

Professional Liaison Group for the review of the standards of conduct, performance and ethics – 28 July 2014

Research report – The Focus Group

Executive summary and recommendations

### **Introduction**

The research period for the review of the standards of conduct, performance and ethics has included a focus on gaining feedback on the content and accessibility of the standards from service users and their carers.

The Executive commissioned the market research organisation, The Focus Group, in September 2012. This research carried out focus groups, workshops and telephone interviews with registrants and service users and their carers to examine how the standards are understood and translated in practice and how accessible the standards are to both audiences.

The findings of the research carried out by The Focus Group are set out in this paper. Their recommendations will be particularly relevant to the professional liaison group's consideration of reporting concerns and dealing with mistakes and inter-professional and team working at its second meeting, among other themes.

### **Decision**

This paper is to note; no action is required of the professional liaison group.

### **Background information**

None

### **Resource implications**

None

### **Financial implications**

None

### **Appendices**

None

### **Date of paper**

11 July 2014



# Research report

**Standards of conduct, performance and ethics –  
accessibility and understanding**

Research with registrants and service users

May 2013



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# Executive summary

This research explores registrants and service user views on the content and accessibility of the Standards of conduct, performance and ethics.

130 registrants took part in this research. Of this number 52 took part in a focus group and 76 took part in a telephone interview. 82 service users took part in either a workshop or focus group.

## Key findings

- The majority of registrants understand the need for overarching standards and are very accepting of the current format. However social workers question the professional relevance and language specifically to their working practices used in some of the standards more than other registrant groups.

*‘It is important that the standards are generalist without losing the complication of the context.’*

- Some registrants are concerned about their ability to adhere to specific standards due to:
  - \* Service cuts in funding and lack of supportive employers/management.
  - \* Working in uncontrolled environments which bring a different set of challenges and decision making pathways.

- Service users felt the standards covered the core attributes that they would expect from their professionals but wanted to see more emphasis placed on caring qualities, such as empathy and compassion, timeliness and joint decision making/working in partnership with service users.

## Overall recommendations to the standards include:

- Inclusion of a specific standard on whistleblowing/raising concerns
- Include reference to incident reporting and the responsibilities of registrants to respond, support and provide information to service users when things go wrong
- Include reference to personal safety and the need for risk assessments particularly when dealing with uncontrolled environments and infection control
- More emphasis on joint decision making and partnership working with service users
- Reflect the increased use of information technology (IT) including stronger reference to security
- Incorporate guidance on the use of social networking
- Include stronger reference and guidance on culture and diversity to reflect the changing nature of culture and the impact this has on services within the UK
- Incorporate reference to current legislation that affects practice, including safeguarding and the Mental Capacity Act

# Introduction

## Background



The Standards of conduct, performance and ethics (SCPE) are ethical standards the HCPC sets for the 16 professions they regulate. The standards sit alongside the standards of proficiency for each profession which set out what professionals must know, understand and be able to do when they enter the HCPC register for the first time.

All the standards set by the HCPC are reviewed periodically to ensure they remain fit for purpose and are up-to-date. The SCPE were last reviewed during 2006 – 2008 and the current standards came into effect on 1 July 2008.

During this time there has been significant growth in the number of professionals registered and three additional professions have joined the HCPC register– practitioner psychologists, hearing aid dispensers and social workers in England. Because of these changes to the register and the changing context of practice for health and social care professions in the UK a new review of the standards was required to ensure they remain fit for purpose.

This research focuses on registrants and service users with the remit to explore their views on the content and accessibility of the standards.

*The discussion guides for the research can be found in the appendix which illustrate the key areas of focus for this research.*

# Methodology

This research took the form of focus groups, workshops and telephone interviews.

- In total 128 registrants took part in this research. 52 took part in a focus group (lasting between 1 – 1.5 hours) in one of the regional locations of Belfast, Glasgow, Birmingham and Cardiff. A further 76 registrants took part in a telephone interview, lasting between 30-50 minutes.
- 82 service users attended either a two hour workshop in Manchester or London, or took part in a smaller focus group (1 – 1.5 hours) in one of the following regional locations: Belfast, Glasgow, Birmingham or Cardiff.

*Details of the registrants and service users who took part can be found in the appendix.*

## Registrants

### Quotas

The quotas for the research were based on the HCPC register with the aim of ensuring a representative number across the different professions. The table opposite shows the number of registrants, the percentage, the target quota and the actual quota obtained.

The target quota was based on the percentage of registrants on the register within each profession.

Quota Table

| Profession                         | Number on register<br><i>January 2013</i> | % of register* | Target Quota | Actual Quota obtained |
|------------------------------------|---|----------------|--------------|-----------------------|
| Arts therapists                    | 3102                                      | 1              | 1            | 6                     |
| Biomedical scientists              | 22,217                                    | 7              | 7            | 7                     |
| Clinical scientists                | 4755                                      | 1.5            | 2            | 3                     |
| Chiropodists/podiatrists           | 12,705                                    | 4              | 4            | 8                     |
| Dietitians                         | 7820                                      | 2.5            | 3            | 3                     |
| Hearing aid dispensers             | 1748                                      | 0.5            | 1            | 3                     |
| Occupational therapists            | 33,171                                    | 10.5           | 11           | 17                    |
| Operating department practitioners | 11,424                                    | 4              | 4            | 5                     |
| Orthoptists                        | 1322                                      | 0.5            | 1            | 2                     |
| Paramedics                         | 18,883                                    | 6              | 6            | 11                    |
| Physiotherapists                   | 46,332                                    | 15             | 15           | 15                    |
| Practitioner psychologists         | 18,775                                    | 6              | 6            | 12                    |
| Prosthetists and orthotists        | 930                                       | 0.5            | 1            | 4                     |
| Radiographers                      | 27,751                                    | 9              | 9            | 7                     |
| Speech and language therapists     | 13,776                                    | 4              | 4            | 3                     |
| Social workers in England          | 88,992                                    | 28             | 28           | 22                    |
| <b>Totals</b>                      | <b>313,703</b>                            | <b>100</b>     | <b>103</b>   | <b>128</b>            |

*\*Note: Percentages have been rounded up*

## Methodology cont....

### Fulfilment of quota

The table shows that the target quota was obtained or exceeded for most registrant groups. The target quota was not met for radiographers, speech and language therapists and social workers, due to not enough responses from these groups to the email request. However this was not a concern as the purpose of this research was to gain a broad spread of opinion rather than concentrate on specific professional groups, and we are satisfied that sufficient representation was obtained from these three groups.

### Additional Information

In addition to the quota for 'registrant profession', the following information was also collected for each individual.

- Age
- Length of time in service
- Category of work
  - Education or research
  - Management
  - Working in practice in independent/private practice
  - Working in practice in National Health Service (NHS)/public sector

*Full details of these categories can be found in the appendix.*

Whilst there were no direct quotas placed on these categories, the work category helped to ensure, as recruitment progressed, that there was strong representation of registrants in a variety of practice environments. This information is also useful to illustrate the range of registrants who took part in this research.

### Recruitment of registrants

The HCPC provided the recruiters with email addresses for a selected range of registrants who were sent an introductory email explaining the research and asking for their involvement. Registrants then responded to the recruiters directly to confirm that they wished to take part in the research.

For the face-to-face research, the data was selected by registrant postcode (either place of work or home address, whichever address had been registered with the HCPC). Four locations were chosen for the face-to-face research and postcodes selected within each location area. The data selection also took into account the percentage of the different professions on the register and selected a sample for each profession based on this, to ensure that the data was as representative of the register as possible.

For the telephone research, a further selection of registrant data was provided by the HCPC. This selection was again by postcode and within a range of different geographical areas to broaden the representation across the UK. The data was also selected to represent the range of professions on the register.

*Full details of the number of emails sent and the introductory email can be found in the appendix.*

## Methodology cont....

**Note: Hearing aid dispensers.** This was the only group who were not able to be recruited in this way as there was no response from any hearing aid dispensers to the email request. To ensure representation of this profession the HCPC provided information about the research (and details of who to contact to take part) to a contact within the British Society of Hearing Aid Audiologists, who supplied the contact details of some hearing aid dispensers who were willing to take part.

### Flexibility of attendance

To help to increase the attendance at a face-to-face group, registrants were offered different time slots at each location, including morning, afternoon and evening. This proved successful in gaining the numbers required. This meant that the size of the focus groups varied from between three to ten registrants at a session. All groups were mixed registrant groups.

Telephone interviews were conducted at times that suited registrants, including some evening interviews.

Registrants taking part in this research were asked to read over the SCPE to refresh their memories – a copy of the invitation email is in the appendix.

### Incentives

Registrants were offered an incentive payment for their participation in this research. This was a small fee given to cover any travel expenses and to thank people for their time. For the focus groups registrants were given £30 and for the telephone interviews the fee was £15.

## Service users

### Quotas

There were no fixed quotas for service users and the researchers agreed to find service users who had experienced particular services rather than focusing upon their experience of individual registrant groups. This is because not all service users will know which profession they have had contact with (for example in the case of diagnostic tests) and also many service users have had contact with multiple professions.

Instead four treatment and care categories were developed to categorise the different experiences that service users may have had that would have brought them into contact with, or under the care of, at least one of the registrant professions. These experiences had to have taken place within the last five years to ensure that their experiences were up-to-date and reflected current standards of care.

No direct quotas were fixed for age, ethnicity or gender, as the emphasis was on the service/care obtained, but the recruitment did aim to obtain a good broad spread of demographics.

*Further details showing the categories and demographics are in the appendix.*



## Methodology cont....

### Recruitment

Service users were recruited for the research by professional recruiters who are experienced in recruiting members of the public for focus groups. Each workshop and group was recruited in a number of ways including:

- Online advertising via the recruiters own consumer database
- Face-to-face recruitment by recruiters based in each location. Recruiters use local community centres, street interviews, local contacts and snowballing\* techniques to find the right people.

\*Note: Snowball sampling uses initial informants to nominate, through their social networks, other participants who meet the eligibility criteria and could potentially contribute to a specific study.

Service users were given a prompt sheet as an introduction to the research before attending to give some background to help focus the discussions. *This can be found in the appendix.*

### Flexibility of attendance

Both the service user workshops (London and Manchester) were run in the evening to ensure a broad range of people could attend. The other smaller groups were held either during the day or early evening to suit the age and demographics of the group.

### Incentives

Service users were given an incentive payment of £35 to participate in this research.

### Analysis of data

All of the workshops and focus groups (registrant and service user) were digitally audio recorded. After each session, the researchers listened to the recordings and made detailed notes.

For the telephone interviews, detailed notes were taken during each interview, and these were then reviewed and additional notes recorded directly after each interview.

All of the notes were then reviewed and key themes drawn out – based on the discussion guides to keep the research focused on its key objectives. Comments about individual standards were coded by the standard number for ease of reference and collation.

Both researchers regularly met to discuss emerging findings and to clarify common themes and discussions. At the end of the fieldwork a full one-day review of data was held between the two researchers to compare findings and ensure the final analysis was accurate and reflected all of the core themes and issues.

## Methodology cont....

### Comparison of demographics

There was no purposeful analysis of the data by demographics – but during the analysis if it became clear that certain views were held by a particular group of registrants or service users because of their demographic (i.e. age, working status, professional group) this was noted and reviewed against the theme that it related to.

***The majority of findings for both service users and registrants did not show any significant differences in the general themes and views expressed by people in different demographic groups.***

### Choice of quotes

Throughout this report quotes are used to illustrate key points. All quotes are anonymised and have been chosen because they illustrate key themes or views held by more than one person – this applies to both registrants and service users. Quotes that are representative of only one person's views have not been used.

Where an important point was made by only one profession and an illustrative quote is used – this is clearly indicated.

# The findings

The findings have been divided into key sections to illustrate the context, understanding and accessibility of the standards before the final section that reviews and suggests recommendations for change.

## Context for registrants

This section explores the current context that registrants work within, the changes that have happened in practice during the past few years and how this affects their ability to engage with, understand and adhere to the standards

## Service users – expectations

This illustrates the expectations service users have for their practitioners and how this impacts on the content of the standards

## The individual standards

This section reviews the discussion from both registrants and service users for each standard to ensure a full understanding of all concerns, changes and revisions suggested. It also describes any differences between the professions in how they interpret or view the relevance of each standard.

## Accessibility

This section explores the issues of accessibility of the standards for both registrants and service users.

## Bringing it all together

Finally the conclusion brings together all of the discussions providing a full understanding of the how the discussions and findings impact on the standards.

# The registrants

## The background context

### Current awareness of the standards

Registrants taking part in this research came from a mixed knowledge base of the standards. For those registrants in practice – most had a vague awareness of the standards but had not read or reviewed them since they registered or graduated. A few registrants had needed to refer to them for fitness to practise issues for specific reference.

Where registrants are also a member of their own professional organisation/college (in addition to the regulation of the HCPC) they often use this organisation as their first point of reference if they have a query on practice issues rather than referring to the HCPC or the SCPE.

***‘It’s easier to make connections with your professional body – Should we be reading both?’***

For those registrants working in a supervisory, teaching or management role the HCPC standards are more familiar and are used as part of their assessment and supervisory work on a regular basis.

***‘We use them for observation in practice so each supervisor observes and marks against those standards.’***

### Engagement with the HCPC

Most of the registrants do not feel connected to the HCPC and have at best a neutral view. There is strong feeling that the HCPC are ‘out to get you,’ focusing on misconduct rather than providing support for your practice and are seen as very ‘hands off.’

A few of the registrants commented that when they received the invitation email to take part in this research – their first thought was ‘*what have I done wrong!*’

***‘No one knows what they do – like god sitting above us!’***

Registrants want the HCPC to be more vocal and active in their support of registrants and suggestions included:

- Having a local HCPC representative.
- Come along to local/branch meetings – to have a presence.
- Give examples of cases that were cleared/concluded – to show the supportive role in practice.

***‘Become more of a friend and less of an enemy.’***

***‘Where there is no case to answer it should show on the website, they have to protect the staff as well as the general public.’***

## The registrants cont...

This negative opinion, whilst probably not unusual between regulatory bodies and their registrants, does impact on how registrants engage with and interpret the standards – at present due to the negative view of HCPC they are seen by some registrants as a tool to use against them – rather than standards to maintain the level of professionalism that makes them proud to be in their profession.

This means that some of the issues raised are based on a concern with being able to apply and evidence that they are adhering to these standards in working situations and contexts that may be out of their control.

## Context of the working environment

The discussions focused on the changes to relationships and working practices that have occurred over the past five years (since the standards were last revised). These discussions are important in understanding the context of practice and the impact that these ongoing changes may have on how the standards are interpreted, used and adhered to.

The discussions below were common themes that were discussed by all registrant groups reflecting the changing nature of the broader health and social care environment in which they work.

## Changing relationships with service users

- Registrants feel that their relationships with service users are being affected by lack of time and resources which affects the face-to-face time they are able to give to their service users; this is due to political and economic factors.
- The fundamental basis of care is changing to a more person-centred approach and service users are working more collaboratively and in partnership with professionals. In social work registrants continue to promote independence and to work with the wider community to help improve outcomes and opportunities for the service users. The personalisation/self-care agenda has led to a more demanding, but more involved and often more knowledgeable service user.
- The increasing diversity of the population means that registrants need to be more culturally aware and understand the impact of culture, language and diversity and how this may affect the way service users interact with them and the services offered.
- Service users have more complex needs, with registrants seeing the impact of increasing poverty and deprivation putting more pressure on limited resources – especially within social work.

## The registrants cont...

- Registrants are also experiencing more violence and aggression from service users which brings with it a concern for their own personal safety at work.

*'If your service user's behaviour is unacceptable to you, you have a right to remove yourself from that situation, that isn't covered (by the standards).'*

### Quick reference - Impact on specific standards

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

## Resources

- The perceived increase in lack of funding and resources within health and social care is felt to have had a significant impact on registrants' abilities to do their jobs effectively and to work in the best interests of their service users, who may have higher expectations of the service than can be provided. There was concern that, across professions, people were working at levels that are dangerous to their service users.

*'We need to be honest and truthful about the quality of care we can provide.'*

*'It's emotionally draining-we lack the time to process and reflect and can often feel overwhelmed – but we have pressure to keep going, to take on more.'*

Funding is also affecting training budgets and many registrants are concerned about this affecting their own individual training and development.

### Quick reference - Impact on specific standards

1. You must act in the best interests of service users
5. You must keep your professional knowledge and skills up-to-date

## Team changes

- **The multi-disciplinary team (MDT)**

The past five years have seen a continued increase in multi-disciplinary working, which brings with it a need for registrants to be more aware of the broader political, social and legal environments that they work within as part of the larger team. As an example, one clinical scientist is becoming more involved in non-NHS team working including the health and safety executive and environmental health and therefore understanding the law and how this impacts on his practice is becoming more integral to his work.

## The registrants cont...

With the broader team comes shared responsibility and accountability. This includes being accountable for reports that are written jointly and being responsible for ensuring the best for your service users. This can sometimes bring challenges and concerns about how each individual can best represent their own service users.

*'An MDT may be co-signing a report that individually they wouldn't be competent to do. So you do need clarification of professional accountability and responsibility in joint working.'*

*'Having your voice heard within the team and your issues and concerns heard – it can be difficult to get your voice heard'*

- **The extended team**

Many registrants have seen their professions extended by the introduction of support positions. This includes job roles such as extended scope practitioners, therapy assistants, rehabilitation assistants, paramedic technicians, clinical support workers and assistant practitioners.

These people are not registered professions but are taking on more and more of the tasks traditionally done by the registrants they work with and this causes concern because these more junior roles are not governed by HCPC but are taking on some of the care responsibilities that are covered by the HCPC standards.

This has an impact for registrants on the delegation and supervision of work and their responsibilities to supervise and support these technicians.

In addition to the extended team, many registrants are also expected to be more involved in student placements, which again brings with it additional responsibilities and pull on their time.

### Quick reference - Impact on specific standards

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

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

## Whistleblowing/raising concerns

This consultation was undertaken during the time the Mid Staffordshire NHS Foundation Trust Inquiry (Francis report) was published and this brought the issue of 'whistleblowing' very much to the fore. It is felt that the current climate is bringing this issue to the attention of service users as well as raising awareness within the professions and this makes these standards more relevant than ever.

## The registrants cont...

Registrants acknowledged that the culture within health and social care still makes raising a concern about a colleague very difficult, but that it is also very important to ensure that this does not prevent bad practice from being reported. Registrants do feel that there is a personal responsibility to report misconduct.

*'It isn't about us it's about protecting those next door (service users) and there is nothing in there (the standards) that I can see that actually says sometimes it's necessary (to raise a concern), yes this talks about passing stuff on about concerns but it's implicit and it's that lack of clarity, I think there needs to be explicit identification of appropriate whistleblowing and the fact there is not necessarily going to be some sort of come back on you, so people feel empowered and safe to do so.'*

*'There is a responsibility to report misconduct of other professionals.'*

One of the recommendations of the Francis report was discussed in one group, which discussed the importance of being open about mistakes and the frustration that this does not happen in the NHS. This is seen as different to reporting on a colleague but more about promoting good practice and recognition of the importance of admitting mistakes and dealing with this appropriately.

*'We need to be open and honest about the mistakes that you make.'*

*'Other industries do this all the time... the aviation industry...you fill in a form, this is what I did today and this is what I learnt, in the NHS it doesn't happen and I want to be able to read about this...you read it and think I won't make that mistake again.'*

There are strong arguments to support the inclusion of a specific standard on raising concerns about poor practice. Further discussions about raising concerns, whistleblowing and incident reporting are shown in the relevant individual standard section where the standard prompted particular discussion on these issues.

### Quick reference - Impact on specific standards

A new specific stand alone standard to emphasise the importance of this



## Service users

### Context

#### HCPC/regulation awareness

None of the service users had any awareness of the HCPC and knew little about regulation or standards of conduct but most had confidence that if there was a problem they would find out where to go.

The focus of trust for the service user is the organisation that the individual professions work within (local authority/NHS/ambulance service) and they assume that the organisation would be protecting their safety and ensuring staff were competent and professional. For the older service users in particular it was very difficult for them to separate the individual from the organisation where they were being treated.

Where service users had gone directly to a registrant as a private patient there was more recognition that there would need to be some sort of governing body 'policing' the quality of treatment and service. However, the assumption was that it was a specific skills-based body aligned to a registrant's profession.

As a result of this a lot of time was taken up in trying to move discussion away from general NHS services to focus on the services provided by registrants. This illustrates the huge influence that the NHS has on service users' impressions of services and that focusing on anything other than hospitals (nurses and doctors) and general practitioners (GPs) was very difficult for service users.

However having taken part in this research many service users felt reassured that they were being well protected particularly in the light of the Mid Staffordshire failures.

*'It gives you more assurance that you can't get away with it....someone is watching them.'*

#### Expectations

Before reviewing the standards service users were asked to describe the attributes they would expect to be in a code of conduct for individual professionals. There are clear standards of conduct that service users expect and these are illustrated below:

#### **Compassionate/humane/understanding/reassuring/empathetic**

These caring attributes were seen as essential for professionals to have. Service users expect a certain level of empathy and understanding in the way they are dealt with. They are often seeing professionals at a time when they feel very vulnerable and therefore their expectation and need for a caring approach and being treated with dignity is very important and they expect these qualities as a fundamental basis of care.

*'False empathy is ridiculous, how do you know how I feel.'*

*'There needs to be a focus on individuals rather than people as a whole and that entails communication and listening to them, the way you listen with compassion, not just yes yes yes...'*

*'You need to feel comfortable, when you are having your feet done or whatever!'*

## Service users cont...

### Honest/trustworthy/integrity/reliability

Service users want to feel safe and feel that their professionals are working within a high moral framework. They also want to be assured that the correct criminal record bureau (CRB) checks and data protection procedures are in place. There was also discussion about the importance of honesty and accountability of their actions and the need to be accountable when things go wrong.

*'The organisation should be doing CRB checks.'*

### Respect /non-discriminatory/non-judgemental

It is very important for service users to feel that they are treated as individuals, with their concerns and questions adequately dealt with. Many are aware that the pressures on services do mean that they have less time to discuss their individual care needs, but that being treated respectfully and not being made to feel like a number is still a very important element in their care.

*'If you don't have the respect you don't deserve the job.'*

The service users are very aware of equality and diversity issues and the importance of being non-judgemental and non-discriminatory in attitude and practice.

### Confidential

Service users expect their cases to be treated confidentially but understand that information needs to be shared with other professionals, particularly as they like to feel reassured that the whole team is in the loop and they don't have to repeat themselves. They also expect to see reference to data protection and CRB checks being kept up-to-date as part of this.

### Continuity

Service users want their professionals to provide continuity of care, either by seeing the same person each time or ensuring that the care team are all aware of their individual circumstances on each visit or appointment. Whilst this level of care may be unrealistic, they do expect that records are easily accessible between teams and that the professionals have read their notes before visiting.

*'I think it would help with individuals with more than one problem to have a case worker...my GP knows everything, but certain people should have that case person... [to stop the frustration of fragmented services]'*

*'If you're seeing a lot of different people they should know what each other is doing and they should take ownership – you hit a brick wall all the time.'*

This is a particular issue for social care service users. One service user who has custody of her grandson and has had four different social workers in the last year and every time she has met with them she has had to go through all the same information which is frustrating.

## Service users cont...

Whilst this is a broader social care issue this lack of continuity does affect the confidence in the services being received and does prove frustrating for the service user.

*'For example if you are dealing with lots of different people and people don't understand your different needs that can be a problem.'*

## Timeliness/efficiency

For those having care within their own homes the issue of timeliness was of very high importance. Many examples were given of social workers (in the England groups) not turning up on time and people having taken time off work for the appointments.

*'If I take time off work then I expect them to turn up on time or let me know.'*

This also included getting things done in a timely manner – so if a service user has asked for information that the professional provides this without delay.

*'Efficiency – getting things done when they say they will be done.'*

## Informative/involved

Service users expect to be kept informed about what is happening to them and why certain treatments or services are being used. They also want to be involved in the decision making about their treatment or care and to be kept informed about what is happening.

*'They are coming into our home and telling us what they can do – they should be asking us what we want.'*

In addition they expect their professionals to be able to inform them about other help or services that would benefit them.

*'Individuals should be able to lead you to other help or services and should be accountable to say that they have sourced other help or services.'*

*'They need to tell you what they are doing, they don't always tell you what they suspect and what they are doing.'*

*'Some in our group were saying in our group that sometimes you don't know what is going on.....there is no explanation.'*

In one group there were two service users who had both seen physiotherapists in the last couple of years. One felt that she had not been informed about what was happening and why her back was bad, the other had been kept fully informed and praised the service she received. It was felt that both should have had the same service and that it should not be reliant on the individual professional that they saw.

*'I don't know what is wrong with my back.'*

*'She told me everything she was doing, why it was happening, how it would improve through the exercises... she explained everything.'*

## Service users cont...

### Clear communication

It is important to service users that they can understand their professional. This means ensuring that individuals have good communication skills and a good command of the English language. A couple of people had seen the recent press (February 2013) regarding the General Medical Council's campaign to strengthen their rules on doctor's minimum level of English. One of the changes that many have experienced in the past few years is the increasing number of health care practitioners from overseas and this does create some concern about the level of communication skills\*.

*'We've seen an influx of international medical professionals – something about the need for a basic marker of speaking English so at least they can communicate clearly.'*

*\*Note: This issue is addressed in the standards of proficiency*

### Competent and qualified

Service users want to be reassured that their professional is fully qualified and maintains a certain level of training to keep their skills and knowledge up-to-date. They were very clear that having a qualification did not mean that they were up-to-date with current practice and legislation.

*'As HCPC they should review each member – just because you have taken a qualification doesn't mean it's relevant...I took an accountancy degree 20 years ago, 70 percent of it is not relevant today.'*

### The standards

When looking through the bulleted list of standards the majority felt that this was a very conclusive list and most felt there was nothing missing.

A couple of people felt that 'whistleblowing' should be included within this list.

*'One thing missing there is no proviso for what is commonly known as whistleblowing...is there any mention?'*

**The table on the following page illustrates how the attributes listed are incorporated into the current standards and where they are not.**

## Service users cont...

### Summary table matching attributes to standards

| Attribute  | Included in standards | Which standards   |
|--|-----------------------|---|
| Compassionate/humane/understanding/reassuring/empathetic | N                     | There is no direct reference or use of these caring qualities mentioned in any of the current standards   |
| Respect/Non-discriminatory/non judgemental               | Y                     | Standard 1 –<br>but service users feel this needs more emphasis   |
| Confidential   | Y                     | Standard 2  |
| Continuity   | N                     | This is touched upon in Standard 6 on referral to another practitioner but nothing specific on maintaining continuity of care for service users |
| Timeliness/efficient                                     | N                     | There is nothing that mentions the importance of time keeping   |
| Informative/Involved                                     | Y                     | Standard 1<br>But more emphasis is needed about joint decision making   |
| Clear communication                                      | Y                     | Standard 7<br>But no inclusion of the importance of clear communications in English*  |
| Competent and qualified                                  | Y                     | Standard 5  |

*\*This is addressed in the standards of proficiency that the service users had not seen.*

**Further comments about individual standards are illustrated in the standards section of this report.**

## Service users cont...

### Experiences and changes

The majority of the service users were very happy with the care and service that they had had over the years. These are the main areas of change that service users had experienced and that they felt affected their care.

- **Workloads and funding**

Service users have noticed or had read about the impact of resource cuts in some services and this does lead to concerns about the quality of local services. Some felt that follow up and aftercare has decreased and there is a general feeling that the professionals they see have less time for them.

*‘Everyone is so busy and workload is heavier’*

*‘Aftercare is almost non-existent now.’*

*‘I’ve seen less staff in the team, a team of 30 has gone to a team of 5.’*

- **Technology**

As well as using the internet to search for information which made some service users feel more in control, the increased use of information technology (IT) has also helped to speed up some processes, such as getting results and booking appointments. Many people get text messages to confirm appointment times.

*‘Lots more choice (of physios and chiropractors) and lots more use of the internet so I can visit with ideas and I am more knowledgeable and I would be much more confident in getting a second opinion.’*

*‘Leads to a lot of good practice because it speeds up a lot of processes, when you have an x-ray you can see it straight away.’*

*‘It’s easier for them to scroll down and see your notes (and so ensuring they are up-to-date with your care history).’*

Technology has also given the service user more power and many recognised the difference that the internet has made to the information that they are able to obtain.

*‘We did say about the Google or the search engines – we do have a power we can now get information we want about their records and who they are, you now have more power and if anything they give you any information...you can search...the information is there.’*

But the downside for service users is that it has also taken away some of the personal contact

*‘They use to have lots of time for you, but now its tick boxes and it’s very rushed.’*

There was also concern about confidentiality with the increased use of IT for patient records.

*‘There is all this data on the computer and confidentiality is getting more important for patients.’*

## Service users cont...

- **Providing feedback**

Service users also recognise that many have a lot more confidence in giving feedback about services and in voicing concerns about poor care. The increase in surveys provides opportunities to have their say and has helped to increase confidence in having more involvement in their care and in defining what is good service.

For example one person was given an iPad on the ward to fill out a survey about her experience and felt this was excellent.

*'I want to give feedback – a questionnaire to say “where do you think we can improve, what were we good at” – that feedback could help so much. I'd like someone to say to me where did we go wrong where did we go right.'*

## The individual standards

This section looks at each of the current standards and describes discussions and suggestions from registrants and service users for changes or alterations.

***This section has a stronger focus on the registrants who had much more detail to discuss about individual standards than the service users.***

Most of the registrants understood the need for the standards to be overarching and therefore more generic in their language and approach but there were concerns that some of the standards did not accurately reflect registrants' individual practice. These concerns are discussed under the relevant standards below.

**Each standard is divided into three sections to illustrate the following:-**

- the main common themes shared by registrants as a broad group - or a particular profession if applicable - that reflect the majority of registrants' views
- less common themes and views that were raised by few or individual registrants
- service user comments



## Standard 1

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

#### Registrants – common themes

This is such an overarching standard that is seen to cover most aspects of care; however there are some fundamental concerns with being able to adhere completely to this standard.

- The lack of funding and resources within health and social care does mean that the best care is not always available to service users and that registrants need to be honest and open about what can and cannot be provided.
- For some social workers this standard seemed a little simplistic particularly when they felt they were not always able to work in the ‘best’ interests of all their service users or that some service users would not view that they were working for their best interests, for example - in situations where they need to split families up. Whilst this was only discussed by a small number of people it does raise the point that some registrants felt a clause around *determining the best outcomes possible* may make this more realistic as they are often in the position of protecting some service users from the actions or situations of other service users.

#### Registrants – less common views

- The standard should include a clause about responding to an incident or recognising where a mistake has been made and working to put matters right or to mitigate a risk to the service user, and keeping the service user informed.
- The word ‘views’ should be replaced by ‘judgement’ because this is about ensuring your judgement does not affect care.
- The first paragraph listing should also include ‘political persuasion’ as this is still very much an issue in Northern Ireland.
- The use of the word ‘protect’ should be replaced with ‘safeguarding’.
- There should be reference to registrants adhering to local equality and diversity policies.
- The end of the first paragraph that references ‘working in partnership’ should be expanded to include something about involving service users in their decision making process.
- The first paragraph should include references to safe, effective person-centred care – as this is the terminology and approach currently being embedded in practice.

## Standard 1 cont...

- In the second paragraph the sentence ‘you should take appropriate action to protect the rights of children and vulnerable adults...’ should include direct reference to safeguarding and child protection legislation. This is more than just protecting rights but is about protecting their wellbeing and protecting them from harm. Other legislation should also be mentioned here – the reference to ‘national and local policies’ sounds very NHS and this should be about relevant legislation.
- The final paragraph should be stronger in promoting ‘whistleblowing’ – you MUST discuss the matter with someone in authority without delay.

## Service users

The service users felt this was a good overarching premise – but that a couple of issues were missing.

- They expect to see a separate standard that mentions equality and diversity - it is missed by being within the detail of this standard and felt to be so fundamental to practice that it should have a more prominent focus.
- There should be something about service users being part of the decision making process or being involved in treatment options.
- They questioned the accuracy of ‘acting in the best interests’ because, being aware of funding and resource issues, the service users feel that where some treatments are rationalised is this working ***‘in my best interests or the NHS budget best interests?’***

## Standard 2

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

#### Registrants – common themes

This standard needs updating to ensure it is clear and up-to-date with modern practice.

- Many of the registrants felt that confidentiality isn't as absolute as it used to be and that they are sharing more confidential information than they used to. Registrants felt that this standard should be clearer about when and why disclosures are necessary. This includes reference to safeguarding legislation.\*

***'Safeguarding issues means that you do break confidentiality in some circumstances.'***

***'You do report more routinely now and report earlier with less information.'***

*\*Additional guidance is provided by the HCPC – 'Confidentiality – guidance for registrants' – but none of the registrants mentioned this during this research.*

- In terms of best practice for handling confidential information – this needs updating to include online security. Many confidential reports are sent via email or shared online and should these be encrypted/password protected where necessary? It is felt just referring to data protection law is not enough and it may be necessary to also refer to their organisation's data protection policies.

#### Registrants – less common views

- With the increase in team working, confidentiality rests with the care team and disclosures will be made within the team. This is important to make clear to service users as confidentiality does not always rest with one individual.

#### Service users

It was taken as read that this would be part of the standards and the issue of confidentiality was listed as one of the key standards they would expect to see within this document. Whilst there was no discussion on what this actually meant in terms of individual cases they were reassured by knowing this issue was covered.

## Standard 3

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

#### Registrants – common themes

- More clarification is wanted on what this standard actually means in practice. This is too vague and registrants are concerned that anything could be used against them. The level of detail shown under standard 4 is felt necessary to have under standard 3 as well – to help registrants understand what constitutes personal conduct.

***‘What does personal conduct mean? There are obvious things, but what about speeding?’***

***‘Does it mean the way I dress?’***

***‘Should it include inappropriate relationships? Student, teacher, service user?’***

- Social networking, especially Facebook and Twitter, should be included here, with guidelines on best practice for the use of social networking. This is one of the main areas missing from these current standards and is one of the main vehicles in which service users can find out more personal information about registrants and their social lives and where the boundaries between professional and personal relationships can be blurred.

- Standard 13 also covered the same principles and could be incorporated into one standard.

#### Registrants – less common views

- A sentence should be included linking this back to fitness to practise to illustrate that poor conduct can affect your future practice. For example - ‘Poor conduct may cause concerns about your fitness to practise.’

#### Service users

The service users also found this standard vague, but from their perspective they do understand that registrants can ‘have a life’ and do not expect very strict rules placed on people for their personal life, but felt there were some aspects of conduct that could be included:

- Personal hygiene – service users expect a certain standard of dress, especially for those registrants coming into their home and they wanted a clear ID badge displayed.
- Non-discriminatory behaviour is relevant to this standard – that personal conduct should ensure that registrants were respectful of different races and cultures.

## Standard 4

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

#### Registrants – common themes

This standard is fairly clear and the examples help to explain exactly what is required. However there are a few clarifications and additions suggested.

- The first paragraph mentions in the same sentence that an individual must inform the HCPC or other regulators about their own conduct as well as other registrants or professionals – *‘You must tell us if you have important information about your conduct or performance, or about other registrants and health and care professions that you work with.’* The standard then lists the instances that an *individual* must declare their own conduct. This mixes the issues of an individual’s own conduct and ‘whistleblowing.’ This standard would be stronger if the two were separated into different bullet points.
- This standard is seen as similar in focus to standard 12 and it is suggested that either the two could be linked or that they should follow each other in the list of standards.

#### Registrants – less common views

- Some registrants feel this standard should also link with their own employer policies and questioned if their own employer would be their first point of reference rather than the HCPC to clarify their position on conduct issues.

#### Service users

This standard was clear to service users but they felt that a statement should be included about CRB checks and ensuring that these are up-to-date.

## Standard 5

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

#### Registrants – common themes

Adhering to this standard generated a lot of concern for registrants. The two main areas of stress were:

- Not having time to undertake adequate continuing professional development (CPD) due to lack of time and funding. Examples were given of training budgets being slashed and managers not providing any time for CPD or training. Many registrants feel unsupported in the workplace to keep their skills and knowledge up-to-date and feel that their manager/employer should also have some responsibility for supporting them in this.
- There is also an underlying fear that the HCPC will call them forward for a portfolio review and a sense of panic that they are unsure what this entails and how much CPD they should be doing in order to meet acceptable standards.

Additions to this standard included the following:

- Further guidance is wanted to clarify what is acceptable in terms of how much, how long and how many hours. Whilst it is acknowledged that additional guidance is available from the HCPC some guidance within this standard would help to clarify the minimum standards expected.

#### Registrants – less common views

- Knowledge and skills should be defined in clearer terms than ‘good quality’. Reference should be made to the importance of evidence based and research based practice and the need to keep abreast with current practice developments. It is important that any CPD undertaken is effective and has an impact on individual practice and this needs to be clarified within this section.
- Within this section a statement on the importance of IT skills was suggested. Most registrants need some level of IT proficiency in order to do their jobs and this needs to be acknowledged.

#### Service users

Ensuring their professionals are skilled and up-to-date was an area service users felt was important. Service users assumed that this standard is monitored by the organisation professionals work within, which they believe to be very important in ensuring safe and up-to-date practice.

## Standard 6

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

#### Registrants – common themes

For most registrants this was a clear standard and very little discussion focused upon this.

- Social workers feel that the issue of referral is not relevant for them as they do not routinely refer onwards.

***‘This is not true of social work, we’re not free to do this, can’t refer on, no one else to take it.’***

***‘We cannot adhere to these standards.’***

- This standard also raised discussion on caseload – and acting within the limits of your capacity. Many of the social workers are overloaded yet still unable to refuse additional work, often, as there is no one else to take on cases. In addition, often the caseload system is an automated one with little input from professionals. Social workers felt that this standard in particular was written for those working within a supportive environment where practitioners had choices about their cases and their ability to carry out their work. It was suggested that this standard needs something about employer responsibility.

***‘You may have the skills and expertise but what if you don’t have the resources or time?’***

#### Service users

For service users, a suggested addition to this was the remit for registrants to provide information about other services that may benefit service users, not because this is outside their scope of practice but just because they think it will be of benefit.

## Standard 7

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

#### Registrants – common themes

This standard is clear but some fundamental additions would help to bring it up-to-date with current practice.

- Online communication should be included. Registrants use email and text to communicate with service users and this should also be clear and effective and secure.

#### Registrants – less common views

- Inclusion of the need to recognise the diversity of language and culture within the UK which includes using interpreters to ensure service users can understand and also be understood.
- Communication is broader than just the service user or other practitioner and this needs clarifying. The increase in multi-agency working means that registrants need to communicate effectively across agencies, including those outside of health and social care.

#### Service users

For service users the issue of clear communication is one of the key attributes that they expect from their professionals and further emphasis should be put on ensuring that communication is clear and effective and understood by the service user.

- The issue of the use of language is relevant here, related to the importance of the service user understanding their professional. This links back to the concern of service users with the increase of overseas staff and the need to ensure a minimum standard of English.
- Missing from this standard is reference to communicating with carers or other appropriate family members. Communication is broader than the service user.
- The type of communication should be confirmed and agreed with the service user. Many are happy with using text or email as part of their communication but this needs to be agreed with them first.



## Standard 8

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

Registrants – common themes

This standard concerned some registrants who were unsure how this standard would work in their current practice, what level of supervision was expected and if placing the responsibility purely on them for delegated tasks was fair.

- It is felt that this standard should also reflect managers' responsibilities in enabling registrants to be able to effectively carry this out.

***'Managers should be enabling registrants to be able to carry this out – are you qualified to supervise?'***

***'What does this mean? – in a managerial role it makes sense, but as a practitioner - I wouldn't understand.'***

- For those registrants working with technicians or support workers they felt this placed an unattainable responsibility on them as they often had to delegate to their support workers who are continuing to take on more and more of registrants' work and this leads to concern about registrants' responsibilities within this.

***'There are lots of assistants/technicians – boundaries are being pushed – you are not there all the time, what does it mean to effectively supervise tasks?'***

- Registrants also felt that where delegation is made to another registrant or professional that supervision would not be expected.

***'When delegating to another professional who has qualifications, we don't need to supervise, we have to respect each other's skills.'***

- For social workers this standard does not accurately reflect their job expectations with some social workers making the point that supervision was not in their job description.

***'If I had to refer a service user to another County – I wouldn't be supervising I would be liaising and getting progress reports – should this be about ensuring the appropriate work requirements are carried out?'***

Registrants – less common views

- There should be something specific about the supervision of students. Many registrants are expected to take students out on placements despite not having any supervisory skills or training.

***'We are all expected to take out students and we are not all at a level to be able to adequately supervise.'***

○

## Standard 8 cont...

- This standard is also about more than 'supervision' but was about ensuring outcomes and being available for advice and therefore the following additions were suggested.
  - The inclusion of being available for advice and continued support – 'If you delegate you must be available for advice'.
  - It should also include something on checking up on the outcomes of the task you have delegated.

## Service users

Service users were unsure what is meant by supervision – 'does that mean checking them every 15 minutes or following up the next day?' They also felt this was a management issue, to ensure that all practice is taking place safely.

## Standard 9

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

#### Registrants – common themes

- This standard is seen as very treatment based – social workers did not feel this directly applied to them particularly as they face situations where they have to go against the wishes of the service user as they have a duty to protect service users from themselves and other people.

***‘We section people against their wishes...we can take their benefits away if people refuse to engage with us. There is nowhere in our case recording that asks for it (informed consent).’***

- For paramedics this standard was also of concern, as they frequently have to make decisions in uncontrolled environments about what may be the best outcome for service users who may not be in a position to make any decisions themselves.

Whilst the standard does state ‘in some situations, such as emergencies or where a person lacks decision-making capability’ this does not clarify the situation fully and the Mental Capacity Act and safeguarding procedures should be mentioned to illustrate why legally this standard cannot be adhered to in certain circumstances and provide more of a point of reference for registrants.

***‘You could increase the priority of mental capacity – what someone wants and what someone needs can be poles apart – so this standard could be a point of reference.’***

#### Registrants – less common views

- Some scientists feel this is not relevant, as they did not seek consent directly from service users at all – although they are aware that the process of consent has taken place prior to their involvement. This is the same for operating department practitioners who do not always directly seek consent from service users but are aware of the importance and process of seeking consent.
- There needs to be further clarification about what is meant by a ‘written record’.
- Should this standard include getting consent for taking part in research?
- The final paragraph – should include if there is a risk to their life – or their *wellbeing*.
- This standard only mentions the risks – should registrants also discuss the benefits?
- There is nothing about giving people time to digest the information they receive before making an informed decision.

#### Service users

This is acknowledged as an important area for service users who do want their care and treatments fully explained to them and wish to be involved in the decision making around this. Service users are familiar with consenting in hospital before treatments by signing a consent form, but were unclear how the process of informed consent operates outside of this environment, for instance - does it always involve signing a form?

## Standard 10

### Standard 10: You must keep accurate records

#### Registrants – common themes

This standard was seen as outdated as the introduction of electronic records has taken over most paper based systems - although many registrants are still using paper based records as well. This standard should be rewritten to incorporate the use of record keeping electronically as well as the increasing use of tablets and other hand held devices to store and share records.

- Electronic record keeping brings with it other issues of security which should be included such as not letting someone login in your name, keeping your password secure, not walking away from your computer without logging off, and of adhering to data protection law and the organisation's data protection policies.
- Good record keeping is not just about 'accuracy' but of the clarity, detail and understanding of what is written. Registrants rely on notes from colleagues and it is important that the correct detail of care is recorded. Dyslexia is an issue that concerned one registrant about the clarity of record keeping from registrants with dyslexia and how this supports the need to include something in the standard about the *clarity* of record keeping.

#### Registrants – less common views

- The second paragraph of the standard discusses the duty to check records completed by students under your supervision – registrants felt this could be extended to assistants/technicians or support workers. This section should also include guidance on 'countersigning' records completed by others.
- The paragraph about reviewing records was questioned – as registrants may not always need to update or add anything to records that are reviewed for information only.

#### Service users

Service users also acknowledged the change to electronic records and feel that the Data Protection Act should be clearly referenced in this standard.

## Standard 11

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

#### Registrants – common themes

This standard was open to many different interpretations. As it is currently written registrants felt it needs some clarification about the different aspects of dealing with infection which include:

- Confidentiality about the infection status of a service user.
  - Physically dealing with infection and risks in the workplace.
  - Working with a service user who has an infection.
  - Dealing with your own infection.
- The current wording was described as a ‘throwback to HIV statements’, which is outdated, and a clearer definition is required. Registrants were unsure what ‘fairly’ meant.
  - The inclusion of risk assessment would make this more relevant to today’s practice. This is about professional and personal safety in dealing with infection risks.
  - For those registrants (paramedics) working with acute trauma – there is concern about being able to adhere to this standard as they face very different standards of infection control and therefore felt this should be recognised within the standard.

***‘How can you evidence you are adhering to these guidelines when working in difficult conditions...’***

- It is not clear what ‘infection’ means in terms of individual registrants having an infection. There is no definition about this – a serious infection (e.g. Hepatitis C, virus) or a common cold?

#### Registrants – less common views

- The remit to protect your service users from infecting each other was seen as unreasonable – how do you do this? Is this about ensuring the environment is clean or is it about the different behaviours of your service users?
- This standard should also include reference to adhering to the infection control policy at your workplace. As some registrants stated - a hospital can raise a disciplinary action against you if you breach their standards of infection control.
- This should cover the protection of equipment against infection.
- It should also include reporting concerns if the environment is putting people at risk.

#### Service users

Service users were also confused about the term ‘fairly’ and what this standard actually covered. They understood how the standards of cleanliness relate to a hospital environment but were unsure how this is followed outside of the hospital context. Their experience of infection control was related to the appropriate use of hand washing, personal hygiene and the cleanliness of the clinic environment.

## Standard 12

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

#### Registrants – common themes

This standard raised the concern that many people may not be aware or willing to admit that their health is affecting their practice. Some registrants had had to refer to other standards within their organisation to overcome this and get further clarification.

- Further detail or definition would be helpful, for example does it include cover stress, grief, bereavement and substance abuse.
- This standard also conflicts with the pressures placed by employers on registrants to go into work and not take too much time off and therefore becomes a management issue which should be acknowledged within this standard. There were many examples of employers who do not pay staff for the first few days 'off sick' so there is pressure to be at work even if you are unwell.
- Registrants were unsure at what stage you should be getting advice and if you should be following your organisational policies and procedures first – which may entail talking with your manager rather than going directly to a consultant in occupational health or other medical practitioner.

#### Registrants – less common views

- A couple of registrants questioned the role of the HCPC as regulator in supporting their registrants and one raised the 'Equality Act' which 'states that you must support people with illness'. It was suggested that the HCPC could include something about them 'supporting your decisions with your employer.'
- Standard 1 includes a paragraph about recognising the ill health in a colleague or other professional – and it may be more relevant to reference that in this standard as it becomes lost in the detail of standard 1.

#### Service users

Service users had similar discussions to the registrants and felt that people would not always admit or recognise their ill health. They were concerned about who measures this and how it can be judged. They also feel that it should be a management issue rather than an individual practitioner issue.

***'Not many people will admit that – that is for the manager isn't it?'***

## Standard 13

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

Registrants – common themes

This standard was seen as being very similar to standard 3 and should be merged as one standard. As with standard 3 - this standard was also seen as lacking in definition and detail.

*'This is so important yet so poorly defined – as is number 3 – what is it over and above number 4 that would indicate poor standards of behaviour – it needs a definition as to what extra this brings.'*

Service users

Service users also felt this was so similar to standard 3 and also standard 4 and that it should be merged with standard 3, if not 4 as well. In addition it was suggested that the wording should include 'the public's and **service user's** confidence.'

## Standard 14

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

#### Registrants – common themes

For most registrants this was not relevant to them but it is acknowledged by many that this is an area that is likely to be increasing as more areas of work go out to tender and the number of private practitioners continues to grow.

#### Registrants – less common views

The following suggestions were made to expand these standards

- Include the term publicity as well as advertising – ‘...advertising or publicity you do is accurate.’
- Change the wording from ‘play a part’ to ‘influence.’ - financial reward should not ‘influence’ advice.’
- Include relevant guidelines for social networking within this standard such as registrant’s use of LinkedIn, Twitter and Facebook to promote their services or products.

#### Service users

Most service users did not understand the relevance of this standard, but did suggest that this could include ensuring that HCPC registration is promoted in any advertising.



## Other issues

### Fitness to practise – page 15

One registrant felt strongly that there needs to be a clear definition of ‘effective’ – is this about improving service users’ health, stabilising them or reducing their rate of decline? It was also suggested that this section should be at the front of the standards, not on the back page, as this explains the fundamental reasons why the standards are in place and what may happen as a result of registrants breaching them.

### Definitions of service user

There was much discussion between both registrants and service users about the use of the term ‘service user’ within the standards. Whilst most understood what this means there was a need for some further clarification for both groups.

- **Registrants**

The meaning of ‘service user’ for registrants can be so varied that would be useful to have a clearer definition to ensure the standards remain clear and relevant. This includes ensuring that carers and other family members were specified. But also for registrants the ‘service user’ could be other registrants or other professionals, particularly those registrants who were not ‘patient facing’ such as scientists. Also for those in management the direct ‘service user’ may be students or other staff.

- **Service users**

Most people did understand what this meant but it is not clear to them that this also includes carers and other close family members who may be involved in their care. One person explained how he had been called a stakeholder by one of his practitioners and had not understood what that meant.

*‘When I first read it I thought service users – who are we talking about?’*

## Accessibility

This section explores the discussions that focused upon the availability, awareness and style of the standards and how they may be better promoted for both registrants and service users.

### Registrants

#### Promoting these standards

Most of the registrants re-read these standards because they were taking part in this research. Most had not read or engaged with them at all prior to joining the register or qualifying, unless they were involved directly in education or supervision. Because of this some registrants were concerned about the effectiveness of the standards and feel they need to be better embedded within personal development reviews (PDRs) and supervision to ensure professional standards were maintained.

***‘There is a responsibility to instil them...otherwise you lose accountability...You can’t have standards if they are not used and monitored.’***

A few registrants suggested that a copy of the standards could be emailed/sent to registrants when they re-register as a way to help embed them in practice.

Registrants were also concerned about the level of knowledge and awareness that their employers had of the standards and wanted these to be better promoted to their employers. It is believed that this would help registrants have more confidence in their ability to adhere to them – particularly those standards that imply some cooperation from their managers/employees (supervision, continuing professional development (CPD)).

***‘How does the HCPC engage with Trusts?’***

***‘I would like the HCPC to have a better relationship with my employer, so they can better understand our remit, it might encourage our employer to better support our practice.’***

#### Style and structure

The style and structure of the standards raised little comment. The registrants felt the style was very similar to other professional standards and documents and were happy with the format and found it very easy to read and understand. Registrants liked the bulleted list on page three as it gave a good general oversight of the standards. There were a few suggestions to improve the style:

- Use more bullets within the main text to break this up and make it easier to read

## Accessibility cont...

- Use some flow diagrams showing different areas of practice to illustrate the standards that are most relevant to specific professions.
- Develop mobile application software (an 'App') to link with the standards\*

**\* HCPC does currently have an iPhone and Android app that indirectly links to the standards via the HCPC website. No one mentioned this during the research.**

### Promotion to service users

Most of the registrants felt that the main issue is ensuring that service users are aware that the HCPC exists as a body that maintains professional standards rather than giving them the detail of the actual standards. It is positive and good for their own professionalism if service users are more aware of the register and HCPC and therefore their proven level of practice.

Some registrants running private practices do use the HCPC branding on their website and literature but service users were still unaware of its existence - only other HCPC registrants ever asked for confirmation of HCPC registration. Only one registrant in this research (a social worker) had ever been asked by a service user about their qualifications or registration.

A couple of registrants suggested that the HCPC could update their ID card to include a photograph.

***'I don't think there is a high enough profile of the HCPC and how they protect service users, especially in private practice.'***

***'They should know about the HCPC but they don't need the standards to be pushed.'***

***'I haven't bothered putting it (HCPC registered) on my business cards or web pages as no-one knew what it meant.'***

***'The only ones who ever check whether we are registrants are the other registrants because they know how to access the system and know the HCPC exists.'***

Registrants felt that promotion of the HCPC in the broader community would help to increase awareness including using local authority and community websites and other places where service users will look for general information about local services.

A few registrants felt that as their role in the community was increasing and that private practice was also increasing, the importance of raising awareness of the HCPC may become more of an issue for service users, particularly if people are paying for poor service.

## Accessibility cont...

### Service users

#### Awareness of the HCPC

None of the service users were aware of the HCPC with the majority assuming that registrants are governed by their employer – the NHS in most cases. Even if service users saw professionals privately they still assumed that the professional belonged to a profession-specific professional body, rather than an overarching regulatory organisation.

**Therefore when discussing accessibility the main issue discussed was ‘why haven’t we heard of the HCPC?’ which was more important to service users than the detail of the standards.**

The service users felt reassured to know that their professionals had a regulatory body that was there to protect them and felt that it increased their confidence and image of their professionalism. But they were surprised that they had not heard of the HCPC. Many were familiar with the Nursing and Midwifery Council and the General Medical Council and felt the HCPC needed to have a higher profile and be better promoted to service users.

They also place their trust in the organisation the practitioner belongs to - trusting the hospital/local authority - rather than focusing on an individual practitioner.

#### Clarity of the standards

The service users were very aware that these standards had been written for registrants, but the majority still felt that the language was clear and easy to understand. There were a few who felt that the standards would not be understood and that a simpler version would be needed for some service users. A couple of people thought this was down to the use of terminology of ‘service user’ which they did not recognise as being about them.

***‘It’s a funny word, when I first read it I thought service user? Who are we talking about it doesn’t really tell me - if you chucked this in front of me now I wouldn’t know what it was talking about. A lot of people who access this service won’t understand that...’***

The use of the bullet pointed list (page three of the standards) was seen as the right level of information for service users and as such they expected this list to be comprehensive and include all the relevant attributes they listed – rather than having this hidden within the broader text. For example, equality and diversity was very important for service users and this was ‘hidden’ in the broader text rather than being up front in the bulleted list.

## Accessibility cont...

### Access to the standards

Some service users felt that they should have access to these standards in a shorter format. It was suggested by a few that the professionals could hand them out, or that there could be copies available in clinics.

*'They could give you an abridged printed copy like you gave us...and then the website...that could be given to you when you first go and see one of these providers.'*

*'You should get a leaflet from the health care professional summarising it. If you dealt with an architect or an accountant you get a contract why should it be any different, I need to know particularly if I'm seeing a private physiotherapist I need to know what recourse I have if I'm not happy with the service.'*

However the underlying issue of the lack of awareness of the HCPC still clouded these discussions – how could they be aware of the standards if they were not aware of the HCPC and its role in protecting them?

While it is clear that the content of the standards is clear and easy to understand, for most service users it was more important to know where to go if there was a problem rather than having an awareness of the details within the standards. So unless there is a greater awareness of the organisation through more general advertising merely presenting a list of standards would not be sufficient.

*'I would expect that they are professional and if you don't get professional behaviour then you and I will recognise that and will take further action. So I don't think we need to see that (the standards) necessarily.'*

*'But you should be expecting it anyway you should be expecting all of this as a standard anyway, why do you need to know about it? ... but if you're not happy about something then you would just complain about it.'*

*'If everything runs smoothly I don't need to see that [the standards].'*

*'I don't think I would have ever read this if I had been offered it.'*

*'To be honest for me to actually read that something would have actually gone wrong, so I'd rather have a flyer... a little something with a phone number or a website...'*

### Promotion of the HCPC

There was discussion about promoting the HCPC more clearly within GP surgeries, at private clinics, and within the patient and liaison service (PALs). A couple of people also suggested that they should be told about the HCPC on their first appointment with their professional. The key issue for service users was having the confidence that they knew where to go if something went wrong.

*'When something goes wrong you want to know how to go about it.'*

*'We just need to know where to go if there is a problem.'*

# Bringing it all together

This section brings together all of the research discussions providing a summary of how the discussions and findings impact on the standards.

## Engaging with the HCPC

This research showed the lack of engagement that registrants have with the HCPC and this will impact on the way that they interpret the standards – seeing them as a tool to judge their practice rather than supporting their professionalism. This relationship is probably not unusual between regulatory bodies and their registrants but improving this perception will help registrants to engage with the standards and see them as a useful reference point for their practice.

## Service user knowledge of the HCPC

For service users it is clear that the key issue for them is their lack of knowledge about the HCPC and its role in protecting them. The need for better awareness or promotion of the HCPC to service users was more important than the detail of the standards. Service users need the reassurance of knowing where to go if something goes wrong.

## The standards

During this review, whilst there are clear concerns about the relevance of individual standards, no one suggested a complete rewrite. Registrants are very accepting of the format, which is fairly standard for documents of this kind and the discussions focused more on registrants' abilities to adhere to the standards and their relevance to current practice and changes that will better reflect this.

***'It is important that the standards are generalist without losing the complication of the context.'***

## Relevance to all

### Social workers

Most of the registrants understand the need for the standards to be overarching and therefore more generic in their language and approach. But for social workers in particular the style of language and the difference in their practice made them question the relevance of some of the standards more often than other registrant groups. The use of the word 'treatment' and the underlying focus on health gives them a sense of losing their own identity within these standards.

***'Is very focused on ill people – but my service users aren't ill people, feels very traditional and health care based.'***

### Patient-facing vs non patient-facing

Some registrants – mainly the clinical and biomedical scientists and some managers in other disciplines, felt that some of the standards are not directly relevant as they are not 'patient-facing' and their service users are other professionals. A clearer definition of service users would help to ensure the standards remain relevant to them.

## Bringing it all together cont...

### Concerns with adherence

Many registrants are concerned about their ability to adhere to the standards and providing evidence that they are adhering to them. There are two main concerns that run through this research:

#### Individual vs the organisation

Many registrants feel that the cuts in service funding and lack of supportive management means that they will struggle to maintain the current standards, especially standards 5 (knowledge and skills) and 8 (supervision). They feel that these standards involve the support and cooperation of management and that this should be reflected in the standards.

#### Controlled vs uncontrolled working environments

When interpreting the standards there is a clear division between those working in 'uncontrolled environments' which includes paramedics and some field social workers, and those working in controlled environments – hospital/clinic – which includes most other registrants.

The uncontrolled environment brings with it a different set of challenges and a different decision making pathway – registrants who work in these environments often have to make immediate and potentially life changing decisions for the service users.

An uncontrolled environment is relevant specifically to standard 1 (best interests); standard 9 (informed consent) and standard 11 (infection). The inclusion and recognition of these different working environments within the standards would help to identify what is acceptable (and manageable) conduct in these specific situations.

## Bringing it all together cont...

### Overall recommendations for change

When reviewing the discussions around the specific standards, together with the expectations of the service users, there are some clear issues that emerged from the data that should be reviewed for the next rewrite of the standards.

#### Whistleblowing/raising concerns

Both registrants and service users feel that there needs to be a specific standard on whistleblowing and raising concerns about colleagues and other professionals. At present there is reference to this in standards 1 and 4 but a stronger emphasis needs to be given to highlight the responsibility of registrants to report poor practice.

#### Incident reporting

There is no mention of the importance of 'incident reporting' in the current standards and it is felt that part of the responsibility of a registrant is to report incidents and ensure the safety of the service user by responding appropriately and supporting and providing information to the service user where things go wrong. This is not about reporting on a colleague but recognising and dealing with 'mistakes' or 'incidents' which happen due to human error rather than negligence.

### Joint decision making and working in partnership

Service users expect to be involved in their care and the decision making. At present this is mentioned in standard 1, but not enough emphasis is given to this. Involving service users has become a key component of health and social care over the past few years, with the focus on person-centred care, personalisation of budgets and the self-care agenda. This needs to be better reflected in the standards.

#### IT security

One of the biggest changes in the past five years has been the increasing use of IT systems that are rapidly replacing paper based systems. The standards need to reflect this by incorporating stronger reference to IT security, password protection, encryption, online sharing of documents and contact with service users via email.

#### Social networking

Alongside the growth of IT systems is also the growth of social networking. There is no mention of this in the current standards and this needs to be incorporated, at least into standards 3 and 14.



## Bringing it all together cont...

### **Culture and diversity**

This is mentioned in standard 1 but both registrants and service users feel that stronger references and guidance are required in order to recognise the impact of diversity and cultures on the use of services and the level of awareness that registrants need to have to support the service user. This also impacts on standards 7 and 9.

### **Specific legislation**

Some of the reference to legislation needs to be updated to include the legislation that affects current practice including safeguarding and the Mental Capacity Act. There should also be reference to the importance of registrants being aware of the relevant legislation that affects their own area of practice. This affects standards 1, 5 and 9.

### **Personal safety**

At present there is nothing in the standards about ensuring your own personal safety. With many registrants facing increasingly difficult working situations and more volatile service users, this is seen as a key area to include. This includes the need for risk assessments to be undertaken particularly when dealing with uncontrolled environments and infection control.

### **Terminology**

The terminology within the standards needs updating to reflect current practice. Key terms suggested were 'person-centred', 'evidence based' and 'safeguarding'.

**The summary table on the next page summarises the key findings from the research.**

# Summary table

| <b>Standard</b> | <b>Change required</b><br>√ = A few tweaks<br>√√ = Some change<br>√√√ = rewrite | <b>Concern with Adhering to the standard</b><br>N = No<br>Y = Yes | <b>Relevance to all registrants</b><br>N = No<br>Y = Yes | <b>Main changes/suggestions</b>   |
|-----------------|---|---|--|---|
| <b>1</b>        | √√  | <b>Y</b>  | <b>Y</b>   | <ul style="list-style-type: none"> <li>• Include involvement of service users in decision making</li> <li>• Include incident reporting</li> <li>• Reference safeguarding and child protection</li> <li>• Reference 'effective person-centred care'</li> <li>• Stronger emphasis on 'whistleblowing'</li> </ul>                      |
| <b>2</b>        | √√  | <b>N</b>  | <b>Y</b>   | <ul style="list-style-type: none"> <li>• Update to reflect current practice around safeguarding and disclosure</li> </ul>   |
| <b>3</b>        | √√  | <b>N</b>  | <b>Y</b>   | <ul style="list-style-type: none"> <li>• More clarification on what this means in practice</li> <li>• Inclusion of social networking issues</li> <li>• Merge with standard 13</li> </ul>  |
| <b>4</b>        | √   | <b>N</b>  | <b>Y</b>   | <ul style="list-style-type: none"> <li>• Link with standard 12</li> <li>• Have different bullets for the individuals conduct and the conduct of others</li> </ul>   |
| <b>5</b>        | √√  | <b>Y</b>  | <b>Y</b>   | <ul style="list-style-type: none"> <li>• Concerns with employers supporting training</li> <li>• Need for more clarity on what is required for continuing professional development</li> <li>• Include IT skills</li> </ul>   |
| <b>6</b>        | √   | <b>N</b>  | <b>N</b>   | <ul style="list-style-type: none"> <li>• Social workers feel this standard is not directly relevant to their practice as it stands</li> <li>• Include the issue of capacity and coping with workload</li> </ul>   |
| <b>7</b>        | √   | <b>N</b>  | <b>Y</b>   | <ul style="list-style-type: none"> <li>• Include IT and the use of online communication</li> <li>• Include the need to recognise diversity of language and culture in communications</li> <li>• Broaden the scope of this standard to include communicating with the team and agencies outside of health and social care</li> </ul> |

Summary table cont...

| <b>Standard</b> | <b>Change required</b><br>√ = A few tweaks<br>√√ = Some change<br>√√√ = rewrite | <b>Concern with Adhering to the standard</b><br>N = No<br>Y = Yes | <b>Relevance to all registrants</b><br>N = No<br>Y = Yes | <b>Main changes/suggestions</b>   |
|-----------------|---|---|--|---|
| <b>8</b>        | √√  | <b>Y</b>  | <b>N</b>   | <ul style="list-style-type: none"> <li>• Concern on where responsibility for delegated work lies in current practice</li> <li>• Social workers did not feel this was relevant to them, as they do not directly delegate their work</li> </ul>   |
| <b>9</b>        | √√  | <b>Y</b>  | <b>N</b>   | <ul style="list-style-type: none"> <li>• Concern about adhering to this standard in uncontrolled environments</li> <li>• Need for clarification on when safeguarding and mental capacity override the need to obtain informed consent</li> <li>• Social workers did not feel this was directly relevant to them</li> </ul>                            |
| <b>10</b>       | √√  | <b>N</b>  | <b>Y</b>   | <ul style="list-style-type: none"> <li>• Needs to be rewritten with the emphasis on electronic record keeping</li> <li>• Include something about the importance of clarity and the detail of record keeping – not just the accuracy</li> <li>• Include checking and countersigning of records for students and support workers/technicians</li> </ul> |
| <b>11</b>       | √√√   | <b>N</b>  | <b>Y</b>   | <ul style="list-style-type: none"> <li>• Needs rewriting to clarify the different aspects of infection – including confidentiality, risks, workplace behaviour and cleanliness, registrant illness</li> </ul>   |
| <b>12</b>       | √√  | <b>Y</b>  | <b>Y</b>   | <ul style="list-style-type: none"> <li>• Further clarification on which aspects of health and illness this covers</li> <li>• This standard conflicts with pressure to work from employers</li> <li>• Include more supportive wording to support self-reporting</li> </ul>   |
| <b>13</b>       | √√  | <b>N</b>  | <b>Y</b>   | <ul style="list-style-type: none"> <li>• Include more definition and detail and merge with standard 3</li> </ul>  |
| <b>14</b>       | √   | <b>N</b>  | <b>N</b>   | <ul style="list-style-type: none"> <li>• Include the term publicity and include guidance on social networking for the promotion of services and products.</li> </ul>  |

# Appendix

This appendix contains the following details

- **Service user quotas**
- **Registrant quotas**
- **Discussion guide – Service users**
- **Discussion guide – Registrants**
- **Information sheet – Service users**
- **Introductory email - Registrants**
- **Information sheet - Registrants**

# Service Users

82 Service users took part in this research

The different treatment and care categories are shown opposite.

## 1. Treatment and care categories

| Category     | Number of service users within the category |
|--------------|---|
| A            | 26  |
| B            | 9   |
| C            | 17  |
| D            | 30  |
| <b>Total</b> | <b>82</b>                                   |

## Treatment and care categories

**A:** Have had treatment from one or more of the following

- Chiropractors/podiatrists
- Dietitians
- Occupational therapists
- Physiotherapists
- Speech and language therapists
- Have seen a ‘talking’ therapist, either a psychologist, art therapist, music therapist or drama therapist

**B:**

- Have had a hearing aid test or had a hearing aid fitted
- Have been treated for an eye problem, for example, lazy eye/squint/glaucoma/cataract/retinal problems

**C:**

- Has had experience of social workers/social care – i.e. they may have been allocated a social worker for a period of time or have needed to consult with a social worker for specific issues.

**D:**

- Have had an accident that resulted in an ambulance journey to hospital
- Have had blood tests taken for a diagnosis
- Have had an x-ray or ultrasound
- Have had radiotherapy

## Further demographic details

### 2: Locations

| Venue        | Number    |
|--------------|-----------|
| Manchester   | 22        |
| London       | 24        |
| Birmingham   | 8         |
| Cardiff      | 8         |
| Glasgow      | 10        |
| Belfast      | 10        |
| <b>Total</b> | <b>82</b> |

### 3: Gender

| Gender       | Number    |
|--------------|-----------|
| Female       | 45        |
| Male         | 37        |
| <b>Total</b> | <b>82</b> |

### 4: Age Ranges

| Age          | Number    |
|--------------|-----------|
| 18-25        | 7         |
| 26-35        | 11        |
| 36-45        | 22        |
| 46-55        | 16        |
| 56-65        | 12        |
| 65+          | 14        |
| <b>Total</b> | <b>82</b> |

### 5: Ethnicity

| Ethnicity                           | Number    |
|-------------------------------------|-----------|
| White British                       | 73        |
| Black African/Caribbean/<br>British | 4         |
| Asian                               | 2         |
| Mixed Race                          | 1         |
| Swedish                             | 1         |
| Lebanese                            | 1         |
| <b>Total</b>                        | <b>82</b> |

## Full treatment and care details

These tables show the treatment details for each participant to show the range of experiences the service users brought to the research.

| Age | Gender | Category | Health / Treatment  | Ethnicity     | Location   |
|-----|--------|----------|---|---------------|------------|
| 24  | M      | C        | Suffered due to an accident and seen social workers since   | Black British | Birmingham |
| 50  | M      | C        | Nephew has cerebral palsy and takes an active role with social workers putting together care packages for him | White British | Birmingham |
| 31  | F      | C        | Mother has MS and has to deal with social workers   | White British | Birmingham |
| 33  | F      | C        | Been in contact with social workers regarding her daughter who is having social problems                      | White British | Birmingham |
| 43  | F      | C        | Has custody of her grandchild and regularly sees social workers   | White British | Birmingham |
| 45  | F      | C        | Foster carer  | White British | Birmingham |
| 49  | F      | C        | Dealing with social workers regarding his mother's care   | White British | Birmingham |
| 49  | M      | C        | Deals with social workers regarding his partners disabled daughter  | White British | Birmingham |
| 60  | F      | A        | Chiropodist, physiotherapist, hearing aid test, blood tests   | White British | Cardiff    |
| 41  | M      | B        | Podiatrists, OT, Physiotherapist, Eye Squint, blood tests and CT scan   | White British | Cardiff    |
| 43  | M      | B        | Chiropodist and eye problems  | White British | Cardiff    |
| 39  | F      | D        | Physiotherapist, Retinal Problems, Accident-hospital ambulance, blood tests, x-ray, ultrasound                | White British | Cardiff    |
| 43  | F      | D        | Physiotherapist, blood tests, x-ray   | White British | Cardiff    |
| 56  | F      | D        | Physiotherapist, Speech language, Blood test for diagnosis, x-ray and ultrasound                              | White British | Cardiff    |
| 42  | M      | D        | Physiotherapist, Blood tests, x-ray   | White British | Cardiff    |
| 56  | M      | D        | Podiatrist, Dietician, Physiotherapist, Speech therapist, Blood tests, x-ray                                  | White British | Cardiff    |

Full treatment and care details cont...

| Age | Gender | Category | Health / Treatment                                  | Ethnicity       | Location |
|-----|--------|----------|---|-----------------|----------|
| 20  | F      | D        | X-ray for ankle fracture                            | Black Caribbean | London   |
| 26  | M      | C        | Social worker due to being diagnosed bi-polar       | Indian/Asian    | London   |
| 31  | M      | A        | Physiotherapist due to an accident                  | Mixed Race      | London   |
| 48  | F      | A        | Dietician   | Swedish         | London   |
| 21  | F      | A        | Talking therapist                                   | White British   | London   |
| 53  | F      | A        | Cognitive therapy for depression                    | White British   | London   |
| 65  | F      | A        | Physiotherapist                                     | White British   | London   |
| 42  | M      | A        | Physiotherapy for Shoulder and Dietician            | White British   | London   |
| 50  | M      | A        | Physiotherapist on shoulder due to cycling accident | White British   | London   |
| 75  | M      | A        | Chiropodist   | White British   | London   |
| 40  | F      | B        | On-going hearing tests due to glue ear when younger | White British   | London   |
| 44  | M      | B        | Hearing aids fitted                                 | White British   | London   |
| 62  | M      | B        | Glaucoma  | White British   | London   |
| 23  | F      | C        | Social Worker due to parents' divorce               | White British   | London   |
| 61  | F      | C        | Social Care   | White British   | London   |
| 75  | M      | C        | Social Care   | White British   | London   |
| 33  | F      | D        | Regular blood tests for thyroid                     | White British   | London   |
| 54  | F      | D        | Bloods and MRI                                      | White British   | London   |
| 61  | F      | D        | Regular mammogram, annual blood test for statins    | White British   | London   |
| 70  | F      | D        | Blood tests   | White British   | London   |
| 27  | M      | D        | Ambulance   | White British   | London   |
| 52  | M      | D        | X-ray and bloods due to broken shoulder             | White British   | London   |
| 60  | M      | D        | Ambulance and x-ray                                 | White British   | London   |
| 70  | M      | D        | Radiotherapy  | White British   | London   |



Full treatment and care details cont...

| Age | Gender | Category | Health / Treatment  | Ethnicity     | Location   |
|-----|--------|----------|---|---------------|------------|
| 33  | F      | D        | Bloods for son who has congenital heart condition               | Black African | Manchester |
| 21  | M      | D        | Bloods taken, x-ray, ambulance                                  | Black African | Manchester |
| 51  | M      | A        | Physiotherapist   | British Asian | Manchester |
| 26  | F      | A        | Physiotherapist for neck issues                                 | White British | Manchester |
| 36  | F      | A        | Speech and language therapist for daughter                      | White British | Manchester |
| 44  | F      | A        | Cognitive therapy for anxiety                                   | White British | Manchester |
| 44  | F      | A        | Podiatrist  | White British | Manchester |
| 27  | M      | A        | Physiotherapist for heel injury                                 | White British | Manchester |
| 63  | M      | A        | Physiotherapist   | White British | Manchester |
| 25  | F      | B        | Hearing tests due to on-going health issues                     | White British | Manchester |
| 49  | F      | B        | Eye tests due to concerns by optician, on-going                 | White British | Manchester |
| 64  | M      | B        | Eye tests due to Diabetes                                       | White British | Manchester |
| 29  | F      | C        | counsellor due to dealing with mums illness (MS)                | White British | Manchester |
| 38  | F      | C        | Counsellor due to son's illness                                 | White British | Manchester |
| 44  | F      | C        | Renal social worker due to kidney problems/dialysis             | White British | Manchester |
| 40  | M      | C        | Social Care – Father's care, recently had a heart attack        | White British | Manchester |
| 59  | M      | C        | Social care, regarding Father's care and physic and chiropodist | White British | Manchester |
| 25  | F      | D        | Blood taking  | White British | Manchester |
| 46  | F      | D        | Routine bloods taken  | White British | Manchester |
| 54  | F      | D        | Ultrasound for fibroids   | White British | Manchester |
| 28  | M      | D        | Ultrasound/scan on testicles for lump                           | White British | Manchester |
| 45  | M      | D        | Bloods taken and x-ray for chest                                | White British | Manchester |

Full treatment and care details cont...

| Age | Gender | Category | Health / Treatment   | Ethnicity     | Location |
|-----|--------|----------|--|---------------|----------|
| 59  | M      | D        | X-ray, OT and Ultrasound   | White British | Belfast  |
| 40  | M      | D        | Accident, X-ray and Ultrasound   | White British | Belfast  |
| 33  | F      | D        | Ultrasound   | White British | Belfast  |
| 42  | F      | A        | Physiotherapy and blood tests  | White British | Belfast  |
| 39  | F      | D        | Ultrasound   | White British | Belfast  |
| 46  | F      | A        | Physiotherapy, operation, ultrasound and X-ray                             | White British | Belfast  |
| 50  | F      | D        | X-ray and ambulance  | White British | Belfast  |
| 52  | F      | A        | Physiotherapy and scans  | White British | Belfast  |
| 41  | M      | D        | Ultrasound and X-ray   | White British | Belfast  |
| 54  | M      | A        | Physiotherapy  | Lebanese      | Belfast  |
| 70  | M      | B        | Eye problem, dietician and blood tests                                     | White British | Glasgow  |
| 73  | F      | D        | Blood tests and x-ray  | White British | Glasgow  |
| 63  | M      | D        | Endoscopy and X-ray  | White British | Glasgow  |
| 68  | F      | D        | Podiatrist, physiotherapy and blood tests                                  | White British | Glasgow  |
| 60  | M      | A        | Chiropodist, dietician, physiotherapy, X-ray and blood tests               | White British | Glasgow  |
| 63  | F      | A        | Chiropodist, dietician, physiotherapy, radiotherapy, x-ray and blood tests | White British | Glasgow  |
| 68  | M      | A        | Physiotherapy, CT scan, blood tests  | White British | Glasgow  |
| 71  | F      | A        | Chiropodist and blood tests  | White British | Glasgow  |
| 73  | F      | A        | Physiotherapy and X-ray  | White British | Glasgow  |
| 65  | M      | D        | X-ray and blood tests  | White British | Glasgow  |

## Registrants

128 Registrants took part in this research.

52 took part in a focus group in one of the 4 regions. Groups consisted of between 3 – 10 registrants and all groups were mixed registrant groups. 76 took part in a telephone interview lasting between 30-50 minutes. Of these 10 registrants took part in a group telephone interview - 2 groups of 3 and 1 group of 4.

The initial data provided did not provide the necessary number of responses and therefore a second data selection was provided by the HCPC. There were problems with email bounces, firewalls, incorrect email addresses and non-response.

### Number of emails sent\*

| Location             | Emails Sent | Replies | Number taking part |
|----------------------|-------------|---------|--------------------|
| Birmingham           | 774         | 32      | 16                 |
| Cardiff              | 808         | 27      | 14                 |
| Glasgow              | 807         | 24      | 12                 |
| Belfast              | 792         | 20      | 10                 |
| Telephone Interviews | 3728        | 156     | 76                 |

\*When recruiting from data lists the average strike rate we use to estimate the amount of data required is '20 for 1' – where the recruiters require 20 contacts to get 1 participant.

### Overall Number of registrants by profession

| Profession                         | Total      | Face to Face | Telephone |
|------------------------------------|------------|--------------|-----------|
| Arts therapists                    | 6          | 1            | 5         |
| Biomedical scientists              | 7          | 3            | 3         |
| Clinical scientists                | 3          | 2            | 2         |
| Chiropodists/podiatrists           | 8          | 4            | 4         |
| Dietitians                         | 3          | 3            | 0         |
| Hearing aid dispensers             | 3          | 0            | 3         |
| Occupational therapists            | 17         | 4            | 13        |
| Operating department practitioners | 5          | 3            | 2         |
| Orthoptists                        | 2          | 1            | 1         |
| Paramedics                         | 11         | 10           | 1         |
| Physiotherapists                   | 15         | 7            | 8         |
| Practitioner psychologists         | 12         | 2            | 10        |
| Prosthetists and orthotists        | 4          | 2            | 2         |
| Radiographers                      | 7          | 5            | 2         |
| Speech and language therapists     | 3          | 0            | 3         |
| Social workers                     | 22         | 5            | 17        |
| <b>Totals</b>                      | <b>128</b> | <b>52</b>    | <b>76</b> |

## Details of Registrants

### Overall Details – All registrants

| <b>Category of Work</b>                             |            |
|---|------------|
| Education or Research                               | 21         |
| Management  | 11         |
| Working in practice in independent/private practice | 15         |
| Working in practice in NHS/Public sector            | 81         |
| <b>Total</b>  | <b>128</b> |

| <b>Age</b>   |            |
|--------------|------------|
| 18-25        | 1          |
| 26-35        | 24         |
| 36-45        | 40         |
| 46-55        | 44         |
| 56-65        | 13         |
| Not given    | 6          |
| <b>Total</b> | <b>128</b> |

| <b>Length of time in service</b> |            |
|----------------------------------|------------|
| 1-3 years                        | 8          |
| 4-10 years                       | 27         |
| 11-20 years                      | 45         |
| 20+ years                        | 43         |
| Not given                        | 5          |
| <b>Total</b>                     | <b>128</b> |

| <b>Region – Focus groups</b> |           |
|------------------------------|-----------|
| Cardiff                      | 14        |
| Birmingham                   | 16        |
| Glasgow                      | 12        |
| Belfast                      | 10        |
| <b>Total</b>                 | <b>52</b> |

| <b>Region – Telephone</b> |           |
|---------------------------|-----------|
| South/South West          | 6         |
| Northern England          | 20        |
| Midlands                  | 4         |
| Scotland                  | 19        |
| Northern Ireland          | 4         |
| Wales                     | 5         |
| London and South East     | 18        |
| <b>Total</b>              | <b>76</b> |

# Discussion Guide - Service Users

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## Initial thoughts?

An exploration of initial thoughts that people had after reading the information sheet

- What they thought of being consulted on the standards/Any misunderstandings/comments/views before asking more specific questions

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## Explore Current understanding and awareness

To explore what they currently know or understand by the HCPC and codes of conduct in general

### Prompts

- Were people aware of the HCPC/Were people aware of Standards of conduct – explore knowledge
- Would you expect to know or be made aware – How?
- How would you expect to access this sort of information? Where/from who?
- Has anyone ever read or referred to a code of conduct or standards when during their health or social care experience? Why? How?

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## Expectations of behaviour and attitude

To explore expectations of their relationships with their health and care professionals and what is important to them.

- List some key points that you would expect to see in a code of conduct about behaviour and attitudes
- Explore how this matches the different professional groups they have experience of
- Looking at the list of standards in your information - does this match your own expectations and thoughts? Expand and explore reactions and specific points
- Anything that appears out of place or unexpected?

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## Current relationships – Examples in practice

Exploring people's experiences of care and how this can be reflected back to the standards.

- Can you give any examples from your own experience that relate to any of the duties outlined in the list of standards? Can you relate them to a particular point?
- Do you think relationships between service users and professionals have changed over the past few years? How/explore

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## Changes to the Standards

To explore anything that is missing, not understood etc. from the list of duties in the standards.

- Are there any points that are missing – relate back to earlier discussions around expectations
- Is there anything that you don't understand? Why/what is unclear/explore other meanings
- What should be changed or included?
- How could these standards better reflect your current relationships with health and care professionals?
- What is most important to you?

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## One Code Fits All

Explore how people view the need/importance of having one code for all professions

- What do you think about the range of professions covered by this code /Is there common ground – explore any issues

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## Accessibility

Explore what they think of having access to these standards and what they would expect – now that they are more aware of the detail and content

- Now you've become more familiar with these particular standards – how do you view them as a service user? How relevant for you?
- The style currently used – any thoughts?
- Would you expect them to be available to you – how? Why? In what amount of detail? What format? Only when you have a concern or complaint?

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## Summary

How have you found this consultation? Explore views on being consulted now they are aware of the issues and detail

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# Discussion Guide - Registrants

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## **Initial thoughts?**

An exploration of initial thoughts that Registrants had after familiarising themselves with the Standards of Conduct, Performance and Ethics (as prompted to do so in the Participation Information Letter)

### **Prompts**

- What they thought of being involved in the consultation process on the standards
  - Any misunderstandings/comments/views before asking more specific questions
- 

## **Explore Current understanding and awareness**

To explore what they currently know or understand by the Standards of Conduct, Performance and Ethics in general and how they are currently used.

### **Prompts**

- Awareness of the range of professions now regulated by HCPC
  - How familiar are they with the Standards of conduct – are they used? How?
  - How relevant are they to you?
- 

## **Current relationships**

Exploring registrants' relationship with service users and how this can be reflected back to the standards.

- Do you think relationships between service users and professionals have changed over the past few years? How/explore
  - Do the standards reflect current professional practice?
  - Do they reflect today's relationship with service users?
  - Can you give any examples from your own experience that reflects how these standards are applicable?
- 

## **Identify any omissions/changes**

To explore whether there are any omissions that should be considered for inclusion or anything that seems out of place or unclear – this will entail reviewing the standards in more depth.

- Anything that appears out of place or unexpected?
  - Anything that is unclear
  - Anything that needs changing
  - Anything that needs adding
  - Are there any that apply only to your professional group?
  - What do you think about the range of professions covered by this code
  - How could these standards better reflect your profession?
- 

## **Accessibility**

To explore how accessible and understandable these standards are both as professionals and for service users

- What do you think of the style and structure of the current standards?
  - Are they easy to read and understand? (that is not covered in the discussions above)
  - How accessible are they to your service users – how do you think they view or understand these standards? Anything that would make them more available or accessible?
- 

## **Summary**

How have you found this consultation? Explore views on being consulted now they are aware of the issues and detail

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# Information sheet – Service users

## Information

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Thank you for agreeing to participate in this research. We would like to give you a little background information about the research before you attend your group to help make the most from the session you attend.

### Who is this research for?



This research is being undertaken on behalf of the Health and Care Professions Council (HCPC). The HCPC regulate health, psychological and social care professions in the UK – the list of those they include are shown below.

Regulation means that the HCPC protects the public by keeping a register of professionals and by ensuring that each individual meets specific standards of training, professional skills and behaviour. The HCPC can also take action against health and care professionals who fall below these standards and those who pretend to be registered. More information about the HCPC can be found on their website – [www.hpc-uk.org/](http://www.hpc-uk.org/)

The professions registered by the HCPC:

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

*You may see these professions in an NHS clinic, privately, at home, in hospital or at school.*

### Why have I been asked to take part?

We want to include a range of members of the public who have had particular experiences that will have brought them into contact with one of the professions listed above. In some instances you may not have directly been in contact but will have had some element of your care/treatment handled by one of these professions. This is why we asked about certain health/social experiences when recruiting you to take part.

### What will be discussed at the research?

The point of this research is to help the HCPC review a particular code of conduct that focuses on the behaviour and conduct of these professionals. This code is called – The Standards of Conduct, Performance and Ethics and these standards play an important role in helping the HCPC make decisions about the character of the people who apply to the Register and their fitness to practice.

There are 14 standards that are listed as part of this code of conduct – and these are summarised in brief below.

Professionals must –

1. Act in the best interests of service users.
2. Respect the confidentiality of service users.
3. Keep high standards of personal conduct.
4. Provide (to the HCPC) any important information about their conduct and competence.
5. Keep their professional knowledge and skills up to date.
6. Act within the limits of their knowledge, skills and experience and - if necessary, refer the matter to another practitioner.
7. Communicate properly and effectively with service users and other practitioners.
8. Effectively supervise tasks that they have asked other people to carry out.
9. Get informed consent to give treatment (except in an emergency).
10. Keep accurate records.
11. Deal fairly and safely with the risks of infection.
12. Limit their work or stop practising if their performance or judgement is affected by their own health.
13. Behave with honesty and integrity and make sure that their behaviour does not damage the public's confidence in them or their profession.
14. Make sure that any advertising they do is accurate.

These are the standards we are reviewing and we would like to understand more about your experiences and views to ensure that these standards remain current and relevant to today's practice. If you wanted to read the full Standards – you can find them on the HCPC website (<http://www.hpc-uk.org/assets/documents/10002367FINALcopyofSCPEJuly2008.pdf>)

– But we do not expect you to do this – and this information sheet does give you all the information we would like you to have before attending the research.

### Some example discussion questions

During the research we will be discussing the following types of questions with you:-

- \* Your experience and expectations of professional conduct
- \* What is most important to you in terms of your relationship with your professional
- \* If there is anything that you feel should be made clearer or anything that is missing from these standards.

There will be plenty of time during the research group to discuss these issues and to learn more about other people's experiences and views. You do not need to bring anything with you to the session, but we felt it would be useful to give you some information about the types of questions we are interested in to help make the most from the time we have.



**Time and venue details**

You have been booked onto the following session/time

|                   |  |
|-------------------|--|
| <b>Date</b>       |  |
| <b>Start Time</b> |  |
| <b>End Time</b>   |  |
| <b>Venue</b>      |  |

Your Facilitators –  
Carol McCloskey and Sarah Mowl




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**If you are no longer able to take part in this session then we would be grateful if you could let us know as soon as possible by contacting XXXXX. Please be assured that you can choose to withdraw from the research at any time.**

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**Your assurance**

All interviews and group discussions will be confidential and will be conducted according to the Code of Conduct of the Market Research Society. We audio record sessions to ensure we capture everything in context and don't miss important points. These recordings are only listened to by the independent research team of The Focus Group (Carol and Sarah) and will be deleted after the work is completed. Any quotations used will be anonymous and the HCPC will not be given the names of individuals taking part in this review nor will they have access to any notes or recordings taken at the groups/interviews.

**Any questions?**

If you have any queries or don't understand anything about this information and want to speak to someone before the session, or to decide if you really want to take part, then please contact Carol McCloskey – who is leading on the research for the HCPC.  
Email: [Carol@thefocusgroup.co.uk](mailto:Carol@thefocusgroup.co.uk)  
Telephone: 01202 432699/Mobile: 07970 997154

We look forward to meeting you and hearing your views.  
Carol, Sarah and Gemma

## Introductory email - Registrants

Dear xxxx

We are contacting you on behalf of the HCPC who have commissioned our research agency -The Focus Group – together with us Podengo- as their research recruitment partner – to ask for your involvement in the 2013 review of the Standards of conduct, performance and ethics. As you know, the standards of conduct, performance and ethics are ethical standards the HCPC sets the 16 professions regulated by them. The standards sit alongside the Standards of Proficiency for each profession which set out what professionals must know, understand and be able to do when they enter the HCPC register for the first time.

These standards are periodically reviewed to ensure they remain fit for purpose and are up to date. These standards were last reviewed during 2006 – 2008 and the current standards implemented on 1 July 2008. It is now time to undertake a new review particularly in light of significant growth in the register and factors such as:

- The changing personal and work boundaries that have taken place over the last few years
- The increasing importance of user involvement in shaping health and social care services – which has led to changing expectations from the public.

The review will take the form of group discussions, interviews and telephone interviews and will aim to involve a representative range of registrants across the UK. There will a number of group and interview options available in your region to make this as flexible as possible to fit with your workloads and working patterns. There will also be a small payment as a thank you for your time.

Please be assured that all research will be confidential and individual comments and views will not be shared with the HCPC. We do hope you will agree to participate in this research - it is only by undertaking regular reviews that the HCPC can ensure that the Standards of conduct, performance and ethics remain current and relevant for all.

If you would like to take part then please contact us directly on this email or phone.....DETAILS...

Please note there is no obligation to take part and we do not let the HCPC know who did or did not wish to be involved.

### **Communication ‘Opt Out’**

We adhere to HCPC Data Policy ([www.hcpc-uk.org/aboutus/terms](http://www.hcpc-uk.org/aboutus/terms)) and if you would prefer to opt out of future communications regarding research projects, then please reply to this email with the message ‘Remove from List’ and we will not contact you again.

With regards,

Podengo/The Focus Group

If you wish to check the validity of this email/research with HCPC before agreeing to take part then please contact Alison Croad, Policy Officer, Policy and Standards Department, Health and Care Professions Council.  
[alison.croad@hcpc-uk.org](mailto:alison.croad@hcpc-uk.org)

### **Data Protection**

We adhere to the Data Protection Act 1988 and any data will only be used for this research with the HCPC. Your contact details (email) were randomly selected from the HCPC register and we are under full contractual agreement with HCPC to only use this information for this review of Standards.

# Information sheet - Registrants

## HCPC - Review of the Standards of Conduct, Performance and Ethics.

Thank you for agreeing to participate in the HCPC Review of the Standards of Conduct, Performance and Ethics.

### Your appointment

You have been booked onto the following session/time

Date:

Time: Start and End time

Venue:

Your facilitator/interviewer will be: Carol McCloskey/Sarah Mowl

### Some thinking points

In order to make the most from the session it would be very useful if you could:

**1:** Take a few moments to look /re familiarise yourself with the Standards of Conduct, Performance and Ethics. A copy can be found on the HCPC website:

<http://www.hpc-uk.org/assets/documents/10002367FINALcopyofSCPEJuly2008.pdf>

**2:** Think about the following points

How relevant are these Standards to today's practice and client relationships?

Any changes/additions/deletions you think are needed to these standards?

The relevance of these standards to your own profession

### Your assurance

All interviews and group discussions will be confidential and will be conducted according to the Code of Conduct of the Market Research Society. We audio record sessions to ensure we capture everything in context and don't miss important points. These recordings are only listened to by the independent research team of The Focus Group (Carol and Sarah) and will be deleted after the report is published. Any quotations used will be anonymous and the HCPC will not be given the names of individuals taking part in this review nor will they have access to any notes or recordings taken at the groups/interviews.

If you are no longer able to take part in this session then we would be grateful if you could let us know as soon as possible by contacting XX.

We look forward to meeting you and hearing your views.