC1)

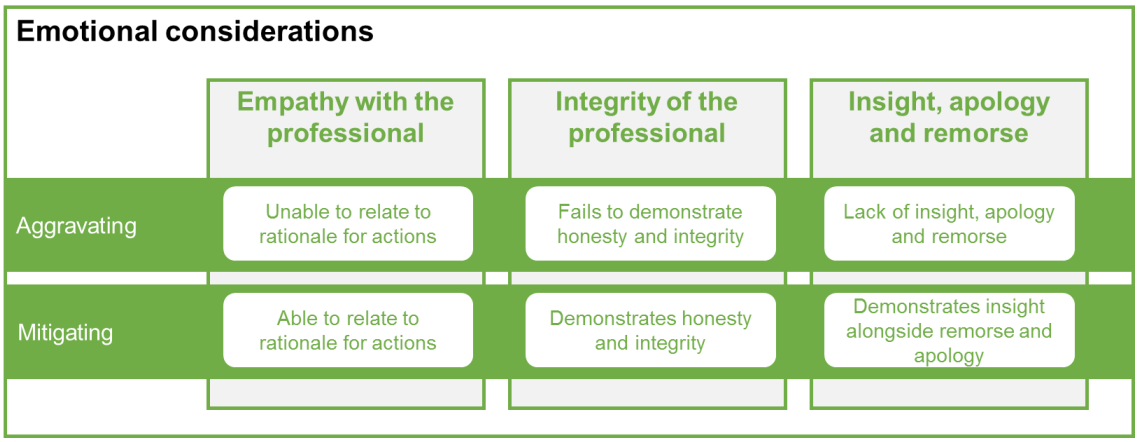
However, a couple of participants did reflect that despite being outside of the work environment, the behaviour of the professional could damage the image of the profession. They felt that this should be reflected in the panel decision.

"It does bring his profession into disrepute." (Cardiff group, 40-59 years, C2DE)

This type of comment was most likely to be made by those who themselves worked in 'role model' professions such as teaching and were therefore more conscious about public reaction to conduct or behaviour in a professional's private life.

7.2 Emotional considerations

The diagram below shows the key aggravating and mitigating factors within this group of considerations.



Participants were quick to respond to cases from an emotional viewpoint. However, there were mixed views across participants regarding the role that these more emotional factors should play in reaching a decision about imposing a sanction. This was particularly the case when participants reflected that these aggravating and mitigating factors were not measurable, and were therefore subjective.

7.2.1 Empathy with the professional

Participants often put themselves in the position of the professional and considered the rationale for their behaviour.

> *"It depends how they can sort of back themselves up really, like say what their reason was." (London group, 18-24 years, C2DE)*

In some instances, this led to empathy towards the professional. This reaction tended to act as a mitigator, with participants expressing some tolerance for situations where they could understand why the professional may have taken the action they did.

Example: Case study 3 – Occupational Therapist who worked as an agency worker whilst on sick leave from her employer citing financial difficulties

Participants tended to be sympathetic about the financial difficulties that this professional was facing, and as a result tended to focus on this aspect of the case study. Their emotional reaction to her situation generated some leniency in their views.

> *"I hate dishonesty but she did that for a reason…she maybe had bills to pay and she didn't have any money." (London, depth, 75+)*

Some participants also considered the professional's work environment, wondering whether their actions were a result of being over-worked or under-supported. These views typically emerged from participants who themselves had experienced difficult working environments and were reinforced by those who mentioned reading media articles about the NHS being over-stretched.

7.2.2 Integrity of the professional

The integrity of the professional was clearly of importance to participants who talked about the following aspects of a professional's behaviour:

- Honesty
- Professionalism
- Attending the hearing

7.2.2.1 Honesty

Participants talked about the importance of professionals being genuine and honest.

> *"I think if you're honest about it, I think people tend to, I mean prefer honesty don't they?" (London depth, female, mental health condition)*

They felt that honesty indicated the character of the individual, which in turn would support the panel in determining an appropriate sanction.

Example: Case study 1 – Operating Department Practitioner convicted for driving a car under the influence of alcohol following a family celebration

Participants noted that this professional had proactively informed the HCPC of what had happened shortly after the incident had taken place. Alongside remorse and demonstrating remediation (attending a drink driving course) participants clearly felt that the professional had integrity, and felt that this should be reflected by the panel in their decision-making.

> *"Staying at the scene and taking all the right steps afterwards shows he's a decent guy." (Glasgow group, 18-24 years, BC1)*
>
> *"[He] was honest. 100%. And took responsibility for his actions. That's the most important thing." (London depth, male, 75+ years, long-term condition)*

There was some discussion about the extent to which honesty should act as a mitigating factor. Whilst participants agreed that it was a positive demonstration of the character of the professional, they agreed that it could not play a role in offsetting serious cases (e.g. those that deliberately caused patient harm).

> *"If he was professional then he shouldn't have done it in the first place. Being open and honest after doesn't make a difference." (Cardiff group, 40-59 years, C2DE)*

7.2.2.2 Professionalism

Participants also queried the integrity of the professional where they felt that the case in question involved a direct breach of the key principles of the job role. Participants felt that

this showed a lack of understanding of their job role, and therefore could be at risk of repeating the behaviour in the future.

Example: Case study 2 – Social Worker who posted details of a case on social media

The over-riding concern about this case was the breach of trust between the patient and professional. However, the underlying issue was that this case involved the principle of confidentiality, which was understood to be a core principle of the social worker job.

"That is one of the main factors of that job, is not to talk about other people's personal lives and she broadcasted it over social media." (Belfast group, 25-39 years, C2DE)

Participants expressed wider concerns that a lax approach to confidentiality of patient information could raise queries about other ways in which the professional was treating patient information.

"I'd worry about confidentiality because if she was so, she felt it was okay to post it on social media, what else is she sharing elsewhere?" (London group, 18-24 years, C2DE)

Example: Case study 3 - Occupational Therapist who worked as an agency worker whilst on sick leave from their employer citing financial difficulties

Participants noted that the professional in this case had demonstrated a behaviour that went against the advice and support that she endorsed to her patients.

Participants queried how patients could be confident in the occupational therapist's work if she was not willing to adhere to key principles of her profession.

7.2.2.3 Attending the hearing

Whether a professional attended their hearing was something that participants took seriously. They felt that the hearing was an opportunity for the professional to give their viewpoint and verbalise their case alongside expressing apology and remorse. The face-

to-face setting of the hearing was considered key in supporting the panel in determining whether the professional was genuine.

> *"Most of the time you can tell when someone is genuine unless they are a really good actor." (Cardiff group, 40-59 years, C2DE)*

Where professionals did not attend their hearing, participants felt that they were demonstrating lack of interest in their job and had therefore missed an opportunity to show willingness to remediate.

> *"I think you should turn up in person. It is like you care about your job and you want to hold on to it. There is no point sending a letter in." (Belfast group, 25-39 years, C2DE)*

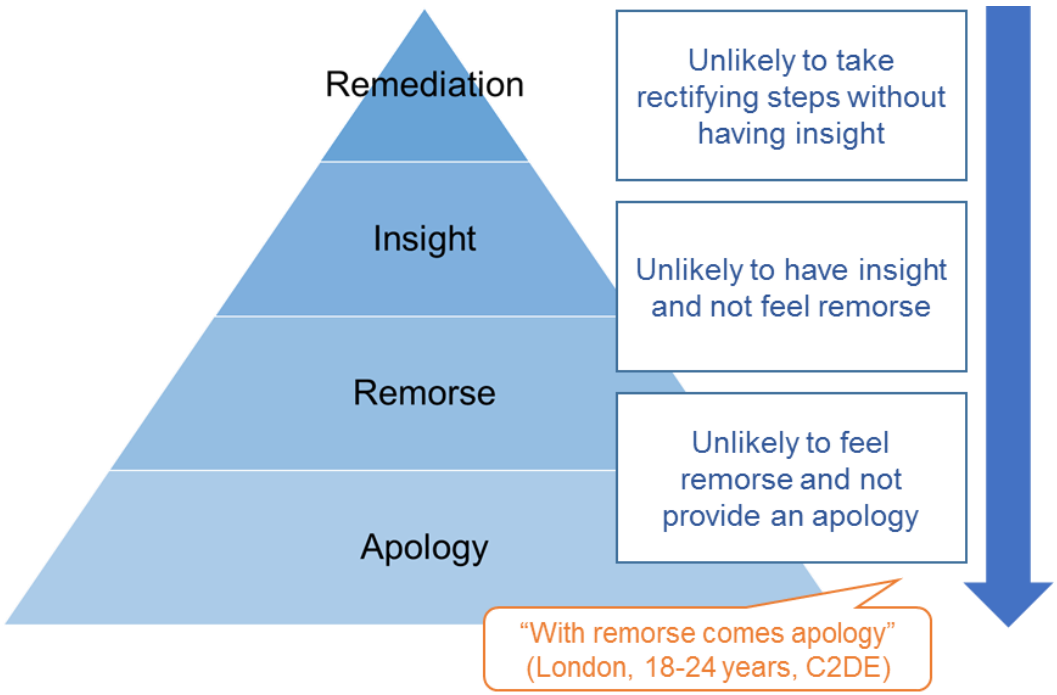
Example: Case study 7 – Hearing Aid Dispenser who failed to keep proper records, demonstrating poor clinical practice

Participants noted that this professional did not attend their hearing. They felt that alongside poor clinical management, this suggested that they were simply not interested in their job. Lack of attendance at the hearing was considered to be an aggravating factor for this case.

> *"Well if she couldn't be bothered turning up for the hearing I would suspend her…if she had sort of turned up and said look I am sorry, I was willing to take some kind of training and that but she didn't seem prepared to do that even." (London depth, female, mental health condition)*

7.2.3 Insight, apology and remorse

Participants reflected that insight, apology, remorse and remediation were closely linked and it was difficult to isolate the specificities of each. However, a hierarchy emerged as shown in the diagram below.



In most cases participants expected the professional to demonstrate at least one of these as a natural response to having done something wrong.

> *"Insight and remorse need to be shown. You need to be genuinely sorry for what you've done." (Cardiff group, 40-59 years, C2DE)*

However, with some scepticism that professionals could simply 'say the right thing' rather than genuinely mean these things, many participants placed a greater emphasis on the role of remediation as an action that could be more easily measured.

> *"They could have the model answers…I guess you need evidence in a way to see that in place; actions speak louder than words" (London depth, male, visual impairment)*

There was also some debate amongst participants about when apology, insight and remorse would act as mitigating factors, and when they should simply not be taken into account. Participants felt that they should not be taken into account for the most serious and severe cases that involved intent and patient harm.

> *"It would have to depend on the actual complaint to be honest. Because if someone was sexually abused or something and they said I am sorry I shouldn't have done it, then I*

wouldn't care [about the apology], that shouldn't come into it at all." (Belfast group, 25-39 years, C2DE)

7.2.3.1 Apology

Participants expected that professionals would want to apologise for their behaviour, and where they did not they wondered whether professionals had really understood that what they had done was wrong.

However, there was widespread scepticism about the value that panels could place on an apology in isolation. Participants were quick to note that apologies were not always genuine or sincere.

"How do you know if it's a genuine apology?" (London depth, male, 75+ years, long-term condition)

Participants felt that the panel would be best placed to determine whether an apology was genuine by speaking to the professional face-to-face. This meant that participants felt that it was important for professionals to attend their hearing. Views regarding this are further discussed in section 6.2.2.3.

With scepticism about genuine apologies, participants felt that the panel could corroborate an apology by taking into account whether the professional also demonstrated remorse, insight and remediation.

"Actions speak louder than words though; you can apologise but you have got to mean it and you have got to show it." (London group, 18-24 years, C2DE)

7.2.3.2 Remorse

Participants felt that it was important that professionals showed remorse and expected this to be a natural response to having done something wrong.

"I think it is a natural response for any,. you know, sort of good human being to show remorse." (London group, 40-59 years, BC1)

Mentions of recent media coverage of the case of cyclist Charlie Alliston[8] shed some light on why participants felt that remorse was important.

> *"When the cyclist killed that woman, the judge said he had a lack of care as there was no remorse or care for it. That was the most shocking thing about it." (Cardiff group, 40-59 years, C2DE)*
>
> *"There's a fellow in London, fixed wheel bike, knocked a woman down, didn't seem to give a fiddlers…I'd bet every penny I have in the bank he'll be back on those bikes. He showed no remorse." (Belfast group, 60+ years, BC1)*

One clear role for remorse was in reassuring the public that the professional had understood that what they had done was wrong and being able to express this emotionally. This demonstrated that they cared about the impact of what they had done.

> *"Remorse is being sorry. Realising what they've done. Apology is saying you're sorry to professionals, work colleagues and the person, your patients. Empathy is understanding where they're coming from and wanting to help the person that's been treated badly." (Glasgow depth, female, hearing impairment)*
>
> *"Being sorry and saying sorry is the difference between remorse and apology." (Cardiff group, 40-59 years, C2DE)*

Another clear role for remorse demonstrated in the quote below was the link that participants made between being remorseful and therefore being unlikely to repeat the behaviour.

> *"If you are remorseful you are less likely to do it again." (Cardiff group, 40-59 years, C2DE)*

The link between remorse and likelihood of repeat behaviour emerged as particularly important for the following case study:

[8] http://www.bbc.co.uk/news/uk-england-41028321

Example: Case study 4 – Operating Department Practitioner caught for stealing a morphine based drug and using this at work on two occasions

Whilst this professional admitted what they had done, they did not show genuine regret or remorse. Participants across the research felt strongly about this and questioned whether without remorse he would be at risk of repeating the behaviour.

> *"Doesn't show any regret for what he's done, that indicates he will do it again," (Glasgow group, 18-24 years, BC1)*

A few participants showed some empathy with the professional given the short time frame between the incident and the hearing, and expressing concern regarding the motivations for his drug use. However, most felt that the lack of remorse only compounded the serious nature of the case.

> *"It is kind of like a hopeless case if he is not willing to admit that he had done wrong so just get rid of him to be honest." (London group, 18-24 years, C2DE)*

However, as with all emotional responses expressed by professionals, participants expressed some cynicism about whether professionals would simply 'say the right things' when it came to expressing remorse.

> *"If he's really sorry maybe there's a chance it will not happen again. People get up in court all the time and express remorse but you know they don't mean it." (Glasgow group, 60+ years, C2DE)*

7.2.3.3 Insight

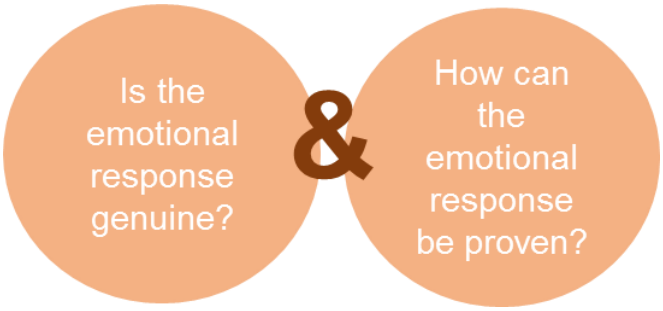
Most participants were not familiar with the term 'insight' suggesting that it is not used in day-to-day life. Some suggested that 'reflection' was a better term that would be more widely understood.

However, across the research, professionals recognising and understanding what they had done wrong and why it was wrong was considered very important.

"I think it's [insight] very important because it shows that the person accused is taking some responsibility and has reflected on the impact that it's had not only on his career or her career but the public as well, and the profession." (London depth, female, mental health condition)

7.2.4 Taking into account subjective emotions

Overall, participants expressed concern regarding the value that could be placed in the professional's emotional response to their behaviour. Two broad areas of concern were raised:



Some participants expressed scepticism and queried whether the panel could trust that the professional was genuine.

"It's just saying sorry, it might just be what someone wants to hear, it might not be how someone feels. You might not really mean it but you do it because it seems the right thing to do, but you might not have learned anything from it or will change your behaviour." (London depth, female, 75+ years, long-term condition)

Other participants reflected that some people were simply better at expressing emotions than others.

"Someone might be genuine but they just can't express themselves emotionally." (London group, 40-59 years, BC1)

A couple of participants also queried whether professionals should have an emotional attachment to patients and therefore whether it was right to expect an emotional response in this context.

"I don't think remorse is important because you shouldn't have any emotional attachment to your patient." (Glasgow group, 18-24 years, BC1)

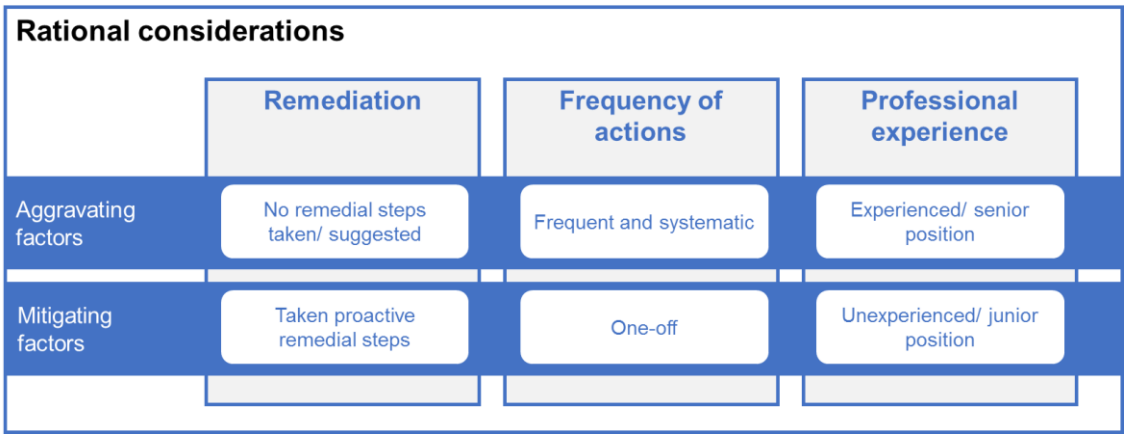
With this scepticism in mind, some participants queried whether there could be a more empirical way to look at the professional's response to what they had done.

"There should be some sort of measure, something that you can quantify because everybody will be remorseful." (London group, 40-59 years, BC1)

Remediation was often considered a more empirical way to look at emotional responses. This is therefore covered in the following section, exploring rational considerations.

7.3 Rational considerations

The diagram below shows the key aggravating and mitigating factors within this group of considerations.



Rational considerations were identified as key aggravating or mitigating factors that were measurable. With this in mind, it was clear that participants felt that they could be confidently used by the panel to help guide their decision making process.

7.3.1 Remediation

Whilst not a term that participants were familiar with, participants agreed that remediation involved taking steps to rectify a behaviour.

"It's important that they accept that they have messed up…and are going on to do something to remedy that." (Belfast group, 60+ years, BC1)

Participants felt that insight and remorse was an important part of a professional demonstrating that they had understood what they had done and reflected on this. They felt that remediation went beyond this, providing some evidence that the professional was keen to remedy their deficiencies.

"You can say you're sorry but do you mean it? Without showing that you have went on and tried to correct your behaviour." (Belfast group, 60+ years, BC1)

Some felt that remediation provided the panel with a measurable outcome which would help the panel determine genuine insight and remorse. They felt that an apology could simply be 'words' that the professional felt they had to say and provided demonstrable evidence of a desire to reflect on what had happened and remedy this.

"As long as they back up the apology with some type of, I am prepared to do this training or I am prepared to do that." (London depth, female, mental health condition)

Participants specifically felt that proactive remediation was a strong mitigating factor. They felt that if the professional had personally sought remediation or was proactively suggesting a course of remediation, this demonstrated insight and a desire to return to practice.

"It shows a quality in themselves if they are actually able to fix the situation after doing something wrong." (Glasgow group, 18-24 years, BC1)

Participants felt that panels should take into account where a professional had taken remediation steps as a key indicator of insight and willingness to change to continue practising.

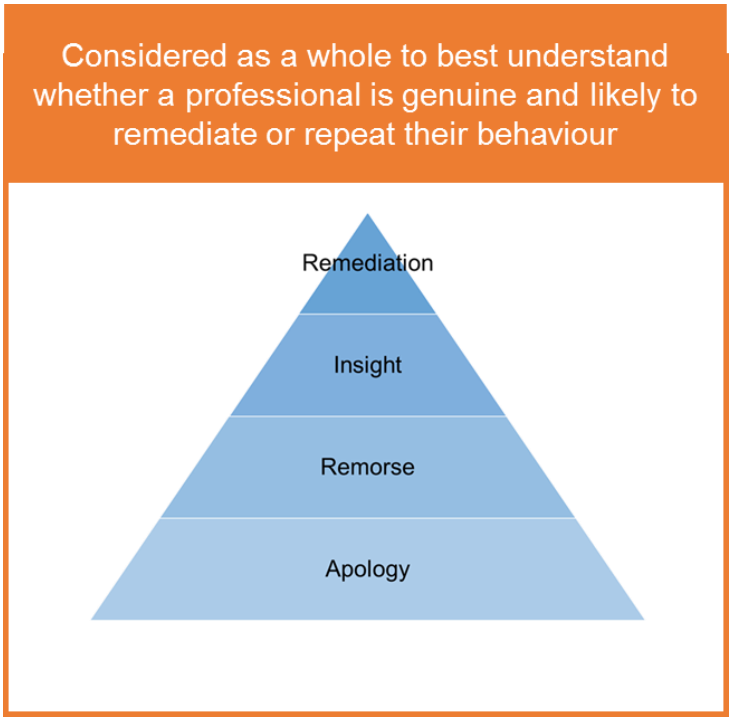
"It should be taken into account that they have tried to fix the problem so it doesn't happen again." (London depth, male, long-term condition)

A few participants were keen to note that it would be important for the panel to determine that remediation had been undertaken based on genuine insight and desire to rectify

behaviour. These participants were sceptical that professionals might simply agree to, or take, remedial steps as a way to lessen any sanction that the panel might impose.

> *"If you're going to do X,Y and Z and it will help you and you will look better, you are going to go and do it, it doesn't mean you're sorry." (Cardiff group, 25-39 years, BC1)*

Overall, participants tended to agree that insight, apology and remorse alongside remediation would help the panel determine which professionals were genuine:



7.3.2 Frequency of actions

Participants agreed that the number of times that an action had happened could make a case more or less serious. Participants felt that if something had only happened once, the panel could be more lenient in its decision making process.

> *"If it was the first time you could be a bit more lenient." (Glasgow group, 18-24 years, BC1)*

There were three main reasons participants considered repeat behaviours more serious. Firstly, the fact that the incident had happened more than once was a concern.

"If this professional has, you know, has a lot of incidents and there is a pattern then you look at the case in a totally different way than you would somebody who has been in the profession all their life and just one incident." (London group, 40-59 years, BC1)

Secondly, the fact that the professional had not recognised that their behaviour was wrong between incidents and could be at risk of repeating the behaviour in the future.

"If it is something they have consistently done then I feel they have obviously not got enough remorse not to do it again." (London depth, male, visual impairment)

Thirdly, participants felt that the professional was probably hiding what they had done over time, which introduced a layer of dishonesty to the case. This led to concerns that the behaviour could have escalated to something bigger, posing risk to patient harm.

"I think…if you are hiding your mistakes, this could result in like a bigger issue, even though it might be something minor to start. It could result in something worse." (London group, 18-24 years, C2DE)

There was some discussion amongst participants regarding how long ago cases that came before the fitness to practise panel may have occurred. Some felt that demonstration of positive working practices and behaviours since the incident had occurred could help mitigate the case by showing that the individual had since improved or revised their behaviour and actions.

Example: Case study 3 – Occupational Therapist who worked as an agency worker whilst on sick leave from their employer citing financial difficulties

This case had come to light two years after the professional had carried out the agency work whilst on sick leave from their employer. Some noted that their good record since this time helped to demonstrate that they had realised what they had done and addressed this.

"It took place 2 years ago so I presume she's been working fine since. That makes it better." (Cardiff group, 40-59 years, C2DE)

7.3.3 Professional experience

The experience and/ or seniority of a professional could act as a mitigating or aggravating factor particularly when considering cases that involved making mistakes. Participants felt that more experienced or senior professionals should not be making mistakes and therefore, their experience would act as an aggravating factor.

> *"They are still learning but somebody who has worked their way up and is near retirement age they should be making sure they're not making a mistake." (Belfast depth, female, 75+ years, long-term condition)*

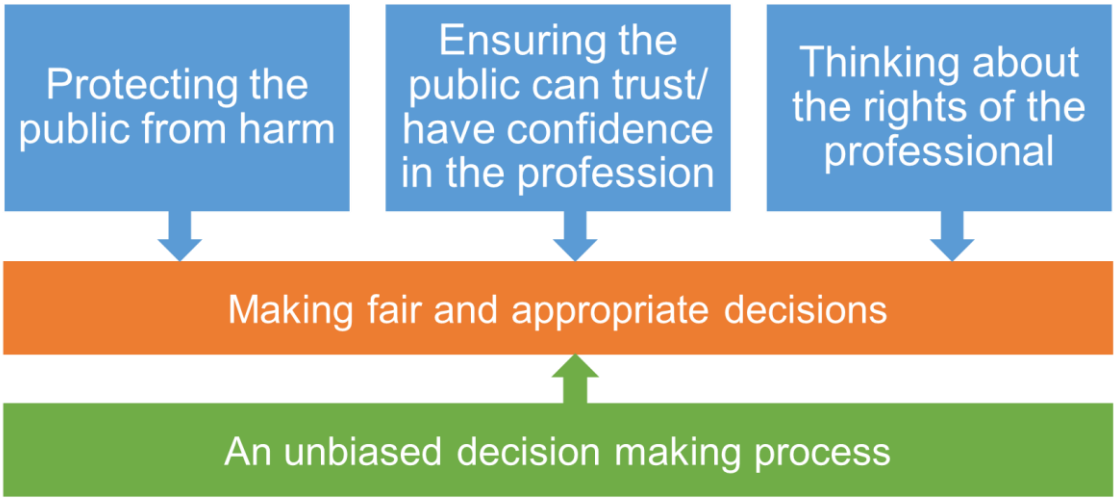
However, if someone was more junior, younger or less experienced, participants tended to be more lenient.

> *"I think if it wasn't intentional and maybe they are starting out in their career and they are not really too familiar with what they are doing then they shouldn't really be like struck off straightaway. They should get a few more chances." (London group, 18-24 years, C2DE)*

8 Views on the principles of proportionality

Participants were asked for their views on the principles of proportionality detailed in the Indicative Sanctions Policy, and were given the information shown below.

Most participants struggled to imagine how panels might go about actually deciding on a sanction. They were aware that there were many factors to be taken into account and anticipated that this was a very difficult process and decision to reach. However, some participants did query whether the panel would start with the most serious sanction and work back based on mitigating factors, or start at the least serious sanction and work their way down the list. It should be noted that this did not emerge as a key finding across the research. Most participants focused on the principles summarised in the following diagram.



These principles are discussed in full below.

8.1 Unbiased decision-making process

Participants were keen to note that the decision-making process should be unbiased. A key part of this was ensuring that the panel members were able to think open-mindedly. Participants also talked about the importance of thinking about the case from a neutral viewpoint. With this in mind, participants often raised questions about who made up the panel and whether this make-up was biased in any way[9].

> *"Not to be biased towards the professional because if it is someone from their own profession, they might be like, oh well, I kind of can see their point of view." (London group, 18-24 years, C2DE)*

Participants felt that the panel should include a range of viewpoints. The make-up of the panel is further discussed in the following chapter.

8.2 Making fair and appropriate decisions

Participants talked about panels making **fair** and **appropriate** decisions. Participants specifically considered the diversity of cases that the panel would deliberate, and strongly

[9] All panel members go through a comprehensive recruitment process which assesses their decision-making abilities. They also receive detailed training when they first become panel members. The training lasts two days. They receive refresher training every two years.

felt that sanctions should be determined on a **fair** basis. With this in mind they felt that it was important that there was no 'blanket approach' to imposing sanctions.

> *"People are allowed to make mistakes. We can't be living in an age where you make a mistake and that's it. There's so many different circumstances and I like to think if I ever made a mistake my employer would look at all circumstances and give me a chance as it's a mistake". (Cardiff group, 25-39 years, BC1)*
>
> *"I think the decision they come to has to be spot on but they can deviate from a set thing because at the end of the day every decision is on its own." (London group, 40-59 years, BC1)*

Although participants anticipated that the panel would look at previous similar cases to ensure some level of consistency, they did not expect panels to use prescriptive guidelines.

> *"Each scenario has to be looked at, you know, with its own sort of merit and circumstances and make an informed…decision." (London group, 40-59 years, BC1)*

Participants felt that making fair decisions needed to balance the public and the professional viewpoint. Participants tended to think first and foremost about the severity of the case and what would need to be put in place to protect the public from harm as well as ensure public trust and confidence in the profession.

> *"The public have the right to be protected more than [registrants] have the right to practise." (Cardiff group, 25-39 years, BC1)*
>
> *"It depends what they've done. Public protection is more important than their rights if they've done sexual misconduct." (Cardiff group, 40-59 years, C2DE)*

Once these principles had been considered, participants felt that it was important to reach a fair decision that would allow the professional to continue, or be supported back to practice where appropriate (e.g., where the appropriate sanction to achieve public protection and trust was not strike-off).

"I'd say the welfare of the public first and foremost. Then when it comes to dealing with the guilty person, fairness." (Belfast group, 60+ years, BC1)

Participants also felt that the panel should take into account the wider value in enabling and supporting a professional to return to work.

"There's a lot of money invested in people and you just don't bin it unless it's serious." (Belfast group, 60+ years, BC1)

8.3 Protecting the public from harm

Participants interpreted achieving public protection to mean safeguarding against the same thing happening again.

"Public protection but also ensuring that those things don't happen again within whatever field it was in, that it doesn't occur again even with the same person or with others." (London group, 18-24 years, C2DE)

This was of paramount importance to participants who felt that this principle should be at the heart of any decision made by the panel. This was particularly important for cases that had involved patient harm or potential patient harm.

"I think public protection is key. Over the professional protection…. You need to reduce that risk before you can go back to public service." (Cardiff group, 25-39 years, BC1)

8.4 Ensuring the public can trust/ have confidence in the profession

Participants reflected that achieving public protection would in turn ensure that the public could be confident in the profession, and therefore most struggled to distinguish these two principles.

"Because achieving public protection eventually results in allowing the public to be confident in the profession so in a sense they work hand in hand." (London group, 18-24 years, C2DE)

Participants strongly agreed that it was important that the public could be confident in the profession. However, this was often interpreted as feeling that they were able to trust the profession.

> *"I think the most [important principle] is making sure the public can be confident in the profession…you've got to be confident that they are trustworthy, honest you know." (London depth, male, long-term condition)*

Again, trust was of paramount importance when participants were thinking about cases that had involved patient harm. In these types of cases they were often specifically thinking about the principle of making sure that the individual professional was safe to continue practising.

> *"They are the professional; you are the patient, so you are putting your life in their hand essentially. So you are expecting them to know what to do." (London group, 40-59 years, BC1)*

However, others thought more broadly about confidence in the profession, thinking about the impact that cases could have on public opinion.

> *"The way the NHS is at the moment, public opinion is really vital. So you want to make sure if there has been wrong doing that is shown that some action has been taken about it." (Glasgow depth, female, hearing impairment)*

8.5 Thinking about the rights of the professional

Participants agreed that the balance of any decision-making done by the panel should heavily focus on protecting the public from harm, and ensuring trust between patients and professionals. This was particularly the case for the more serious cases.

However, there was more debate across participants when thinking about the rights of the professional, participants often considered whether the case involved something unrelated to work, outside of the work environment and did not involve harm to an individual or intent.

Example: Case study 1 – Operating Department Practitioner convicted for driving a car under the influence of alcohol following a family celebration

Not all participants were convinced that this case needed to go before the panel because the incident occurred in the professional's private life.

> *"I don't think my right of public protection means I have a right to publicly know because Bob crashed his car – I don't need to know about it. As long as it's dealt with. There should be a threshold where it becomes in the public interest to know about these situations." (Cardiff group, 25-39 years, BC1)*

However, others were less compassionate in their thinking suggesting that because health professionals are in the public eye, they should be more aware of their actions outside of work.

> *"I think he should be cautioned. I feel a medical professional or anyone in that industry should be…sharp with what they do. Even if they are coming from a family event, they need to be aware." (Glasgow group, 18-24 years, BC1)*

In addition to thinking about the rights of the professional outside of the working environment, participants across the research also thought about providing support to the professional. Participants felt that professionals had the right to access support although there were mixed views on how and when this should be provided.

Overall, participants expressed concern that the current decision making process did not take into account access to support and felt that there should be a structured way of making sure this was addressed.

> *"You either get nothing, support or shafted and punished. The things which are the most serious ones – the really bad ones, don't on that basis have any structured help." (Cardiff group, 25-39 years, BC1)*

Participants considered access to support as something that should be offered if appropriate regardless of sanction imposed (e.g. not just as a condition of practice).

"Whoever is in this needs to be mindful of their well-being and situation. Striking someone off straight away might leave them tight for cash and they would need to do something else or might get ill or have mental health issues. It's important to consider the person who committed the crime as well." (Cardiff group, 25-39 years, BC1)

Example: Case study 4 – Operating Department Practitioner caught for stealing a morphine based drug and using this at work on two occasions

Because this case involved drugs misuse, there were generally mixed views across participants depending on their own views on this issue. However, participants agreed that some kind of support would be important for this professional.

"But if you can support them through that then I guess it might lead to them cleaning up their act and being much more of a positive person in society." (London depth, male, visual impairment)

However, there was discussion about who would be responsible for paying for any support with a strong view that this should not be the taxpayer.

"My work won't pay for me to go on a drug rehab course. I don't want the NHS to be paying for some druggie to go on a course. I don't want my tax money to go to that." (Cardiff group, 25-39 years, BC1)

For less serious cases, participants felt that the panel should be making a decision about how best to support the professional back in to work; if this was possible whilst ensuring public protection, trust and confidence.

"The public need to be protected but also sometimes the person who has done the wrong offence, they're not maybe all bad, they've made a mistake. Okay, yes mistakes can be made, as we say, we've all made mistakes but if they're willing to correct it, I think everybody, well everybody deserves a second chance providing that the public is safe." (Belfast group, 60+ years, BC1)

Participants also felt that the impact on the professional should be carefully considered by the panel.

> *"When it comes to a situation like that where somebody could, it could ruin their life for the rest of their life." (London group, 40-59 years, BC1)*

9 Equality and diversity

Participants were prompted to consider the role of equality and diversity when it came to the panel making decisions. Participants agreed that all professionals should be treated equally and fairly.

> *"I would treat it as one, everybody should be treated the same. Shouldn't be any different, they should be all treated the same." (Belfast group, 25-39 years, C2DE)*

However, participants struggled to identify characteristics that they felt should be taken into account.

Participants were specifically asked for their views on how differences in cultural backgrounds could be taken into account.

Participants spontaneously considered the different qualifications that somebody from a different country might have. Participants agreed that any professionals regulated by the HCPC should be practising to the same professional standards regardless of their cultural background.

> *"I think depending on what they did, culture might come into it. But basically if they've been trained as a professional and are operating in this country I'd expect the standard to be set." (Glasgow depth, female, hearing impairment)*
>
> *"Different countries and cultural backgrounds could mean a less strict way of practice and possibly mistakes would not be mistakes in a person's own country." (Glasgow depth, male, mental health condition)*

When thinking more broadly about differences in cultural norms (not standards of practice) it was agreed that any cases that involved a misunderstanding based on cultural norms

and backgrounds should be resolved before they reached the stage of going to a fitness to practise hearing.

> *"If it's just a cultural thing I am sure it could be sorted out without any kind of serious sanctioning going on." (London depth, female, mental health condition)*

When prompted, participants recognised that people with different cultural norms and backgrounds may express themselves differently. There were different levels of tolerance towards the differences that cultural norms may present. Some participants simply felt that people should adapt to British norms.

> *"If they don't express that they're sorry, it seems like they don't care maybe. Especially to the British public…and you're working in the UK you can't just be ignorant to our culture." (London depth, male, long-term condition)*

Others reflected that despite differences in cultural expression it should still be possible for a professional to demonstrate honesty, integrity and anticipated that these factors would remain important across cultures.

Others suggested that remediation was something that could be determined regardless of cultural barriers.

> *"They will have to look at it from a more broader perspective to what it is that they might have done and how they are going to rectify it. Whether they don't apologise, they might still have an idea of how they might change." (London group, 18-24 years, C2DE)*

9.1 Make-up of the panel

Some participants further suggested that the panel should itself be diverse to reflect the diversity of health and care professions. This was particularly noted by London participants who spontaneously noted the diversity of England.

> *"I think in terms of having people from different cultures; because we live in England…but it is filled with different cultures already so that is why it is good to have a panel that has a variety of people from the public that we live amongst." (London group, 18-24 years, C2DE)*

In addition to diversity of the panel, participants suggested that the panel should be carefully chosen to include those with experience that would support them in making fair and appropriate decisions. This often resulted in participants suggesting that the panel include older people with more 'life experience'.

> *"I would say the younger the panel the harder it is for them to make judgements. The older, the more experienced and they can sense certain things…I think you've got to experience life." (London depth, male, 75+ years, long-term condition)*

Finally, participants were keen to note that those on the panel should not express any bias towards any individuals involved in a fitness to practise hearing, and should be open-minded.

> *"They shouldn't be biased whoever they have in front of them." (London depth, male, 75+ years, long-term condition)*

10 Conclusions

This research study has successfully explored the public's view on the principles underpinning the Indicative Sanctions Policy and has established opinions across a wide demographic. There were a number of key findings, which are set out below.

10.1 Types of cases participants considered to be serious

There was broad consensus from participants about the types of cases they viewed as being serious. They felt that the most serious cases are those involving child pornography, sexual misconduct, violence and abuse. They considered this to be particularly serious where there is a clear breach of trust between the patient and professional, particularly where that breach of trust is driven by an intentional act of dishonesty.

Vulnerability is also an area of particular concern amongst participants. They consider that exploitation of vulnerable patients is very serious, and that the involvement of a vulnerable patient in a case where concerns are raised is an aggravating factor. However, although participants recognise that vulnerability is most often associated with age and physical or mental health, they highlight that any patient seeking help regarding health or care could be considered to be vulnerable.

10.2 Range of sanctions available to panels

Participants voiced strong agreement that sanctions should be tailored to individual cases. However, they felt that there is clear link between the most serious cases and the most severe sanctions. They anticipate that cases involving child pornography, sexual misconduct, violence or abuse will result in the professional being struck-off.

Participants also assume that cases that involve incompetence will result in some element of retraining which will take place during a period of suspension or as a condition of practice.

10.3 Mitigating and aggravating factors

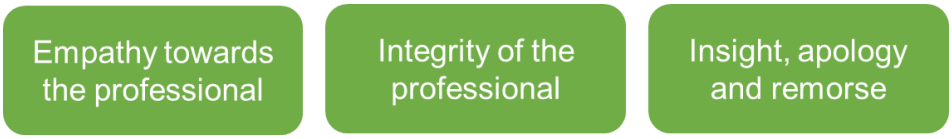
Across the research, participants identified a range of mitigating and aggravating factors. These fall into three broad groups of considerations.

1. Motivation and impact considerations

Participants agreed that the most serious cases will have taken place in the professional context or had a clear link to working duties, involved harm to the patient, and were intentional acts.

Where more than one of these factors is present in a case, there was very little expectation amongst participants that anything can mitigate concerns about the professional continuing to practise.

2. Emotional considerations



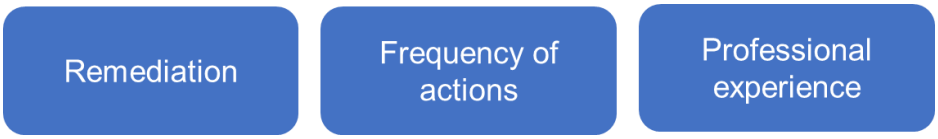
Participants took into account the justification that professionals provided for their actions as well as the way in which the professional acted throughout the fitness to practise process.

Empathy with rationale for a behaviour, and perceived integrity of the professional (based on honesty and professionalism) acted as mitigating factors where present and aggravating factors where not present.

Although closely linked, expression of insight, apology and remorse are considered important. Participants expect that a professional will demonstrate at least one of these as a natural response to having done something wrong. Participants place value on apology, remorse and insight as a demonstration that the professional has understood that what they have done is wrong. With this in mind, apology, insight and remorse can act as mitigating factors. However, they have limited impact for the most serious and severe cases involving intent and patient harm.

Overall it is agreed that it can be difficult to ascertain whether apology, remorse and insight are genuine. Remediation is often considered a more empirical way to look at emotional responses from professionals.

3. Rational considerations



Participants agreed that remediation is a measurable outcome that will help the panel determine whether the professional is genuine in their remorse, insight and desire to return to practice. They felt that remediation provides evidence that the professional is keen to remedy their deficiencies. However, some queried the sincerity of remediation and it is suggested that the panel take into account a combination of apology, remorse, insight and remediation to gather an overall understanding of the authenticity of response from the professional.

The number of times an action has happened is something that participants felt could make a case more or less serious. Frequent actions suggested a lack of insight from the professional, and a risk of repeat behaviour.

The experience and/ or seniority of a professional was also something that participants felt could be taken into account. Where a case involved incompetence there was greater lenience amongst participants for junior/ inexperienced professionals.

10.4 Views on the principles of proportionality

Five core principles are considered key in panel decision making.

1. Unbiased decision-making

Participants felt that it is important for panels to consider cases from a neutral viewpoint, with an open mind.

2. Making fair and appropriate decisions

Participants expect panels to tailor sanctions to each case, avoiding a ‘one size fits all’ approach. However, there is still an expectation that there will be some consistency across similar case types.

There is a strong view amongst participants that the priority decision-making considerations taken into account by panels should be: severity of the case; what will protect the public from harm; and how to ensure public trust and confidence in the profession. Once these are taken into account, participants are keen to note that a fair decision should be reached, allowing the professional to continue, or be supported back to practice where appropriate.

3. Protecting the public from harm

Across the research achieving public protection is interpreted as safeguarding against the same thing happening again. It is agreed that this should be at the heart of panel decision making especially where a case involves patient or potential patient harm.

4. Ensuring the public can trust/ have confidence in the profession

Participants anticipated that public protection will in turn ensure public confidence in the profession. Ensuring public confidence in the profession is considered crucial, and is often interpreted as being able to trust the profession. Across the research, participants agreed that being able to trust the profession was particularly important for cases that involve patient harm and determining whether the professional is safe to continue practising.

5. Thinking about the rights of the professional

Overall, not all participants were convinced that incidents that occur in the professional's private life, are unrelated to working duties and do not involve harm to an individual or intent need to go before a panel.

When considering the rights of the professional, there is a desire to see a structured process to ensure professionals are able to access support where needed, regardless of sanction imposed (e.g. not just as a condition of practice).

10.5 Equality and diversity

Participants agreed that all professionals should be treated equally and fairly. There is strong opinion that any professionals regulated by the HCPC should be practising to the same professional standards regardless of their cultural background.

Overall, there are different levels of tolerance towards the differences that cultural norms may present. Regardless of this, it is anticipated that it is possible for a professional to

demonstrate honesty and integrity as factors that are intrinsically important to all cultures. It is also suggested that remediation can be demonstrated regardless of cultural barriers.

Thinking more broadly, there is some suggestion by participants that the panel should itself be diverse to reflect the diversity of health and care professions. It was further expected that the panel be carefully chosen to include those with experience that would support them in making fair and appropriate decisions such as older people with more 'life experience'.

11 Appendices

11.1 Case studies

The following case studies were shown to participants across the research, enabling them to consider real life cases.

Case study 1a

Background:
- Mr W is an operating department practitioner. He is responsible for supporting operating theatre staff and providing care to patients at all stages of an operation.
- Mr W was convicted of driving a car under the influence of alcohol.
- He crashed his car into a parked lorry in the early hours of the morning. He damaged the lorry and did not harm any people. He was banned from driving for 17 months and fined £500.
- Mr W informed the HCPC of what had happened 5 days after his arrest.

The hearing:
- Mr W attended the hearing and told the Panel that he had been at a family member's birthday celebration and had more drinks that he had originally planned. The crash had taken place on a bend in the road in wet conditions. He had pleaded guilty at Court and attended an alcohol awareness course (which had reduced his driving ban by a quarter).
- Mr W told the Panel that he had learnt a very hard lesson and would never repeat his actions. He realised his judgement had been very poor and the alcohol awareness course had made him fully appreciate how regrettable his actions had been.
- Mr W's partner also gave evidence. She stated that Mr W's family had been shocked and surprised at his behaviour. She described him as a good person who had taken responsibility for his behaviour.

Case study 1b

The decision:
In reaching their decision, the Panel took into account the following four things:

1. **Mr W's current behaviour**
   - The Panel decided that Mr W's genuine remorse and regret meant that there would be little or no likelihood of repetition.
2. **Maintaining public confidence in the profession**
   - The Panel felt that the public would be concerned about Mr W's behaviour as he broke the law, put other drivers and pedestrians at risk and damaged another person's property.
3. **Aggravating factors: facts that increase the severity of what has happened**
   - Mr W's actions could have resulted in serious harm to him and other road users.
   - His Court conviction was a serious matter.
   - He made a decision, although this was under the influence of alcohol, to drive when he knew he should not.
   - He knew that road traffic accidents have potentially serious consequences.
   - He caused physical damage to another vehicle.
4. **Mitigating factors: facts that lessen the severity of what has happened**
   - Mr W remained at the scene, fully admitted his actions and informed the HCPC of what had happened. He fulfilled the terms of his Court conviction.
   - He expressed regret and remorse and apologised for his actions.
   - He took steps to ensure the situation would not be repeated.
   - He was able to express that he understood that his actions were wrong.
   - Through the alcohol awareness course he had recognised the serious nature of his actions.
   - He was fully engaged with the HCPC proceedings and was open and honest with the Panel.
   - There was enough evidence to suggest that his actions were out of character.
   - He had support from his employer.

The Panel decided to take no further action.

Case study 2a

Background:
- Ms X is a social worker.
- Ms X posted comments on a social media site about a case that she was managing.

The hearing:
- Ms X attended the hearing. She said that lack of support from her manager was partly to blame for her behaviour. She also said that the information in the social media posts could have been relevant to a number of families in the local area and with this in mind did not feel that she had put the confidentiality of the family concerned at risk.
- The social media posts were provided as evidence to the Panel. The Panel noted that the social media posts were disrespectful and demonstrated poor judgement from Ms X.
- The Panel felt that a member of the public reading the social media posts would be likely to develop a very negative view of social workers especially as the posts were felt to be disrespectful and insensitive.
- Evidence was given by a member of the family whose case Ms X had posted comments about. The family member said that they had lost all confidence in social workers as a result of what had happened.

Case study 2b

The decision:

In reaching their decision, the Panel took into account the following two things:

1. **Ms X's current behaviour**
   - The Panel were not satisfied that Ms X recognised that she was fully responsible for her actions. The Panel felt that she did not recognise the serious nature of her actions.
   - Whilst Ms X made assurances that this would not happen again, the Panel felt that she had not taken any steps to prove that this would be the case.

2. **Maintaining public confidence in the profession**
   - The Panel felt that public confidence in social workers would be undermined if no action was taken in this case.
   - The Panel noted that many professionals use social media and care should be taken to ensure this is not used to share information that could have a negative impact on the public opinion of a social worker, or could risk patient confidentiality.

The Panel decided to put in place a conditions of practice order lasting 12 months. This was put in place to:
- Ensure that the public could be confident that steps were taken to address Ms X's action.
- Act as a deterrent to other social workers.

Ms X was allowed to continue to work as evidence demonstrated that she was still working safely and effectively as a social worker whilst carrying out the conditions of practice. These included Continuing Professional Development training on confidentiality, and training to help her understand the consequences of her actions.

12 months later there was a review hearing. Ms X gave evidence that she now fully appreciated the inappropriateness of her actions. Her employer gave evidence that she had fully followed the conditions of practice order. The Panel felt that there would be little likelihood that Ms X would repeat her actions. The conditions of practice were removed and Ms X is now practising unrestricted.

Case study 3a

Background:

- Mrs Y is an occupational therapist. Occupational therapists help people overcome difficulties caused by physical or mental illness, accidents or ageing.
- Two years ago, on seven separate occasions Mrs Y worked as an agency worker whilst on sick leave from her employer.

The hearing:

- Mrs Y admitted that she had been dishonest.
- She stated that she had been experiencing financial difficulties at the time.
- Mrs Y was on sick leave when she carried out the agency work and therefore certified unfit to work.
- She said that two years had passed since this had happened and she had learnt her lesson and would not make the same mistake again.
- Evidence was given from witnesses who talked about Mrs Y's good character.

Case study 3b

The decision:

In reaching their decision, the Panel took into account the following four things:

1. **Mrs Y's current behaviour**
   - Whilst Mrs Y showed genuine remorse the Panel felt that this case was very serious.
2. **Maintaining public confidence in the profession**
   - The Panel felt that the public would be concerned about Mrs Y's behaviour as she put patient safety at risk.
3. **Aggravating factors: facts that increase the severity of what has happened**
   - Mrs Y was on sick leave when she carried out the agency work and therefore certified unfit to work. She was therefore putting patient safety at risk.
   - There were seven separate acts of dishonesty committed over 2 months.
   - The reason for the dishonesty was personal financial gain.
4. **Mitigating factors: facts that lessen the severity of what has happened**
   - Mrs Y admitted her dishonesty and showed genuine remorse.
   - The dishonesty took place 2 years ago and Mrs Y had reflected on her actions and been honest.

The Panel felt that the case was too serious to take no further action. They also felt that a conditions of practice order would not address the serious nature of Mrs Y's actions. They decided to suspend Mrs Y for 12 months – she was not allowed to work as an occupational therapist during this time.

Case study 4a

Background:

- Mr V is an operating department practitioner. He is responsible for supporting operating theatre staff and providing care to patients at all stages of an operation.
- Mr V was cautioned by the police for two offences of theft.
- On two separate occasions he had stolen a morphine based drug and taken this drug whilst at work.

The hearing:

- Evidence provided by the police case reported that Mr V had been seen alone in an operating theatre with a syringe in his hand. At the time, a search had been carried out and three empty drug ampoules were found.
- Irregularities were found with the latest entries in the hospital's controlled drug record book.
- During the police interview Mr V admitted that he had taken the drug and injected it on two separate occasions.
- Mr V whilst admitting his behaviour did not show genuine regret for his behaviour.

Case study 4b

The decision:

In reaching their decision, the Panel took into account the following four things:

1. **Mr V's current behaviour**
   - The Panel felt that Mr V's behaviour affected his ability to carry out his work safely and effectively.

2. **Maintaining public confidence in the profession**
   - The Panel felt that this was a serious matter damaged the public's confidence in health and care professionals.

3. **Aggravating factors: facts that increase the severity of what has happened**
   - Use of the drug would have negatively affected Mr V's ability to carry out his job safely.
   - He put patients at risk.
   - His behaviour was dishonest.
   - His stole from the hospital, which means he stole from the public purse.
   - Mr V did not engage with the fitness to practise process.
   - Mr V did not show that he understood the severity of his actions or regret for his behaviour.
   - Mr V had not taken any steps to rectify his behaviour.

4. **Mitigating factors: facts that lessen the severity of what has happened**
   - There had been a short time period between the drugs misuse and the Panel hearing which meant that Mr V had little opportunity to address his actions.

The Panel suspended Mr V from working as an operating department practitioner for 12 months.

Case study 5a

Background:

- Mr Z is a biomedical scientist. Biomedical scientists carry out tests (e.g. blood tests) to help identify patient diagnosis and appropriate treatments.
- On two occasions Mr Z failed to report to a Consultant blood sample abnormalities found in patient samples which indicated possible acute leukaemia.

The hearing:

- Mr Z gave evidence at the hearing. He genuinely tried to explain and find reasons for his errors.

Case study 5b

The decision:

In reaching their decision, the Panel took into account the following four things:

1. **Mr Z's current behaviour**
   - The Panel found that the errors made by Mr Z were mistakes and therefore that Mr Z lacked competence.

2. **Maintaining public confidence in the profession**
   - The Panel felt that this was a serious matter which damaged the public's confidence in health and care professionals.

3. **Aggravating factors: facts that increase the severity of what has happened**
   - Mr Z had not taken any steps to rectify his lack of competence.
   - There was serious risk to patients as leukaemia may need to be treated urgently.

4. **Mitigating factors: facts that lessen the severity of what has happened**
   - Mr Z was open and honest.
   - He was an experienced professional who understood the potential serious consequences of the errors he had made.
   - Mr Z had worked as a biomedical scientist for a number of years without any issues.

The Panel decided that Mr Z was not safe to do his job without supervision. They put in place a conditions of practice order where Mr Z had to be supervised in his work, and carry out training to improve his skills. This allowed Mr Z to continue working whilst addressing his lack of competence.

Case study 6a

Background:
- Mr U is a radiographer. Radiographers take images of the insides of patients' bodies to diagnose injury or disease.
- To carry out these screening procedures, radiographers must be registered to do so with the Care Quality Commission.
- Mr U carried out screening procedures without being registered to do so.
- Mr U was given a caution by the Care Quality Commission and the case then went to the Health and Care Professions Council to consider.

The hearing:
- Mr U admitted that he had conducted scans in his local village hall on private patients for 2 and a half years when he was not registered to do so.
- Mr U did not attend his hearing but in a letter to the Panel accepted that he had been aware of the need to be registered to carry out screening procedures.
- He said that he had made a number of applications to be registered but all of these had been rejected for what he described as 'minor and insignificant reasons'.
- He said he eventually gave up trying to register.
- He said that he was now employed at an NHS hospital and was no longer carrying out any private work and did not intend to do so in the future.

Case study 6b

The decision:
In reaching their decision, the Panel took into account the following four things:

1. **Mr U's current behaviour**
   - Mr U did not understand that it was important to be registered, and therefore the Panel considered that there was a risk that this could happen again in the future.

2. **Maintaining public confidence in the profession**
   - The Panel noted that Mr U had already received a caution from the Care Quality Commission and felt that some kind of sanction would be needed to further reassure the public.

3. **Aggravating factors: facts that increase the severity of what has happened**
   - Mr U was aware that he needed to be registered to carry out the screening procedures.
   - Mr U understood that he would be committing an offence if he did not have the required registration.
   - This was not a one-off mistake as it happened over a 2 and a half year period of time.
   - By not being registered, Mr U was a risk to the public.
   - Mr U did not understand that it was important to be registered, and therefore the Panel considered that there was a risk that this could happen again in the future.

4. **Mitigating factors: facts that lessen the severity of what has happened**
   - Mr U had experienced genuine difficulty when trying to register to carry out screening procedures.
   - Mr U had no previous complaints made about him.

When considering what sanction, if any, to put in place, the Panel took into account that the purpose of the sanction is not to punish Mr U, but to protect the public interest. The Panel looked to balance the interests of the registrant with those of the public. It considered the range of sanctions available starting with the least serious option of taking no further action. However, the Panel felt that the case was serious and therefore considered putting in place a caution order. This was considered appropriate because Mr U had stopped carrying out scans for private patients.
The caution order was put in place to last 3 years. This means that the word 'caution' appears next to Mr U's name for the next 3 years.

11.2 Stimulus information

This information was provided to participants during the first part of each research session to support and develop their understanding of the HCPC and fitness to practise cases.

A

- The Health and Care Professions Council (HCPC) was set up to protect the public.
- The HCPC regulates 16 health and care professions.
- These professions must register with the HCPC.
- To be on the HCPC register, these professions must meet HCPC standards to ensure they have the skills, knowledge and character to be able to effectively and safely do their job.

B

The 16 health and care professions regulated by the HCPC are:

- Arts therapists
- Biomedical scientists
- Chiropodists/ podiatrists
- Clinical scientists
- Dietitians
- Hearing aid dispensers
- Occupational therapists
- Operating department practitioners
- Orthoptists
- Paramedics
- Physiotherapists
- Practitioner psychologists
- Prosthetists/ orthotists
- Radiographers
- Social workers in England
- Speech and language therapists

C

Youtube Video: http://www.hcpc-uk.org.uk/complaints/fitnesstopractise/

D

The types of cases that HCPC look into include cases where the professional:

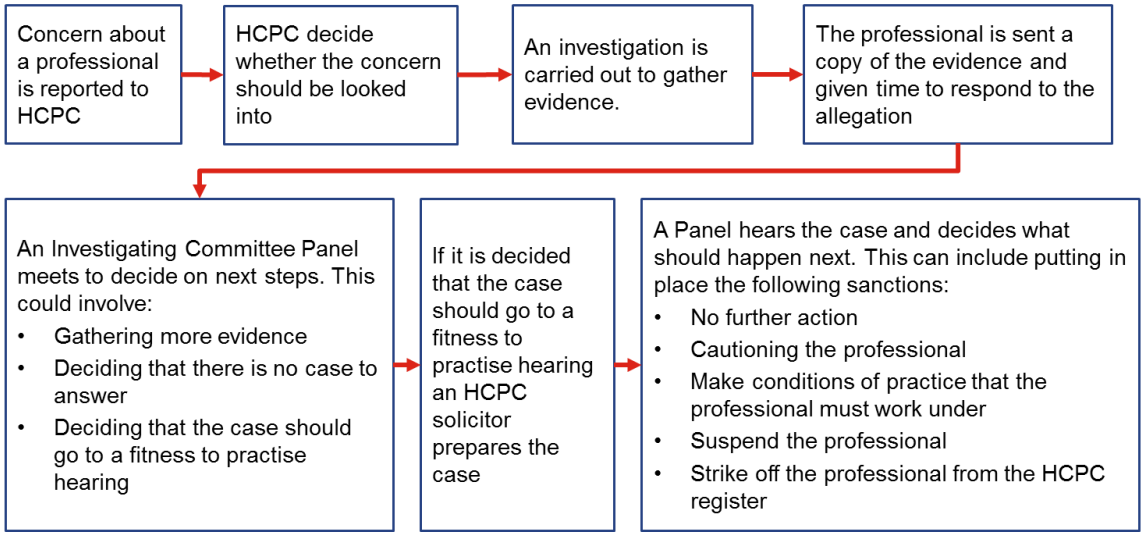
- Was dishonest
- Committed fraud
- Abused someone's trust
- Exploited a vulnerable person
- Did not respect a patient's rights to make choices about their own care
- Had/ has health problems which they did not deal with and which could affect the safety of patients
- Hid mistakes
- Had an improper relationship with a patient
- Carried out reckless or deliberately harmful acts
- Seriously failed to meet standards of their profession
- Persistently failed to meet standards of their profession
- Has been involved in sexual misconduct or indecency
- Has been involved in child pornography
- Has been violent
- Has shown threatening behaviour
- Has carried out a serious activity that would affect public confidence in the profession

E

Some service users are likely to be more vulnerable than others because of certain characteristics including:

- People with mental health issues
- Children or young people under 18 years old
- People with a disability or frailty
- People who have recently been bereaved
- People with a history of abuse or neglect

F



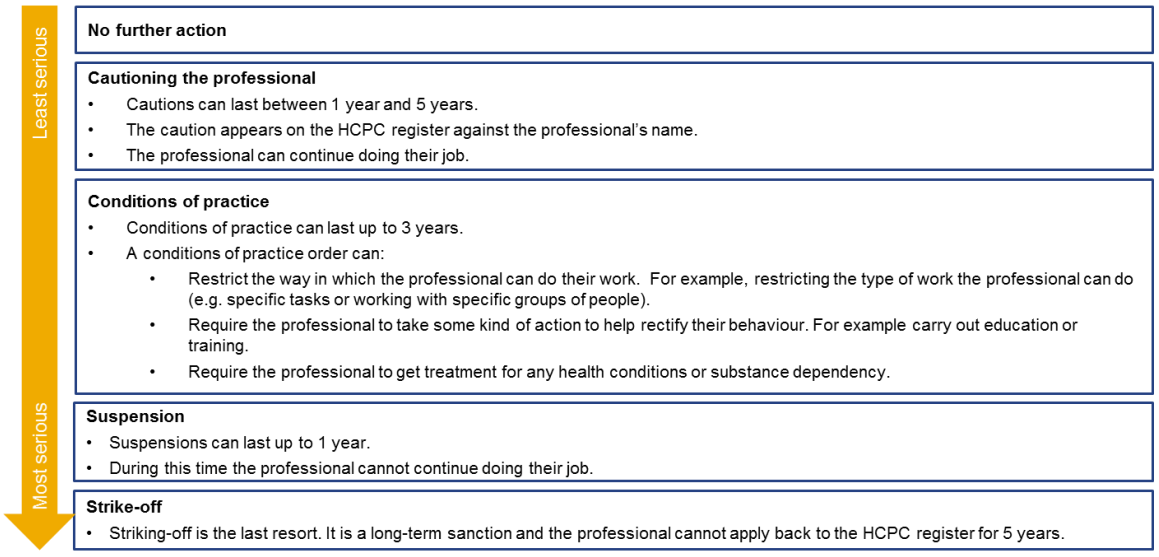
G

Who are the Panel?

- All Panel members receive detailed training when they first become Panel members.
- Panels are made up of a mix of professions. Each hearing will consist of:
  - A registrant member from the same profession as the person the hearing is for
  - A lay member
  - A chair, who can be a professional or lay member
- They receive refresher training every two years.
- The training lasts 2 days.
- During the training Panel members look at example cases and focus on:
  - The decision making process
  - Weighing up evidence provided during a case
  - Reaching decisions that are appropriate

Sanctions are not designed to punish the professional. They are designed to take into account public protection and whether it is safe for the professional to continue doing their job. Types of sanctions:

H



I

Guidance used by the Panel

To help Panels make decisions about which of these sanctions to put in place, they are given some guidance. This guidance helps Panels to make sure that their decisions are:

- Fair
- Consistent
- Transparent

J

- Insight is where a person reflects on the concerns that have been made about them.
- They understand that what they did was wrong, and why it was wrong.
- They show empathy towards the people affected by what they have done.
- They take steps to make sure that the same thing does not happen again. For example, if they have made mistakes in treating patients, they may carry out training to improve their skills.

K

Insight (understand that what they did was wrong and why it was wrong)

Remorse

Apology

Empathy

L

- Remediation is the action a person takes to address the concerns that have been raised about them.
- They take steps to make sure that the same thing does not happen again.
- For example:
  - Self-reflection, and considering their actions and behaviours.
  - Carry out training.
  - Seek help and support from a mentor.
  - Rehabilitation.

M

When Panels make decisions about what, if any, sanctions to put in place they take into account the following:

- Achieving public protection
- Making sure that the public can be confident in the profession
- The least restrictive way to achieve public protection
- Striking a good balance between public protection and the rights of the professional

N

- **Insight** (understand that what they did was wrong and why it was wrong)
- **Remorse**
- **Apology**
- **Empathy**
- **Remediation** (taken steps to rectify their action/ behaviour so it does not happen again)

O

- From different countries with different cultural backgrounds
- Different work environments
- Different levels of experience in their job

P

Achieving public protection	Making sure that the public can be confident in the profession
The least restrictive way to achieve public protection	Striking a good balance between public protection and the rights of the professional

11.3 Discussion guide

The discussion guide was used across research sessions. The same guide was used for both mini-group discussion and individual depth interviews although different timings for these sessions were reflected.

GfK Research: HCPC ISP Discussion Guide FINAL REVISED (26 September 2017)

Objectives:

- Explore the public's view on the principles that under-pin the Indicative Sanctions Policy including views on:
- The importance of insight, remorse and apology.
- Remediation.
- The most serious cases in which less serious sanctions (such as caution orders and conditions of practice) may be inappropriate.
- The principles of proportionality.
- How equality and diversity should be taken into account.

Please note:

- This guide is intended to provide an over-arching flow for the discussion detailing the key areas for coverage. Moderators will tailor the guide to the group/ individual. With this in mind, not all questions may be asked in the order shown or using the exact language shown.
- Timings for focus groups are shown in red.
- Timings for individual depths are shown in green.
-

1. Introductions **5 mins/ 5 mins**

(Aim: introduce the research to participants, the moderator, and participants to each other within groups)

- Thank you for taking part.
- Introduce self and GfK.
- Explain audio recording and MRS code of conduct.
- Explain purpose of the research: The research is on behalf of the Health and Care Professions Council, who regulate a number of health and care professionals.

During the research we will look at a range of examples of situations where complaints have been made about a healthcare professional. All examples will be made up for the purposes of the research but some may cover sensitive topics. We will be talking about the types of things that should be taken into account when deciding whether the Health and Care Professions Council needs to take any action to restrict or stop the healthcare professional practising.

- There are no right or wrong answers.
- For all: please remember that if there is anything that you feel uncomfortable talking about just let me know and we can move the discussion on.
- For groups: it is important to bear in mind that people might have different views about the different things we're going to discuss this evening. That is absolutely fine – everyone is different – but please respect each other's opinions.

Participant introduction:

- First name, home life, interests

2. HCPC and their role **5 mins/ 5 mins**

(Aim: Introduce participants to the HCPC and their role)

- Before coming along this evening, had anyone heard of the Health and Care Professions Council?
    - If yes: what had you heard, where did you come across this?
- Show STIMULUS A and STIMULUS B
    - What are your thoughts about the HCPC?
    - Any questions?

3. Fitness to Practise process **5 mins/ 10 mins**

(Aim: Introduce participants to the FtP process so they can understand how the ISP fits in)

- When a complaint is made about a professional that is on the HCPC register, HCPC will look into this case, and take appropriate action where necessary.
- Show STIMULUS C
    - Any thoughts about the process?
    - Any questions?
- Show STIMULUS D
    - Which of these cases do you think are most serious?
        - Which would you as a member of the public be most concerned about? Why?
- Thinking about vulnerable people…
    - Who would you say are vulnerable people/ groups?
    - Let's look at a definition of vulnerable groups…
    - Show STIMULUS E
        - Any thoughts on this definition?
        - Anything missing?
    - To what extent does it make a difference if a case about a health and care professional involves a vulnerable person?
        - Why/ why not a difference?

4. ISP introduction **5 mins/ 10 mins**

(Aim: Introduce participants to the ISP including the purpose of the ISP)

When a complaint is made about a professional to HCPC, it is carefully considered.

- ONLY SHOW IF PARTICIPANTS HAVE FURTHER QUESTIONS FOLLOWING THE VIDEO (Stimulus C): STIMULUS F and G
- As we saw in the video, Panels can put in place a number of sanctions.
- Show STIMULUS H
- When putting in place these sanctions Panels use some guidance
- Show STIMULUS I
- Part of this guidance is about ensuring that Panels think about public protection and the rights of the professional

- STIMULUS M
- Any thoughts about this?
- Any questions?

5. The decision making process: spontaneous views 5 mins/ 10 mins

(Aim: Gather spontaneous views regarding the types of things that the public think should be taken into account when making sanction decisions including exploration of mitigating and aggravating factors)

- I'd now like us to look at the different cases that Panels might hear, and the types of sanctions that are available for them to use …
    - Are there any types of cases where you think it is obvious which type of sanction should be used?
    - Where do you think there might be circumstances that make something more or less serious?
        - For example, what makes the difference between someone getting conditions of practice, or struck off for 'fraud'?

6. The decision making process: case studies 30 mins/ 55 mins

(Aim: Gather public views towards the decision making process when determining sanctions including exploring public views regarding insight and remorse, remediation and proportionality.)

- Let's look at an example of a case

Moderator: please note that there are 8 case studies – please use a random order, and cover as many as possible with each group/ depth.

Questions to ask for EACH case study shown

- Show case study page **'a'**:
    - What do you think about this case?

- What do you think are the most important factors to take into account when deciding which sanction to put in place?
- What are the key things that you think that the Panel should be taking into account when they make their decision about which sanction to put in place?
- *Refer to list of sanctions*
- Which sanction would you put in place? Why?

- Show case study page **'b'**:
  - What do you think about the different factors that the Panel took into account?
  - Now that we have seen what the Panel took into account, which factors do you personally think were most important to take into account?
  - *Moderator: as relevant please prompt:*
    - How important was it whether [name] apologised? Why?
    - How important was it whether [name] recognised that what they had done was wrong? Why?
    - How important was it whether [name] had already taken steps to try and rectify their behaviour? Why?
  - As a member of the public to what extent do you feel confident about the sanction put in place? Why?

7. Overall views on ISP principles **15 mins/ 20 mins**

(Aim: Having looked at case studies, explore over-arching views towards insight and remorse, remediation and proportionality)

Insight and remorse

- The guidance that Panels use to help them make decisions about which sanctions to put in place talks about taking insight and remorse into account.
- Firstly, what do you think 'insight' means?
- Show STIMULUS J
- What are your thoughts on this?

- Having looked at some cases, how important do you think 'insight' is when deciding which sanction to put in place?
    - To what extent does it matter if someone does or does not have insight? Why?
    - Should insight always be taken into account? Are there any types of cases, where you think insight should not be taken into account? (STIMULUS D of types of cases)
- In addition to insight, the guidance that Panels use also talks about taking remorse, apology and empathy into account when making a decision.
- Show STIMULUS K
- What do these different things mean?
- How are they different?
- How important do you think it is to take apology, remorse and empathy into account when deciding which sanction to put in place? Why?
    - To what extent does it matter if someone does or does not apologise/ show remorse or empathy? Why?
    - Should apology/ remorse/ empathy always be taken into account? Are there any types of cases, where you think these should not be taken into account? (STIMULUS D of types of cases)

Remediation

- Another aspect of the guidance that Panels use talks about remediation.
- What do you think 'remediation' means?
- Show STIMULUS L
- What are your thoughts on this?
- Having looked as some cases, how important do you think 'insight' is when deciding which sanction to put in place?
    - To what extent do you think it matters if someone has taken steps to rectify their actions or behaviour? Why?
    - Should this always be taken into account? Are there any types of cases, where you think the fact that someone has taken steps to rectify their actions or behaviour should not be taken into account? (STIMULUS D of types of cases)

Proportionality

- The guidance that the Panel uses to help them make their decision includes the following information.
- Show STIMULUS M
- What are your thoughts on this?
- Is any one specific element more or less important? Why?
- Thinking about the examples we have looked at, do you think it is important to take all of these things into account or not?

Equality and diversity

- Health and care professionals regulated by the HCPC will be diverse.
    - Show STIMULUS O
    - Is there anything missing from this list?
        - It may be that some professionals express themselves differently. For example, some cultures may place less importance on apologising.
        - How should these types of differences be taken into account by Panels?

8. Wrap up **5 mins/ 5 mins**

(Aim: Gather any final comments and questions)

- Overall, given everything that we have discussed, what would you say are the important things that Panels should be taking into account when making decisions about which sanctions to put in place?
    - *Moderator: ask for one comment from each participant.*
- Any questions?

Thank and close