People like us?

Understanding complaints about paramedics and social workers[1]

Final Report

31 August 2017

Anna van der Gaag

Ann Gallagher

Magda Zasada

Grace Lucas

School of Health Sciences, University of Surrey

Robert Jago

School of Law, Royal Holloway, University of London

Sarah Banks

School of Applied Social Sciences, Durham University

Zubin Austin

Koffler Chair in Management, University of Toronto

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[1] The HCPC regulates paramedics across the United Kingdom and social workers in England. Social workers are regulated separately in Scotland, Wales and Northern Ireland

Contents

List of Tables

Table	Title	Page number
Table 1	Summary of prevalence data on complaints about paramedics	20
Table 2	Summary of prevalence data on complaints about social workers	35
Table 3	Areas of expertise and countries of participating expert panel members in each Round	47
Table 4	Participants in the interviews and focus groups	64
Table 5	Themes and sub-themes – paramedic interviews and focus groups	65
Table 6	Preventative strategies - paramedic interviews and focus groups	77
Table 7	Themes and sub-themes – social work interviews and focus groups	84
Table 8	Preventative strategies – social work	93
Table 9	Paramedic referrals to HCPC 2014-2016	110

List of Figures

Executive Summary

Study aims

This study set out to improve understanding of the reasons for the disproportionately high number and nature of complaints to the Health and Care Professions Council (HCPC) about two professions - paramedics from across the UK, and social workers in England. Both these professions show a higher rate of referral to the regulator than other professions regulated by HCPC (11 and 12 per 1000 respectively compared with an average of 6 per 1000 across 16 professions). It also considered what preventative action could be taken to address this issue.

Methods

It used a mixed methods approach, which included a literature review, Delphi exercise with international experts, interviews and focus groups with UK-based professionals and service users, and an analysis of a random sample of cases from the three stages of the HCPC's fitness to practise process.

Findings

The review of the relevant published **literature relating to paramedics** identified only two studies of the prevalence of complaints beyond the data published by HCPC on an annual basis. There may be a number of reasons for this. First, complaints in the health and care sector overall is a small, albeit growing area of research interest, and much of the data that exists is not in the public domain. Second, unlike some of the other health and care professions, paramedics are not regulated in the same way in different countries – in some they have been regulated fairly recently, and in others they remain unregulated. Australia, for example, does not currently regulate paramedics, and in the UK paramedics have only been regulated since 2000. Obtaining reliable and complete data from sources other than regulators is a challenge.

The review revealed a rich source of studies on the nature of paramedic practice, which informed the analysis and discussion on the second question posed by this study on the preventative actions that might work to reduce the number of complaints about paramedics in the future. In particular, the review revealed a rapid expansion in the scope and autonomy of the profession, particularly over the last decade, along with significant increases in the pressures on paramedics and their emergency care colleagues, with similar increases in volume and range of services required. In the UK, paramedics no longer simply provide a 'patient transport' service, but deliver a highly variable, often volatile, complex mix of life-

threatening emergency and non-emergency responses through a wide variety of channels.

Furthermore, the review highlighted changes in societal expectations. Members of the public expect consistently rapid response times from highly trained professional staff. Organisationally, research suggests that the relationships between managers and front line staff are not always well designed and delivered, and targets are not always appropriate. Where there is poor communication and a lack of mutual trust, either between management and staff or within teams, services may suffer. Several studies suggest that paramedic cultures have a tendency towards under-reporting of errors and a blame-focussed work environment. There was also evidence to suggest that paramedics demonstrate low scores on health and well-being indices, in terms of psychological stress and physical illnesses.

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

Like the literature review in the field of paramedicine, the review of the relevant **social work literature** did not reveal a strong evidence base on the prevalence of complaints about social workers. However, the review did reveal literature highlighting the difficulties faced by social workers whose job roles are based on contradictory purposes and values (e.g. care and control) and societal ambivalence towards their work with vulnerable and/or dangerous people (e.g. social workers as 'bullies' or 'wimps'). This feature of social work practice – situated at the heart of a welfare system that is under increasing pressure – may to some extent account for the disproportionately large number of concerns being lodged against social workers by the public. It may also indicate reasons why employers may refer concerns to the regulatory body, as a way of maintaining public credibility, and protecting themselves from blame by ensuring 'misconduct' or 'incompetence' is seen to be dealt with at an individual level. A tendency towards a blame culture and defensive practice militates against honest relationships and conversations between service users, professionals and employers, which might defuse concerns before they escalate to an official level.

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

The findings from the **Delphi exercise,** undertaken with 14 international experts from regulation, social work and paramedicine, resonated strongly with themes in the literature review. On a societal level, participants agreed that changing public attitudes and expectations of health and social work professionals, together with increasing emphasis on accountability and awareness of how to make a complaint, were likely to be having an impact on the rate of complaints. On an organisational level, factors such as poor leadership, heavy workloads, poor staff development provision and pressure on services, resources and support were contributory factors. On an individual level, contributory factors included the selection, training, supervision and professional development of practitioners, and the need for clearer guidance on the ethical responsibilities of individual registrants.

The **interviews** with 27 individuals with expertise in paramedicine, social work and regulation and 4 **focus groups** (2 with service users and 2 with practitioners) found common ground with the findings from the literature review, Delphi exercise and case analysis as to the reasons for the number and nature of complaints about paramedics and social workers. Four overall themes emerged. These included the impact of public perceptions and expectations; the challenges of practice for both social workers and paramedics; the organisational, cultural and political climate affecting their work; and the evolving nature of these professions. Both paramedics and social workers operate within contexts of uncertainty and ambiguity.

There was consensus amongst those interviewed regarding actions that could contribute to preventing complaints, with an emphasis on the importance of inter-agency collaboration and improved communication about constructive ways to handle complaints and reduce unnecessary referrals to the regulator.

The **case analysis** explored the nature of complaints about paramedics UK-wide and social workers in England by examining a randomly selected 10% sample of 284 cases (52 paramedics and 232 social workers) from all three stages of the investigative process. This provided a detailed description of the characteristics and circumstances associated with cases that did not meet the threshold for investigation as well as those that led to regulatory action. The case analysis identified a higher number of older, male practitioners in the overall sample relative to their numbers on the registers in both professions.

In the paramedic sample, 85% were employed in the NHS and 67% worked in acute settings. There were some variations in rates of referral across the UK. The sample indicated a disproportionately high number of self-referrals from paramedics, 46% compared with an average of 10% for social workers and 6% across all other HCPC regulated health professions during this period.

In the social work sample, 67% were employed by local authorities and 69% worked in children's services. 56% of referrals about social workers were from members of the public (compared with an average of 18% for paramedics and 12% for all other

HCPC regulated professions during this period). Only 5 of the referrals from members of the public progressed to a final hearing and 1 resulted in a sanction. 48% of complaints from the public arose from residence and contact disputes relating to time spent with children and families.

Few of the cases in either sample examined in the first two stages of investigation were characterised by deliberate acts of malice or incompetence, or indeed a previous history of local complaints. As might be expected, there were more examples of these in the final hearing stage, most commonly either cumulative incidents of incompetence or breaches of the ethical standards as a result of criminal convictions. Overall, we did not find a disproportionate number of complaints leading to a judgement of impairment. Instead we identified a disproportionate number of referrals to the regulator that did not meet the threshold for further investigation. The majority of these emerged from circumstances in which the individuals concerned were working in complex, ambiguous, highly pressurised environments, often distant from or feeling unsupported by their managers and confronted with patient and service user frustrations with wider, organisational service delivery failures during a time of social and political turmoil.

Summary

These findings have implications for the way we view those against whom complaints are made, as well as the nature of complaints and complaints handling. They suggest, perhaps surprisingly, that there are many more referrals about professional 'people like us' than people who may differ in terms of their motivations, circumstances and actions. Very often the perception of complaints has been that they concern individuals who are exceptions, unlike the vast majority of professionals who are never complained about.

Secondly, the findings point towards the adoption of a more nuanced set of regulatory tools, and much greater emphasis on local, employer-led interventions. They do not challenge the vital role which professional regulation plays in setting standards and ensuring that all health and care professionals continue to meet those standards throughout their working lives. There will always be a small number of individuals who do cause deliberate harm. They must be held to account, and there is no evidence in this study to suggest that the HCPC's current system of regulation does not meet its obligations to the public in this regard. However, there are many more professionals who, with appropriate local support and intervention, would, and arguably should, never have been referred to the regulator in the first place. Responsibility for delivering a more proportionate response lies with all the agencies involved - employers, professional bodies, advocacy groups, educators and regulators - working together.

Key messages

This study explored the reasons behind the disproportionate number of complaints about paramedics and social workers relative to other HCPC registered professions

The literature review discovered a paucity of prevalence studies and a wealth of literature on the complex interplay of factors that make the practise of these professions continuously challenging. This theme was confirmed through interviews and focus groups with service users and practitioners.

A case analysis looked at a sample of complaints (n=284) at all three stages of the investigative process and found a disproportionality in the number of complaints that did not meet the threshold for investigation.

The report recommends the application of a more nuanced set of regulatory tools and a greater emphasis on local interventions and partnerships across agencies to reduce the number of inappropriate referrals to the regulator.

Acknowledgements

Ethical review

The research proposal was submitted to the University of Surrey Ethics Committee for ethical review and a favourable ethical opinion obtained before recruitment and data collection commenced. Participant Information Sheets detailing the nature of the study, risks, benefits and issues relating to confidentiality and anonymity, were distributed to potential participants. Those willing to participate were invited to sign a consent form and reminded that they could withdraw from the study at any time.

Introduction

The health and social care system in the UK is facing unprecedented demand and rising complaints in an era of financial restraint. In 2016, a report on the activities of professional regulators in the UK carried out by the General Medical Council identified a 31% increase in complaints over the preceding six years (CESG, 2016). Reports from the systems regulators in England also show that concerns at an institutional level are increasing. For example, the Care Quality Commission in England reported a 133% increase in enforcement actions against poorly performing hospital-based services compared with the previous year (CQC, 2017). 70% of local authority children's services assessed by Ofsted were rated as either requiring improvement (48%) or inadequate (22%) (Ofsted, 2016). Understanding and learning from the reasons behind concerns and complaints, and offering insights into ways in which harm may be avoided and complaints reduced, has the potential to influence change in a positive direction. Very often, the catalyst for change comes from high profile, adverse events which raise our collective ambition to improve (Donaldson, 2000, Laming, 2003, Haringey Serious Case Review, 2008, Francis, 2010, Clwyd and Hart, 2013). Professional regulation in the UK and elsewhere is moving towards a more proactive, risk-based approach, recognising that reactive processes alone cannot address the complex challenges that exist in the health and care system. Our ambition for this work is that it contributes to the evidence base from which our collective 'architecture of listening' to complaints data can be re-designed (McNamara, 2015).

The Health and Care Professions Council is an independent UK wide regulator of 350,000 individuals from 16 health and care professions. Six percent of those on the Register are paramedics, and 27% are social workers in England. Paramedics represented 10.65% and social workers 57.65% of all fitness to practice cases in 2014-15 (HCPC, 2015).

This is a report of a study that set out to increase understanding of the number and nature of complaints raised with the HCPC about paramedics across the UK and social workers in England relative to other HCPC regulated professions. A mixed methods approach was used to capture the breadth and depth of data necessary to respond to the two primary research questions:

1) Why is there a disproportionate number of fitness to practise concerns raised about (a) social workers and (b) paramedics, and what might be the reasons for this?

2) What preventative action could be taken to address this?

The first phase of the study comprised a review of the literature across a range of peer reviewed and grey literature relevant to the study aims (**Chapter 1).** The research team continued with a Delphi exercise with 14 experts from outside the UK **(Chapter 2).** In addition, one to one interviews were conducted with 26 stakeholders drawn from practitioners and service users, professional bodies, universities, unions, fitness to practise panel members, lawyers and HCPC case managers. Four focus groups were held, two with practitioners and two with users of services. These took place in Cardiff, London, Durham and Guildford **(Chapter 3).** The team also analysed just over 10% of all fitness to practise cases in these professions over two years, totalling 284 cases from the two professions **(Chapter 4).** Towards the conclusion of the data collection phase, the findings were presented to two groups of stakeholders from across the UK, one group of paramedics and the other group of social workers. They took part in discussions on the implications of the research for future policy and practice. **Chapter 5** gives an interpretation of the findings and recommendations for further collective action.

Chapter 1 Literature review

The literature review focused on identifying published work about paramedics and social workers. However, it seemed appropriate to comment briefly on the wider prevalence data on complaints about health and care professions, in order to provide a context for the data on social workers and paramedics.

The review found considerable variation in the ratio of complaints across different health professions. For example, Spittal et al.'s comprehensive study in Australia found an average of 6 complaints per 1000 health professionals, with higher rates for dentists and doctors (21 per 1000 and 14 per 1000) than for nurses and midwives (2 per 1000) (Spittal et al, 2016). A UK comparison found similar ratios across these professions, with dentists and doctors demonstrating significantly higher rates than other health professions (36 per 1000 and 25 per 1000 respectively) (CESG, 2016). The ratios for HCPC regulated professions are much lower than for doctors and dentists, averaging 6 per 1000 in 2016. However, amongst the 16 HCPC regulated professions, paramedics and social workers consistently represent the highest ratios over time. In 2015/16, these ratios were 11 per 1000 and 13 per 1000 (HCPC, 2016) together representing over two thirds of all complaints received.

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

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

Part 2 of the literature review provides background on the development of social work practice and the data on prevalence of complaints. Seven themes arising from the literature are critically examined in relation to the research question: the nature of social work practice; workplace factors; management of errors and complaints; job stress; alcohol and drug use; social and emotional vulnerability; and public and media perceptions of social work.

Review Methodology

The review included both peer-reviewed and grey literature using systematic searches of electronic databases, web searches, professional body and regulatory body publications and government publications. Searches included but were not limited to CINAHL, Medline, ASSIA and SCOPUS databases. See Appendix A for the search terms, strategies and yields.

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

The social work database search generated 419 unique entries, which passed the initial title screening. Of these, 127 were articles from the UK based Community Care magazine from the years 2006-2011. A further search was carried out on the Community Care website to find relevant articles from the years 2012-2016, filtering by the tags 'Fitness for practise' and 'Workforce' and identified 122 articles. These were then further assessed for relevance by reading abstracts and then full texts. These texts were largely qualitative in nature. See Appendix B for detailed flow diagrams, which show the selection process of the peer-reviewed and grey literature included in the literature review. The final list of publications also includes some that were found in the reference lists of the reviewed articles. Appendix C provides details of the sources included in the final review.

Paramedic literature review

Background – the evolution of paramedic practice in the UK

The work of paramedics has changed significantly over the last few decades. Until 1960, paramedics in the UK had no nationally recognized qualification (Kilner 2004). Prior to this, they required a full driving license and a certificate in first aid in order to work. Their role was to transfer patients to hospital and offer basic first aid as appropriate. From 1966 onwards, the Ambulance Services Proficiency Certificate was introduced across the UK. This developed into the Institute of Healthcare and

Development (IHCD) ambulance technician programme, which was delivered as on the job vocational training. This was the only route to qualification until the mid-1990s. From this time onwards, more and more university programmes have been developed, (see College of Paramedics 2017, Furber, 2008, Donaghy, 2008). In 2013, the Paramedics Evidence–based Education Project (PEEP) commissioned by the Department of Health in England recommended that there should be greater standardisation of education and training for the profession across the UK, leading to an all graduate status by 2019 (Lovegrove and Davis, 2013). The PEEP report confirmed the views of many within the paramedic profession that an all graduate status was both desirable and essential for the profession to meet the needs of a 21st century health and care service (Newton 2012). A similar evolution in both practice and education standards has occurred over the same time period in other parts of the globe, such as Canada, US, Australia and New Zealand (Mannon 1992; Metz 1982; Devenish 2014). Paramedics became a regulated profession in the UK in 2000, and the professional body, the British Paramedic Association (now the College of Paramedics) was formed in 2001. In many jurisdictions, paramedics work in teams with regulated nurses, doctors and other health and care professionals and alongside emergency care technicians and support workers who are not regulated.

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

Lovegrove and Davis describe the ways in which UK Ambulance Trusts place an ever increasing emphasis on delivering the clinical service rather than the historical transport service of the past (Lovegrove and Davis 2013; SECAMB 2009; Marsh, 2017). This shift requires skills in assessment and referral across a wide range of conditions, including dementia and mental health, stroke, end of life care and a knowledge base that supports paramedics to respond to the needs of socially excluded groups. In addition to paramedics employed in the four National Health Services across the UK, paramedics are also employed by independent health care services and voluntary sector organisations such as St Johns Ambulance.

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

proposed a 54% increase in commissioned places for 2016/17 educational intakes (HEE, 2015).

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

The prevalence of fitness to practise complaints

We found very few studies in any jurisdiction that addressed the specific question of prevalence (% of the population) or incidence (number of new cases during a given period) of complaints about paramedics beyond the data held by the HCPC, suggesting that there is currently a weak evidence base on this topic. We did not find published data on complaints to other agencies such as NHS Employers, for example, nor did we find many studies carried out in other jurisdictions. Risavi and colleagues (Risavi et al 2013) examined complaints in a rural emergency medical care setting in the US. This was a retrospective study involving detailed review of all complaints over a 9-year period, which found only a small number that proceeded to a full investigation, and none which resulted in a suspension or striking off on the basis of a 'clinically related' complaint. They identified 110 complaints from a population of 3,000 paramedics and found an average of 12 complaints per year over the 9 years. Forty five individuals had more than one complaint made against them (classified as 'repeat' complaints) and 40% of complaints were unfounded.

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

the prevalence figures between these two studies, as there is no specific information on the size of the paramedic population in the Denver study.

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

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

Table 1: Summary of prevalence data on complaints about paramedics

Data Source	2003	2013	2015/16
Colwell	0.9:1000		
Risavi		36:1000	
HCPC			11:1000

Themes from the literature that may impact on complaints and concerns

Seven themes were identified from the literature, which have a bearing on the research questions;

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

Theme one - Complex and challenging work environments

There are a number of accounts of the characteristics of paramedic work environments from different jurisdictions (Mccann et al.,2013; McCann et al., 2015; Jessica L. Paterson et al., 2014; Lu et al.,2013, Devenish, 2014). Devenish (2014)

undertook a qualitative study exploring the socialisation of university-qualified paramedics in Australia. He describes the contrast between 'high acuity' jobs involving incidents such as major injuries at road accidents, cardiac arrests, emergency deliveries, and 'low acuity' routine work in which patients are stable, rarely require transfer to hospital and do not require any invasive treatment. Devenish suggests, along with others, that the high acuity jobs are viewed more favourably by paramedics, despite the associated higher levels of stress and fatigue, but are less frequent occurrences over the course of a typical shift. Within the profession there is what Devenish describes as a 'cultural emphasis' on dealing with high acuity cases, and he compares paramedic practice with Hancock and Kreuger's observations of military life – 95% boredom and 5% terror (Devenish 2014; Reynolds 2004; Wollard 2009; Sofianopoulos et al. 2012).

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

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

> *We receive a radio message to relocate in [district]. We park near the [major road] on an industrial estate near [street]. We talk about Sarah's experience.. she recalls having to go to some rough houses.. she tells me she had been assaulted by patients 'a few times' one man had psychosis and wanted to self harm. He had a knife and seemed to be on cannabis. Another encounter left a fellow crew member, Chris with blood on his face.. the patient had taken ketamine and the crew had to pounce on him to restrain him…Chris got smashed in the face. The first of these two cases went to court, the second did not.. Sarah seems sanguine that they are, after all, patients requiring care* [Field Notes, Researcher B].

Some studies explore the consequences of these work environments on paramedics. For example, Paterson et al (2014) examined associations between poor sleep quality, fatigue and self-reported safety outcomes in a sample of 556 responses from

30 agencies in the US and found strong correlations on all measures. This is explored in more detail under Theme three below.

Theme two – Managerial pressure

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

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

This disconnect is reported to have increased in recent years, as Trust performance targets have become the pervasive measure of effectiveness. Despite the appearance of autonomy, ambulance crews are constantly in contact with their control centres, and these become a source of frustration rather than support. In addition, the top down ways in which changes to protocols are communicated to the teams are not always clear or well received (McCann et al., 2013, p763).

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

Theme three – Impact on paramedic well-being

Given the unpredictable, high risk, volatile work environments and perceptions that there is inadequate support, it is not surprising that there are reports of high numbers of health complaints amongst this professional group. Weaver et al. (2012) found 16% of their sample reported experiencing an injury at work during the previous 3 months. Aasa et al. (2005) describe a high prevalence of sleep problems, headaches, and stomach symptoms significantly associated with the psychological demands of the work. Worry about work conditions was a risk factor particularly

evident amongst ambulance personnel. Higher incidence of psychological symptoms was not always associated with paramedics. One study in Norway found that the ambulance workers in their sample did not show higher rates of anxiety or depression compared with rates in the general population. However, they did find higher rates of musculoskeletal pain (Sterud et al. 2006; Sterud et al. 2008), as have similar studies in Australia (Broniecki et al. 2010) and Canada (Coffey et al. 2016).

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

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

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

Theme four - Potential for error and reporting challenges

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

Theme five - Changing public expectations of emergency services

Increase in admissions via A and E departments in recent years have been widely reported (Campbell, 2017, Scott, 2017). Ethnographic studies of paramedics on duty during nights provide a graphic illustration of the complexities and challenges of the work (Mccann et al. 2013; McCann et al. 2015). In a study of patient experience and views of emergency health care, satisfaction with emergency services was high, but diminished when four or more services had been contacted in a given episode (for example, emergency services, GP services, hospital consultant, social care service) (Knowles et al. 2012). This study also gave a breakdown of the characteristics of those in the sample of 1,000 patients. The authors suggest that longer care pathways may reflect the complexity of a health condition but they may also reflect confusion about where to access appropriate services for particular conditions.

Togher et al. (2015) undertook a qualitative study of 22 patients with a wide range of conditions, and 8 carers who were users of three different types of emergency service – call centres, on scene assessment and transport to hospital. They found, not surprisingly, that reassurance was a key outcome for users, and specifically that

feeling listened to, being informed, being treated with courtesy and appropriate use of humour all contributed to this. Continuity across transfer points, for example from the call handler to the ambulance, was also seen as important.

Theme six - Changing nature of professionalism and professional identity

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

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

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

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

A UK study on professionalism, commissioned by the HCPC (Morrow et al, 2011, Burford et al. 2014), focused on paramedics as one of three professions. The HCPC study reported the perspectives of paramedic educators and students and referred to professionalism as 'a holistic construct' that develops over time and which is connected with behaviours, attitudes, communication and context. A study by Brown et al. (2005) identified a range of qualities which included: patient advocacy; integrity; self-motivation; empathy; careful delivery of service; respect; time management skills; and teamwork.

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

The qualitative component of the same study involved interviews with paramedics (Bands 5-7) and paramedic students (Gallagher, Vyvyan, et al. 2016). Factors were again identified that both enable and inhibit paramedic professionalism, including poor communication, disconnect between teams and management and uncertainty about the relationship with the regulator. The qualitative component of this study was small and conducted in one paramedic NHS Trust so caution needs to be exercised in terms of generalisability.

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

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

The US based EMS Magazine and EMS World contain many such examples which explore the nature of professionalism in paramedic practice (Page 2016; Touchstone

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

Theme seven - Expanding scope of practice

Alongside the changes in education and training, (Kilner, 2004, Donaghy, 2008, Lovegrove and Davis 2013), the profession continues to undergo huge changes to the scope of its practice, reflecting the changes in demand from services and successive governments policy directives (Department of Health 2008; Lovegrove and Davis 2013; NICE 2017). These changes include the creation of specialist, advanced and consultant paramedic roles, as well as new hybrid roles such as emergency care practitioners. These roles have created higher levels of autonomous practice, allowing practitioners to deliver services in the community with less reliance on their medical colleagues for diagnosis and treatment. This development has played an important role in improving health care at the point of need and reducing unnecessary hospital admissions. The professional body, the College of Paramedics, has played a key role in this, working closely with the Joint Royal Colleges Ambulance Liaison Committee (JRCALC), the Health and Care Professions Council and Health Education England (Donaghy 2016).

There is little published evidence of the impact of these changes in delivery. Mason et al. (2007) compared appropriateness, satisfaction and costs of emergency care practitioners (ECPs) in three areas in England and found that ECPs carried out fewer investigations, provided more treatments and were more likely to discharge patients home compared with 'usual providers' concluding that they were 'no less effective'. ECPs are drawn from paramedics and nurses, practitioners with additional development and extended scopes of practice. They reflect a move towards the creation of more hybrid practitioners with a combination of skills. Another example are non-medical endoscopists, drawn mainly from nursing backgrounds who are trained to perform diagnostic procedures once the domain of consultants. Mason and her colleagues went on to publish the results from a cluster randomised controlled trial with patients aged 60 years and over who contacted emergency services about a minor injury or illness (Mason et al., 2008). This study found no significant differences between study and control groups, suggesting that these developments have no adverse effects on the delivery of care, and offer significant cost savings for overall health budgets. Donaghy (2008) called for further research, looking at the ways in which higher education is equipping the modern paramedic to work autonomously in the out-of-hospital unscheduled care environment. To date, there have been no

studies in the UK context looking at differences between the vocationally trained practitioners and university graduates.

Conclusions from the paramedic literature review

This review identified 2 studies of prevalence beyond the data published by HCPC on an annual basis. There may be a number of reasons for this. First, research on complaints in the health and care sector overall is a small, albeit growing area of interest, and much of the data that exists is not in the public domain. Second, unlike some of the other health and care professions, paramedics are not regulated in the same way across jurisdictions, or have not been regulated for as long a period of time. Australia, for example, does not currently regulate paramedics, and in the UK paramedics have only been regulated since 2000. Obtaining reliable data from sources other than regulators is a challenge (Spittal, et. al. 2016).

What the review has revealed is a rich source of studies on the nature of paramedic practice, all of which will inform the analysis and discussion on the second question posed by this study on the preventative actions that might work to reduce the number of complaints about paramedics in the future. In particular, the review has revealed a rapid expansion in the scope and autonomy of the profession, particularly over the last decade, along with significant increases in the pressures on paramedics and their emergency care colleagues and similar increases in volume and range of services required. It is no longer a 'patient transport' service, but one which delivers a highly variable, often volatile, complex mix of life-threatening emergency and non-emergency responses through a wide variety of channels.

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

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

Social work literature review

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

Like paramedics, the nature of social work practice has not stood still, but has undergone huge change since the beginning of the 21st century.

The social work profession works with people experiencing difficulties in their lives, using processes of care, control, empowerment and social support, largely delivered through interpersonal relationships. Core values underpinning the profession include the promotion of social welfare, social justice and human rights. While social workers work with individuals and groups to improve the circumstances of their lives, they also have an explicit core purpose to work for social change – to challenge inequality and injustice and promote fairness and the social participation of individuals and groups. The global definition of social work is as follows:

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

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

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

the early twentieth century, with the School of Sociology in London in 1903, amalgamating later into what became the London School of Economics.

Social workers were attached to many of the agencies dealing with social problems, including hospitals and courts. In 1907 the Institute of Hospital Almoners and the Association of Hospital Almoners devised a voluntary professional register, which gave social workers a formal framework of ethics (Mclaughlin et al., 2016). During the Second World War demand for qualified social workers increased and their employment in local authorities began to rise after the establishment of the welfare state in 1948. Following the Report of the Committee on Local Authority and Allied Personal Social Services (Seebohm Report, 1968), local authority social services departments were set up in the early 1970s. The British Association of Social Workers (BASW) was formed in 1970 as a voluntary membership body, with a code of ethics formulated in 1975. National regulation of professional education programmes was introduced through the Central Council for Education and Training in Social Work (CCETSW) founded in 1971. Until its dissolution in 2001, CCETSW approved educational providers, awarded qualification certificates and held a register of all qualified social workers (although it did not perform any disciplinary functions). This role was taken over by the Social Care Councils in each of the four countries of the UK, which became the statutory regulatory bodies for social workers and social care workers. For the first time, social workers were required formally to apply to be registered, providing evidence of qualifications and declaring physical and mental fitness, criminal convictions or disciplinary proceedings. The statutory body in England was the General Social Care Council (GSCC). These bodies were given the responsibility to refer alleged cases of misconduct to a panel, which then had the power to impose sanctions on individual social workers, including striking someone off the social care register if the complaint was upheld. The national Codes of Practice for Social Care Workers and Employers were published in 2002 and protection of the title of social worker came into force in April 2005. The GSCC was abolished in 2012 when its duties were taken over by the renamed Health and Care Professions Council (HCPC).

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

Complaints and concerns about social workers in numbers

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

UK-wide regulation of social workers

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

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

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

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

Some interesting patterns were found relating to the gender of registrants sanctioned (Furness, 2015), some of which mirrors the literature from the criminal justice field as well as from other regulators of health professionals. All these contexts reveal a

greater proportion of men committing the most serious breaches of misconduct. In the context of social work, the highest number of such cases across both genders related to criminal convictions or cautions, however they differed in the nature of their offences. In 54% of cases in which women were sanctioned for criminal convictions, these related to theft and fraud. In approximately two-thirds of cases this occurred in the private lives of women and involved fraudulent benefit claims and obtaining property by deception (for men two-thirds of such cases occurred in the workplace). In 40% of cases in which men were sanctioned for criminal convictions, these related to sexual assault, sexual activity with minors or adult service users, and possessing indecent images of children; the majority of cases the offences were work-related. The second most significant category of misconduct of women was failing to safeguard service users and others, whereas for male social workers this was for inappropriate behaviour and having inappropriate relationships.

Studies from the USA

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

- Dual relationships and boundary violations (23.4%)

- License-related problems (18.2%)

- Criminal behaviour (14.2%)

- Poor standards of care or practice (9.5%)

- Failure to maintain paperwork to professional standards (8.9%)

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

- Record-keeping, confidentiality, consent (24.6%)

- License-related problems (24.5%)

- Dual relationships (18.9%)

- Criminal behaviour (15.5%)

- Poor standards of care (5.6%)

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

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

- Surrogate (NASW members not party to complaint but made aware of published accounts of violations or licensure board actions) – 77.3% of cases filed

- Self-reporting – 71.4% of cases filed

- Employer or supervisor – 47.5% of cases filed

- Client – 35% of cases filed

- Colleague – 20.4% of cases filed

- Relative of client – 18.6% of cases filed

There was also a significant finding relating to gender: men were over-represented both in the group that had proceedings and amongst those who were found in breach of ethical standards. Men were the subject of almost half of the cases in which code violations were found despite constituting only 21% of NASW membership. Boundary violations were by far the most common area of complaints, representing 28% of cases. In another study Strom-Gottfried (2000) analysed 58 NASW complaints made by or against social work students, faculty members and field instructors in the years 1986-1997. Of these

- 14 failed to meet criteria for acceptance

- 10 were withdrawn after acceptance

- 3 closed for other reasons

- 2 resolved through mediation

- 26 went to hearings, of which 14 found violations

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

Daley and Doughty's (2006) study compared complaints made against rural and urban social workers based on data from the Texas State Board of Social Worker Examiners (TSBSWE) in 2003. Despite suggestions that rural social work carries a greater risk of breaches of confidentiality and dual relationships, they found complaint profiles for rural and urban social workers to be similar. However, ethical allegations regarding poor practice were reported with the greatest frequency in rural areas, which may be explained by the scarcity of rural social workers (fewer per 1000 of population) and, they suggest, poorer availability of supervision and referral resources. The rate of complaints about ethical violations in 2003 was reported as 3 per 1000.

Table 2: Summary of prevalence data on complaints about social workers

Data Source	2007/08	2013-14	2015/16
General Social Care Council	5:1000		
Scottish Social Services Council		22:1000	
Northern Ireland Social Care Council		10:1000	
Care Council Wales		11:1000	
HCPC		12:1000	13:1000

Themes from the literature that may impact on complaints and concerns

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

1. Nature of social work
2. Workplace factors
3. Management of error and complaints
4. Job stress

5. Social and emotional vulnerability
6. Public and media perceptions of social work

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

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

Following an ethnographic study in an American Supportive Community Housing programme, Summerson Carr (2015) concluded that ethically it is more important that social workers are attentive in their practice rather than being intentionally focused on objectives. Burns (2011), writing from a UK perspective, additionally highlights the importance of reflection in practice that employs a diverse range of concepts and tools. Walter conceptualises social work as a space of "professional improvisations" (Walter, 2003: p322) which reference familiar categories of knowledge and remake them to respond to needs and advance practice.

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

Ellis (2011) conducted four studies on the use of frontline discretion in Adult Social Care which comprised observation, interviews and analysis of policy and operational documents. Frontline decision-making was found to be a dynamic interaction between top-down authority and street-level discretion. It was subject to a varying level of influence from managerialism, professionalism and user empowerment and shaped by the social workers' micro environments of practice. Yet even in settings where professionals could negotiate managerial demands, their practice would

reflect a 'hybrid code of ethics forged out of the penetration of professional identity by managerial priorities, albeit in ways that could be squared with traditional social work values' (Ellis, 2011: 240).

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

Banks examined how personal engagement and professional accountability are negotiated in social work: 'balancing the personal and professional, between closeness and distance, between rationality and emotion' (Banks, 2013: p602). She argued that professional misconduct often relates to situations where this balance is, wilfully or unwittingly, compromised resulting in, for example, either inappropriate personal engagement with service users or taking an excessively rule-bound approach to dealing with them. Although inappropriate personal engagement is commonly referred to in both data on complaints (see above) and in discussion of establishing and maintaining appropriate professional boundaries, the current dominance of bureaucratic rules is also emphasized in publications (Garboden, 2010; Leigh, 2014).

An independent social work trainer and consultant quoted in a Community Care article emphasized that the Baby P case changed professional judgments on the balance between "common sense" and "tick boxes" in social work:

> '*the culture within child protection is now so driven by the fear of exposure for incompetence or poor practice, practitioners and their managers have become far more preoccupied with ticking the right boxes and staying close to guidelines*' (Sue Woolmore quoted in Garboden, 2010).

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

> It was apparent that in this organization, there was clear conflict between issues of ethical decision-making and defensive practice, issues that have led to a particular doctrine being developed, one which embraced the needs of the practitioner and excluded those of the family (Leigh, 2014 p.417).

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

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

Decisions about professional boundaries are found to be particularly ethically complex in social work and related occupations. Shevellar and Barringham (2016) discuss practitioners' experiences of negotiating boundaries in community inclusion work in disability and mental health. They highlight the 'messiness' and ambiguity of practice which does not fit into neat ethical frameworks, leaving workers feeling anxious and challenged in knowing what to do. O'Leary et al. argue that in social work ethical codes, professional boundaries are portrayed as professionally determined and 'clear for all to see' (2012: 15). However, shifting towards a relationship-centred approach in social work makes boundaries more permeable and dynamic. This makes them more difficult to negotiate and the expertise of the social worker is required to co-construct them with service users. There is some evidence that a focus on the quality of relationship between the social worker and service users is significant for intervention outcomes, more so than the model of intervention used (Coady, 1993; Howe, 1998; Lee and Ayon, 2004 in: O'Leary et al., 2012).

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

• Focus on supervision that facilitates challenging and questioning learnt assumptions about the ethics of boundary crossing.

• Validation of the ambiguities of effective practice and of the need for—at times— intuition, 'muddling through', trial and error, hunches, common sense, etc.

• Commitment to an open culture in work teams in which workers can feel safe to raise and discuss boundary tensions.

• A willingness by organisations to reimagine an audit culture that is open to debate, acknowledges boundary challenges and reviews codes of conduct, position descriptions, training models, and quality systems accordingly.

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

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

Theme two – Workplace factors

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

Adequate support and supervision are recognised as key to delivering high quality services (Kadushin and Harkness, 2002; Rabinowitz, 1987 in: Bradley, Engelbrecht,

and Höjer, 2010) and contributing to a social worker's motivation and resilience (Collins, 2007 in: Bradley, Engelbrecht, and Höjer, 2010, Bulbulia and Hanrahan, 2014). Bradley et al.'s comparative study of the role of supervisors in child welfare settings in South Africa, England and Sweden found that supervision in England 'is focused predominantly on an administrative function' (Bradley et al., 2010: 784) in line with New Public Management Principles and ideas of organisational professionalism, thus neglecting the educative and support functions of supervision. The research also highlighted the inherent tension between managers' supervisory/support role and their performance management role in their relationship with subordinates, who may find it difficult to report not coping with their cases.

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

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

Theme three – Management of error and complaints

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

> '*A theme that has emerged on each occasion is that complainants will tell me that our discussion regarding..why a complaint has been made, is the first time they consider they have found someone who*

simply listened to them. It is also the case that had complainants felt listened to early on, and some simple solutions explored, a number of formal complaints I have later had to unravel would not have seen the light of day. (…) It seems to me that the challenge in today's professional world is that we risk losing the elegant and powerful simplicities of human compassion, engagement and concern – driven out by attention to process and targets. Let's not forget that these are useful and valid tools for social work but are not ends in themselves' (Roberts, 2007).

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

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

Theme four – Job stress

Social work is considered to be an occupation with a high risk of stress and burnout (Moriarty et al. 2015). Survey data collected in England (Beer, 2016) with a sample of 427 social workers employed across 88 local authorities and in the private and third sector showed that 75% were concerned about burnout, 63% of respondents had difficulties sleeping, 56% said that they were emotionally exhausted, 15% currently took, or had taken within the past 12 months, anti-depressant medication as a result of their social work role. Only a quarter of these respondents felt their organisations did enough to support them, and only just over half knew where to access support for work-related stress.

A review of literature conducted by Lloyd et al. (2002) some years ago found that although there were many job-related factors at play (involvement with resistant

service users in emotionally-fraught and complex situations and working in impoverished environments), the most significant contributing factors were organisational: work pressure, work load, low work autonomy, lack of challenge on the job, role ambiguity, low professional self-esteem and poor relationships with supervisors. The review identified supervisory support to be a significant moderating factor.

Wilberforce et al. (2014) identified the Job Demand/Control Model (Karasek, 1979 in: Wilberforce et al. 2014) as a useful theoretical framework for identifying those social workers who are at greatest risk of stress. Job demands refer to 'the degree of mental pressure placed upon individual workers' (excessive workload, tight deadlines, conflicting demands, high levels of responsibility), job control is 'the degree to which an employee can dictate and shape the activities undertaken in their work' and includes decisions about the content of, and approach to, their work and having a choice about the skills they develop and use in their job (Wilberforce et al. 2014: p4). A significant risk of physical and mental health problems is associated with a high level of job demand combined with low job control. This model was applied by the authors in a study of 249 social workers and care managers involved in piloting Individual Budgets and found that workers younger than the sample average, working longer hours, working in large teams and working with older people were significantly more likely to be at risk of high strain i.e. in poorer psychological health. The authors concluded that social workers and care managers did not find greater discretion in decision-making satisfying in itself, however job control was significant in mitigating stress associated with additional job demands. The actual hours worked relative to contracted hours were a strong contributor to job demands.

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

Theme five – Social and emotional vulnerability

Emotional suppression is discussed in social work literature in several jurisdictions (Ruch, 2011; Munro, 2011; Morrison, 2007 in: Ingram, 2015) and Ferguson (2005 in: Ingram, 2015) noted that it could have significant impact on the efficacy of decisions and actions in practice. Bulbulia and Hanrahan have drawn attention to the importance of resilience in social work practice, arguing that there needs to be a stronger focus on recognising, building and maintaining resilience amongst practitioners in order to reduce burnout and improve retention (Bulbulia and Hanrahan, 2015, Bulbulia, 2016) Some studies have found that individual social and emotional vulnerabilities can be underlying factors in the misconduct of health and care professionals (Katsavdakis, et al., 2004). These areas of professional practice are rarely acknowledged, however. Ingram's (2015) study found that the emotional content of social work practice was not comfortably explored within the available forums for reflection, supervision and guidance, but was more frequently explored informally through peer support.

Theme six – Public and media perceptions of social work

Some published papers suggest that social work has been particularly vulnerable to adverse public and media opinion, in part because of the complex and poorly-understood nature of social work practice (Penhale and Young, 2015). Social workers have a dual role; on one hand they serve as gatekeepers in the state system which involves coercion, control and discretion, on the other, they are advocates who endeavour to support and guide their clients (Jessen, 2010). The disjunction and often perceived dominance of the gatekeeper role are likely to contribute to mistrust and negative attitudes. Trust and recognition from service users could be increased through greater emphasis on the advocacy role of the social worker. This would mean giving service users more opportunities to voice their expectations and, through dialogue, empowering them to become participants in a more responsive service (Lipsky, 1980; Rothstein, 1998 in: Jessen, 2010).

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

> '*middle class folk devils; either gullible wimps or else storm troopers of the nanny state; either uncaring cold hearted bureaucrats for not intervening in time to protect the victims or else over-zealous do gooding meddlers for intervening groundlessly and invading privacy*' (Cohen, 2002: xv in: Warner, 2013).

Galilee's (2005 in: Moriarty et al. 2010) literature review found that, on one hand, social work is usually of little interest to the media due to its complexity, on the other, social work failures, particularly those involving children, are viewed as newsworthy.

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

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

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

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

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

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

> '*The biggest lesson I learned was when you're an agency social worker, no-one has a duty of care to you. And I'd never needed to*

think about that because I never thought I could make such a foolish mistake that would lead to what happened for the whole of the following of that year. (…) so if you make a mistake, you have nowhere to go. I wasn't a member of the British Association of Social Workers (BASW) and I didn't belong to a union' (Stevenson, 2014).

Conclusions from the social work literature review

This literature review did not reveal a strong evidence base on the prevalence of complaints about social workers, indicating a weak evidence base on this topic. However, the review did reveal literature which highlights the difficulties faced by social workers whose job roles are based on contradictory purposes and values (e.g. care and control) and societal ambivalence towards their work with vulnerable and/or dangerous people (e.g. social workers as 'bullies' or 'wimps'). This feature of social work practice – situated at the heart of a welfare system that is under increasing pressure and whose service users are often branded as 'skivers', 'undeserving' or 'troubled' – may to some extent account for the disproportionately large number of concerns being lodged against social workers by the public. It may also indicate reasons why employers may refer concerns to the regulatory body, as a way of maintaining public credibility, and protecting themselves from blame by ensuring 'misconduct' or 'incompetence' is seen to be dealt with at an individual level. A tendency towards a blame culture and defensive practice militates against honest relationships between service users, professionals and employers, which might defuse concerns before they escalate to an official level.

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

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

Chapter 2 The Delphi exercise

This section presents the methodology and findings from the international consultation exercise. The Delphi technique is a well-established research tool and is considered a proactive way of involving stakeholders in the search for consensus responses to complex research questions. The technique has been used previously, in the HCPC context, to explore the use of service users' feedback tools (Chisholm and Sheldon, 2011). It is a process of structured group communication designed to reach reliable group consensus amongst a panel of experts in areas where there is uncertain knowledge (Adler and Ziglio 1996 p.5).

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

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

The Delphi Process

In this study, a three-round collaborative Delphi electronic survey design was employed, bringing together a panel of international experts, to respond to questions about the increasing number of complaints and possible reasons behind these complaints as well as seeking comments on preventative actions that might be implemented to reduce complaints in the future.

The Round 1 Delphi questionnaire invited open text responses to the questions. For the Round 2 questionnaire, responses to the questions were distilled to statements. The process of distillation and validation involved 3 researchers checking and agreeing each of the statements to be included on the Round 2 online questionnaire. The link to the Round 2 questionnaire was then sent to expert panel members who had agreed to participate in the Delphi process. Panel members were invited to express their level of agreement on a 5-point Likert scale - from 'strongly agree' (1) to 'strongly disagree' (5). There was space for expert panel members to add new statements after each question in Round 2. In the invitation email to the Round 2 questionnaire, participants were provided with additional information on the complaints data from the HCPC's Fitness to Practise Annual Report. In Round 3 the panel had the opportunity to express their level of agreement again in relation to the

entire list of statements and to compare their previous responses with the group mean. They also had the opportunity to express their level of agreement with the additional Round 2 statements. At the end of Round 3, statements reaching over 70% agreement (combining 'strongly agree' and 'agree') were considered as consensus statements.

The Expert Delphi panel

Experts were identified by the research team and the Project Advisory Group, selected for the international perspectives. Twenty five individuals were approached, drawing on international contacts in professional regulation and in paramedic and social work practice, education and research. Those invited were from Canada, Australia, New Zealand, the Republic of Ireland, South Africa, the US, Norway and the Netherlands. The rationale for countries selected was that they had regulatory processes comparable to the UK and were English speaking. However, it is acknowledged that the practices of social workers and paramedics in these countries may differ from the UK and this needs to be borne in mind as the results are interpreted. Perspectives from the UK were sought through the interviews and focus groups.

The Round 1 questionnaire was completed by 14 experts; 12 individuals completed the Round 2 questionnaire; and 9 individuals completed the Round 3 questionnaire. **Table 3** below summarises the expert panel members' areas of expertise and countries of residence.

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

	Areas of expertise	**Countries**
Round 1 14 experts	Regulation expertise x 5 Social work expertise x 6 Paramedic expertise x 3	New Zealand, Norway, South Africa, Ireland, Australia, USA, Canada and the Netherlands.
Round 2 12 experts	Regulation expertise x 4 Social work expertise x 6 Paramedic expertise x 2	New Zealand, Norway, Ireland, Australia, USA Canada and Netherlands
Round 3 9 experts	Regulation expertise x 2 Social work expertise x 5 Paramedic expertise x 2	New Zealand, Norway, Ireland, Australia, USA and Canada.

Overall Delphi Statements and Themes

Much rich data was generated in response to the questions. Consensus findings in relation to each of the five questions will be discussed in turn below. The complete list of statements is included in Appendix D.

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

The distillation of the question data generated 23 consensus statements, which were aligned with 7 themes:

- Public attitudes/expectations
- Pressure on services
- Inadequate support
- Media and political influence
- Regulatory factors
- Nature of practice and
- Questioning the increase.

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

Public attitudes/expectations	
1. There are changing attitudes towards what health and social services should deliver to the public and an increasing belief in what the public's rights to help are.	100%
2. The increase may be more related to a better-informed public than an increase in misconduct or incompetence of professions.	100%
3. There is a reduction in deference to professions by society generally	100%
4. The public is more exacting about standards of care and levels of professionalism and not as willing to accept poor communication or below par standards.	100%
5. The public has less trust in the infallibility of professional expertise.	100%
6. The public has increased access to information - about legal provisions, services, health indicators etc. - and so a more questioning, even challenging, approach is inevitable.	100%
7. There is an increasing willingness on the part of members of the public to raise a complaint.	77.5%

The 7 consensus statements in this first theme relate to public expectations regarding standards of care, increased access to information and attitudes regarding rights and a reduction in deference and trust. These statements suggest a more general trend whereby the public is more questioning and less accepting of standards of service (Ashenden, 2015). Interestingly there does not appear to be a correlation between complaints and public ranking of trust in professionals. Doctors, for example, were identified as the 'most trusted' profession in 2015 (Ipsos MORI 2016) and yet, proportionally, are amongst the professions with the highest number of complaints amongst health professionals - 36 per 1000 compared with an average of 6 per 1000 across all health and care professions (CESG, 2016).

Awareness of complaint process	
8. There is greater public awareness of how to make a complaint resulting in their filing complaints in increasing numbers.	77.8%
9. The public is becoming increasingly more aware of the role of the regulator in receiving complaints.	75%

The second theme supports the impact of increasing awareness regarding the role of the regulator and the means to make complaints.

Pressure on services

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

This theme is in keeping with much current discussion regarding pressure on services in health and social care and the drive for cost-effectiveness (CQC 2015). Reference to 'crisis', to limited resources and to enhanced scrutiny is commonplace in public discourse (Scott, 2017, Campbell, 2017). Reference to 'complexity' suggests, what has been described as 'the swampy lowlands' (Schon 1983) of everyday paramedic and social work practice.

Inadequate support

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

The lack of professional development opportunities is linked to fatigue, loyalty and moral commitment. This reflects research by the Kings Fund relating to staff engagement. This is described as 'a psychological state associated with feelings of commitment and loyalty to one's organisation and involvement in one's work' (West and Dawson 2012).

Media and political influence

16. Bad press coverage - TV and newspapers - may impact on the perception of the services being offered.	75%
17. The media is largely responsible for this as is the risk society that has steadily been created over past decades.	75%

| 18. Social media (e.g. twitter and Facebook) make it easy for the public to complain and spread stories about poor service. | 75% |

The three statements relating to this theme offer a more limited consensus, however, they resonate with perspectives regarding the contribution of the media in other datasets. This is particularly so in relation to social work practice where there was a good deal of negative media attention in response to perceived failures in safeguarding (Warner J. 2013). The suggestion that social media contributes to complaints warrants further exploration and is also highlighted by Archer et al, 2014.

Regulatory factors

| 19. Employers and regulatory authorities have taken accountability much more seriously and practitioners are more likely to be reported by colleagues for inappropriate behaviour or conduct that is of concern. | 87.5% |
| 20. From a standards perspective, there is a heightened awareness both within and outside of the professions, in terms of ethics, integrity and appropriate behaviour, and a concomitant emphasis on making complaints/grievance procedures transparently available. | 75% |

These statements suggest that an increased awareness of accountability, standards and complaints/grievance procedures lead to more reporting of complaints.

Nature of practice

| 21. Nature of the work of certain groups such as social workers - dealing with tough situations, having to make very tough decisions with unhappy parties no matter what. | 75% |

As with the 'pressure on services' theme, this is in keeping with a 'swampy lowlands' lens (Schon 1983) whereby tough and complex decisions have to be made and dissatisfied service users are an inevitable consequence.

Questioning the increase

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

These statements suggest a scepticism regarding the underpinning rationale for this study, suggesting perhaps that whilst there may be an increase in the number of complaints it does not follow that there is an increase in unethical conduct. It is also suggested that there are changes in what is described as 'unethical,' perhaps resulting in lower thresholds on what is and is not acceptable.

Question 1A – Particular reasons that apply to paramedics.

Public attitudes/expectations	
1. A psychological situation which affects paramedics specifically is the 'my home is my castle' situation. From the resident's standpoint, subconsciously, the resident is the king - and therefore also has some kind of right to dominate. So even if one should expect a trained health care professional to be high up in the hierarchy of the local group, this is not always so. If care offered is not aligned with expectations, conflict may arise.	100%
2. If there is a discrepancy between expectations of high level of care (or just a specific, but unnecessary type of care), and what the ambulance service or paramedics can or wish to give, there will be a conflict.	85.7%
3. There is an increased tendency for the public to be aggressive towards paramedics and firemen so complaints may arise from this.	85.7%
4. The public has the expectation when they call an ambulance that they will be taken to hospital and seen by a doctor. When this does not happen they may feel that they are being denied access to hospital care and vent their frustration at the paramedics.	71.4%
5. There is a high level of public expectation about the effectiveness of medical/emergency intervention, and less acceptance that people are going to die/be damaged as a result and possibly a greater sense of litigation and individual rights here.	71.4%

Some of the reasons relating to paramedic complaints resonate with the general statements in the previous themes, for example, relating to high public expectations. However, profession-specific reasons relate to the specific context of care (working in people's own homes) and the predicament of the service user.

Nature of practice

6. Paramedics work in situations of extremis (at times) and in heightened situations of emotional and physical distress.	85.7%
7. Paramedics provide their services in less than ideal circumstances, for example, on the side of the road, in tight spaces, in homes, off a cliff or on a beach. By the nature of the calls to emergency services, patients do die or may not have the expected outcome, compared to if the illness had occurred in hospital.	71.5%
8. Paramedics are on the front line of crisis, trauma and emergency services. They are under the watchful eye of a range of people as they go about their jobs. Family and significant others are often involved in emergency situations, and the heightened emotion at times of crisis can result in misperceptions and miscommunication. This can result in complaints.	71.5%

Again this theme and statements resonate with previous statements regarding the complexity, messiness and emotionally charged aspects of everyday paramedic and social practice. What is different for paramedics, as suggested in statement 8, is the fact that paramedics' work is more often in public spaces. They deliver care, for example, at the side of the road and in other places in full view of the public, often in highly charged environments. The example of emergency services' response to the attacks on the public in Manchester and London is a case in point (Allen and Henderson (2017).

Education/training	
9. We need more inter-professional training and education.	85.7%

Question 1B - Particular reasons that apply to social workers

Despite there being 16 statements relating to this question, none reached consensus. The response range was from 12.5% to 62.5%. This may be suggestive of uncertainty and/or disagreement as to whether the reasons suggested were valid, or because not all the participants had expertise in this particular area of practise.

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

Six themes were identifiable from the 38 consensus statements relating to preventative action:

- Selection and training and education;
- Educating the public;
- Organisational support;

- Further research;
- Regulatory strategies; and
- Questioning the perceived increase

Selection and training/education of workforce

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

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13. Rigorous admission protocols and criteria at the time of admission to training programmes.	71.4%

A wide range of preventative actions, relating to training and education, are proposed with 7 reaching 100% consensus. The statements relating are diverse with reference to the need for educational input relating to teamwork; communication, cultural care, ethics, self-care, empathy and reflection. There was consensus that admission protocols and criteria should be 'rigorous' and that students demonstrating 'unethical behaviour' should be screened out. Complaints data should be 'fed back into the training of practitioners both undergraduate and post-graduate'. The statement that student experiences in practice should be monitored 'to detect where the problems are' indicates the panel's awareness, perhaps, of the significance of organisational context or culture. In terms of assessment, it was agreed by most Delphi panel members that communication should be assessed at the outset and throughout professional programmes.

Educate the public/Manage expectations	
14. Professional bodies have responsibility for explaining the social work role to the public with the odd 'good news' story occasionally.	87.5%
15. Educate the public about the different channels of complaints and when it is appropriate to make a complaint to the regulator or when it is a complaint against a system.	75%
16. Better guidance to the public on airing concerns is needed so that this is more likely to occur at an earlier stage while the situation may be more easily remediable.	75%
17. Service users need to know their rights and have their concerns listened to.	100%

The role of professional bodies in educating the public about professional roles, channels of complaints and about the role of the regulator is highlighted. Awareness raising regarding how members of the public might 'air' concerns and mechanisms for earlier resolution reflects the findings from elsewhere in this study, as well as wider literature relating to complaints in health and social care (for example, see advice on NHS complaints procedures, Citizens Advice 2017).

Organisational support/improve work conditions	
18. Create opportunities for peer support and appropriate professional supervision/reflection.	100%
19. Allow greater flexibility of work place, leave, co-workers, shift cycle and duration.	87.5%
20. Employers have workplace responsibility to provide effective supervision and stress management support.	87.5%

21. There should be focus on what the registrant is doing to protect themselves from burnout.   87.5%

22. Professionals need 'how to look after me' programmes to minimise the risk of disengagement.   87.5%

23. Provide better organisational support towards each employee, especially support from leadership and coaching programs.   85.8%

24. Employers should run courses along the lines of 'thank you, let's support you in the next phase of your career'.   75%

These statements are in keeping with literature relating to the theme of organisational support and work conditions and highlight the importance of leadership, staff development programmes, peer support and self-care initiatives (see, for example, Raab 2014). This is also consistent with findings from elsewhere in this study.

Research to deepen our understanding of complaints

25. Categorise the types of complaints so there is a better idea as to what remedial action needs to be taken.   100%

26. We need better data collection about complaints so all of this can be better understood.   100%

27. Categories of complaints should be very specific and not general so data can be interpreted more accurately.   87.5%

28. We should get better at distinguishing between resource availability and practice standards.   87.5%

29. Identify the specific types of concerns and practice settings - analyse data and look for patterns - what role have employers got in addressing concerns? What role can professional associations and educational bodies play? Is there a specific role for the HCPC Council?   75%

30. We need to link data from a variety of systems to detect patterns and deteriorating clinical governance in health and social care services.   75%

The role of research in identifying and categorising the types of complaint, the roles of different stakeholders (employers, professional organisations and the HCPC) and of linking data from different systems is highlighted. Getting better at 'distinguishing between resource availability and practice standards' was allocated to the 'research' theme, however, it can be argued that this is the responsibility of all involved.

Regulatory strategies

31. Regulators have a role in opening up the discussion with the professionals themselves and invite them to be part of the preventative action. The regulator has a leadership opportunity here in promoting debate and understanding.	100%
32. Develop information materials to support employers and supervisors, professional associations and educators in recognising and responding to areas of concern.	100%
33. Appoint an ombudsman to help identify common complaints and allow management the opportunity to develop strategies to reduce these complaints.	87.5%
34. Regulators should work with paramedics and social workers on such matters as maintaining resilience with multi-professional groups.	87.5%
35. Publish case studies of disciplinary matters.	87.5%

These statements highlight the important role of the regulator in preventative action. Collaboration with, and the provision of leadership to, registrants to enable them to be part of preventative strategies reached 100% consensus. So too, the development of information materials supporting employers and educators is highlighted as important. The publication of case studies is recommended and an area of recommendation which will be discussed in a later section of the report.

Questioning the increase

36. Do we need to take preventative action? The increase in complaints and concerns can be seen as a positive thing if poor practice is highlighted and the avenues for the expression of public/service user/ concerns are more visible.	100%

This statement, questioning the need for preventative action, reached 100% consensus. It is an important statement which connects with findings in other project datasets.

Question 3: Strategies suggested to support health and care professionals to deliver high quality health and social care.

There is some overlap in this section with statements made in relation to Question 2. There are seven themes in this section as follows:

- Staff training/education
- Ethics education
- Time and space
- Organisational factors
- Regulatory approaches

- A multi-level approach
- Questioning the strategies

Staff training/education and assessment

1. Continuing professional education type programmes can be offered to provide additional training to professionals to reduce the number of complaints (e.g. how to communicate effectively, manage cultural diversity, gender issues, etc.)	100%
2. Taking the very real life lessons learned from the complaints made and filtering this back into the professions at undergraduate level and continuous professional development.	100%
3. Sound education that covers relational skills and critical reflection, need to be supported by employment environments that provide scope for continuing professional development.	100%
4. Practice teachers or assessors working with students during their placements need to feel more able and be more ready to recommend fail outcomes naming their concern in terms of very specific aspects of capability and suitability.	100%
5. Even in an under resourced system opportunities for reflection are not costly and can bring great value.	100%
6. Staff should be trained in patient safety issues.	87.5%
7. Staff should be trained in customer relationship management.	87.5%
8. Practitioners need to be equipped with the requisite skills to be able to diffuse conflict situations, for example, being blamed for poor response times.	87.5%
9. Rostered time off should be provided for practitioners to undertake targeted training, workshops, retreats etc to focus on growing skills to deliver high quality care.	87.5%
10. Continuing professional development (CPD) focussed on area of practice but also elective CPD that gives practitioners the opportunity to expand their training to include training pursuant to alternative future career pathways.	87.5%
11. Ensuring that undergraduate and ongoing professional training reflects on the nature of complaints and the hazards associated with this work	87.5%
12. Educators should not assume that concepts such as emotional resilience or work engagement are easily understood concepts that can be taught - a lot of work needs to be done still around understanding these	87.5%

concepts and how they may be fostered and supported. Importantly they need to be looked at in terms of outcomes.	
13. Best practices would suggest training at the under-graduate level be focused less on book knowledge and more on competencies needed to deliver high quality care.	75%
14. Exams and assessments at both the entry and on a continuing basis should be done on health and care professionals using competency -based assessments that involve Objective Structured Clinical Examinations using standardized patients.	75%

Education, training and assessment is a strong theme in the Delphi data and also discussed in relation to Question 2. There was a good deal of emphasis on practical educational strategies, for example, relating to 'relational skills' and communication, the management of cultural diversity and gender issues. The value of learning from 'real life lessons' was highlighted as was the value of 'critical reflection'. There was support for training in 'patient safety issues', 'customer relationship management' and conflict management. There was emphasis also on ongoing professional development and training relating to complaints and also a focus on competency and 'competency-based assessment'.

Ethics education	
15. Empowering professionals to understand the nature of what it means to be an ethical professional rather than someone who must adhere to guidelines. Space needs to be created to explore what this in fact means.	100%
16. Training in ethical decision making processes	100%
17. Ongoing professional development in ethics and professional practice.	100%
18. It is important to introduce practitioners to key ethics concepts, provide rich examples of complex ethical dilemmas, and discuss ways to manage these dilemmas (applying relevant ethics concepts standards and using practical decision-making protocols).	100%
19. In-depth, sustained, rigorous ethics and risk-management education.	100%
20. Professional bodies have responsibility for explaining the social work role to the public with the odd 'good news' story occasionally.	87.5%

21. Instilling value and a sense of self-compassion back into the professionals themselves.	75%
22. Better guidance to the public on airing concerns is needed so that this is more likely to occur at an earlier stage while the situation may be more easily remediable.	75%
23. We need to link data from a variety of systems to detect patterns and deteriorating clinical governance in health and social care services.	75%
24. Employers should run courses along the lines of 'thank you, let's support you in the next phase of your career'.	75%

A focus on ongoing professional development in relation to ethics in practice and ethical decision-making characterised this theme. There was emphasis on moral agency – being an ethical practitioner - as opposed to rule-following and on gratitude ('thank you') for things done well and on learning from potential harms ('deteriorating clinical governance'). The importance of introducing registrants to key ethical concepts and to ethical dilemmas was also referred to.

Time and space	
25. Create time and a safe space for discussion.	87.5%
26. Make space for reflection and acknowledgement of both strengths and development needs.	87.5%

The quest for time and space resonates with 'slow ethics' (Gallagher 2013) and also connects with the recommendations for ethics education in the previous section.

Organisational factors	
27. Active and open peer support networks.	100%
28. Supportive and accessible managers.	100%
29. Organisations must be quick to respond to complaints posted on social media.	87.5%
30. Better support from colleagues and employers in workplaces, and identifying barriers to this.	87.5%
31. Implement workload controls.	87.5%

32. Management in organisations needs to recognise the sensitivities of the relational nature of the work and to support the workers rather than taking on a punitive role because of their funding streams.	87.5%
33. Leadership needs to have an emphasis on ethics and values as well as outputs.	87.5%
34. Organisations should use social media to share good stories.	75%
35. Onsite chaplaincy should be available.	75%
36. Pay attention to inter-professional team dynamics and conflict resolution.	75%
37. Professional supervision for all health and social care workers.	75%
38. Be aware of fatigue cultures developing amongst colleagues.	75%
39. Health professionals need to feel that they are supported as often the complaints are not related to the individual practitioner's skills and competence but rather broader system and resource constraints. The practitioner is the face of the organisation and often is blamed by the public for general system failures.	75%

As before, there is much attention to organisational factors and on the relationship between individuals, teams and cultures. The importance of 'open peer support networks', supportive and non-punitive management and ethical leadership are emphasised. Supervision, workload controls and the role of chaplaincy are recommended as is awareness of 'fatigue cultures'.

Regulatory approaches	
40. Regulators should have a humane approach.	100%
41. Create a greater interface between the systems regulator, the professional bodies (including unions), educators and client/advocate groups.	100%
42. Regulators should emphasise the responsibilities of the employers.	87.5%
43. Implement a code of conduct for employers.	87.5%
44. While fitness to practise/conduct cases are about individuals, the findings can be utilised to highlight bigger issues. The regulator has a role in appropriately disseminating this information.	87.5%

> 45. There needs to be more effective professional publicity regarding complaints/concerns that enables the prospective complainant to identify whether it is the availability (or lack of) resources OR the professional practice in delivering these that is the problem. 75%

The idea of a 'humane' and connected regulator is suggested here with a recommendation to work more closely with the systems' regulators (for example, the Care Quality Commission in England, Health Improvement Scotland, Healthcare Inspectorate Wales and the Regulation and Quality Improvement Authority in Northern Ireland), educators and public advocacy groups. An emphasis on the responsibilities of employers is recommended alongside a code of conduct for this group. The recognition by regulators of the inter-relationship between the individual and wider issues and of publicising the role of resource availability or lack in complaints is also suggested.

> **A multi-level response**
>
> 46. Interventions are needed at every level - in student selection, undergraduate training, post graduate training and monitoring compliance with professional standards, using data to detect risky practitioners and deteriorating clinical governance, targeting of continuing professional development requirements, revalidation, use of performance assessment powers targeted to at risk groups. 88.8%
>
> 47. Rather than just targeting individuals, target the systems within which they work - employers, managers, professional bodies, insurers and governments. 77.8%

These two statements draw attention to the multi-faceted preventative approach recommended by most of the expert Delphi panel members. Interventions need to be at every level: individual (micro-level), organisational (meso-level) and governmental (macro-level).

> **Questioning the strategies**
>
> 48. The vast majority of health and social care professionals genuinely deliver services of the very best quality that they can and no amount of berating them with the possibility of complaints or conduct investigations is going to improve this. It's only going to lead to ever more defensive practice. 85.8%

The final statement challenges the focus on complaints, suggesting this will lead to 'ever more defensive practice'. This point will be returned to in other parts of the report.

Conclusions from the Delphi process

The findings from the Delphi process, undertaken with 14 international experts, resonated strongly with themes in the literature review. In terms of how the Delphi findings might be interpreted and compared with findings from the other datasets, it may be helpful to categorise in terms of different levels of analysis. In the social sciences, cognitive sciences and political science, analysis is organized as three levels generally moving from smaller to larger units of analysis. A common categorization is as: micro-level (individual), meso-level (organisational) and macro-level (societal/political) (Gallagher et al, 2016). On a societal level, participants agreed that changing public attitudes and expectations of health and social work professionals, together with increasing emphasis on accountability and awareness of how to make a compliant were likely to be having an impact on the rate of complaints. On an organisational level, factors such as poor leadership, heavy workloads, poor staff development provision and pressure on services, resource and support were contributory factors. On an individual level, contributory factors included the selection, training, supervision and professional development of practitioners, and the need for clearer guidance on the ethical responsibilities of individual registrants.

Chapter 3 Interviews and focus groups

This section of the report presents the methodology and findings from the qualitative interviews and focus groups.

One to one interviews were conducted with 26 stakeholders identified by the research team and the Project Advisory Group. These included those with expertise in paramedic and social work practice and in regulation from across the four UK countries. Eleven interviewees had a paramedic background including practitioner, union and professional body representation, employers and educators from across the UK. Eleven interviewees had a social work background including practitioner, professional body, education and union representation. Four were regulators or lawyers working in regulation.

Two focus groups with professionals were held; one consisted of six participants who were frontline paramedic practitioners or managers working in Wales. The other consisted of seven participants who were senior social workers and managers working in the North East of England.

Two focus groups with service users were held; one consisted of seven participants who were users of mental health and physical disability services, as well as a wide range of generic primary and secondary care services from across London. The other consisted of three service users who were users of mental health, cancer and elderly care as well as a wide range of primary and secondary care services across the South East of England. All had personal experience of receiving care from paramedics and social workers in a variety of settings. Both groups included service users with long term conditions, including cerebral palsy, spinal injury, mental health conditions and cancer, as well as users of children and family social services. Some were involved in teaching students in university settings, in inter-professional and uni-professional settings. Attempts were made to run a further user group in two other parts of the UK but this was not deemed feasible by the services within the timescale for data collection.

All participants were asked to comment on the reasons for the number and nature of complaints and what preventive action might be taken to address this (see Appendix E, F, G for examples of the information sheets and consent forms and the topic guide used in the study).

Table 4 Participants in the interviews and focus groups

Individual Interviews	Number
Paramedics	11
Social Workers	11
Regulators	4

Focus Groups	
Paramedics (Wales)	6
Social workers (Durham)	7
Service users (London)	7
Service users (South East England)	3
TOTAL	**49**

A thematic analysis was used to extract themes and sub-themes from the qualitative interview data (Braun and Clarke, 2006). Regarding the validity of the findings, the researchers were mindful of sources of bias (Norris 1997, Noble and Smith 2015) and of the value of initial analysis by 2 members of the research team who had not conducted the interviews and focus groups. They cross-checked codes and themes as the analysis progressed. The overall analysis of the interview and focus group datasets (relating to paramedics and to social workers) was then circulated to the research team for input.

Findings: Reasons for disproportionate number of concerns – Paramedic interviews and focus groups

Five themes were identified from the analysis of the interviews and focus groups relating to paramedic practice.

Table 5 – Themes and sub-themes – paramedic interviews and focus groups

Themes	Sub-theme 1	Sub-theme 2	Sub-theme 3	Sub-theme 4
Public perceptions and expectations	Mismatch of expectations	Last resort	Big news	
Challenging practice	Practicing defensively	Autonomous practitioners	Enough of this	Frustration that builds
Pressurised services	Don't have enough staff	Mopping up	No time for training	

Culture of fear and conflict	Head-down	Discipline first	What leadership?	Big brother
Evolving profession	Professional values	Embryonic profession	Why should I change?	

Theme one – public perceptions and expectations

This theme described the ways in which public expectations and perceptions might relate to the number of complaints made against paramedics.

Mismatch of expectations

Participants suggested that public expectations of what paramedics can do are unrealistic. Participants in the focus groups debated this point, and agreed that patients view paramedics as the 'advocates for their care', with a 'massive expectation' to fix the gaps they have experienced in primary care, to 'do something' and 'resolve' their problems. Participants recognised that the traditional role of the ambulance driver to take the patient to hospital had changed, but that the public still expected this to be the outcome of paramedic intervention, often leading to a mismatch of expectations.

One service user explained that she had been involved in a car accident and was 'patched up at the roadside' rather than taken to hospital. She had questions about her injuries which she then needed to take to a GP. While this service user knew that she might not be taken to hospital, she felt other members of the public might not understand why the traditional 'lift and shift' approach was no longer being used for all patients. This mismatch was coupled with the fact that the public were perceived to be more able and willing to act, imbued with a sense that 'the customer is always right' (academic). On occasion, members of the public would want to deal with their frustrated expectations by complaining. As one employer put it, 'If paramedics are not 'geared up to provide what [patients] want' then the patient feels entitled to take action. Service users also discussed this point, agreeing that, 'I think perhaps we expect too much of them, and I think that's generally nowadays people want to complain a lot don't they, and they want to put blame … I think people often don't think whether they've contributed to something and they'll just want to find somebody else to blame.'

In the service user group, participants also discussed how paramedics are expected to understand and manage individual needs – including disabilities – but participants had examples where this was not the case and where the needs of wheelchair users, for example, were not understood. This created a great deal of frustration and distress. As

one participant explained, after a car accident, that paramedics were unable to take her wheelchair in the ambulance and it was therefore left at the scene:

> *And I said, 'But what about my wheelchair?' And they said, 'But your wheelchair's going to have to stay behind because there's no room for it'. And I was like 'Yeah but that's saying your legs have got to stay behind, there's no room for your legs' and we just had 15 minutes of arguments about the wheelchair coming, and they just wouldn't have it. And so, I was left on the gurney, not knowing where my wheelchair was.*

This service user felt that paramedics did not understand or seek to listen to her needs. The group suggested that paramedics should have better training on the needs of people with disability. Indeed, service users discussed more broadly how individual needs seemed to get 'lost in algorithms' from the moment they make a call for help, and how getting lost in this 'rule' structure, 'sets the hackles rising, it makes it difficult to communicate. Because they're following an algorithm, the individual who's in contact is not on the same page.' Service users felt that paramedics were often constrained by the heavy emphasis on rules that often conflicted with patients' wishes. As each case is different, and every patient and family's needs are individual, it becomes imperative for paramedics to listen and respond to those needs. A service user (who was a wheelchair user) described a situation in which her child needed emergency care. The paramedics were 'not listening' to her when she explained that she could not put weight on her feet. As a result, she fell on the pavement before being transported with her child in the ambulance, fortunately without injury. As the service user explained, 'if they only had listened to what I was telling them, that incident could not have happened.' Another service user described how patients' wishes for end of life care had often been contradicted because ambulance staff did not acknowledge patients' wishes or have access to that information.

Last resort

There was a consensus in the interviews and focus group that paramedics entered people's lives at a moment of crisis. In such emotionally charged situations, participants suggested that people were more likely to raise complaints and look for someone to blame, and this often fell to paramedics. Even if objectively some cases were not at crisis point, the situations were experienced as such by patients and families and sometimes paramedics might fail to empathise with this. As one participant explained:

> *maybe then the patient feels that they're not being taken seriously or not receiving sort of the appropriate timely care. So that possibly is a high risk for paramedics if they were potentially upsetting the public. (employer)*

For some patients, calling 999 is a 'last resort', having unsuccessfully tried other healthcare pathways and not getting the help they need (focus group) In these cases,

67

paramedics may bear the brunt of a protracted story about trying to get help and this might mean that paramedics become the focus for distress and anger because the broader healthcare system has not helped them. In both crisis and last resort situations, it was suggested that paramedics needed to demonstrate sensitivities, even if they were worn down and frustrated. When they did, patients were reassured and satisfied and when they did not, patients were more likely to complain.

It's big news

Public expectations and perceptions were also felt to be shaped via print, television and social media representations of paramedics' work and this led to some misrepresentation. Paramedics also had to be mindful that they might be filmed when working in public. Participants felt that this might increase the number of complaints: 'because of the visibility of social media, CCTV – you're watched everywhere aren't you?' (professional body). The pressure was also said to be exacerbated by headline-dominating news focused on a few individuals who have abused trust (academic). This pressure, and sense of high expectations, coupled with a perceived sense that people were watching them and critiquing them – ready for them to make a mistake or slip up and be exposed – was perceived to contribute to misaligned perceptions about the role. Service users also felt that this was a big factor in shaping public expectations. As one service user put it:

> *The public media image of paramedics is they'll come on the scene in the most incredible circumstances crawling under buildings and stuff like that you know, and it's fantastic - and that in general is the expectation of the entire health service in fact. And you see big headlines on the front page of the red tops 'My mum was 94 and they came to fix her and they killed her instead' you know.*

Theme two – challenging practice

This theme focused on the day to day challenges paramedics face in practice, seen to be something of a 'perfect storm' (consultant paramedic) for issues and complaints to arise.

Practising defensively

Paramedics work in challenging practice environments. Due to the nature of those challenges (violent or confrontational, drug or alcohol fuelled, emotionally charged involving verbal or physical abuse) paramedics are often 'practising defensively' which creates a tense situation that can fuel provocative responses (academic). To handle these situations, paramedics need to have advanced people management and communication skills, which may go far beyond their clinical practice. These situations are potential 'triggers' and if they are mishandled, or evoke a reaction from paramedics, they may potentially lead to reactive situations where complaints will arise (professional body). In emergency situations, the pressure to manage the situation, as well as the

patient and other members of the family, can be particularly challenging. If paramedics react to these triggers, they may end up finding themselves subject to a complaint.

Autonomous practitioners

Paramedic practice can often involve lone working with high patient contact. While this can mean that care is hugely valued and highly rated, there is also the potential for these close relationships to be 'abused' (employer). For some individuals, lone working provided them with 'a chance to misbehave' (paramedic academic). Further, participants argued that in a context where there is minimal supervision, when mistakes are made, there may not be the opportunity to correct them, and they may be repeated. As one participant put it, paramedics are sometimes working without 'the supervision and support that they actually need' (civil servant). Paramedics working in this way also make 'difficult and complex' decisions which, participants suggested, might lead to concerns being raised. Some of the cases they encounter are high risk and 'life and death decisions' which put a lot on paramedics' shoulders (regulator). Service users also highlighted that the speed and difficulty of decision-making was challenging for paramedics:

> *But you can see how they're forced into making decisions very quickly aren't they, and perhaps not always make the right decision, and then can be criticised afterwards*

Furthermore, the breadth of skills that paramedics need to do their work might also create a higher likelihood of complaints. As one participant explained, 'We expect a paramedic to go to every single healthcare speciality that is encountered in the NHS' (paramedic complaints manager). In this challenging practice environment, there is a sense that there is a greater risk of problems arising than for some other healthcare professions, who also work autonomously but deal with a narrower set of challenges and smaller numbers of patients over the course of a working day. Participants in the focus group reflected that education had not caught up with the skill sets needed in current paramedic practice:

> *Well let's be pragmatic about it – paramedics are paramedics at the moment, and what we actually train them to do is manage emergency patients. We don't train them in pathophysiology, of multiple unscheduled care co-morbidities, we don't train them in chronic disease management or planning. They don't receive any pharmacology training in terms of pharmo-kinetics or pharmo-dynamics, in terms of primary care medicine (paramedics complaints manager)*

"Enough of this"

Participants felt that the high stress of paramedics' work leaves them worn down, without the tools to cope and communicate effectively, unable to manage some aspects of their work and how these factors make them more vulnerable to potential complaints. If paramedics were not given the right coping and managing skills in terms of their own wellbeing then this may have consequences for practice.

As these challenges continue, and long shifts overrun, 'patience' and 'tolerance levels' decline and reactions may become inappropriate (patient advisory forum). Participants described how these 'humanistic factors' overwhelmed them, leading them to 'let their guard down' and diminishing their 'caring, empathetic' responses. In difficult situations, 'communication becomes really important' (academic) but optimum communication might be one of the first things to falter in high stress situations. In such circumstances, 'a simple comment' might lead to a complaint (paramedic).

Frustration that builds

Participants commented on paramedics' changing scope of practice from acute emergency care towards involvement with cases traditionally managed within primary care. This was described as a growing challenge, which led to frustration and a sense that some skills were being underutilised. As one academic articulated:

> *[…] there's nothing more frustrating and demoralising thinking "I want to go and help, because with that one I can save a life, this one I'm now going to spend 2 hours trying to negotiate with a GP to come out and see this patient and give them some antibiotics."'*

With frustration and demoralisation came the potential for paramedics to feel devalued and less invested in their work. There were also observations of paramedics experiencing a 'deskilling' and the potential clinical consequences that this could have, ultimately leading to fitness to practise referrals. As one participant explained, 'because the truly life threatening calls are such a small percentage compared to the wider call volume, their exposure to those calls are now limited, and it's around competency. It's whether they're maintaining those core skills' (paramedics' complaints manager).

Theme three – pressurised services

This theme related to the organisational structures that paramedics work within and the context of pressurised services that affect their work.

Don't have enough staff

Participants pointed to two-fold pressure of increasing volumes of 999 calls coupled with the shortage of paramedics. As a result, response times were slower. Indeed, as one participant who dealt with trust complaints explained:

> The bulk of our complaints […] relates to the response we provide, and it's nothing to do with the care provided. (paramedic complaints manager)

The perceived problem was not just about individual practice, but the context that paramedics worked within. With trusts under pressure financially, several participants felt that complaints which might have once been dealt with internally by the trust were being passed to the regulator. As one participant hypothesised, 'I wonder if it's the ambulance service saving resources and going "The HCPC can deal with it"' (professional body), or as another participant put it, they may have, 'not abdicated, but possibly not actioned what they might have done in the past' (employer). In this way, issues which have once been actioned internally were being referred to the regulator, obfuscating the sense of scale of cases which concern fitness to practise.

Mopping up

Participants discussed how ambulance services were seen to be 'mopping up' from primary care and other parts of the NHS (lawyer). To meet the demands of the system, jobs that would have been done by GPs or were meant to be picked up by the 111 service were falling back to ambulance services. Participants said that both patients and paramedics could become frustrated by these service changes. Service users also identified that discharge from hospital could be a particular issue and that:

> the system says discharge this patient because the roads are quiet, the ambulances are quiet, let's get this person out of hospital at 9 o'clock at night - that's extremely distressing and difficult for the patient so they blame the paramedic rather than the hospital. For some patients, who have been waiting for a long time to be discharged, the paramedic takes on the effect of the 'whole systematic thing'.

Another service user observed that response times often generate complaints, but that the circumstances are often outside the paramedic's control:

> *as if the ambulance crew are sitting there going "No, you know what, I don't think we'll bother rushing to this one" – that never happens you know. They're prevented by conditions that are largely outside their control.*

Paramedics thus find themselves responsive to other, more systemic shortcomings and patients find themselves confused by the changed model of paramedic operation, both of which create potential for generating complaints.

No time for training

Participants discussed how low staffing levels and high volume of calls put pressure on paramedics' time for ongoing training and development. Participants referred to a lack of CPD leading to concerns being raised about practice. The lack of time for training was said to be compounded by targets to keep ambulances on the roads. Even when time for CPD was provided, participants suggested that it was not usually 'targeted to individual needs' (focus group) nor was it, 'embedded in the organisation's ethos that CPD is this continuous thing that everybody does and everyone enjoys' (union representative). Furthermore, training did not focus on broader issues of practice such as 'professional ethics' (paramedic). Participants felt that given the breadth of skills paramedics increasingly needed and the challenging practice that they face, training was essential, and a lack of it could be a reason for some aspects of practice receiving a higher number of complaints.

Theme four – culture of fear and conflict

This theme describes paramedic culture, characterised by feelings of being 'under attack' from management and the regulator. This cultural emphasis suggests two different challenges: one encourages paramedics to keep problems hidden thus potentially worsening their impact. The other can lead to over-reporting of concerns.

Head-down

Participants described an internalised, closed culture in the Ambulance Service. This had three facets. First, paramedics are resistant to opening up about stress and mental health issues they face. A union representative explained:

> *'it's not the environment where people step forward and say "I think I have a problem and I'd like some help"' (union representative).*

As a paramedic/academic explained, this relates to a sense of needing to play a hero role:

> *'Yeah when we're wearing green we are completely … you know*
> *we are just Superman, nothing can touch us. We don't like to admit*
> *we've come across kryptonite and it's stopped us.'*

Second, this culture is also designed to keep management away. It is an act of self-protection – a sense that if paramedics speak up about the problems they face or incidents that occur, that managers will 'cause [them] difficulties' and so they 'operate in a way that keeps them off our backs' (paramedic patient advisory forum). This can lead to entrenched ways of working and ultimately poorer practise. Third, participants suggested these issues emanated from the historical culture of the ambulance service. However, there was a sense that they continued to be issues, and could affect those new to the profession steeped in the values of open reporting who 'become contaminated and they become quite hidden in their activities' (paramedic).

Discipline first

Participants suggested that this historical disciplinary emphasis within ambulance services persisted today. This had consequences for the prevalence of complaints: both the volume of self-referrals and more general complaints. First, participants observed paramedics as self-critical: 'we are very hard on ourselves as paramedics' (academic). Second, this critical nature extends outwards, as a union representative explained, it is common practice that 'colleagues report colleagues'. In some cases, the reporting system was used as a way of expressing other issues: 'whatever the beef is between the two parties, they're using the regulator as a big stick' (paramedic).

More broadly, these self-critical and reporting behaviours were situated in a culture used to dealing with issues through discipline, rather than 'discussion' or 'appraisal'. As one focus group participant explained, the military or police-style model and code of conduct meant that 'however you behaved outside of work, it could have serious repercussions inside of work, and that was even before registration'. A large number of concerns being raised would not be seen as a negative in this context, but as the individuals adhering to the code and the organisation providing an authoritative stance.

What leadership?

Participants suggested that there was a lack of leadership from employers on key issues including the meaning and remit of being a health care professional which employers didn't 'really see […] as being part of their bag' (paramedic). Furthermore, because paramedics worked long shifts, and were physically out of sight from managers, participants reported that they also lacked support and feedback. A lack of support and leadership made paramedics particularly vulnerable to closing down problems and 'under-reporting adverse events' (paramedic), or alternatively over-reporting themselves. As a paramedic/academic described, because ambulance services do not clearly articulate what the criteria for self-referral are:

> It's all left to individuals inside an organisation, totally left to individual's interpretation of what's [their] perception of fitness to practise.

This mix of discipline and autonomy was seen as a fertile ground for both complaints and self-referrals.

Big Brother

Participants from both the interviews and focus groups reported that paramedics can sometimes be fearful of the regulator. This was felt to be fuelled by employers and the unions, who embed the notion that paramedics might be 'struck off' for making the 'slightest mistake' (academic). The kind of fearmongering propagated the notion of the regulator as a sort of powerful 'big brother' (academic). With 'big brother' watching over them, a number of participants said that paramedics often self-refer to try and improve their chances of a positive outcome and that this behaviour had been directly encouraged by their employers and by the unions.

Participants in the focus group discussed that this kind of reactive self-referral may be creating a culture in which 'If I just put my hands up early, I'll be fine' and that this was not the culture that should be encouraged. However, as one interview participant put it, 'Is that because it's their way of defending themselves against an attack?' (patient advisory forum).

Theme five – evolving profession

This theme identifies a developing profession and the impact this has on complaints being raised about paramedics. At one end of this spectrum is a new generation of paramedics with heightened awareness of their professional registration, who can sometimes struggle with upholding this in practice. At the other end, there is a group of experienced paramedics who are more comfortable with traditional ways of working and may be resistant to change.

Professional values

Paramedics entering the profession from university courses were described as having a heightened awareness of the regulator and of the values of professionalism. As one participant put it, the cost of university education added weight to the significance of their role: 'they're realising that it's … how easy it is to lose, and how you will lose everything. As opposed to it's just a driving job which someone 20 years ago would have done' (paramedic). However, paramedics are sometimes torn between doing what they think they need to do to 'protect' their registration and what they think is in the best interests of the patient. These two are sometimes misaligned – for example – in the transfer of patients to A&E departments where paramedics need to wait for handover to another healthcare professional, even if this means waiting for hours and being unable to be available for other calls (paramedic).

The emphasis on professionalism could actually promote self-referral as the best option if any incident occurred. This model of working was compared by one participant to an airline model of 'no blame' where 'you raise issues …from a safety point of view' and where the idea is to 'stick your hand up and tell us about it' (professional body). This is seen as a professional 'obligation' (regulator), something that helps cement the profession. In attempting to move away from the traditional disciplinary culture paramedics are 'looking to do all the right things' (consultant paramedic), which may provide some explanation of the observed increase in self-referrals.

Embryonic profession

As an 'embryonic profession' (consultant paramedic) shifting from a model based on local disciplinary processes to a regulated profession, participants suggested that there can be conflicting advice from HR staff at the local level about reporting processes. The notion of uncertainty around when something should be referred to the HCPC and the 'subjective' interpretation around this was a consistent theme throughout the interviews and focus groups.

Participants felt that for some paramedics there was a lack of understanding about what being a healthcare professional means and the 'ethical side' involved. In both the focus groups and interviews, participants questioned the extent to which paramedics would know the standards they should adhere to. Indeed, participants acknowledged that professionalism doesn't 'happen overnight' and involves more than just clinical practice but 'development in a lot of other areas' (employer). In this evolving context, there remain some people who just 'don't get it' (consultant paramedic) and this, some participants articulated, is reflected in the fact that a minority (20% was suggested) of paramedics belong to the professional association.

Why should I change?

At the other end of the evolving profession are those paramedics wedded to old ways of working and less familiar with the meanings of professionalism who argue, 'why should I change?' (paramedic academic). This was not necessarily a clear-cut divide; some participants were keen to point out that university education was not a panacea nor was it a case that younger paramedics were necessarily better or more knowledgeable. In the focus group, participants felt that generational issues might be a possible reason for complaints, but posed it as a question for the profession rather than a clear-cut answer.

Those members of the workforce comfortable with more traditional processes were sometimes seen to be 'burnt out' or not prepared to make changes to their experienced practice (union) because they 'are not interested in the profession going forward' (professional body). Participants suggested that this lack of engagement with newer processes might come across as arrogance about decision making. This attitude, it was suggested, might contribute to an inflammatory reaction to situations, or leave gaps in paperwork, both of which could contribute to complaints.

As one participant put it, these paramedics do need to change and: 'need a bit of a kick that we are now a profession and we need to behave as such' (paramedic academic). Participants in the focus group also reflected that some paramedics need to change their 'problematic attitudes', 'I think all ambulance services could be better at challenging our perceived bad attitude colleagues'. As members of the focus group discussed, the accountability which accompanies being a professional is an opportunity to develop and grow and needs to be positioned as such:

> *.. have we embraced professionalism? And with professionalism comes accountability. And we see accountability as a punishment rather than … we should look at accountability as an opportunity to change.*

Findings: Preventative strategies - Paramedic interviews and focus groups

Participants proposed preventative strategies which could be implemented to address the number of concerns raised about paramedics. Typically, these were directed to: employers, the regulator, the professional body and educators. Many of the preventative actions discussed involved joint working or systemic changes. The role of individuals in addressing their own practice also emerged as important but – outside of those paramedics who committed serious misconduct or criminality – most of the actions discussed were felt to be related to the organisations leading and guiding paramedics. Although public perceptions were identified as a reason for some complaints made against paramedics, tangible actions to engage the public were less clearly articulated. Finally, although the role of the unions did not emerge as a separate theme, it was felt

they did play an important part in improving relationships with other agencies and supporting paramedics.

Table 6 – Preventative strategies - paramedic interviews and focus groups

Themes	Sub themes
Employers: 'we have a responsibility'	• Framework for learning and training • Mentorship and support • A safe environment
Regulator: 'more supportive and protective'	• Re-education • Re-positioning
College of Paramedics: 'promoting professionalism'	• Working together
Educators: 'a responsibility as educators'	• Teaching communication and professional conduct • Teaching disability awareness
Joint Working: 'mutually supportive'	• Clarifying support and boundaries • Supporting accountability

Theme one – Employers: 'create better framework for learning'

Participants felt that employers played a central role in preventing complaints being raised about paramedics. However, this was tempered by an acknowledgement that ambulance services were struggling to meet service demands and asking them to find time and resources to deliver additional training would be challenging.

The right framework for learning and training

Participants in the interviews and focus groups recognised that ambulance services were under great pressure in terms of being able to deliver training because of the need to keep paramedics on the road. However, it was also felt that the 'right framework for learning and training' was essential to enable paramedics to carry out their work safely (union). There was an emphasis from several participants on the role of employers in providing CPD, and creating the opportunity to tailor CPD to individual needs and to develop careers. Participants argued that CPD needed to be more than a 'tick box' exercise; and embedded in 'reflective learning' (lawyer, regulator, service user). Indeed, as service users discussed, group reflective practice as well as individual reflection

would help create change. Areas identified for CPD included those around attitude and communication, changing technologies, and understanding mental health issues. Participants felt that CPD should also provide a broader understanding of the role of the regulator and the parameters for self-referral.

A focus on CPD about professionalism was widely acknowledged to be a challenge – both to engage paramedics, and for employers to find time to address this versus more critical clinical updates. However, it was felt to be important to deal with the number of self-referrals, which were sometimes considered unnecessary. While this was not felt solely to be the responsibility of employers, it was acknowledged that employers played a part.

Beyond opportunities for regular CPD, participants suggested that the head-down, fear-led culture could be addressed by providing a clearer career framework. The role of the advanced practitioner and consultant paramedics were felt to be an important development but participants said more was needed:

> *[…] when we have a profession with a proper career structure where you know people can expect to move on from where they are, then I think that aspiration will to a certain extent neutralise the other aspiration which is to keep your head down. (paramedic)*

Participants in the focus groups added that these senior level clinicians were different from the experienced ambulance managers, and it was important they had representation within the regulatory structures.

Mentorship and support

Participants described the need for a supportive structure for paramedics; one in which they felt there was 'support' and 'reassurance' from the ambulance service on a day to day basis. Mentorship was specifically mentioned in relation to newly qualified paramedics, to bridge gaps between education and practice. Strategies suggested included a preceptorship period or shadowing period to enable them to, 'get experience of some of these fairly volatile situations and how to handle them, and […] get that experience of the places where the complaints occur.' (professional body) Participants in the focus group also discussed the idea of putting more educators 'on the ground' – 'locality based trainers' who would be able to provide essential 'support and supervision' in practice.

Given the challenging work environments, participants felt that giving paramedics the right coping and managing skills was important. It was incumbent on employers to be a part of this; acknowledging the stressful work that is done and finding ways to 'prevent this kind of burn out'. (lawyer). As one participant explained, these situations might not change but how a paramedic chooses to react can be worked on:

> *'[…] we're always going to go to the same patient groups and be in the same situations with them, but it's how we communicate with them, how we deal with them, how we're seen to deal with them.' (academic)*

Service users also commented on the impact of dealing with stressful situations and the need for support: 'Because the paramedic crews, they've seen a lot and they experience these things, they have to contain those issues and be professional'.

A safe environment

As paramedics were often fearful of their employers in a disciplinary-heavy culture, participants felt that this needed to be addressed directly. Participants suggested that paramedics needed to feel 'safe' and be encouraged by employers to engage in reflective learning. This cultural shift could form part of the learning around 'taking stock' rather than immediate kneejerk reactions to situations (academic). One participant articulated how employers needed to clearly articulate what might be proportionate in terms of complaints. A response to a problem should not be phoning 'the HCPC up at 4 o'clock in the morning', but a considered process (union). Employers might offer 'an action plan' in which practice is 'refresh[ed] and redevelop[ed]' rather than 'first written warning, second written warning, final written warning' (academic). Participants in the focus group discussed the notion that individual errors could happen to anyone:

> *Because I'm going back to … our philosophy, and certainly my philosophy is we are human beings in this room, human beings make mistakes, they're known not to be infallible…And it can happen to anybody, the important thing is to recognise that it's happened, and to react to that accordingly (paramedic).*

Employers could encourage employees who have been through a complaints process to share their stories. It was felt that these may go some way to diminishing fear, building 'a safe environment' and demonstrating positive learning outcomes. A service user discussed how, although the majority of paramedics were responsive and sympathetic and wanted to learn, there would be some who 'shouldn't be doing their job' and that the system needed to also recognise that these people need to either 'change their behaviour, or not … and then consequences should follow.' It was felt that it was important that these paramedics were not 'hidden' under layers of the system; there may be a 'reticence' to discuss colleagues' professional behaviour and that this needed to change.

Participants in the focus group were clear that it was incumbent on employers to help paramedics with these changes, not just expect them to be accountable without support.

> *We say to them listen you're registrants now, you're professionals, you're accountable – you've got to change … but we do nothing to try and help them change. And we just use a stick … and by saying that,*

> *by saying that to them, we abdicated our responsibilities by saying that*
> *to them, and expect them to change … (paramedic).*

As one service user explained, complaints could be viewed in a different light; not with dread but 'as constructive opportunities to improve, to engage […], and to you know get their staff involved in making improvements.' Indeed, in an example from Wales, a participant detailed a practical working example of how preventative actions had been taken and were making a difference to practice.

Theme two – Regulator: 'clarify criteria, provide support'

Participants identified several ways in which the regulator could help to reduce complaints raised against paramedics. These came under two areas: 're-education' of paramedics and 're-positioning' the role of the HCPC.

Re-education

Participants suggested that the regulator could be involved in clarifying the process of dealing with complaints, as there was a perceived lack of understanding of these processes amongst practitioners and employers. It was also identified that sometimes the regulator might suggest sending in a complaint because they were too busy to take detailed calls and talk through the circumstances. Participants suggested that practical and detailed information (using case examples) about the processes would be useful and that this could be fed back to educators. It was felt that the regulator should educate the sector on the criteria for self-referral. Without this clarity, paramedics were acting subjectively and concerns would be more readily referred. Participants in the focus group felt that a clearer 'filtering system' or a 'helpline' or 'checklist' or 'firmer guidance' was needed when it came to complaints and talked specifically about ensuring consistency of approach.

Re-positioning: 'guiding uncle not big brother'

Participants referred to the need for the HCPC to engage with ambulance services and with professionals on the ground, and to promote and make more visible 'what a good thing they do' for the profession (consultant paramedic). Participants felt that the HCPC did have visibility with paramedics but that it was only as a 'big brother' and that it was important that the regulator reposition its role as more about protection (paramedic academic). As one participant said: 'I mean should paramedics ever see them as a body to which they can go for advice for example?' (patient advisory forum).

Participants said that validating and sharing good practice would be a way to achieve this to demonstrate that the regulator was also supportive of successful work (paramedic academic). Service users also commented on the way in which the regulator could measure and look at the 'causes of *good* practice' rather than just focusing on bad practice. Some comparisons were made with other registrant bodies such as the General

Medical Council, where it was felt that there was a better public understanding as well as a sense that the body was 'advancing' not just 'disciplining' the profession (patient advisory forum). There could be local advocates appointed by the HCPC, and the guidance on referrals could be clearer (focus group). However, whilst this type of engagement was positive in theory, some participants argued that it would be challenging work, especially in engaging with experienced paramedics. One suggested solution was to engage via an online incentivised survey.

To move away from the 'big stick' model, with paramedics 'terrified' of the regulator taking away their registration, participants suggested that the HCPC would need to promote a 'more supportive role and protective role' (paramedic academic); it needed to demonstrate consistency in the fitness to practise decisions, and not be 'punitive' (focus group). As one participant explained, by sharing case studies it would help clarify what happens in cases. As one participant articulated, to protect the public, the registrant body needs to support the profession to improve and this could be done by acting more as a 'guiding uncle rather than a big brother' (academic), 'a body that disciplines but also advances' (service user). Indeed, another service user saw the regulator as important in service transformation using the example of 'the Healthy London Partnership and transformation boards for the London footprints all working together' and how in this example, 'instead of the regulator sitting in their office somewhere near Parliament, they've got people in the top tier, the strategic tier, embedded in implementation teams to transform services.'

Theme three – College of Paramedics: 'promote professionalism and ethics'

Working together

Throughout the interviews, the College of Paramedics was discussed as an organisation with the potential to help reduce the number of complaints about paramedics. Suggestions included: surveying paramedics about what could be helpful to them; sharing stories about good cases; clarifying pathways about reporting; recognising and responding to the UK wide context; and encouraging paramedics to engage with their employers first, growing its membership to enable it to have more influence and 'joining up the dots'. However, most of the discussion around the College centred on guiding the profession to a greater appreciation of the meaning of professionalism and performance ethics. Whilst it was recognised that some work had been done in this area, there was a call for this to be more integrated into education and training. In the focus groups, it was felt that the professional body could do more work with the regulator and go further than curriculum development. It was recognised that there had been tensions with unions in the past, and that improving this relationship would be of benefit to the profession and moving it forward. Service users discussed a different angle – highlighting how complaints could be viewed not as always negative but as 'useful feedback' and disseminated more widely amongst practitioners and student practitioners.

Theme four – Educators: 'support changing practice'

Across the interviews, education was discussed as critical to laying the foundations for paramedics in understanding their professional role, their registration and regulations, and how to deal with challenges in practice. A range of suggestions were put forward as to how educators could contribute to preventing the disproportionate number of concerns raised about paramedics.

Teaching communication, professional conduct

One was a greater focus on developing communication skills. This issue returned to the way in which paramedics respond and react in challenging situations. By recognising the importance of communication skills and finding more effective approaches to managing stressful encounters, paramedics would be better equipped. Educators were also seen as able to teach about the nature of professionalism and the regulator:

> […] we have a responsibility as educators to ensure that students understand that it's actually it's not personal, it's about public safety and this is our registered professional body. (academic)

Another participant suggested that students needed to be taught that their job was not only about clinical skills, but also that 'professional and personal conduct needs to come up to the standards that will be expected of you by the public and your regulator' (lawyer, regulator). One participant felt that feedback from practice into training about fitness to practise was essential, and that this 'feedback loop' was perhaps a 'missing link' (paramedic/HCPC partner). Although other participants said that they knew of educators who did deliver modules about the HCPC and regulation and what it meant for the paramedic student, there was a sense that this should be more consistent. In the focus groups conversations about education turned to how it should support changing practice. There was some disagreement amongst participants as to the extent to which academia was keeping up with changes in paramedic practice.

Teaching disability awareness

A service user with acquired disabilities described how the paramedics who came to her on more than one occasion showed a 'lack of listening' as well as poor awareness of disability. In her view, communication skills training and disability awareness training needed to be addressed by educators. Another service user in the group (also a wheelchair user, but with cerebral palsy) described an experience of needing emergency care. The paramedics had tried to get him to 'lie down' in the ambulance when this was physically not possible for him. He found the experience 'painful and distressing' – all preventable through listening to the service user and having some knowledge of the impact of cerebral palsy on movement. As a member of the group articulated:

I think one of the things is that I'm not entirely clear how much disability awareness training paramedics actually get. I know they get a lot of medical based acute sort of training, but I'm not sure that they know that much about disabled people's bodies and how disabled people need to sit in their own wheelchair because otherwise they're at risk of injury - you can't just put them in any old wheelchair.

Theme five – Joint working: 'achieve better understanding of respective roles'

Clarifying support and boundaries

Joint working towards preventative actions was discussed as essential in dealing with the systemic issues. Joint working between the College of Paramedics and regulator was proposed as a possible partnership so that the HCPC could 'rubber stamp' CPD initiatives for example, helping both organisations shift perceptions about complaints handling.

As well as working together, participants suggested that boundaries and responsibilities also needed to be clarified. As one paramedic employer put it:

I think all professional bodies and all registrant bodies should be inextricably linked, although they have definitively different roles. And I think we need to make sure that over all professions that people understand those roles, and how they really align with each other and how they are mutually supportive of each other.

Service users agreed and discussed the problem of clarifying and mapping out sometimes-conflicting 'rules, regulations and standards' through a 'systematic approach'.

Supporting accountability

In working to prevent complaints and address issues which emanate from individual, organisational and societal spaces, a systemic and joined up approach was required, one which made links and connections and that moved out of a culture of conflict towards one which was supportive and open. Participants in the focus groups described that a clear understanding of supported accountability was needed where individuals felt empowered and supported to develop and grow, viewing accountability as an opportunity not a threat. As service users discussed, practitioners need to be 'open and broad shouldered' to actively respond to, interact with, and learn from complaints, which 'comes from having confidence in the system to support them properly and that they're not going to lose their job over something trivial'. There was a clear sense that such a 'paradigm' change would be needed to make this happen.

Findings: Reasons for disproportionate number of concerns - Social work interviews and focus groups

Four themes were identified from the analysis of the interviews and focus groups relating to social work practice. The four themes were in accord with four of those identified from the paramedic interviews with sub-themes as in **Table 7** below.

Table 7 – Themes and sub-themes – social work interviews and focus groups

Themes	Sub-theme 1	Sub-theme 2	Sub-theme 3	Sub-theme 4
Public perceptions and expectations	Confusion about role of regulator	Less respect	Motivation for complaints	
Challenging practice	Relationship-based practice	Underprivileged service users	Doing the undoable	Limited experience and continuity
Pressurised environment	Lack of resources	Inadequate support	An intrusive profession	UK differences
Evolving profession	Newly regulated	Regulatory understanding	Not treated as professionals	Consultant roles

Theme one – public perceptions and expectations

The three sub-themes which emerged from the analysis were: confusion about the role of regulator; less respect; and motivation for complaints.

Confusion about role of regulator

Regulator participants, in particular, highlighted the problem of service users not understanding the role of the regulator. As one participant explained, the regulator is, 'not a complaints resolution body […] we are dealing with a professional's fitness to practise and the risk that they would pose to other service users or the public. And that is a very difficult message to get through' (regulator). According to this participant, a more accurate description of the role of the regulator was:

[...] to protect the public by taking action about any concerns which might suggest that someone's fitness to practise is in question, and I mean even the terminology 'complaint' suggests that if someone's done something wrong, I can complain about it and I should get some sort of resolution to that […] We're not here to bring people a resolution. That's not our function. We are here to deal with concerns that suggest that someone might not be capable of safe and effective practice (regulator).

For some service users, complaining to the regulator was described as the end of the road, having exhausted all other complaint processes.

Less respect

One participant highlighted what was viewed as a general loss of respect in professional and social life: 'I think there's an undermining of professionals' (academic). There was a perceived lack of understanding of social work expertise and less deference compared with health professionals

Motivation for complaints

Participants felt that complaints were made to the regulator when members of the public have 'tried every other avenue' to 'seek redress' (Scottish Social Services Council). One interviewee described 'two categories' of complaint:

[…] There's the person, the member of the public, that maybe is disgruntled with a decision that's been made or what the social worker has done in relation to their case and the only way they see of resolving it is to make a complaint, because they don't like that the social worker has said actually 'no.' Then there's the lack of competence cases, where there's vast number of examples of where they haven't done something that they should have. (lawyer)

As one service user in the focus group put it, there was a sense that complaints might be an inevitable consequence of the job because of 'the areas of people's lives that social workers were drawn into' but that this was also compounded by a culture 'where when things don't go absolutely right for people they'll look for someone to blame.'(FG). This meant that some people became 'serial complainers' and would be prepared to go to several organisations to have their case heard. Indeed, the motivation of complainants was complex and varied. Social work participants described some cases where there were vexatious complainants:

I remember one person wrote to what was the GSCC to complain about me splitting up his marriage. Well he'd beaten his wife with a vacuum cleaner. I think the truth is that there will always be somebody that's not happy no matter what you do. (consultant social worker)

However, others wanted to make a positive change or improvement as one participant explained: '[…] this person kept saying "But I don't want this social worker to treat another family the way they treated us."' (SW Regulator). Indeed, there was a sense that users of services needed to feel that they were being taken seriously and wanted to be kept informed on how a complaint was dealt with.

Theme two – challenging practice

A strong theme that social workers have in common with paramedics is the challenging nature of their everyday work. Four sub-themes were identified within this: relationship-based practice; the nature and circumstances of social work service users; doing the undoable; and short-term practice.

Relationship-based practice

The relational aspect of social work practice is both what makes it unusual, and what potentially might contribute to complaints, coupled with responses to 'complex situations with people who may resent what they see to be the interference of social services and social work' (Regulator). As one participant commented, the interpersonal nature of social work means that 'It's about the kind of divination and refinement of routing human understandings and skills in a social context. I think that's something that it's incredibly hard to do well and quite easy to do badly' (academic).

Processes of 'divination' and 'refinement' capture some of the complexity of social worker practice. It was pointed out that 'good practice' sometimes had to be smuggled in, and that challenges go beyond the individual and professional/client relationship to include the workplace (academic). The importance of 'the relationship between the practitioner and the service user' and how this may be undermined, was emphasised:

> […] everything is against there being a relationship. Cutting it short, limiting it, having negative aspects to the role … and service users of course are not stupid and they know what's going on (academic).

Participants in the social workers' focus group also agreed that the high staff turnover and heavy caseloads prohibited building relationships. Service users commented that they had experienced poor services as a result of these issues. As one participant put it: 'They [social workers] really are more about how can I quickly close this case, and just move on to the next one without really meeting the need of the service'.

The interviews and focus groups generated discussions about the relational dimension of social work practice and how it could make practice open to abuse and boundary violation by some. As in all professions, there were individual outliers who came into the profession looking for opportunities to 'exploit vulnerable people'. In this way, not all cases related to complaints linked to the unavoidable challenges of practice: some were 'genuine' cases of impaired fitness to practise.

Attitudinal or generational differences between social workers that impact on relationships were also discussed. Issues were identified with newer social workers:

> *I am concerned about newly qualified social workers and their attitude. … probably that bit about 'I'm a social worker, I have the authority' – they become authoritative in that encounter because that's the safest way for them to feel to deal with it … and service users then experience that type of engagement (regulator).*

Service users confirmed this in their perceptions of interactions they witnessed amongst social workers in practice and student social workers in multi-disciplinary classroom settings. One service user described how a social worker had 'rushed' her through an assessment for a care package:

> *I'm a very easy person to work with, I didn't see the need for her to force stuff or think she can take things out without explaining how things work or why we are doing it (service user).*

Another service user described interactions between social work students and a group of student nurses, in which the social work students challenged the nurses over their pay, and questioned their knowledge in a competitive way:

> *Oh you health professionals, you don't know anything about the social model of disability (service user).*

The service user's view on relationships between these two professions was that 'you can feel where the nurses are, and their compassion and their desire to provide care. You meet the social worker and there is this vibe of "I'm coming to save the world but I want to do it on my own"'.

The users in this group said that their experience of social workers was that they were not 'team players', had issues with hierarchy and power relationships and often 'told' service users what to do. Service users reflected on the way in which the nature of the relationship had changed:

> *Where things went badly wrong is when social workers stopped being social workers and became care managers, they started seeing themselves as administrators of people, and wanting to fit you into specific commissioned services and boxes…moving away from the advocacy role (service user).*

The nature and circumstances of users of social work services

It was common for social work and academic participants to describe service users as being at 'the margins of society', an 'underclass' who are 'disenfranchised' and disadvantaged (academic). This was identified as a contributory factor to complaints, as well as to high levels of stress. One participant reflected on the unconscious bias that can exist; the need for social workers to become more aware of the impact that different

families might have, and to ensure that the principles of equality were applied, including in challenging circumstances (consultant social worker).

Participants in the social work focus group also drew on the issue of 'people in crisis' albeit in slightly different terms, focusing on the change in practice from 'a time of plenty when we could go in there with a big tool box as it were and say "we're going to fix everything for you"', to a focus on getting people to help themselves. Service users also commented on this change from being 'excited' about the 'event' of a social worker coming to make things 'happen' and a perception that social workers are now 'little more than functionaries'.

Doing the undoable

The challenging nature of social work was expressed through participants' metaphors around fire-fighting. As one participant voiced, the work involves 'situations where there aren't enough people to go out and do the visits' so they are 'possibly almost sometimes undoable, just they can't get it done' (Lawyer). Participants in the social worker focus group commented that social work is 'on a cliff edge' and it is not possible 'to take your foot off the accelerator'.

Recruitment challenges were also discussed by participants compounded by the profession's 'lack of sexiness' and the way that it was 'downgraded, diminished [and] ever diminishing in status' (academic). Indeed, a lack of resources together with inadequate supervision were seen as a 'toxic or potentially incendiary mixture of factors' for social work (academic). As one participant explained, difficulty characterizes the challenging nature of their role:

> *Often they have to make decisions and do things which won't keep anybody happy, and it feels like an expected by-product, as it were, to then get emotive complaints, just because of the nature of what they have to do. (regulator)*

Another participant highlighted the challenges of inadequate funding so people cannot always have what they want or need: 'I'd like to give you a Rolls Royce service, unfortunately, we can only afford a Robin Reliant.' (Social worker). Furthermore, service users suggested that, like the work of paramedics, social work existed in a wider landscape of social problems which impacted on social work practice as systemic issues. One service user commented on the inter-dependence of benefits agencies, housing and other local authority services – where there were failures in one there was often a knock on effect on people's lives.

As a result, when people are re-located and 'cut off from their support system' they may direct their anger at social workers.

The dual functions of social workers as providers of 'care' and 'control' were also noted, suggesting a tension that is difficult to reconcile. There are similarities with paramedics responding to crisis situations with interventions that may not be welcome:

> *if you're executing a control function and you're going into someone's … effectively their sanctuary, their own space, and telling them what to do – it's never going to go down well (academic).*

Limited experience and continuity

Two factors were said to contribute to compromised practice: the 'brief' length of stay of social workers in direct practice, which meant that 'people do not garner enough expertise' (academic) and the reliance on locums or agency workers. Service users commented on this lack of continuity and its impact on relationships. Several also observed that 'good' social workers often ended up leaving practice to teach students. Participants in the social work focus group reflected that social workers were often promoted due to gaps which needed filling as a result of organisational re-structures rather than based on ability and the right person for the role. As one participant explained:

> *I meet people who've been practising for 15 years and yet there'd be an element of practice that they haven't completed, whether it be types of court orders or never ever having a case from the beginning reaching adoption, so there's lots of learning that people don't experience.*

The use of agency workers 'coming and going' was also felt to be an issue because of the lack of continuity for families. This was also referred to by service users, who had experienced a lack of continuity in their social care. One member of the focus group, a wheelchair user, said she was used to having to explain 'again and again' the background to her situation. The experience of social workers 'being there for a couple of weeks and then moving on' was also common (service user).

Theme three – pressurised environment

Four sub-themes were identified as characterising the pressurised environment or climate that social workers practise within: lack of resources; inadequate support; not being liked; and regional differences.

Lack of resources

Resource constraints in local authorities were identified as factors that may inhibit good practice. It was suggested that social workers were often at 'the sharp end of rationing services' where there have been funding reductions of 30- 40% with some pockets of 'creative' practice (professional body). Indeed, several participants in the social workers' focus group described social workers being on the 'edge of a cliff' under the pressure of

increasing demand with 'unmanageable caseloads' and the lack of resource to deal with demand. This has implications, it was argued, for maintaining continuing professional development. Working in environments where resources are inadequate was described as challenging.

Inadequate support

Social work participants frequently made reference to a lack of support by managers, which compounded the challenge for social workers. Support was described in a variety of ways, including support with workload management, practical help from support workers, mentoring, and debriefing. As one participant explained, 'I think it's 50% of our newly qualified social workers end up in frontline child protection' with little support from more experienced practitioners (lawyer). Efforts were being made to redress this; Social Care in Wales for example was introducing 'models whereby there's greater support' and 'attempts at workload management' in localities.

Participants suggested that there was a need to challenge a culture of blame. As one described it:

> It's just basically 'no it's all your fault, everything's down to you'. There's no acceptance that things could've been done better by the parties or whatever, and then, people then become entrenched and what you get is we have to unravel that when we meet registrants. (union representative)

Indeed, untangling the complex mix of individual and organisational factors was not straightforward. One participant explained that 'sometimes it's difficult to disentangle those employment issues where possibly there was a lack of employer support, but then equally there have been genuine practice concerns' (Regulator case manager). Participants in the social workers' focus group also discussed the implications of a lack of employer support, where those whose practice was known to be consistently poor over a long period of time moved to different jobs and are not dealt with appropriately:

> I have a big issue with people who've been working with a local authority for a very long time, and practising very, very poorly for a very long time, and local authorities even though they anticipate complaints coming, never act on it … and I've seen it in every local authority I've worked in. And where someone is perceived to be a problem and high risk, they've then been moved from one department to another department to practise dangerously … (social work manager).

An intrusive profession

Some participants described how the activities and decisions of social workers made people unhappy and dissatisfied with outcomes. Social workers may be subject to 'myth'

and negative 'representations' emphasising the control function, or as 'shorthand for "oh they're the people who take your kids away"' (academic). As one participant recalled:

> *A social worker once said to me: 'No one wants a social worker in their life'. I suppose the other professions people see as being there to help you, to get you better, to fix an issue that's there. Whereas social workers are simply there because there is an issue that needs fixing, but the remedy to that is not necessarily going to be to everyone's satisfaction or benefit (regulator).*

Participants in the focus groups confirmed this. One service user participant explained that a 'deficit approach' was seen to be at the basis of social work, which entailed 'looking to see what's wrong in someone's life' and that this laid social workers open to hostility.

Another service user in the focus group, with many decades of experience of services, described how social workers in the past were 'the voice of the vulnerable', whereas now they are 'there to scrutinise you and to be on the state's side almost against you' (service user). In another service user group, one participant described how families felt under scrutiny and saw social work as an intrusion that could often cause an inflammatory or defensive reaction:

> *so it's like an alien coming into your family you know – their defences are up, aren't they, you know? There are secrets in my family, you know, hiding from certain people when they knocked on the door, pretending you're not in … the financial turmoil, the getting bashed about thing – all that is a secret behind thing, and there's this alien comes in, penetrates it all. That is bound to cause a very strong reaction you know. Whether what people are doing is acceptable or not, socially, you know.*

UK wide differences

Some participants referred to the impact of the size and context of the regulator and country regulated. Bodies responsible for registering fewer social work registrants had the opportunity to make a positive difference in building relationships with registrants (this comment was made by professional body, SW regulator, Northern Ireland, Wales and Scotland participants). Specific country differences were highlighted in terms of 'tightness of relationships', 'collective relationship' and differences in 'economy of scale'. This meant that 'the relationship between social workers, the public and the regulator is generally speaking much less fractious in the smaller UK countries' (Regulator Northern Ireland). As one regulator explained: 'I can lift the phone to any director of social work and have a conversation with them'. The fact that in Wales, some politicians had a social work background was also viewed positively (Regulator Wales).

There were also references to UK wide differences in terms of the variable management conditions which may shift the focus from the individual social worker: 'There seems to have been a little bit of a shift towards the quality of services, quality of management, funding, those sorts of issues and a bit less on the individual social workers' (professional body).

Theme four – evolving profession

The identification of social work as an evolving profession was a strong theme with four sub-themes: newly regulated; not treated as professionals; new roles; and regulatory understanding.

Newly regulated

This first sub-theme relates to 'the fact that social work has only been a regulated profession since 2003, that's 13 years, but it's still very new for people, in terms of expectations' (professional body). It was suggested that neither the NHS, which is accustomed to 'managing regulated professions' (such as doctors and nurses), nor local authorities, were able fully to understand or support social workers' role as professionals.

In terms of social workers' own appreciation of their regulated status, it was suggested that this might be more challenging for those qualified for a longer time. With newer registrants, the regulator and universities 'try to instil that early on', that is 'this is not just any Masters course they're undertaking, it's one to be a professional, and certain responsibilities go with that' (professional body). Service users also discussed how changes in what they described as the identity and ethical basis for social work practice were having an impact. As one service user explained: 'We have complaints because we have cognitive dissonance […] you are tearing them apart.'

Regulatory understanding

The fact that regulated status was relatively new to social work was linked to a perceived lack of understanding of what this meant and highlighted the need for building relationships between regulator and registrant (regulator). Raising awareness of the fact that misdemeanors or convictions in personal life could impact on professional status was seen as important: 'having people fore-armed from the outset I think has been really helpful' (regulator).

The lack of voluntariness regarding signing up to the HCPC register, and understanding of what this involved, was commented on: 'They just got some letters one day from the General Social Care Council saying: "we no longer exist and your registration will be passed to the HCPC"' (regulator). One participant suggested that the HCPC did not understand social work (social worker). This was echoed by a participant in the focus group, who suggested that those involved in the complaints procedure, 'don't know the framework that they're working in' (social work manager).

Not treated as professionals

An additional observation relating to this lack of self-perception as a regulated profession was that local authorities 'have never really been that good at managing a profession as a profession'. Social workers, with 'lots of notable exceptions' are treated as 'just like a kind of office of accounts rather than as professionals in their own right, so they don't necessarily support their professional obligation' (social worker). This participant said that social workers are '[..] proper full, whole human beings. They're not pawns on a chess board that you can shove around.'

A practising social worker commented that social work was 'a lower status profession' as compared with other health professions. Service users also commented on social workers not 'feeling valued' in the same way as, for example, doctors. One service user suggested that it was within the control of social workers to reconnect with their raison d'etrê:

> social workers need to reconnect with the why, and stop thinking of themselves as "I'm coming here to fill in a form", and then next year to ask you whether you're still getting out of bed (service user).

Consultant social worker roles

In contrast to the emphasis on not feeling valued, several mentioned the importance and impact of new consultant social workers. There was reference to 'pride' in such roles (regulator). In Wales, a survey of those in contact with a consultant social worker confirmed that the role offered 'that kind of continuance of practice and expectation of continuance in practice, so you don't get this kind of almost disconnect between the management and the practitioners' (consultant social worker). The positive impact of such roles may enhance professional status in a relatively new and emerging profession. Additional aspects of the role include the provision of mentoring, supervision and support to staff, all of which were viewed as ways of reducing complaints.

Findings: Preventative strategies – Social work interviews and focus groups

Findings from social work interviews and social work and service user focus groups regarding preventative strategies resonated strongly with those suggested in relation to paramedic practice. Responsibilities for improvement were allocated to employers, regulators, professional bodies, educators and to joint working. The recognition that social workers are accountable practitioners also supports strategies focused on their own practice.

Table 8: Preventative strategies – social work interviews and focus groups

Themes	Sub-themes

Employer	- Fostering a culture of learning and openness - Addressing the blame culture - Providing support - Employers' responsibilities - Better communication within and between authorities
Regulator	- Improving decision making processes - Improving communications with employers - Learning from good practice from other regulators - Increasing public understanding of social work - Engaging face to face with complainants - Pursuing mediation - Establishing a registrants' forum - Enhancing regulators' understanding of social work - Considering the impact of registrants - Working towards proportionality - Provision of education and training
Professional body	- Need to become stronger - Dissemination, supporting and advocating for the profession - Review the Professional Capability Framework (PCF)
Educators	- Raising awareness of fitness to practise - Teaching on importance of record-keeping - Open approach to 'borderline' students - Providing students with 'reality check' - Balance of practice and academic work - Explore meaning of professional identity and ethical values - Teach disability awareness
Registrants	- Reflection - Self-care
Joint working	- Education and training - Using scenarios - Learning from patient safety and human factors - Creating career pathways - New role for Ombudsman in Scotland - Values-based recruitment - Government responsibilities

Theme one – Employers: 'provide better support and supervision'

The role and responsibility of employers in preventing the conditions for complaints was a strong theme and related to the nature of organisational culture: having a no-blame culture, providing support, and with taking responsibility for appraisal and supervision.

Fostering a culture of learning and openness

A number of participants referred to the impact of a positive learning culture and 'a healthy environment', where social workers were given support in learning from 'mistakes' (professional body, union representative). Part of fostering a learning culture involved encouraging social workers to be open and honest. This was seen as a mechanism for preventing complaints arising 'later down the line' (professional body, union representative, manager).

Addressing the blame culture

Participants referred to the negative impact which work cultures could have on social workers. In some environments, there was a pervasive blame culture, leading employers into internal disciplinary procedures, with little or no attempt to resolve disputes through informal means. Where employers took the opposite approach, and provided support, mentoring, regular appraisal, and promoting a more open approach, complaints were less likely to occur (union representative, consultant social worker, manager, practitioner).

Providing support

Participants referred to the need for support at a local level. This linked to the negative impact of a blame culture, where managers were inclined to use discipline rather than informal dispute mechanisms and mentoring to find resolutions. Poor record keeping was one example where the type of support offered could make a significant difference (academic). Participants in the professional and service user focus groups felt that supervision and appraisal and 'reflective examination' could help give social workers the tools they needed in difficult environments. This support was also discussed in relation to where complaints were made, providing support for the social worker involved, even in cases where the complaint was not followed through – that there should be 'aftercare' and a chance to 'de-brief', because it may well impact on the social worker doing their job, 'terrified of making the same mistake'.

Employers' responsibilities

Participants highlighted the role of employers, and how a supportive management culture could have a significant impact on staff well-being as well as performance in the role. The need for strong supervision, appraisal systems and CPD was a recurring theme through many of the interviews.

Participants in the focus groups also explored this, suggesting that some poor practice needed addressing promptly. One participant felt it was important to emphasise what had been successful and referenced 'the assessed and supported year in employment approach' as an example. Such initiatives were felt to ease the transition from education into employment and helped to hold the space for social workers as they moved into practice.

Better communication within and between authorities

Service users suggested that local authorities could do more to share information when users moved from one borough to another. They also referred to the variation in social workers' specialist knowledge of working with people living with long term conditions and associated disabilities, and felt that more could be done to share expertise.

Theme two – Regulator: 'widen regulatory options'

Participants identified a wide range of preventative strategies that were already implemented, or could be adopted, by regulators.

Improving decision making processes

Regulatory participants reported that the HCPC had introduced improvements to the way their fitness to practise teams processed referrals to ensure that they were better equipped and informed when dealing with initial enquiries. They were also better able to separate referrals that did need to proceed to the next stage of an investigation from those that did not. One participant referred to the changes to the HCPC's standard of acceptance in May 2016, which had made a difference to the decisions at the first stage of referral, for example, 'we are getting better at closing off those silly, silly cases' and 'getting braver, as we should be, as sort of knocking things on the head at an earlier stage, and partly because of the revised standard of acceptance that came out in May 2016' (regulator England). Other recent changes to the process included the introduction of a triage function for responding to incoming calls.

Improving communications with employers

Participants also described the need for further improvements to communications with employers, aimed at raising awareness of the work of the regulator's Fitness to Practise Department in ways that were meaningful and helped to increase understanding of what the regulator was there to do. An example was 'sending round to the workforce a regular fitness to practise bulletin which gives links to the outcomes from our hearings' (regulator Wales).

Learning from good practice examples from other regulators

There was little reference to examples of good practice from elsewhere in the health professional regulatory sector. However, the General Medical Council website was one example where complainants were felt to be given clear guidance on the remit of the regulator. It was felt that the HCPC website did not provide a 'filter' in the same way (regulator).

Increasing public understanding of social worker role

Participants referred to the need to increase public understanding of the role of the social worker as a means of preventing complaints. They argued that better public awareness could lead to fewer complaints.

Engaging face to face with complainants

One of the social work regulator participants suggested that there were benefits to face to face encounters with complainants, as a mechanism for increasing understanding, noting that other regulators were also using face to face meetings with some complainants as part of the suite of options. This had worked well in Northern Ireland, for example. In the focus groups, it was felt that employers needed to take first action in aiming for a local resolution and that their response could dictate what follows. It was felt that complainants could be listened to and provided with something of an 'explanation' and that this often was what was needed:

> *And as an assistant manager I've been in a situation where a very, very angry service user is making complaints over the phone, they've been invited in and had a meeting. And sometimes it's just about listening to them, but being very clear what that social worker's role is, and that does not happen anywhere near as often as it should. (social worker)*

Pursuing mediation

Recent moves to explore a wider range of regulatory interventions was mentioned by both professionals and service users as a way of preventing complaints being subjected to the same 'one size fits all' approach. Individual practitioners and service users in both groups suggested that earlier, local resolution at a local level had many advantages over the adversarial approach. As one service user put it:

> *And when the client says 'I want to complain about you' they say 'Oh great, I'll help you' and then we give them the form, it gets to my boss, she facilitates a discussion. And then the client becomes motivated because they've got access to an immediate process that says I'm going to address your concerns.'*

Opportunities to feel listened to and supported were welcomed.

Establishing a registrants' forum

Another example of good practice was a forum for registrants used by the SW regulator in Northern Ireland, a mechanism whereby registrants could engage with their regulator and provide feedback directly, as well as a mechanism for the regulator to give feedback to registrants (regulator NI). Service users felt that there could be a role for the regulator to 'encourage a systematic improvement', what one service user described as 'some kind of performance support atmosphere' focused on laying out the mission and values of the professions it regulates.

Enhancing regulator's understanding of social work

It was suggested that the HCPC would benefit from enhancing its in-house expertise on social work practice. Several participants referred to the differences between social work and healthcare professions, and how few HCPC employees had sufficiently in-depth knowledge of social work practice (in particular the legal aspects). This issue was also addressed in the social worker focus groups, where participants discussed the need for specific expertise for each case under consideration, because of the complexity of the work.

Considering the impact on registrants

Participants with regulatory expertise referred to the need to improve communications with registrants who had been subjected to investigation. Awareness of the human impact of this process could receive more of a focus. Registrants for whom there was no case to answer often suffered huge stress, especially when investigations took months or even years to conclude:

> *[…] it was absolutely pinging into my head that this worker is going to have been dragged through this awful process by us, and our letter at*

> *the end is just saying 'right we're not taking any action, good bye' and how that is a really critical point to try and do something to get that reengagement back with the profession. (regulator Scotland)*

As one participant in the social worker focus group explained:

> *You get so far along the line and then the case might just be dismissed, but you may have left the person in tatters […] I've had social workers shed tears in front of me just for that point …*

Working towards proportionality

There was some discussion about whether the current fitness to practise rules allowed the appropriate degree of proportionality. As one participant explained, the range of offences is considerable:

> *I think the whole system of this 'one size fits all' of regulation is wrong. You are effectively applying the same process […] to rapists, to paedophiles, to people whose only motivation for becoming a practitioner is to be able to get at vulnerable people. And you are applying that same system to people where there may be a bit of a competence issue and they need training, and you're going through an almost criminal trial sort of proceeding to deal with people where it's totally unnecessary, it's totally over the top and looking at the issue of risk and public protection, that should be the priority. (union representative)*

The emphasis on 'public interest' could, at times, create perverse incentives. Employers were using the regulatory system to avoid addressing long standing capability issues, and registrants were finding themselves subjected to disproportionate investigations by the regulator. One participant gave an example from an experience of this in another regulatory context:

> *I did one case probably two years ago where a panel, and this was a very bad panel, a panel found that because a manager hadn't approved somebody's application for flexible working, not only was that misconduct, but it was also a matter of public interest, which is obviously perverse, but [the regulator] conceded.[…] you're putting together people who are very definitely a risk and […] the public needs to be protected against, alongside people who - these issues shouldn't even be with the regulator […] They should be dealt with at capability process at work, you know, constructively. (union representative)*

Provision of education and training

Participants suggested an important role for the regulators in providing training and education to local authorities, councils and registrants:

> *The other thing then is also, I think, for the HCPC to give some type of education and training to the local authorities and councils themselves about things that they can do internally in order to assist social workers (lawyer).*

A participant suggested a role for the regulator in working with employers so that hearings appeared less intimidating. There was a consensus that, as one participant put it, 'a huge amount of work should be done at employer level' (union representative).

Theme three – Professional body: 'exert stronger influence'

Participants felt that the professional body had an important role to play in preventing complaints about social workers. However, there were varying views as to whether this was possible.

The need for the BASW to become stronger before it could actively influence this agenda was commented on by a number of participants, for example, 'challenging employers around terms and conditions' and doing more to promote the 'status' of the profession.

The representative from the professional body described the role of the professional body in advocating for the social work profession and disseminating good social work practice, for example, in drawing attention to the Leeds restorative justice approach.

One of the service user group members had spent time with other service users reviewing the PCF (Professional Capability Framework) and come to the view that it was not fit for purpose, describing 'a massive disconnect' in the way the PCF 'orientate[s] social work', with a 'top down' framework which encouraged hierarchy. This participant felt that involving users in its re-design was important.

Theme four – Educators: 'broaden professional education'

A range of strategies were recommended in relation to professional education. It was felt that educators have a role in: raising awareness of fitness to practise; teaching on the importance of record-keeping; having an open approach to 'borderline' students; providing students with a 'reality check'; and in balancing practice and academic work.

Raising awareness of fitness to practise

There was a clear consensus that educators had a role to play, working with students to raise awareness, including more in the curriculum on fitness to practise and its implications.

Teaching importance of record-keeping

Specific teaching on the importance of keeping consistent and clear records was an example: 'if somebody says something to you that's of any concern or anything, you've got to record it' (academic).

Open approach to 'borderline' students

Issues with poor conduct or competence at pre-registration levels were mentioned by a small number of participants. There was a sense that a more open approach to 'borderline' students was helpful, rather than a reluctance to address the fact that a student was struggling because 'there should be no shame in this' (academic). There was a suggestion that universities may be reluctant to address poor practice due to the fear of losing a placement, as one participant put it, 'the university didn't want to know, because they didn't want to lose the placement, because they're short of placements' (social worker).

Providing a 'reality check'

One participant commented on the need for universities to provide students who come in 'all bright-eyed and bushy-tailed thinking that they can change the world' with 'a reality check':

> […] knock the ideals out of them as soon as they walk through the door, but if they did that a little bit at university level, the bit in the university before they get here […] And they want to help so desperately…and we all do. None of us lose that 'We want to help so desperately' feeling. But there is a bit reality…possibly even going back to the selection process for who gets on the course, and at the university…you know, in reality if you're working in statutory social work, you're going to come up against huge barriers, and the biggest barrier is going to be lack of money and lack of services. And then they might not be quite so disillusioned when they come here on their first little placement (social worker).

One service user suggested that the age at which students could enter social work education needed to be raised, so that newly qualified practitioners had more life experience before beginning their careers. This group also felt that it was important for social work educators to continue in practice whilst teaching students, to ensure that they kept up to date with real life situations.

Balancing practice and academic work

Participants in the social worker focus groups also emphasized the importance of good placements alongside the academic work:

> *I think it's about achieving that balance. If you can give people good practical placements over a lengthy period of time then that gives people a good introduction into the realities of social work. Not that you want to put people off, what you try to do is to encourage them (social worker).*

Explore meaning of professional identity and ethical values

In this sub-theme generated from the service user groups, users felt that educators could do more to prepare social workers for practice. They suggested that this could be done by exploring ethical values and professional identity more fully, preparing them for the 'cognitive dissonance' they were likely to encounter as practitioners, and working with them on creating a clearer sense of professional identity. One service commented that 'the happiest social workers are those who have a really clear sense of their own identity… they need to reconnect with the "why", and stop thinking of themselves as "I'm coming here to fill in a form"'.

Teach disability awareness

Service users felt that enhanced teaching on the impact of different types of disability on people's day to day lives was needed in education. Their experience of social workers having little or no knowledge, of, for example, young disabled people's lived experience, needed to be addressed. Providing teaching on a wider range of disabilities, and on how best to communicate with a person with disabilities, was seen as a means of preventing concerns about practice later on. A service user with cerebral palsy said that he had been 'ignored' by his social worker, and all questions were directed to the carer, articulating that it seemed that 'the way in which social workers are taught is very … it's kind of very generalistic.' As most people with long term conditions will need the services of a social worker at some point in their lives, this seemed an important area for inclusion in the social work curriculum as well as through CPD opportunities.

Theme five – Registrants: 'foster self-care and reflection on practice'

Once qualified, registrants had a responsibility to maintain their competence, to use the tools of reflective practice on a day-to-day basis, remaining sensitive to the experience of the service user and the potential for distress or dissatisfaction. Being prepared to give clear explanations to service users who might disagree with decisions was also seen as important.

Reflection

There were consistent references to the importance of reflective practice, but also a sense that taking time to reflect was not common for social workers. One participant described how, in her experience:

> […] when people talk about reflection in social work, they're usually talking about the worker reflecting on their own thoughts and feelings about the work that they've done and recounting it to a supervisor or discussing it with a supervisor and they're not talking about reflecting on what the end user of their services is saying (professional body)

Another learning opportunity was suggested by a participant that could also facilitate reflective practice:

> […] we don't routinely get any feedback from service users, so one of the questions on, that I'm … and I think it's quite remarkable that we don't, because we're supposed to be this reflective profession and we have no, we don't use, it's not standard in any sort of CPD framework or whatever that people would get that direct feedback, and I think that maybe has, maybe that's got some bearing in some way on levels of complaints, because we don't, maybe we're actually not as reflective as we think we are. (social worker)

Self-care

There was reference to the ways in which social workers could come to ignore their own needs, driven by a 'macho' mantra of 'just keep doing it':

> What I see and what I experienced in referral and assessment was just very much this attitude of: you just get on, keep doing it, keep doing it, keep doing it. Self-care is not important and stress management is not important, we're not going to think about how this family impact on you as a worker. We're not going to think about how you impact on that family as a worker. You know that sort of thing, which, all of which I see as massively important to making changes with families, but also keeping workers healthy. I suspect this is why there's such a high burn-

out rate in social work, but I absolutely don't think that it needs to be that way (consultant social worker).

This was described as different from other professions in the NHS for example, where staff had direct access to supervision. For social workers, supervision was seen as almost like a 'dirty word'.

Theme six – Joint responsibilities: 'improve inter-agency working'

Participants suggested preventative strategies that were not the responsibility of one agency or individual but required a collaborative response.

Education and training – undergraduate and CPD

Much of the commentary on preventing complaints alluded to the need for the various agencies to work together - regulator, professional bodies, educators and unions to bring about improvement. One area where more could be delivered was the approach to CPD opportunities, which were currently considered to be ad hoc and 'insufficient' (professional body):

> *There needs to be a kind of clearer education that actually incorporates a more, if you like, role based study […] In a social work training, of course you work in practice, but the interplay between actually discussing cases in a much more thoughtful way is still I think to my mind insufficient. Then as you continue in your practice within a service, you need to have robust and continuing supervision, both group and individual, to enable you to develop your practice so you don't just become 'Oh yeah, well I read about that 10 years ago' and you need a much more institutional commitment to updating practice, to letting social workers know about what the latest stuff is saying.*

This 'institutional commitment' to ongoing education and training was referred as a shared responsibility – employer, educators and regulators.

Using scenarios

Several participants suggested using scenarios based on fitness to practise cases as educational tools, to improve understanding of the types of complaints that were arising:

> *Using scenarios in terms of how can things go wrong. I think that bit of it we probably don't really look at in the same way, and I think that would be quite … how do you prevent these sorts of things happening? (SW regulator, Northern Ireland).*

One participant described this as 'decisions guidance which sets out scenarios' (Regulator). Participants in the focus groups also discussed that good practice also

needed to be shared as well to 'learn where things have gone right' as much as those where things have gone wrong.

Patient safety and human factors

A participant who worked across social care and health suggested that there were useful examples that could be adapted and used in social work education.

> *Now when I look at the patient safety curriculum … and a lot of it is about those human factors, it sits very well in and around social work and social work training (SW regulator Northern Ireland)*

Creating career pathways

Several participants observed that the creation of consultant posts in social work, where individuals continued to work alongside their colleagues in delivering services, had an impact on the number and nature of complaints. Highly skilled and experienced social workers provided mentoring and support for colleagues, whilst continuing to be directly involved in delivering services to children and families:

> *I suppose the whole kind of strategy around creating career pathways. Within Wales, those individuals who are in consultant roles are having an impact not just in a sense on their working practice but on others, that's actually…in terms of prevention quite an important development isn't it (SW regulator, Wales).*

New role for the Ombudsman in Scotland

One regulatory expert described some of the proposed changes in Scotland with a new more proactive role for the Ombudsman that might lead to improvements and reduce the flow of complaints. This would apply particularly in cases where the decision of a social worker was being challenged by a service user, whether over entitlement, or decisions about time spent with a child.

Values-based recruitment

Another example of ways in which a collective approach was seen to be important was in recruitment into the profession. One participant described an initiative in Scotland where a collaboration between the regulator and the Care Inspectorate included a focus on values in the recruitment of new staff.

Government responsibilities

One participant talked about the responsibilities of government to support and to help change perceptions of the role of the social worker which would, in turn, have an influence on the education of social workers, and the recruitment of a new generation of social

workers. This participant went on to explore the impact of stigmatisation of social work, between agencies and within multi-disciplinary teams:

> *Part of the trouble is that I think this kind of stigmatisation of social work [...] - that also occurs between agencies as well. So I think you have a very significant kind of cultural/structural issue challenge there, that often doctors I've worked with or other kind of service providers are like 'Oh what, you're a social worker?' – it's something that's not looked upon favourably (academic).*

There were several descriptions of the challenges of working effectively in multi-disciplinary teams, where health professionals were viewed as 'opting out' leaving social workers feeling isolated, for example, in a safeguarding context. There was sometimes a sense that health professionals were able to do this, referencing their Trust protocols, whereas social workers could not unless they 'abandoned' the service users. Conversely, there was an example of a consultant social worker who described her experience of working in a highly successful multi-disciplinary team, with professionals who were supportive of each other and placed an emphasis on ongoing support. This team was part funded by a local authority and part funded by Barnardo's, employing a range of social work and health professions working with children and families 'on the edge of care' with significant 'inter-generational problems' (consultant social worker).

The value of having parliamentarians with a social work background was referred to as a positive development in the discussion of UK wide differences in an earlier section of this report.

Stakeholder meeting

Once the substantive data collection phase of the project was complete, a stakeholder meeting was held in London, inviting those who had participated in the interviews as well as other key stakeholders with an interest in the research. Two meetings were held, one for paramedic stakeholders and the other for social work stakeholders. There was good UK wide representation in the paramedic session, including the professional body, a patient forum, the trade union, higher education, practitioners and regulators at the paramedic session. The social work session was less well represented but nevertheless representatives from the trade union, education and regulation attended as well as experts from the social work regulators in Scotland and Northern Ireland.

The team summarized the findings and invited the participants to discuss the implications and possible impact of the research on future policy and practice. Both groups supported the preliminary observations and interpretations of the data. There was a consensus that a collective focus on preventing complaints through joint initiatives, raising awareness with employers, educators and practitioners could contribute to improvements. Participants welcomed the research as a valuable contribution to this area.

Conclusions from the interviews and focus groups

The qualitative interviews and focus groups found much common ground as to the reasons for the number and nature of concerns about paramedics and social workers. Themes identified were the impact of public perceptions and expectations, the challenges of practice for both social workers and paramedics, the organisational, cultural and political climate which impacts their work, and the evolving nature of these professions.

There was a good deal of consensus regarding actions that could contribute to preventing complaints, which will be explored in the discussion section. Findings suggest the multi-faceted influences likely to impact on the perceptions and practice of paramedics and social workers. The data highlights most vividly the challenges and complexity of their professional identities and their everyday practice. Both paramedics and social workers operate within contexts of uncertainty and ambiguity, within perhaps, what Schŏn (1983 p.42) referred to as 'the swampy lowlands' where 'problems are messy and confusing and incapable of technical solution.'

Chapter 4 Case analysis

This section presents the methodology and findings from the case analysis.

The case analysis aimed to provide insight into the characteristics and circumstances surrounding complaints about paramedics across the UK and social workers in England, and to look at particular issues that were prevalent in each. Three members of the research team were given on-site, supervised access to the HCPC's case management system over a six-month period.

During this time, they reviewed a random selection of just over 10% (n=52) of paramedic (n=52) and social worker (n=232) referrals covering the time period 2014-5 to 2015-16. The 10% sample was from cases where a decision was made at each stage of the fitness to practise process, rather than of the total number of cases received for each profession each year. This is because some referrals to the HCPC may be received in one financial year, but a decision is not made to progress or close that case until the following financial year. The sampling ensured that an equal proportion of cases closed at each stage of the fitness to practise process was reviewed. One team member looked at final hearing cases for both professions, and the second at just over half (51%) of the sample of social work cases that did not meet the standard of acceptance. The third team member reviewed the whole sample of social worker and paramedic cases closed at the no case to answer stage and just under half of social work cases at the standard of acceptance stage.

Quantitative information was sought across 19 variables agreed in consultation with the HCPC and the Research Advisory Group. Some of these were pre-existing fields in the case management system (age, gender, employment status, home country, incident location, source of referral, referral characteristics). The others were generated by the research team and populated from the case files. These included work setting, local authority or ambulance service, employment location, number of previous local complaints, engagement at work, engagement in the fitness to practise process, recipient of incident/harm, classification of alleged harm/harm and case length. It was not possible to collect complete data on date or type of qualification, as this was not available / captured when the paramedic register transferred to HCPC in 2003, nor when the social work register transferred in 2012. It was also not possible to obtain data on ethnicity, as this information is not a mandatory requirement and less than 0.5% of the sample chose to provide this. In addition to the quantitative data collection, each case received a narrative review, in which the team collated qualitative details such as aggravation, mitigation and further background information on the circumstances of the case. The information was de-identified, entered into a single database and subjected to quantitative and qualitative analysis. All information was stored in password-protected files.

The HCPC Fitness to Practise process

The HCPC's investigative process consists of three substantive stages. When a referral is first received, it is risk assessed by a case manager to determine whether or not immediate action is necessary in the interests of the public or of the individual concerned. For example, an assessment is made as to whether the individual is an immediate risk to the public or there are health or safety implications to allowing the individual to remain in work. In such circumstances, an application will be made to a panel for an 'interim order' to immediately suspend the individual from practice or make their registration subject to conditions of practice. Referrals deemed in this high-risk category are expedited by the Fitness to Practise team.

All cases are initially assessed by the Case Reception and Triage Team. This Initial Stage determines whether or not the referral meets the threshold for a further investigation. The source of the referral and potentially other sources are contacted, requesting further information, and the case manager makes a decision on how to proceed. If the referral meets what is known as the 'standard of acceptance' (SOA) for an allegation, then it proceeds to the next stage, where the evidence is brought before an Investigating Committee Panel (ICP) (HCPC 2016a). The role of the ICP is to assess the evidence and to decide if there is either 'no case to answer' (NCTA) or to recommend that the case is progressed to a hearings stage. 'No case to answer' means that the ICP concludes there is no realistic prospect of the HCPC proving that the individual's fitness to practise is impaired (i.e. that they do not meet the standards of conduct and competence). The ICP can issue learning points to the registrant at this stage. If the case is progressed to a final hearing (FH), then the HCPC instructs solicitors to undertake an investigation of the allegation or allegations. Once the HCPC has prepared its case, the registrant then has the opportunity to provide evidence and further information. Once all the evidence has been gathered, the HCPC brings the case before a three-person panel. At least one panel member must be from the same profession as the registrant. Witnesses may be called by the HCPC and by the registrant. It is for the panel to reach a conclusion as to whether or not the facts of the case are proven; whether the facts amount to the statutory ground of the allegation (misconduct or lack of competence); whether the individual's fitness to practise is impaired; and if so, what sanction should be applied.

Case analysis: Paramedics

The following section provides a description of the methodology and an analysis of the total number of cases received during the study period and the number reviewed, followed by tables showing the analysis of the sample cases across 17 variables. Of the 19 variables identified for examination, it was not possible to obtain sufficient data on ethnicity or type of qualification.

Table 9 Paramedic referrals to HCPC 2014-2016

	2014-2015	2015-2016	Number sampled at each stage
Number of concerns received	231	239	
Number closed at Initial Stage	115*	162*	30
Number closed by ICP	49*	44*	9
Number considered at Final Hearing	48*	58*	13
TOTAL			**52**

- * numbers relate to decisions made in each period

The team reviewed just over 10% of these cases (n=52), evenly distributed across each stage and source of referral.

The tables below present the quantitative analysis of the 52 cases, followed by a qualitative account of the cases reviewed.

In 2015-2016, paramedics made up 6.5% of the HCPC Register, 11% of fitness to practise referrals overall,10% of standard of acceptance (SOA) cases and 14% of ICP cases.

Table 10 Paramedic cases by gender

	Initial Stage n=30	%	**ICP n=9**	%	**FH n=13**	%	**Total n=52**	%
Female	8	27%	3	33%	4	31%	**15**	29%
Male	22	73%	6	67%	9	69%	**37**	71%

There was a higher number of men (71%) in the sample, relative to their numbers on the Register overall (62%). The ratios of men to women in the samples were similar across

the three stages. This differed slightly from the gender ratios across all paramedics referred between 2014-16, where men made up 71% of referrals at the SOA, 66% of ICP, and 82% of final hearings.

Table 11 Paramedic cases by age

	Initial Stage n=30	%	ICP n=9	%	FH n=13	%	Total	%
18-29 yrs	3	10%	2	22%	3	23%	**8**	15%
30-39 yrs	7	23%	2	22%	2	15%	**11**	21%
40-49 yrs	9	30%	3	33%	5	38%	**17**	33%
50-59 yrs	9	30%	2	22%	3	23%	**14**	27%
60+ yrs	2	7%	0	0%	0	0%	**2**	4%

The distribution across the age range reflected a majority in the middle age ranges (30-59 years) and fewer in the under 30 and 60 + age ranges. There were no notable differences in the age profiles across the three stages.

Table 12 Employment status

	Initial Stage n=30	%	ICP n=9	%	FH n=13	%	Total	%
Employed in NHS	27	90%	6	67%	11	85%	**44**	85%
Employed outside NHS	2	7%	0	0%	0	0%	**2**	4%
Unknown	0	0%	3	33%	2	15%	**5**	10%
Suspended	1	3%	0	0%	0	0%	**1**	2%

The majority (85%) of those referred were employed in the NHS. In 10% of cases, the employment status of the registrant was not clear from the case notes.

Table 13 Work setting

	Initial Stage n=30	%	ICP n=9	%	FH n=13	%	Total	%
Acute	20	67%	7	78%	8	62%	**35**	67%
Community	5	17%	0	0%	4	31%	**9**	17%
Call centre	1	3%	0	0%	0	0%	**1**	2%
Unknown	0	0%	0	0%	1	8%	**1**	2%
Concern not work-related	4	13%	2	22%	0	0%	**6**	12%

The research team generated these categories. 'Acute' referred to ambulance service and hospital based services, and 'Community' referred to primary care based services. The majority of incidents occurred in an acute setting. Only 1 out of 52 cases related to a call centre setting.

Table 14 Route to qualification

	Initial Stage n=30	%	ICP n=9	%	FH n=13	%	Total	%
HEI	8	27%	2	22%	6	46%	**16**	31%
Trust	3	10%	3	33%	1	8%	**7**	13%
Unknown	19	63%	4	44%	6	46%	**29**	56%

Table 14 above shows the numbers who registered via completing a qualification in a Higher Education Institution (HEI) or via an in-service training route delivered by an NHS Trust. Qualification information was not available for a large number of cases. The HCPC database does not hold information on qualification for all paramedics, as this information was not available when the paramedic register was transferred to HCPC. Paramedics became registered 'in bulk' by the Council for Professions Supplementary to Medicine (CPSM) in 2000, with the HCPC Register formally opening in 2003.

All paramedics in the sample were UK trained. Of all paramedics referred in 2014-2016, 0.8% (n=4) were trained outside the UK.

Table 15 Home country

	Initial Stage n=30	%	ICP n=9	%	FH n=13	%	Total	%
England	19	63%	8	89%	12	92%	**39**	75%
Scotland	2	7%	0	0%	0	0%	**2**	4%
Wales	3	10%	1	11%	1	8%	**5**	10%
Northern Ireland	4	13%	0	0%	0	0%	**4**	8%
Jersey	1	3%	0	0%	0	0%	**1**	2%
Cyprus	1	3%	0	0%	0	0%	**1**	2%

The proportions across the HCPC Register of paramedics in 2016 was 83% for England, 8% for Scotland, 6% for Wales and 2.5% for Northern Ireland, indicating a higher proportion of referrals in this sample from Northern Ireland than might be expected.

Table 16 Ambulance Trust

	Initial Stage n=30	%	ICP n=9	%	FH n=13	%	Total	%
East Midlands	4	13%	0	0%	2	15%	**6**	12%
East of England	0	0%	1	11%	2	15%	**3**	6%
Jersey	1	3%	0	0%	0	0%	**1**	2%
London	2	7%	2	22%	2	15%	**6**	12%
North East	4	13%	0	0%	0	0%	**4**	8%
North West	1	3%	1	11%	1	8%	**3**	6%

Northern Ireland	4	13%	1	11%	0	0%	**5**	10%
Scotland	2	7%	0	0%	0	0%	**2**	4%
South Central	2	7%	1	11%	0	0%	**3**	6%
South East Coast	0	0%	0	0%	1	8%	**1**	2%
South West	2	7%	1	11%	2	15%	**5**	10%
Wales	2	7%	1	11%	1	8%	**4**	8%
West Midlands	2	7%	0	0%	0	0%	**2**	4%
Yorkshire	3	10%	1	11%	2	15%	**6**	12%
Not applicable	1	3%	0	0%	0	0%	**1**	2%

The highest number of complaints in the sample came from the East Midlands, London, Yorkshire and the South West of England and Northern Ireland. The lowest number of complaints in the sample comes from South East Coast, Scotland and the West Midlands, with Wales at the mid point.

Table 17 Employment location

	Initial Stage n=13	%	ICP n=9	%	FH n=13	%	Total	%
Urban	17	57%	7	78%	6	46%	**30**	58%
Rural	9	30%	1	11%	7	54%	**17**	33%
Unknown	4	13%	1	11%	0	0%	**5**	10%

This data was obtained from the address of the employer, and therefore does not take into account that some services cover both urban and rural areas.

Table 18 Incident location

	Initial Stage n=30	%	ICP n=9	%	FH n=13	%	Total	%
Community	2	7%	0	0%	0	0%	**2**	4%
NHS hospital	1	3%	0	0%	1	8%	**2**	4%
Patient's home	2	7%	2	22%	0	0%	**4**	8%
Other NHS setting	8	27%	3	33%	7	54%	**18**	35%
Other private employment	1	3%	0	0%	0	0%	**1**	2%
Not during work	4	13%	2	22%	0	0%	**6**	12%
Other	8	27%	1	11%	1	8%	**10**	19%
Not known	4	13%	1	11%	4	31%	**9**	17%

These categories were recorded in the case management system. There appeared to be some inconsistencies in the way these categories were used. 'Other NHS setting' usually referred to incidents taking place on an ambulance call out. There is little to distinguish this category from 'community', which refers to an incident that happened on a call out to a public place such as a shop, pub or public street. The category of 'Other' was used inconsistently to refer to ambulance services other than NHS such as St John's Ambulance, as well as other less well defined locations for particular incidents, such as failure to complete records, and failure to report to operations centre. Details of the locations of the 4 cases at the final hearing stage recorded under 'Not Known' were obtained from the files. The narrative descriptions would therefore support combining the majority of these into 'Other NHS setting', giving an overall figure of 70% of incidents occurring whilst on a call, and 12% occurring out of working hours, and the remaining not identifiable from the data.

Table 19 Source of referral

	Initial Stage n=30	%	ICP n=9	%	FH n=13	%	Total	%
Employer	4	13%	3	33%	5	38%	**12**	23%
Service user/Patient	3	10%	0	0%	0	0%	**3**	6%
Public	1	3%	1	11%	0	0%	**2**	4%
Self referral	13	43%	5	56%	6	46%	**24**	**46%**
Other registrant	2	7%	0	0%	1	8%	**3**	6%
Anonymous*	7	23%	0	0%	0	0%	**7**	13%
Article 22(6)*	0	0%	0	0%	1	8%	**1**	2%

- Article 22(6) is used to make an allegation on an anonymous complaint where HCPC have sufficient evidence to support it. It is also used when it is decided that a self-referral should go through to further investigation. The case management system recorded these separately.

The high number of self-referrals amongst paramedics was consistent at all three stages. This number is significantly higher than the number of self-referrals for all other HCPC regulated health professions (6%) and social workers (England) (10%)(see Figure 1 below) (HCPC, 2016). Analysis of the proportion of self-referrals by paramedics over the last three years revealed a similar pattern (51% in 2012-2013, 43% in 2013-2014, and 57% in 2015-2016). The proportion of referrals from employers is comparable to the percentage for HCPC professions overall (25%) (HCPC, 2016).

Figure 1 Pattern of self-referrals: % of Paramedic and Social Worker (England) cases initiated through self-referral 2013-2016 compared with all other HCPC regulated professions
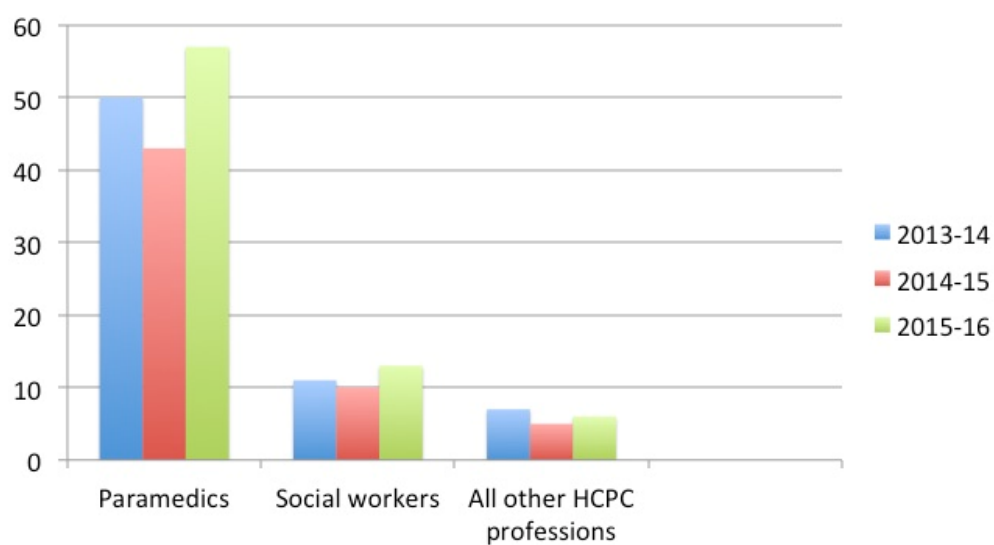
Table 20 Number of known previous complaints at local level

	Initial Stage n=30	%	ICP n=9	%	FH n=13	%	Total	%
0	16	53%	6	67%	8	62%	**30**	58%
1	3	10%	1	11%	2	15%	**6**	11%
2	2	7%	0	0%	0	0%	**2**	4%
3+	1	3%	0	0%	0	0%	**1**	2%
Unknown	8	27%	2	22%	3	23%	**13**	25%

In 25% of the case files, it was not possible to draw any conclusions on the number of previous complaints at the local level. The information, where it did appear, came from employers' reference to previous history. There were a small number of cases in which the paramedic had received a previous written warning, or been subject to an investigation by the Trust, or had received complaints about similar issues with record keeping.

Table 21 Engagement at work

	Initial Stage n=30	%	ICP n=9	%	FH n=13	%	Total	%
High	4	13%	1	11%	9	69%	**14**	27%
Moderate	6	20%	4	44%	3	23%	**13**	25%
Low	0	0%	0	0%	1	8%	**1**	2%
Unknown	20	67%	4	44%	0	0%	**24**	46%

This described the extent to which individuals were reported as demonstrating any of the following: 'commitment', 'involvement', 'positive attitude to work', 'enthusiasm and initiative' (West and Dawson, 2012, Boxall et al.,2011, Austin et al., 2015, Austin and Gregory,2017). Like the number of known previous referrals, this information was inferred from employer reports where possible, but there was a high percentage of missing data. Random independent cross checking was carried out to ensure consistency of approach

across the raters. A majority of cases at the first and second stages of investigation explicitly referred to the individual experiencing a combination of stress, anxiety or adverse personal circumstances prior to the incident or incidents occurring.

Table 22 Engagement in the fitness to practise process

	Initial stage =30	%	ICP n=9	%	FH n=13	%	Total	%
Yes	21	70%	8	89%	10	77%	**39**	%
No	5	17%	0	0%	3	23%	**8**	%
Not contacted	4	13%	1	11%	0	0%	**5**	%

Registrants who engaged in the process, through email correspondence, documentation and supporting statements were rated, those that were contacted by the regulator and failed to respond were not. With the obvious exception of self-referrals, registrants are informed of an allegation and asked for their observations only if the case proceeds to the Investigating Committee stage (ICP). The majority of referrals that are closed at the standard of acceptance stage will not precipitate any contact with the registrant, however, the registrant will normally be informed if the employer is contacted. Efforts are made with the complainant and other parties such as the employer to secure evidence, and if the referral does not meet the threshold for the standard of acceptance, the registrant may not be engaged at this first stage.

Table 23 Referral characteristic

	Initial Stage n=30	%	ICP n=9	%	FH n=13	%	Total	%
Misconduct	10	33%	3	33%	3	23%	**16**	31%
Lack of competence	10	33%	0	0%	1	8%	**11**	21%
Misconduct and lack of competence	7	23%	5	56%	8	62%	**20**	38%
Conviction/ caution	3	10%	1	11%	1	8%	**5**	10%

These were the referral characteristics recorded in the case notes by HCPC case managers. The number of referrals with convictions/cautions was high, relative to the sample of social work referrals – 10% compared with 3% in the social work sample.

Table 24 Incident recipient

	Initial Stage n=30	%	ICP n=9	%	FH n=13	%	Total	%
Patient	15	50%	3	33%	9	69%	**27**	52%
Colleague	5	17%	0	0%	1	8%	**6**	12%
Adult*	1	3%	3	33%	1	8%	**5**	10%
Child*	1	3%		0%		0%	**1**	2%
None	8	27%	3	33%	2	15%	**13**	25%

* as specified in the data, where unclear how this related to the category 'patient'

This records the individuals who were, or were alleged to have been impacted by the incident or breach of standards. In 25% of cases, there was no specific individual implicated, for example where the impact of the incident was on the performance or public confidence in the service.

Table 25 Classification of alleged harm/ harm arising from Incident

	Initial Stage n=30	%	ICP n=9	%	FH n=13	%	Total	%
Psychological	5	17%	1	11%	2	15%	**8**	15%
Physical	9	30%	3	33%	7	54%	**19**	37%
Public confidence	10	33%	4	45%	3	23%	**17**	33%
Organisational	6	20%	1	11%	1	8%	**8**	15%

The research team agreed on the criteria for these ratings. Psychological and physical harm tended to be confirmed by the panel in the final hearing cases. Public confidence

concerned cases where the conduct of the registrants (for example failure to attend emergency call outs or failure to conduct court based assessments) undermined the profession and the public's view of the profession. Organisational tended to be impairment that was internal to the organisation. Instances might include mishandling of funds or failure to meet a target. It was recognised there may necessarily be some overlap here where the organisational harm might lead to a harming of public confidence.

Table 26 Case length from receipt to case closure or conclusion of hearing

	Initial Stage n=30	%	ICP n=9	%	FH n=13	%	Total	%
6 months or less	14	47%	3	33%	0	0%	**17**	33%
7-12 months	12	40%	3	33%	0	0%	**15**	29%
13-18 months	2	7%	0	0%	3	23%	**5**	10%
19-24 months	0	0%	1	11%	4	31%	**5**	10%
2 years+	1	3%	0	0%	6	46%	**7**	13%
Unknown	1	3%	2	22%	0	0%	**3**	6%

This measured the length of time from the date of receipt to the closure of the case at SOA or ICP or conclusion of the final hearing. The length of time taken for a case to progress at the first stage was frequently due to lack of response from the source of the referral or other parties required to provide evidence e.g. employer. The case files document each contact made with the source of referral and it was not uncommon for HCPC case managers to make up to six attempts before a response was forthcoming from the source of a referral. Lack of response was due to a range of factors, including change of HR personnel dealing with the case, non-response from a referral made by a member of the public, or no notification of change of contact details.

Qualitative review of paramedic cases

Case notes on the 52 referrals were reviewed and recorded in spreadsheets in a systematic way by the research team. This allowed detailed coding based on the principles of Braun and Clark (2006), using a combination of manual codes and computer-generated cross-checks.

The following section describes the thematic analysis generated under each of the three stages of the investigative process, initial ICP and final hearing stage. Each contains a

typology and description of the cases, and provides an illustration of the issues that were prevalent.

Initial Stage

The analysis identified two broad typologies; conduct and behaviour (10) and competence and performance (20). Within these, there were a number of sub-types.

Conduct and behaviour

1. Interpersonal issues (2)
2. Conviction or caution (6)
3. Social media (1)
4. Registration (1)

There were 10 cases that related to conduct and behaviour issues in the sample, including an allegation relating to a police investigation into the possession of pornographic material, which was dropped following forensic analysis of a home computer. Another concerned an accusation of non-payment of maintenance by an ex-partner. The Trust investigation concluded that this did not impact on the paramedic's clinical ability to carry out duties. There were two drink driving cases, one of which resulted in dismissal from employment and the other did not. The first involved a second conviction for dangerous driving and the paramedic was dismissed. In the second, the paramedic was off duty and had been signed off work as a result of stress and mental health issues (see box below).

Case 1

Off duty incident; drink driving offence

A paramedic experiencing stress at home and in the work environment was signed off sick. One of the issues at work was a new requirement by the employer to move to a different ambulance station, which caused the paramedic to have problems with childcare. The service was described as being under severe pressure due to staff sickness. A short while after the period of sick leave began, the paramedic and their companion were driving home at night. The car was stopped by the police and the companion (the driver of the car) was taken to the police station and later charged with drink driving. The paramedic, who was left alone with the vehicle in a setting where there was no public transport, drove the car a short distance towards home and was subsequently stopped and charged with a drink driving offence, receiving a fine and a 12-month ban. There was no previous history of driving offences. Actions that followed were that the paramedic recognised that their behaviour did not meet required standards and apologised unreservedly. The combination of personal and work related pressures had led to this one off incident, for which the paramedic sought help.

> Case length: 3 months
>
> Source: self referral

There was one referral that concerned use of social media. A paramedic posted an image of a newborn baby (with the parent's permission), celebrating the paramedic's first delivery. The issue was not with the image, as the baby could not be identified, but the language accompanying the post. The Trust issued a written warning, following a response from the paramedic demonstrating remorse and insight into the inappropriate nature of the language used in the post.

Competence and performance

1. Clinical

    - Administrative duties (6)

    - Clinical (9)

2. Clinical and record keeping (5)

There were 20 cases in the sample that related to alleged competence and performance issues. The majority involved a combination of actions and incidents. Very few involved one clearly defined clinical error or incident, and most involved a combination of either interpersonal and administrative issues, or poor clinical care and poor record keeping. Amongst the examples of cases that related to administrative duties, one paramedic allegedly refused to provide back up to certain operational colleagues. The individual had had a period of sick leave following a diagnosis of anxiety and depression and had returned to find that they had been separated from their crew, despite having requested a return to the same crew. There were other examples where personal issues came to light through a referral. A paramedic, who, over the course of a day, failed to secure an ambulance vehicle and did not complete a patient record form, acknowledged that personal issues had been a distraction and had interfered with performance. The employer recognised that this behaviour was related to personal circumstances and was a one off incident.

Another allegedly refused to work beside a particular colleague and book onto a shift with this colleague. It transpired that there had been a long-standing disagreement between these colleagues that had not been addressed. There was another referral following an alleged refusal to alert the duty controller to the fact that the paramedic was cancelling overtime and leaving work. The employer's investigation revealed a number of mitigating factors - first, that the paramedic was concerned about taking a vehicle out when it had not been checked and therefore putting HCPC registration at risk, and second that the paramedic had been suffering from acute symptoms of stress prior to making the decision to cancel overtime and leave work. The investigation concluded that this was the result of a clash of expectations between the paramedic and the employer.

> **Case 2**
>
> **Conduct and competence**
>
> A paramedic was alleged by a member of the patient's family to have 'fallen asleep' during work hours, was described as unkempt in appearance, and late in arriving to pick up a (non-emergency) patient. The employer's investigation found that the ambulance had been late in arriving at the expected time, but this was not judged to be the fault of the paramedic. The evidence that the paramedic actually fell asleep was described as 'inconclusive'. Actions that followed were that the paramedic wrote a letter of apology to the patient, undertook communication and listening skills training, and recognised that distress had been caused to the patient and their family as a result of these combined events. The employer put in place additional training to develop the paramedic's communication skills.
>
> Case length: 9 months
>
> Source of referral: member of the public

There were two cases in which an elderly patient died during the course of the paramedic interventions. Neither were deemed by the employer's investigation to be attributable to the actions of the paramedic involved. One involved the administration of CPR following a cardiac arrest. The investigation concluded that there was no credible evidence that basic and advanced life support were not commenced at the earliest opportunity. Another involved an elderly patient presenting with abdominal pain and a high temperature. A family member who was an ambulance technician and colleague alleged that the paramedic (a lone responder) had failed to recognise the possibility of septic shock and had not completed a patient record form. The patient did not suffer any harm. The employer investigated, and put in place on-going monitoring, having satisfied itself that the paramedic showed self-awareness and was fully engaged in the process of self-improvement.

In the main, referrals involving poor record keeping were frequently combined with other, clinically based errors or omissions. For example, a paramedic who, over the course of one day, was alleged not to have completed a full clinical assessment on a patient, and subsequently did not complete the patient record for this contact. The employer's investigation revealed conflicting reports on the incidents, issued a formal warning, and the paramedic undertook a period of training and monitoring to ensure that the error did not happen again. Another example involved a paramedic who was called to a patient's home, but was refused entry. The patient spoke aggressively to the paramedic through a broken window from a darkened room, and refused treatment. The paramedic did not complete a patient record form on this patient, as no physical contact was made and no treatment had been given. During the trust investigation, the paramedic expressed

remorse, and in mitigation described the situation as highly charged. The investigation concluded that the likelihood of repetition was low.

Another similar example involved a paramedic who allegedly delayed taking an injured patient to hospital, and asked a colleague to retrofit the description of events to cover the paramedic's actions. This patient, who was described as a drug user under the influence of alcohol at the time of the injury did not suffer any long-term harm as a result. The employer's investigation acknowledged that this was an extremely volatile situation. The paramedic showed remorse and made strenuous efforts to undertake further analysis and training in order to deal differently with such volatile situations in the future.

There were a few examples that related solely to record keeping, for example, one paramedic who did not ensure that there was a carbon copy between the pages of a record, preventing the writing from transferring through to the patient copy. A follow up audit of the individual revealed that there had been a previous incident of poor record keeping. A support plan was put in place to prevent this from re-occurring in the future.

Paramedics: Investigating Committee Panel (ICP) Stage

The analysis of 9 cases revealed a similar typology, with a higher incidence of one off occurrences than in the final hearings cohort. The numbers were split between alleged conduct and behaviour (3) and competence and performance issues (6).

Competence and performance

1. Clinical
   - Administrative duties (2)
   - Diagnosis and treatment (3)

2. Record keeping (1)

The clinical and performance referrals fell broadly into two categories – the first relating to failures to perform administrative duties and the second alleged concerns around clinical aspects of the work. One example of the former involved an alleged failure to respond to a Red One call (where an urgent response is required) and not updating the Operations Centre after a patient handover.

Case 3

Administrative duties

An employer referred this paramedic following an alleged failure to respond to a Red Two call, and failing to provide the Operations Centre with correct details regarding the vehicle location whilst responding to an incident. The paramedic had suffered a minor injury whilst on duty but given the demands had decided to continue to the end of the shift. The case was investigated by the Trust and as a result the paramedic was dismissed. The paramedic appealed, and during the appeal, it became clear that the delayed response was due to the paramedic's injury, and was not considered 'characteristic' of the individual. As a result, the paramedic was re-instated. The ICP also concluded that the incident was a result of health reasons and not moral blameworthiness.

Case length: 9 months

Source of referral: Employer

Another example was of a paramedic who got out of his vehicle and confronted an aggressive driver at traffic lights whilst conveying a patient and family member to hospital. There had been no complaint from the patient, family member or the car driver and the ICP concluded that this was a one-off incident, exacerbated by a stressful work environment and workload pressures.

Concerns around diagnosis and treatment that did not constitute a breach of the standards included an instance during which a paramedic allegedly allowed an obese patient to 'drop' from a trolley whilst waiting for treatment in A and E. The patient sustained a minor injury. The patient was described as being too large for the trolley. During the trust investigation it became clear that it 'probably' would have been in the best interests of the patient to wait for a bariatric transport, but this would have delayed treatment further. The paramedic had attempted to apply a safety belt but without success. After the incident, the paramedic tried to conceal the event, did not report it accurately, later giving a full account of actions and reasons for them.

Another involved a self-referral concerning the care of an elderly patient, who died an hour after admission to hospital. The Trust investigation found that although there were failings in the treatment of the patient arising from poor communication between the two attending paramedics, these actions were not the cause of death. The paramedic showed insight into the failings, remorse, and underwent a period of training. The ICP panel concluded that this behaviour was unlikely to be repeated.

Conduct and behaviour

1. Conviction/caution (1)
2. Driving offence (1)
3. Personal dispute (1)

All these referrals related to incidents outside work, two of which related to family matters. One paramedic received a caution from the police following a disagreement in a pub, in which the paramedic had become involved in a dispute between his son and another man. This was not the first occasion in which there had been conflict between the man and the paramedic's son. On a previous occasion, the son had been assaulted by the man and had suffered serious injury. Another example involved a dispute with an ex-partner, who had accused the paramedic of harassment and reported this individual to the police. Although the Trust had issued a formal verbal warning following the incident, it transpired that there had been long standing conflict over the custody of the children. In both these cases, the ICP considered that these events had no bearing on the individual's fitness to practise.

Case 4

Conduct outside work

A paramedic who had returned home from a shift received a call from the employer asking, at short notice, to provide shift cover for a colleague who was unwell. On the return journey to work, the paramedic activated a speed camera. The paramedic subsequently did not inform the employer of the offence, and was referred to the HCPC. During the employer's investigation, it was clear that the paramedic was experiencing personal issues at the time. The paramedic showed remorse and a commitment to learn from the incident. A character reference gave evidence of consistently good performance. The ICP concluded that there was a lack of care rather than any intention to deceive. The paramedic engaged fully with the investigation throughout the process.

Case length: 7 months

Source of referral: Employer

The distinction between cases which concluded at the initial stage and the ICP stage is not clear-cut. However, there are some patterns, particularly in relation to one off incidents. For example, cases that did not meet the SOA tended to be self-referrals for incidents occurring outside work, such as speeding offences, misuse of travel cards, and disputes within personal relationships that resulted in a caution. Cases that were considered by the ICP and found to have no case to answer included those which were one off incidents in the work environment, such as posting inappropriate comments on

social media, alleged failure to communicate with colleagues in the Operations Centre, or to complete patient records. In terms of age and gender profiles, 4 out of 39 were under the age of 35 years, and 28 out of 39 were men.

Paramedics: Final Hearings Stage

Table 27 Breakdown of sanctions at the final hearing stage

Sanction	Number of cases in FH
Struck Off	4
Disposal by Consent (voluntary removal order)	1
Suspended for 12 months	3
Conditions of Practice for 6 months	1
Caution Order	2
Not well founded	2

The thematic analysis of 13 cases brought before HCPC panels in the two-year period found two broad typologies: conduct and behaviour (5), and competence and performance (8). Within these two, there were clear sub-types (see Figure 2).

Figure 2 Paramedics: typology of final hearings
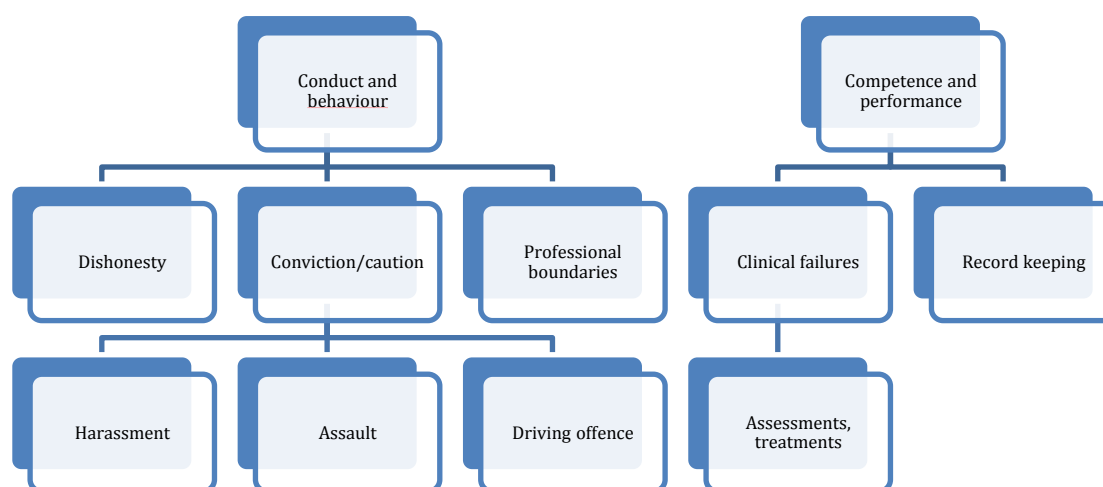
Conduct and behaviour

1. Boundary issues (2)
2. Dishonesty (2)
3. Conviction/caution (1)

There were two cases in the sample that constituted breaches of the standards on conduct. One was an anonymous referral and concerned an incident in which the paramedic began a conversation with a woman, which moved from initial banter to more intimate discussions and then to behaviour in which unwanted physical contact took place. The panel concluded that, despite positive testimonials about his clinical practice over many decades, the paramedic had not shown sufficient insight in to the implications of his behaviour both for the individual and for the profession. He showed little remorse and did not apologise to the complainant. The outcome was disposal by consent (voluntary removal agreement).

> **Case 5**
>
> **Boundary Issues – Unacceptable conduct in a clinical setting**
>
> The paramedic self-referred following a written warning from the Trust. In the first incident the paramedic is alleged to been overheard applying a soothing gel to the patient in an inappropriate place and describing it inappropriately. The complaint was made by the patient's partner 12 months after the alleged incident. The second incident involved a complaint from the parent of a daughter whom the paramedic had struck up a friendship with and sent an inappropriate phone image that was then seen by a younger sister. The disciplinary hearing noted their disappointment that the paramedic did not apologise and showed limited insight. Upon self-referral the paramedic refuted the first allegation indicating that the message was misheard and in the second allegation the paramedic suggested it was part of the paramedic's private life and had nothing to do with being a paramedic. The Panel concluded the case was not well founded on the grounds that there was insufficient evidence due to a witness being unwilling to cooperate in the first incident and the allegation did not constitute impairment in the second.
>
> Case length: 2 years
>
> Source of referral: Self referral

The two cases of dishonesty also resulted in different sanctions. The first concerned a paramedic who removed two vials of morphine from a service vehicle without authorisation. The paramedic demonstrated remorse and insight, received a caution from the HCPC panel and took steps to improve his practice following this. In the second, this act of dishonesty was found to be a repeat of a previous incident of theft, which had led to a written warning by the employing Trust. The paramedic in this case did not show insight and was removed from the register.

Another case that resulted in a removal from the register concerned a paramedic who had received a conviction for serial assaults on three different colleagues over a two-year period. In the first case the paramedic engaged in a course of conduct where he failed to maintain professional boundaries by continually making sexual remarks to his colleague. In the second case the paramedic made both sexual remarks and engaged in sexual touching of his colleague and then in the third case the paramedic engaged in inappropriate sexual contact with his colleague. In all three cases the paramedic did not dispute the fact of conviction but disputed the facts upon which the convictions were based. The panel declined to look behind the convictions and confirmed that as these had

been proven in a criminal court beyond reasonable doubt, the fact, which underpinned the convictions were already established.

Competence and performance

1. Clinical (5)
2. Record keeping (3)

There were eight cases in the sample concerning clinical competence and performance. In terms of clinical cases one was a self-referral and concerned a paramedic who failed to act in an emergency by not attending an emergency call at the end of a night shift. Another self referral case following a trust investigation involved a single incident of a failure to provide adequate care from the moment of attending a patient through to that patient arriving at hospital, which was then exacerbated by the paramedic's attempt to cover up a series of clinical omissions in this case and an attempt to shift blame during presentation of their defence. This failure to provide adequate assessment or to have the correct equipment meant there was a delay in treating a patient's life threatening symptoms. In contrast, a case referred by an employer alleged that the paramedic had not provided adequate care in two separate cases. The panel found that the paramedic lacked insight, and there were concerns that, if confronted with a similar clinical situation, would not act differently but given the opportunity for remediation the paramedic was suspended from practice. In a similar employer referral case, a more experienced paramedic was struck off following a failure to administer the correct drug accompanied with an attempt to conceal this error by altering clinical records and making false representations to an out of hours doctor which further delayed the correct treatment to the patient. Given this was not a one off incident, and the paramedic had shown neither remorse nor insight, they were struck from the register.

Case 6

Clinical – failure to respond

The paramedic self-referred following dismissal from their employer. The paramedic had made an emergency vehicle unavailable 40 minutes before their shift had ended and had refused to attend an emergency call even though no other crew was available at the time. The Panel found these actions were not in the best interests of patients and involved a serious departure from the fundamental tenets of the profession. The paramedic did not demonstrate any remorse for their actions but the Panel noted this was an isolated incident in the paramedic's long, unblemished history in the profession and the incident took place after an 11 hour overnight shift without a rest break. The paramedic was suspended for 12 months. This suspension was then extended for another 12 months following a review hearing where no evidence of remediation or insight had been demonstrated. A further review concluded that the paramedic should be struck off.

Case length: 4 years (including review of suspension that led to striking off)

Source of referral: Self referral

Case 7

Clinical – Unacceptable conduct in a clinical setting

The paramedic self referred following dismissal from their employer. This occurred after two incidents in one day where the paramedic used their mobile phone inappropriately, were heard to have said they were 'bored' and 'losing interest' whilst on duty and questioned a decision to take a patient to hospital. They then drove through red lights when inappropriate to do so and were laughing during resuscitation attempts on a patient. Finally during the Trust's disciplinary process the paramedic produced a forged letter from a surgeon, which attempted to provide an excuse for the alleged misconduct. The paramedic was suspended for 12 months. This suspension was then reviewed and the Panel decided that, given the paramedic failed to accept and continued to dispute the facts of the incidents and the findings of the original Panel, striking off the register was the only appropriate sanction. The Panel defended this decision due to a lack of insight and remorse by the paramedic and their lack of intention to return to the profession.

Case length: 3 years (including review of suspension that led to striking off)

Source of referral: Self referral

Case 8

Clinical – administering of treatment

An employer referred the paramedic following two separate incidents 4 months apart. The first concerned administering a drug without the authorisation of a doctor and a failure to record and to alert a hospital of a patient's vital statistics. The second concerned administering a drug when it was not clinically indicated. Both cases saw the paramedic in either a mentor or leading role within a team and the Panel appeared concerned for the paramedic's cavalier disregard for established treatment protocols. Both allegations were found proved and were therefore not isolated and the Panel indicated the paramedic had demonstrated an over-confident attitude resulting in a disregard for the interests of two service users. Conditions of practice were deemed inadequate in this case because no conditions could be formulated to guarantee patient safety. A suspension order was then made for 12 months to enable the paramedic to reflect on their wrongdoing and provide sufficient evidence of remediation.

Case length: 2 years (including review of suspension)

Source of referral: Employer referral

The cases involving record keeping varied in severity and context. For example, a paramedic self referred, following a one off incident in which their deliberate actions placed a patient at risk. The paramedic subsequently falsified records of three sets of observations, which had not taken place. During the hearing the paramedic argued that health issues had contributed to the incident, which was a one off in an otherwise unblemished career. The paramedic had indicated during her Trust interview that the whole event was a 'moment of madness' and she 'just wanted to go home to bed'. The paramedic did not attend the final hearing and the Panel took the view that although a one off incident it involved a series of serious, deliberate, reckless and dishonest acts and so the paramedic was struck off from the register.

In an employer referral case, there was evidence of a number of examples of falsified records, some with serious consequence, all of which took place on one day. The paramedic concerned showed a lack of insight or remorse and was suspended from practice for 12 months.

Case 9

Record Keeping - alongside other misconduct

An employer referred the paramedic following an investigation where, during the course of attending a service user, there had been a failure to identify the cause of a service user's bleeding. The paramedic then failed to send a pre-alert to the hospital of delivery and failed to complete the patient's clinical record and check whether this record had been completed by others. The Panel felt that taken in the round this did amount to serious misconduct and in the context of record keeping the Panel were reminded that under the HCPC standards of conduct, performance and ethics, a paramedic must keep accurate records. This omission was accompanied by a series of other incidents of misconduct. The Panel imposed a conditions of practice order on the paramedic for a period of 6 months on the basis that that remediation would take place and insight had been demonstrated.

Case length: 1.8 years

Source of referral: Employer referral

Case analysis: Social workers

The following section provides an analysis of the total number of cases received during the study period and the number reviewed, followed by showing the analysis of the sample cases across 17 variables. The methodology for analysing the social worker cases was identical to the approach used with the paramedic cases described on p104 above. The sample was substantially larger because of the number of social workers on the HCPC Register, as well as the number of referrals received during the two year period.

Table 28 Social work (England) referrals to HCPC 2014-2016

	2014-2015	2015-2016	Number sampled at each stage
Number of concerns received	1251	1174	
Number closed at Initial Stage	614*	1006*	173
Number closed by ICP	167*	122*	28
Number considered at Final Hearing	155*	148*	31
Total cases selected			**232**

* numbers relate to decisions made in each period

The team reviewed just over 10% of the cases (n=232), evenly distributed across each stage and source of referral. Information was obtained on the same variables described on p104 for the paramedic case review, with the exception of three social work specific categories: employing authority, work setting, qualification. A full breakdown of the data is given in the Tables below, followed by a themed analysis of the qualitative data.

Table 29 Social work cases by gender

	Initial Stage n=173	%	ICP n=28	%	FH n=31	%	Total	%
Female	127	73%	15	54%	19	61%	**161**	69%
Male	46	27%	13	46%	12	39%	**71**	31%

The ratio of women to men in the sample differs from the proportions of women to men on the social work part of the HCPC Register by just over 10%. In 2016, the proportion of

men to women was 80:20, suggesting a higher number of referrals about male social workers at all stages relative to their overall numbers on the Register (HCPC, 2016).

Table 30 Social work cases by age

	Initial Stage n=173	%	ICP n=28	%	FH n=31	%	Total	%
18-29 y.o.	22	13%	0	0%	1	3%	**23**	10%
30-39 y.o.	35	20%	5	18%	6	19%	**46**	20%
40-49 y.o.	47	27%	8	29%	7	23%	**62**	27%
50-59 y.o.	59	34%	10	36%	12	39%	**81**	35%
60+	9	5%	4	14%	3	10%	**16**	7%
Unknown	1	1%	1	4%	0	0%	**2**	1%

The distribution across the age range reflected a majority in the middle age ranges and fewer in the under 30 and 60 + age ranges. There were a higher number of referrals at the initial stage in the younger age group, 13% compared with 3% at final hearing stage, but no other notable differences in the age profiles across the three stages.

Table 31 Employment status

	Initial Stage n=173	%	ICP n=28	%	FH n=31	%	Total	%
Local authority	125	72%	14	50%	16	52%	**155**	67%
NHS	8	5%	2	7%	0	0%	**10**	4%
Cafcass[*]	3	2%	0	0%	0	0%	**3**	1%
Private practice	2	1%	0	0%	0	0%	**2**	1%
Independent	2	1%	2	7%	0	0%	**4**	2%
Agency/locum	1	1%	1	4%	0	0%	**2**	1%
University	2	1%	0	0%	0	0%	**2**	1%
Not in employment/ retired	4	2%	3	11%	3	10%	**10**	4%
Unknown	26	15%	6	21%	12	39%	**44**	19%

*Children and Family Court Advisory and Support Service (represents children in court proceedings)

The majority of referrals were about social workers employed by Local Authorities. This was higher for referrals at the Initial stage (72%) than for the ICP (50%) and Final Hearing stage (52%).

Table 32 Work setting

	Initial Stage n=173	%	ICP n=28	%	FH n=31	%	Total	%
Adult	22	13%	7	25%	8	26%	**37**	16%
Child	121	70%	19	68%	21	68%	**161**	69%
Mental health	19	11%	2	7%	2	6%	**23**	10%
Unknown	11	6%	0	0%	0	0%	**11**	5%

The majority of referrals (69%) were about social workers employed in children and family services. Statistics from the Department for Education report that around one third of registered social workers in England were employed in local authority children and family services in 2016 (Note this does not include those at Cafcass or employed in the voluntary or private sector)[2]. Of the 121 children and family social worker cases referred and dealt with at the Initial stage, 58% related to residence and contact disputes (disputes between family members over place of residence and access to children).

Table 33 Residence and contact related referrals

	Initial Stage n=173	%	ICP n=28	%	FH n=31	%	Total	%
Yes	70	40%	6	21%	1	3%	**77**	33%
No	103	60%	22	79%	30	97%	**155**	67%

[2] https://www.gov.uk/government/statistics/childrens-social-work-workforce-2016 .

Table 34 Route to registration

	Initial Stage n=173	%	ICP n=28	%	FH n=31	%	Total	%
UK*	172	99%	28	100%	30	97%	**230**	99%
International	1	1%	0	0%	1	3%	**2**	1%

* All social workers who transferred from GSCC to HCPC in 2012 have a UK route to registration recorded.

This is lower than the ratio of UK to internationally trained registrants on the HCPC Register, currently at 5% (HCPC 2016). Overall, internationally trained registrants accounted for 4% of cases referred to HCPC in 2015-2016.

Table 35 Service location

	Initial Stage n=173	%	ICP n=28	%	FH n=31	%	Total	%
East Midlands	12	7%	2	7%	3	10%	**17**	7%
East of England	16	9%	2	7%	1	3%	**19**	8%
London	35	20%	0	0%	2	6%	**37**	16%
North East	9	5%	2	7%	1	3%	**12**	5%
North West	22	13%	6	21%	4	13%	**32**	14%
South East	30	17%	6	21%	8	26%	**44**	19%
South West	16	9%	4	14%	4	13%	**24**	10%
West Midlands	21	12%	3	11%	4	13%	**28**	12%
Yorkshire and the Humber	10	6%	3	11%	4	13%	**17**	7%
Unknown	2	1%	0	0%	0	0%	**2**	1%

The highest proportions of referrals came from the South East, London, North West, West Midlands, with smaller numbers referred from the North East, East Midlands, Yorkshire and Humber and East of England. These may reflect higher numbers of registered social workers in these parts of England, or regional differences, for example, in the quality of Local Authority services.

Table 36 Employment location*

	Initial Stage n=173	%	ICP n=28	%	FH n=31	%	Total	%
Urban	136	79%	27	96%	19	61%	**182**	78%
Rural	31	18%	1	4%	12	39%	**44**	19%
Unknown	6	3%	0	0%	0	0%	**6**	3%

*This data was obtained from the address of the employer, and therefore does not take into account that some services cover both urban and rural areas.

Table 37 Source of referral

	Initial Stage n=173	%	ICP n=28	%	FH n=31	%	Total	%
Employer	18	10%	12	43%	21	68%	**51**	22%
Service user	61	35%	5	18%	0	0%	**66**	28%
Public	61	35%	2	7%	1	3%	**64**	28%
Self referral	16	9%	7	25%	5	16%	**28**	12%
Other registrant	8	5%	0	0%	0	0%	**8**	3%
Professional body	0	0%	0	0%	1	3%	**1**	0%
Other public body	2	1%	0	0%	0	0%	**2**	1%
Police	0	0%	0	0%	1	3%	**1**	0%
Other	1	1%	1	4%	1	3%	**3**	1%

Anonymous*	4	2%	0	0%	0	0%	**4**	2%
Article 22(6)*	0	0%	1	4%	1	3%	**2**	1%
HCPC registration dept	1	1%	0	0%	0	0%	**1**	0%
Unknown	1	1%	0	0%	0	0%	**1**	0%

* Article 22(6) is used to make an allegation on an anonymous complaint where HCPC have sufficient evidence to support it. It is also used when it is decided that a self-referral should go through to further investigation. The case management system logs these separately from 'Anonymous'

The highest number of referrals (56%) came from members of the public (family members, friends) and users of services. This is lower than the proportion of referrals about social workers from members of the public overall for the years 2014 - 2016 (70% for both years) and significantly higher than the proportion of referrals from members of the public about paramedics, as well as all other HCPC regulated professions (see Figure 3 below) (HCPC, 2016).

Figure 3 Pattern of referrals from members of the public (Social Workers in England and Paramedics in percentages (2013-2016) compared with all other HCPC regulated professions)
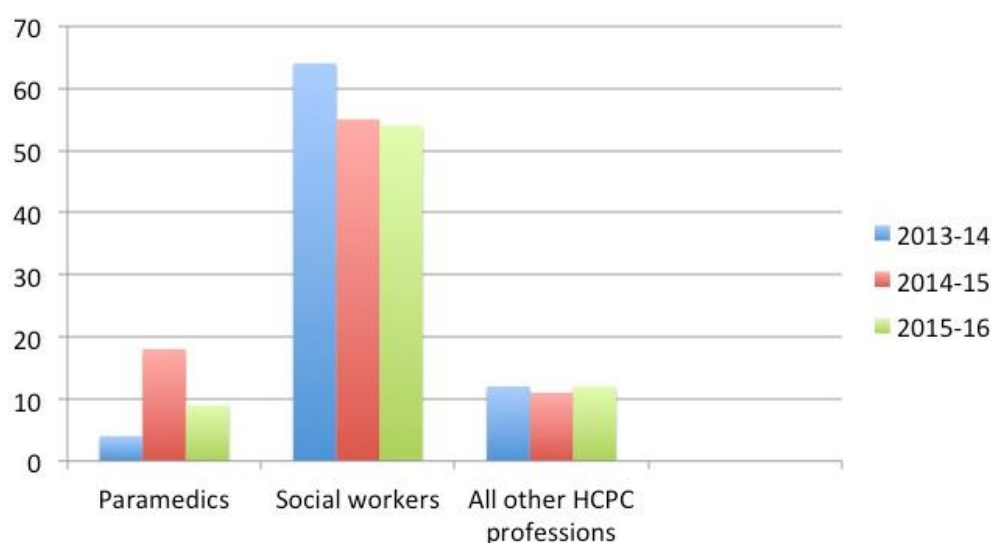
Table 38 Incident location

	Initial Stage n=173	%	ICP n=28	%	FH n=31	%	Total	%
Local Authority establishment	88	51%	15	54%	21	68%	**124**	53%
NHS hospital	6	3%	0	0%	0	0%	**6**	3%
Other public sector place of employment	2	1%	1	4%	2	6%	**5**	2%
Other private place of employment	2	1%	1	4%	0	0%	**3**	1%
Court/Expert witness	2	1%	0	0%	0	0%	**2**	1%
Private care company	1	1%	0	0%	0	0%	**1**	0%
Voluntary sector	1	1%	0	0%	0	0%	**1**	0%
Patient's home	3	2%	2	7%	1	3%	**6**	3%
Education establishment	1	1%	0	0%	0	0%	**1**	0%
Not during work	15	9%	1	4%	2	6%	**18**	8%
Other	25	14%	5	18%	3	10%	**33**	14%
Not known	27	16%	3	11%	2	6%	**32**	14%

These categories were recorded in the case management system. It was not straightforward to verify the exact incident location from the case notes, which may have given rise to some inconsistencies in the way these categories were used. 'Other' usually referred to incidents relating to a decision by the social worker (s) for example, concerning residence and contact of a child, and could therefore be included under the category of local authority/social care establishment, giving an overall percentage of 67% of incidents relating to 'incidents' or decisions taken by the social workers whilst employed by a local authority. Only 8% were recorded as referrals relating to an incident outside work.

Table 39 Previous history of complaints at local level

	Initial Stage n=173	%	ICP n=28	%	FH n=31	%	Total	%
0	166	96%	27	96%	31	100%	**224**	97%
1	6	3%	1	4%	0	0%	**7**	3%
2	1	1%	0	0%	0	0%	**1**	0%
3+	0	0%	0	0%	0	0%	**0**	0%
Unknown	0	0%	0	0%	0	0%	**0**	0%

In only 3% of referrals was the social worker reported as having been the subject of a previous complaint at a local level.

Table 40 Engagement at work

	Initial Stage n=173	%	ICP n=28	%	FH n=31	%	Total	%
High	8	5%	3	11%	19	61%	**30**	13%
Moderate	1	1%	15	54%	11	35%	**27**	12%
Low	0	0%	1	4%	1	3%	**2**	1%
Unknown	164	95%	9	32%	0	0%	**173**	75%

This information was inferred from employer reports wherever possible. There was no pattern to suggest that engagement at work was a significant factor in this sample. For the majority of cases, no rating was given due to insufficient data.

Table 41 Engagement in the fitness to practise process

	Initial Stage N=173	%	ICP n=28	%	FH n=31	%	Total	%
Yes	67	39%	24	86%	20	65%	**111**	%
No	31	18%	2	7%	11	35%	**44**	%
Not contacted	31	18%	0	0%	0	0%	**31**	%
Unknown	44	25%	2	7%	0	0%	**46**	%

Registrants who engaged in the process, through email correspondence, documentation and supporting statements were rated; those that were contacted and failed to respond were not. With the exception of self-referrals, registrants are informed of an allegation and asked for their observations only if the case proceeds to the Investigating Committee stage (ICP). The majority of referrals that are closed at the standard of acceptance stage do not require any contact with the registrant. Efforts are made with the complainant and other parties such as the employer to secure evidence, and if the referral does not meet the threshold, the registrant may not be engaged at this first stage.

Table 42 Referral characteristics

	Initial Stage n=173	%	ICP n=28	%	FH n=31	%	Total	%
Misconduct	85	49%	8	29%	11	35%	**104**	45%
Misconduct and lack of competence	68	39%	19	68%	14	45%	**101**	44%

Misconduct and health	1	1%	0	0%	0	0%	**1**	0%
Misconduct and conviction	1	1%	0	0%	0	0%	**1**	0%
Lack of competence	14	8%	0	0%	1	3%	**15**	6%
Conviction/ caution	2	1%	1	4%	4	13%	**7**	3%
Health	1	1%	0	0%	1	3%	**2**	1%
Unknown	1	1%	0	0%	0	0%	**1**	0%

These were the referral characteristics recorded in the case notes by HCPC case managers.

Table 43 Incident recipient

	Initial stage n=173	%	ICP n=28	%	FH n=31	%	Total	%
Patient/service user	26	15%	6	21%	3	10%	**35**	15%
Family member	88	51%	8	29%	1	3%	**97**	42%
Colleague	12	7%	1	4%	0	0%	**13**	6%
Student	6	3%	0	0%	0	0%	**6**	3%
Adult*	7	4%	0	0%	0	0%	**7**	3%
Child*	9	5%	2	7%	4	13%	**15**	6%
None specified	25	14%	11	39%	23	74%	**59**	25%

* as recorded in the data set, may be some overlap

This table records the individuals who were, or were alleged to have been involved in the incident that gave rise to the referral. In 25% of cases, there was no single individual implicated.

Table 44 Classification of harm/alleged harm, arising from the incident

	Initial Stage n=173	%	ICP n=28	%	FH n=31	%	Total	%
Psychological	116	67%	19	68%	3	10%	**138**	59%
Physical	11	6%	0	0%	3	10%	**14**	6%
Public confidence	30	17%	8	29%	9	29%	**47**	20%
Organisational	16	9%	1	4%	16	52%	**33**	14%

The research team agreed the criteria for these ratings (see p116 above). The highest ratings of alleged psychological harm were at the initial stage, the majority of which related to decisions taken by social workers judged to be harmful to one or more family member, including the child, for example in disputes over child residence and contact. Organisational tended to be impairment that was internal to the organisation. Instances might include mishandling of funds within a foster placement. Harm which impacted externally would be classified as undermining public confidence.

Table 45 Case length from receipt to case closure or conclusion of hearing

	Initial Stage n=173	%	ICP n=28	%	FH n=31	%	Total	%
6 months or less	96	55%	9	32%	1	3%	**106**	46%
7-12 months	54	31%	11	39%	4	13%	**69**	30%
13-18 months	16	9%	5	18%	7	23%	**28**	12%
19-24 months	5	3%	2	7%	4	13%	**11**	5%
2 years+	0	0%	0	0%	15	48%	**15**	6%
Unknown	2	1%	1	4%	0	0%	**3**	1%

The length of time taken for a case to progress at the first stage was frequently due to lack of response from the source of the referral. The HCPC case files document every contact

made with the source of referral (phone call, email, letter). It was not uncommon for HCPC case managers to make up to six attempts before a response was forthcoming. The most common non-responses were those made by members of the public or employers.

Qualitative review of social work (England) cases

Case notes on the 232 referrals were reviewed and recorded on the spread sheet in a systematic way by the research team. This allowed detailed coding based on the principles of Braun and Clark (2006), using a combination of manual coding and computer-generated verification.

Initial Stage

Analysis of 173 referrals to the HCPC in the two year period revealed two broad typologies relating to conduct and competence. There were 154 cases involving alleged misconduct, half of these alleged both misconduct and lack of competence. Only 8% of the cases were classified as relating exclusively to a lack of competence and all of these related to alleged inaccurate assessment or reporting of a case. For the majority of cases therefore, seeking to identify a typology distinguishing clearly between conduct and competence did not seem applicable. The analysis did reveal a number of sub-types.

1. Convictions/cautions (8)
2. Dishonesty (7)
3. Breach of confidentiality (6)
4. Interpersonal/communication issues (5)
5. Allegations of a sexual nature (8)
6. Health related (1)
7. Inaccurate/inadequate assessments/reporting (70)
8. Inadequate care/knowledge (50)
    a. Disputes within teams or with managers (12)
    b. Disputes with students (4)

Convictions/cautions

There were a small number of self-referrals (3) from social workers who had received convictions. Two were related to driving offences, and one to fare evasion. One of the driving offences involved alcohol consumption resulting in a twelve-month ban, the other the result of driving without insurance. Other examples of self-referrals included a 'simple caution' for possession of a bladed implement discovered at airport security. The individual was going on holiday and had omitted to put the implement in hold luggage, resulting in a caution.

Referrals from employers included a social worker who was at a friend's house when it was raided by police on suspicion that the residents were cultivating cannabis. The resident was arrested and bailed and the police confirmed that they were taking no further action against the social worker.

Dishonesty

There were a small number of referrals relating to dishonesty that occurred across personal and professional contexts.

One involved a driving ban and failure to inform the employer of this ban. Another was a referral from a service user who alleged that the social worker had acted dishonestly in giving assurance that their child would be returned to them and then failing to follow this through. Another service user alleged that 6 social workers had acted dishonestly in conducting unnecessary assessments into her mental well being, and alleged that all the social workers were determined to section her under the Mental Health Act. An employer referred a social worker following an investigation into alleged financial mis-management of overtime payments. The employer investigation did not result in sanctions, but there were 'capability' issues with financial management. The social worker later took voluntary redundancy.

Examples of alleged breaches of confidentiality were small in number and also crossed personal and professional boundaries. The majority involved accessing personal information on cases in which there was a personal interest.

Case 10

Breaching confidentiality

A social worker was referred by their neighbour for allegedly accessing confidential files about the neighbour's children. This was part of a long-standing dispute between the two families, disagreements amongst the children and assertions by the social worker that the children next door were not being properly cared for. The local investigation found no evidence of the alleged breach of confidentiality.

Case length: 3 months

Source: Member of the public

A similar referral related to accessing confidential files to determine whether a social worker had been allocated to her father-in-law for whom the social worker was an informal carer. The social worker apologised, admitted wrongdoing and subsequently resigned. A work related example concerned an alleged breach that led to a parent losing access to a child. The social worker had accessed information in a report to the family court. In this case, the employer did not uphold the allegation of a breach, regarding this as a safeguarding situation that was followed up by the team. In another example, a referral was made by a service user who alleged that a social worker had shared confidential information about them with an ex-partner. The employer did not support this as a breach of confidentiality, as the identifiable information was judged to be negligible.

Interpersonal / communication issues

These referrals were commonly a mix of interpersonal issues and communication breakdown between service users and social workers, often concerned with the manner in which decisions were conveyed, or with a lack of communication following a contentious outcome. Many referrals described social workers as 'unprofessional' in the way they communicated either face to face or on the phone, as well as not communicating or not following up communications. Examples included failing to communicate with a family following a decision about residence and contact of a child or placing a child under a protection plan, failing to inform a birth parent of changes to a foster placement, failing to communicate the reasons for a change in a foster arrangement, failing to provide adequate explanations for actions and failing to inform other professionals of decisions. These alleged failures occurred in volatile and distressing circumstances, in which service users expressed anger, resentment and disappointment with the social workers concerned.

Case 11

Interpersonal / communication issues

A family member referred a social worker to the HCPC for allegedly failing to inform the family of changes to a care plan for their elderly relative. The social worker had allegedly failed to inform the family of their relative's whereabouts following discharge home from a step down residential setting. The relative was re-admitted to the care facility shortly afterwards. The family member complained that the social worker was 'lazy and disinterested' in their welfare. The complainant did not make contact with the employer, who reported having no concerns about the conduct or performance of the social worker. The HCPC followed up with the relative and the family member, but did not receive any response. All written correspondence was returned unopened.

Case length: 11 months

Source: Member of the public

Allegations of a sexual nature

There were a small number of allegations of a sexual nature (8), which were very different in nature - these were either allegations that the social worker had engaged in a sexual relationship with a service user, or that a social worker had failed to deal with an alleged incident of sexual abuse within a family (an example of alleged inadequate care or assessment).

There was an allegation from a service user who alleged that a social worker had disclosed that she had been raped by her former manager. This was raised with the

employer who confirmed that there was no information on this, it had not been reported to the police. The alleged victim denied any knowledge of this.

Another example was a service user in a mental health setting who alleged that the social worker had a sexual relationship with her, but did not provide any further evidence to the HCPC. The employer did not verify whether the evidence presented to them by the service user was linked to the social worker and did not respond to requests for further information. Another was a referral from a colleague who alleged that a social worker used language of a sexual nature in a supervision session with a student and subsequently towards another colleague when referring to the supervision session. Neither the student nor the university had raised any issues with this incident when followed up. The social worker subsequently acknowledged that inappropriate language had been used, recognising that this had caused offence to the colleague.

Inaccurate assessment/reporting

The majority of cases in the sample relating to children's services arose from decisions taken by social workers over residence and contact. 70 out of 121 (58%) of the cases dismissed at this first stage of referral related to disputes over child residence and contact. Many of these were complaints against multiple social workers lodged at the same time, usually 3-6 individuals, in one case against 14 social workers. Typically, a family member or foster parent complained that the social worker(s) had failed to make an accurate assessment in relation to their suitability to visit, care for, or provide a home for the child. Typically, the complainant would also describe the social worker's conduct in negative terms, using such descriptions as 'incompetent', 'dishonest', 'untrustworthy', 'manipulative', 'rude', 'aggressive', 'cunning' and 'vile'. One parent complained about three social workers, all of whom were alleged to have made inappropriate assessments, 'lied' about the parent, failed to acknowledge the parent's mental health issues, and caused feelings of distress and anxiety. The court decision had resulted in placing the child in care.

In another case, the parents referred 5 social workers, following the removal of their children. They alleged failure to carry out adequate assessments and 'lying' about the conditions in the home, which were described during court proceedings as conditions of neglect and discord, in which the family were living in squalid conditions with a large number of animals. This case had involved 2 psychiatrists and 2 psychologists, all of whom had reached similar conclusions following independent assessments, recommending long term foster care. The court had opposed an application for a placement order to be revoked and made application under Section 34 (4) of the Children Act for permission to refuse the parents contact with the children.

> **Case 12**
>
> **Parental care – alleged biased assessment**
>
> A mother made a referral about 3 social workers involved who made the decision to take her baby away before birth. This was not the first time that this parent had had her children removed into care. On this occasion she argued that the father had been treated 'unfairly' and that the social workers were biased against her and her family. The complaint was followed up by HCPC four times but there was no further response from any member of the family, and no further information on the allegation was obtained. The employer's view was that there were no fitness to practise concerns in relation to this case.
>
> Case length: 16 months
>
> Source: Service user

There were a number of referrals such as the example in the box above that were followed up by the HCPC team, but resulted in 'no further evidence' forthcoming from the complainant. Some of these came in the form of hand written letters, outlining in detail the failures and inadequacies of the services received, many did not respond to HCPC's requests for further information.

There were examples in which one parent complained about the social worker's decision regarding access. A birth father alleged that the social worker had failed to make an accurate assessment and that this had been detrimental to his application for a residency order. He claimed that the social worker was biased in favour of the (estranged) mother with whom the child lived. There had been a history of violence between husband and wife resulting in a court injunction against him.

There were also examples of disputes with foster parents, in which the child's perspective influenced the outcome of a decision. For example, foster parents alleged that the social worker had asked their child leading questions, resulting in false assertions about the way the foster parents had treated the child, and that these assumptions had led to the decision to remove the child. The foster parents were attempting to stop the child from biting her nails and had put stripes on her hands at night. They were also in the habit of 'patting' the child as she went to sleep. The child reported to the social worker that the foster parents had tied stripes on her hands and that she had been 'hit everywhere.' This case was independently assessed by 2 psychologists and by a more senior member of the social work team who supported the decision of the social worker.

Another example concerned a dispute over parental rights. The parents alleged that the social worker had withheld information from them, and had not carried out an adequate assessment. Their adopted child, aged 16 years, had gone into respite care following a

period of conflict with them, and then chose not to return to them. She was placed with foster parents where it was alleged she was assaulted. The employer investigation, and the HCPC investigation, found no evidence to support the allegations. There were, however, errors on the part of the Local Authority in allowing the delegated authority form to be changed by the child and her foster carers so that the adoptive parents no longer had full parental rights.

There were a small number of referrals concerning allegations of wrongful assessments of sexual abuse or failure to report sexual abuse (3). These allegations were all made within a context of residence and contact disputes. They included one in which the parents alleged that the social worker made wrongful assumptions about the sexual behaviour of friends towards their child. The employer investigated these concerns and did not uphold them, concluding that the social worker had exercised appropriate professional judgement in this context.

In another residence and contact dispute, the birthparents alleged that the foster parent had sexually abused their child. This case had been referred for a police investigation and there was no case to answer. It had also been considered by the local authority and the Ombudsman. A similar case involved allegations of sexual abuse by other family members, in which the social worker allegedly 'covered up' the abuse. This case had also been referred to the local authority and the Independent Police Complaints Commission. Neither investigation found credible evidence of the allegation.

Inadequate care or knowledge

A number of cases described incidents in which the social worker had not demonstrated adequate care, or was alleged not to have the necessary knowledge of a long-term condition to offer or obtain appropriate help. This type of referral occurred in relation to child, adult and mental health services, and most commonly concerned the provision of educational or health services, or granting access to family members for people with disabilities such as autism, dementia, Parkinson's disease, learning disabilities and cerebral palsy.

Case 13

Inadequate care for a child with disabilities

A family of a child with disabilities alleged negligence and failure on the part of five social workers to provide adequate assessment and care for their child. The family alleged that the social workers' behaviour during meetings was unacceptable, and that there had been alleged breaches of confidentiality. They had struggled to obtain support, felt that they had not been listened to and had not received appropriate services. The employer had investigated the complaint, and none of the allegations against the individual social workers were upheld. The HCPC follow up confirmed this.

Case length: 11 months
Source: Service user

A care manager in a residential setting for people with learning disabilities alleged that a social worker did not treat a resident with 'respect' and was 'unrealistic' in his expectations of what a service user with learning disabilities could do, suggesting a lack of adequate knowledge about learning disabilities. When challenged about the proposal, the social worker had allegedly replied 'I'm going to do it because I have the power to take everything away from you if you don't agree with me.' The employer investigated and 'resolved' the situation. Following this, the care manager informed the HCPC that he no longer wished to pursue the complaint.

A number of referrals concerned allegations relating to disputes over specific care packages or alleged poor care. For example one came from the parent of a young man with drug addiction, alleging that the social services had failed to provide adequate follow up care. Another came from a service user with a long history of involvement with social services who alleged that the social worker had been responsible for withdrawing prescribed medication, failing to facilitate contact with the birth family, and ignoring concerns about the foster carers.. Another came from a relative who alleged that the social worker was incompetent in caring for her elderly parent with dementia, and showed no interest in the parent's welfare. The family member had not contacted the employer, and did not respond to any requests for further information. The employer investigated and reported no concerns about the social worker's competence. A social worker self referred following a written warning from her employer, as he 'forgot' to follow up a minor injury to a child that could have been non accidental in nature. A social work assistant reported the injury. The injury was followed up and was found to be accidental.

Case 14

Alleged misconduct and competence

A service user contacted the HCPC on multiple occasions over several months to complain about a social worker assigned to provide support. The social worker had allegedly told the service user that they had 'not taken responsibility for [their] actions' and it was alleged that this had worsened the service user's mental health condition. The complainant telephoned the HCPC after being sent seven letters in five months asking for further information about the allegation. The service user informed the HCPC that they did not understand the letters and had 'no idea' what 'fitness to practise' meant. Following further explanation by the case manager, the complainant said that all they 'wanted was an explanation'. They had raised the concern with the employer, but wanted reassurance that this behaviour would not be repeated with other service users with mental health conditions. The social worker subsequently apologised for this 'one off' incident.

Case length: 6 months

Source: Service user

All of these types of referrals concerned disagreements between service users and social workers over decisions about current or future care, or the accuracy of assessments. All expressed varying degrees of anger, dismay and disappointment with the social worker(s) involved. One example was of a woman who alleged that 4 social workers had 'lied' to facilitate the removal of her five children. She was issued with a restraining order following harassment of the social work team, and had alleged online that her children had been 'stolen' from her by Children's Services, using fascist symbols to illustrate her feelings about the team. She also alleged that one member of the team had a history of drug offences and stealing.

Disputes within teams and with managers

There were also examples of referrals that concerned disputes within social work teams and with line managers. One concerned an allegation of poor conduct inside and outside work, in which the social worker had experienced ridicule at a work social event, and was not offered support by this more senior colleague in dealing with a particularly traumatic incident with a service user. Colleagues of the senior colleague were reluctant to offer their support as they were also described as 'close friends.' There were several referrals alleging that managers had 'abused positions of power', placing pressure on more junior staff to 'meet targets', had demonstrated bullying behaviour, or had not provided appropriate supervision, training or support. One example concerned a social worker who had allegedly failed to complete a safeguarding assessment and was suspended by her employer, but re-instated after investigation and signed off on sick leave. This social worker subsequently put in a grievance against her employer and alleged that her referral was a cover up for other team members. The HCPC investigation did not find sufficient documentation to evidence the concern, but did establish that the social worker did not have adequate supervision at the time and had not had safeguarding training. Another example was a social worker who self-referred after being suspended from duties following a period of sick leave. The suspension was imposed for 'lack of managerial oversight' due to lack of management skills, but there was no evidence of any impact on service users and fitness to practise as a social worker was not deemed to be impaired.

Case 15

Bullying behaviour

The complainant was a social work agency worker, who alleged bullying behaviour by the social work manager who was also alleged to have maliciously provided a poor reference. The complainant described working in an over-stretched service, where payments for overtime were not made, and out of hours visits were expected of the social workers in an environment where managers offered little support and the social worker felt alienated from the rest of the team. The complainant did not provide any further information or evidence when followed up by the HCPC.

Case length: 3 months

Source: Colleague

There was one allegation of discrimination on grounds of sexuality in the context of a re-deployment decision. An employment tribunal heard the case, which was critical of some aspects of the social worker's assessment, but the tribunal dismissed the case.

Organisational failures

There were cases that did not meet the standard of acceptance for the individual social worker, but did point to organisational failures. These included examples where agencies did not share information, and as a result services to children and families were described as inadequate. One example involved serial domestic abuse of a young child. The decision not to investigate further was taken with the social worker's line manager, but without access to relevant information from the nursery, where concerns about the family circumstances had been raised.

Case 16

Organisational failures

The complainant was the former partner of a young woman in foster care, also the father of their child. He presented a detailed history of problems with her foster care arrangements and with arrangements for contact with his son. The social worker named in this referral was not involved at the time that concerns were raised. The investigation did find evidence of non-disclosure of information to the complainant. This was not a fitness to practise issue, but an organisational one.

Case length: 4 months

Source: Service user

Complaints from Students

A small number of referrals (4) were from students who complained about the inappropriate behaviour of university staff and social workers responsible for them whilst on placement. One described how they had been asked to attend a meeting with no briefing or preparation and, as a result, felt unprofessional and inadequate. The student subsequently failed the placement and did not complete the programme. Another concerned alleged bullying by a member of staff, and two alleged evidence of drug abuse by a member of staff. These examples had been previously investigated at a local level.

ICP: Social workers

In-depth analysis of 28 cases revealed a typology which did fall into conduct and behaviour and competence and performance. The numbers were evenly split between alleged conduct and behaviour issues (14) and competence and performance issues (14). There was also a much higher incidence of one-off occurrences than in the final hearings cohort.

Competence and performance

1. Inaccurate assessment/reporting (10)
2. Inadequate care (2)
3. Administrative failings (2)

Competence and performance issues predominantly concerned inaccurate or incomplete assessment and recording (the social worker did not accurately record a home visit and the circumstances of the child, did not make contact with a parent not living with the child when the child's circumstances changed and did not conduct a full assessment of a child's wishes in relation to a future placement). The majority of these were one off incidents.

There were a small number of instances where the registrant allegedly did not provide adequate care, for example, did not undertake a same day visit to an alleged rape victim, did not recognise urgency in relation to a child's medical condition, did not report a suspected drug overdose. These were all reported as one off incidents.

The majority of these social workers engaged fully with the investigation, and they and their employer provided evidence of steps taken to remediate (for example, peer supervision, studying, good record keeping) and an expression of regret that the incident had occurred. There were a small number of examples where the social worker had experienced long term illness during the period in which the incident(s) took place, were suffering from anxiety and depression, or had made it clear to their manager that the incident had been related to workload pressures. For example, the social worker who had failed to make contact with a parent when the child's circumstances changed acknowledged that this should have been done, but workload pressures had meant that this had been overlooked.

Once the oversight was recognised, the social worker did make several attempts to contact the parent and apologised.

There was only one example of a serial complainant in this sample who had made complaints about other social workers over a period of time. This parent complained that the social workers had failed to make an accurate assessment of the family circumstances.

There were two cases of administrative failings, both of which implicated the wider service and were not deemed by the ICP to be attributable to the individual concerned. One such case concerned an alleged failure to inform family members of a change in circumstances in relation to a child, together with a failure to provide feedback on the outcome of an assessment. This was viewed as an organisational failure, rather than as an individual responsibility.

Case 17

Administrative failings

This was a self-referral by an experienced social worker who had concerns about the timescales for processing domestic abuse notifications. This social worker had delayed inputting 'medium and standard risk' notifications in order to make decisions regarding the contacts that were already logged before more contact details were added. This was to prevent numbers of contacts remaining on the system overnight without any action having been taken. This had the effect of reducing the number of contacts deemed to be incomplete whilst outside the target timescale for completion. This practise was implemented under direction of the team manager. The social worker was investigated, acknowledged and expressed regret over these the actions, as well as the fact that although this had not led to any harm to the children there was 'potential harm' from this practice. It was described as an 'error of judgement' and a 'flawed system' which had occurred during a period of 'extreme' workload pressure. The ICP concluded that there was no case to answer.

Case length: 12 months

Source: Self referral

The 14 cases relating to conduct included:

1. Registration issue (1)
2. Breaches of confidentiality (3)
3. Interpersonal/communication issues (9)
4. Dishonesty (1)

The registration issue concerned a social worker who had been continuing to practise without registration. The individual admitted wrongdoing and it was clear there was no intention to avoid registration, and took steps immediately to rectify this. Breaches of confidentiality cases included a referral by an employer who alleged that a social worker had left a work laptop open at the family home. Another social worker visited the home and found the laptop. This social worker was investigating safeguarding issues in relation to her ex-partner and father of her children. This breach followed a prior written warning for accessing information on the safeguarding investigation.

The final example concerned an allegation that a social worker had shared a report containing sensitive information with service users. In this example, there was evidence of dysfunctional relationships between the social worker and management and within the team. The social worker and management did not agree that the report was a management report and that the information was not to be shared. They also disagreed on other actions in relation to this service user, for example whether it was appropriate to visit them out of normal working hours. The social worker argued that, in adoption cases, there were circumstances in which visits outside working hours were appropriate.

Evidence of conflict with service users was also apparent in some of the referrals categorised under interpersonal/communication issues. For example, in one such referral, the service user alleged that the social worker had been rude and dismissive towards them in a case conference. From the description of the events, the meeting was highly charged and the service user and social worker had disagreed on a number of other occasions as well as during this meeting. The social worker's response revealed that, with hindsight, they 'would not act in the same way should a similar situation arise' and had undertaken further training in relation to this incident. In another referral, the service user alleged that the social worker had failed to take notes during a meeting and subsequently informed the family that notes had in fact been taken. There were also examples of disputes between managers and social workers, resulting in a referral to the HCPC. In one such case, it was alleged that the social worker had falsified assessment activities on the electronic record system. The social worker's response included reference to a lack of support by the manager, who allegedly encouraged this activity in order to prevent the service from breaching the 28-day waiting time targets for routine assessments.

There were a number of referrals relating to alleged use of alcohol during working hours (allegations that the social worker smelled of alcohol) and a drink driving conviction outside work, described as a one off incident. There was one incident of alleged financial wrongdoing. This was not upheld – it concerned a commercial arrangement between a service user and a social worker for a report which was subsequently not required by the service user, who then asked for a refund. There was insufficient evidence to identify what the agreement was.

Case 18

Dishonesty

An employer made a referral about a social worker for alleged dishonest behaviour in relation to record keeping. It was alleged that the social worker had falsified assessment activity on electronic records, duplicating previous assessments as 'new'. The authority investigated the allegations. The social worker reported that they had been let down by their line manager, and had been 'encouraged to create inaccurate records' by the manager in order to meet targets. In addition to these activities, the social worker had been encouraged to use telephone assessments in order to 'stop the clock' on the 28 day waiting time target for routine assessments, in order to prevent a breach of the waiting time target. The authority upheld the allegations and recommended dismissal but the social worker had resigned before the dismissal was implemented. The line manager was investigated by another regulator, but retired before the outcome.

Case length: 5 months

Source: Employer

Although the sample was too small to draw any conclusions, the age profile for the majority of cases was the 40-60 years group. There were no cases in this category of referrals of social workers under 30 years, compared with 13% in the Initial Stage.

Social Workers: Final Hearings Stage

The in-depth analysis of 31 cases brought before HCPC panels in the two-year period found two broad typologies: conduct and behaviour (12), competence and performance (18) and health (1). Within these two, there were clear sub-types (see Figure 4 below).

Figure 4 Social workers - typology of final hearings
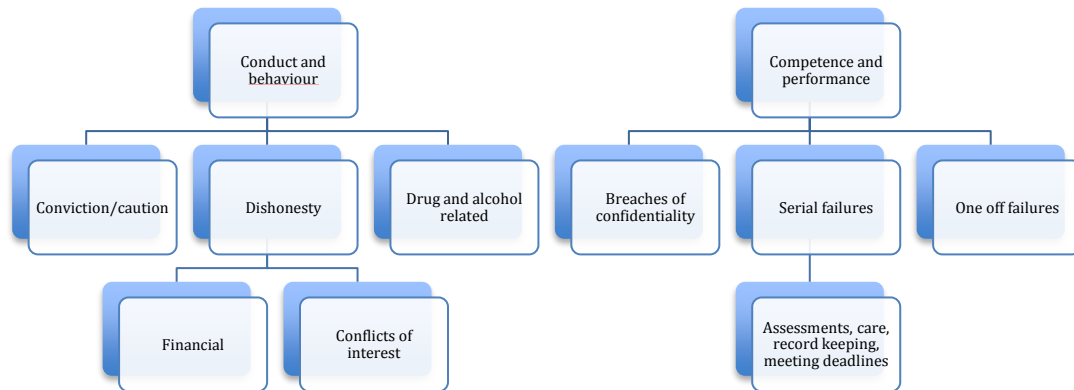
Convictions and cautions related to behaviour outside the work environment, and included common assault, generating indecent images of children and racist behaviour towards the police.

Table 46 Breakdown of sanctions at final hearings stage

Sanction	Number of cases in FH
Struck Off	9
Disposal by Consent	0
Suspended for 12 months	9*
Conditions of Practice for 6 months	4**
Caution Order	6***
Not well founded	3

* 4 suspensions were later struck off

** 1 conditions of practice order was later struck off

*** Caution orders can remain on the register for different lengths of time

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Case 19

Conduct and Behaviour- Conviction/Caution

Following a disciplinary hearing the social worker was summarily dismissed from employment and referred by their employer to the HCPC, who issued an interim order. The social worker had been cautioned and required to sign on to the Sex Offenders Register for two years as a result of police discovering downloaded indecent images of young boys on the social worker's home computer. Given the social worker was involved in the safeguarding of children, the Panel took the view that such conduct was incompatible with the role. Although the social worker admitted downloading the images the Panel were concerned that neither remorse nor insight was apparent and no professional help had been sought. Given the concern about the past and the potential for future harm the social worker was struck off the register.

Case length: 11 months

Source of referral: Employer

Cases concerning dishonesty were wide ranging and related to instances of financial fraud, including fraudulent claims for expenses to mishandling of funds in a foster care setting.

Case 20

Conduct and Behaviour - Dishonesty

Following dismissal from employment, the social worker was referred to the HCPC by their employer. The social worker had engaged in a relatively sophisticated course of conduct, claiming mileage whilst on sick leave and then claiming excessive mileage upon return to work. The social worker then copied claim forms for a series of months and entered inaccurate postcodes and data of clients on claim forms. Having been discovered, suspended and later dismissed, the social worker submitted to the HCPC that they were no longer working as a social worker even though they had secured alternate work. In their reasoning, the Panel indicated that the social worker, who was absent, had been under a substantial degree of personal and domestic pressure but this had not impacted on their professional practice. There was evidence of regret and remorse, but given the breach of trust and pattern of dishonest behaviour with little prospect of remediation the Panel decided to strike the social worker's name from the Register.

Case length: 14 months

Source of referral: Employer

There were several cases concerning boundaries which were often linked to conflicts of interest. These included a failure to declare a personal commercial interest when referring a service user to another provider, applying to foster a child on the social worker's own caseload or having a relationship with the parent of a child assessed during a previous investigation. There was also a case of inappropriate discussion of sexual matters in a childcare setting.

> **Case 21**
>
> **Conduct and Behaviour – Boundary Issues**
>
> The social worker was referred to the HCPC by their employer. The social worker had not maintained professional boundaries in that they had formed an inappropriate relationship with the father of a child who had previously been assessed by the social worker. There were ancillary matters concerning accurate assessment and the securing of receipts for items purchased but the relationship was the focus of the case. The social worker, now pregnant by the father of the child who had been assessed by the social worker, had started a relationship six months after the child's case had been closed. Although there was no evidence that the relationship had started prior to the child's case being closed the Panel found that the social worker had formed an inappropriate relationship with a service user. It was considered that there had been insufficient distance between the closing of the case and the relationship being formed and although highly regarded as a social worker the Panel felt the misconduct could impact on confidence in the social worker and the profession. There was also insufficient evidence for the Panel to conclude that there was no risk of repetition here due to a lack of conclusive insight on the part of the social worker. The Panel therefore decided to suspend the social worker for 12 months.
>
> Case length: 2 years
>
> Source of referral: Employer

In the sample there were limited instances of drug and alcohol related cases. One such case saw the social worker develop an ailment, which was alleviated by alcohol. The social worker was dismissed for smelling of alcohol at work but the case was not judged to be well founded by the Panel.

Competence and performance cases included serial examples of failure to keep adequate records, to undertake appropriate assessments, manage deadlines, use IT systems, follow up on risk assessments, and follow safeguarding and other protocols, some of which put service users at risk and demonstrated serial instances of inadequate care and administrative failings.

Case 22

Competence and performance - Serial instances of inadequate care and administrative failings

The social worker was referred to the HCPC by their employer. This complex case involved three social workers who worked in child protection. Serious concerns were raised as to the social worker's practice over a two year period in relation to three specific child care cases where a child was put at risk of harm because child protection procedures were not initiated in a timely manner, an allegation of sexual abuse against another child was not investigated and care proceedings were not initiated for another child who had been referred with possible non-accidental injury. Due to the serious nature of the repeated failings in this case and a general lack of information (the social worker was not present but was available by phone) as to insight and remediation, the Panel decided that it could not be sure as to the risk of repetition or to the public. Following the Panel making a 12 month suspension order, the social worker requested voluntary removal by way of a Voluntary Removal Agreement and this was granted. The social worker's name was removed from the HCPC register.

Case length: 2 years

Source of referral: Employer

Case 23

Competence and performance - Serial instances of failure to provide adequate assessments and keep adequate records

The social worker was referred to the HCPC by their employer. Following a case audit it came to light that serial instances of failure to provide adequate assessments and keep adequate records had taken place over a year of practice in 4 separate cases involving at least 10 children. A wide range of failings included multiple failures to conduct statutory visits in accordance with child protection plans, a tendency not to see children alone and a failure to provide adequate records of home visits undertaken. It was also alleged that the social worker's line manager was not kept appraised of cases during supervision and the social worker failed to follow direct management instructions or conduct group meetings and respond to concerns raised by third parties with regards to child protection. In a complex case the Panel confirmed that such wide-ranging failings placed

children at risk of harm. The Panel heard evidence of physical disabilities on the part of the social worker, which explained their reluctance to conduct home visits given the access impediments apparent. However, the Panel took the view that these disabilities did not prevent the social worker from doing the job but would have made it more difficult. Reference was made to a 'blame culture' within the department by the social worker but the Panel confirmed the social worker's caseload was neither unduly large nor complex. Given the social worker's experience, lack of insight and lack of remediation, the Panel struck the social worker's name off the Register.

Case length: 18 months

Source of referral: Employer

Breaches of confidentiality included accessing records and sharing information on family members without authorisation and coercing service users into sending positive feedback during an internal complaints investigation. A small number of these were conflated by attempts to cover up or deny responsibility for any performance errors or omissions. There was only one case amongst those relating to competence and performance where the panel considered evidence in relation to a one off incident; all others were cases where there was evidence of multiple occurrences.

Case 24

Breaches of confidentiality - disclosure of confidential information and soliciting of compliments

The social worker was referred to the HCPC by their employer. In a wide ranging case, the social worker had failed to maintain professional boundaries by purporting to provide legal advice to a service user and to criticise another service user by email and voicemail. The social worker also disclosed confidential information about one service user to another and then solicited compliments from one service user by asking them to write a letter to the social worker's manager praising their practice. Finally the social worker attempted to conceal these communications with the service user. The Panel concluded that although the social worker was suitably contrite and clearly desired to act in the child's best interest, the breach of trust had caused a three-month delay in the resolution of Family Court proceedings, which would have been of no benefit to any of the parties. Consequently the Panel imposed a Caution Order for a period of three years.

Case length: 15 months

Source of referral: Employer

There was only one instance of a health related case, and the hearing was held in private. The social worker was suspended from practice for 12 months and subsequent suspensions due to an inability to work mean the social worker is still suspended from practice.

Conclusions from the case analysis

The case analysis explored the nature of complaints about paramedics and social workers in England by examining a random sample of 284 cases from a two year period, giving a detailed description of the characteristics and circumstances associated with the cases. At a descriptive level, the case analysis identified a higher number of older, male practitioners in the sample relative to their numbers on the Register. In the paramedic sample, the majority were employed in the NHS and worked in acute settings. There were some variations in rates of referral across the UK. The sample reflected the pattern of a high number of self-referrals from paramedics across all three stages of the investigative process. In the social work sample, the majority were employed by local authorities and worked in children's services. A high number of referrals about social workers were from members of the public. In the social work sample, there were few cases where any previous incident had been reported.

Very few of the cases examined in both professions were characterised by deliberate acts of malice or incompetence. There was not a disproportionate number of complaints that led to final hearings in which a judgement of impairment was made and/or sanctions were imposed. Instead we identified a disproportionate number of referrals that did not meet the threshold for further investigation. The majority of these emerged from circumstances in which the individuals concerned were working in complex, ambiguous, highly pressurised environments, often distant from or feeling unsupported by their managers and confronted with patient and service user frustrations with wider service delivery failures during a time of social and political turmoil.

Chapter 5 Discussion

This study set out to understand why there is a disproportionate number of referrals about paramedics and social workers in England than might be expected from their numbers on the HCPC Register, and secondly to explore what actions might be taken to prevent referrals from arising in the future. This section offers an interpretation of the findings, followed by recommendations and suggestions for future research.

The mixed methods approach generated a high level of agreement, both on the reasons behind referrals and the possible preventive actions that might be taken. A Delphi exercise, interviews, focus groups and case analyses were consistent in their findings on the possible impact of the complex and demanding nature of paramedic and social work practice. There were similarities in terms of the perceptions of changing public expectations, reports of significant increase in service demand, day-to-day ambiguity in evolving professional roles, as well as organisational changes, targets and administrative burdens, all of which surfaced in the literature review as well.

The following sections provide an interpretation of the findings, first addressing the issues surrounding the number of complaints, secondly addressing the nature of complaints and finally discussing what steps might be taken to prevent referrals in the future. Recommendations for future action are included in relevant sections and summarised at the end.

Understanding the number of complaints

The Health and Care and Professions Council (HCPC) identified these professions because the published data showed that they were consistently over-represented in referrals. The proportion of cases for both professions was much higher than the average across all 16 HCPC regulated professions, and also much higher than the proportion of these professions on the register. In 2015, when the study was commissioned, paramedics made up 6% of the register and 11% of all cases referred, and social workers in England made up 27% of the register and 58% of all cases referred (HCPC Fitness to Practise Annual Report, 2015). More recent data reflects this pattern (HCPC Fitness to Practise Annual Report, 2016), although this is showing signs of levelling off.

The literature review concluded that there is currently a weak evidence base on the prevalence of complaints about these two professions, at least across the jurisdictions included in this study. From the data available, we do know that the rate of referral about these professions still remains lower than that of some other health professions such as dentists and doctors, but higher than others, such as physiotherapists, nurses and midwives (Spitall et al, 2016, CESG, 2016). Moreover, this study has not found comparable data from other jurisdictions which might suggest that concerns about these

professions are more prevalent in the UK than in other countries (Risavi et al., 2013, Colwell et al., 2003, Boland-Prom 2009, Strom-Gottfried, 2000, Daley and Doughty 2006).

It may not be possible, therefore, to fully address the first question regarding why there is a disproportionate number of fitness to practise concerns raised about these two professions without further research involving other health and care professions. However, the findings do offer some answers to the questions about why there is a significant number of referrals relating to social workers and paramedics and what might explain the nature of these referrals.

Understanding the nature of complaints

In the discussion that follows, we explore the findings from the case analysis, highlight key themes from the Delphi exercise, interviews and focus groups and discuss these in relation to what is known about complaints in existing literature.

The case analysis examined a sample of 284 complaints, the first study of its kind to look in detail at cases selected from all three stages of the HCPC's investigative process. No previous research, as far as we know, has had the opportunity to undertake such an analysis. There appeared to be a high number of 'one off' incidents of alleged failures to meet standards, and few cases that resulted in actual harm to patients or service users. This suggests that the disproportionality lies less in proven cases of impairment and more in the number of referrals that do not meet the HCPC's standard of acceptance for an allegation. We explored the patterns in the cases in some detail. From this, we propose a theoretical model that draws on the work of Malcolm Sparrow (2008), a continuum of impact from potential to actual impairment, as a way to frame our understanding of complaints and how they might arise.

In conjunction with this, the study identified four themes relating to the possible reasons behind complaints: public and societal expectations, challenging work practices, pressurised work environments, and the evolving nature of the two professions (see Table 47 below). These provide further illumination to the model we propose.

Table 47 Summary of common themes emerging from the study

Theme	Literature review	Delphi	Interviews and focus groups	Case analysis
Public/societal expectations	✓	✓	✓	✓

Challenging practice	✓	✓	✓	✓
Pressurised work environments	✓	✓	✓	✓
Evolving profession	✓	☒	✓	✓

The following sections will start with some interpretations on the nature of complaints drawn from the case data, continue with a discussion of the four themes summarised in Table 47 above, concluding with an account of the model we are proposing.

Characteristics of the cases referred

The reasons for referrals and the nature of the complaints were examined through the lens of the case analysis. The majority of cases in the sample were a mix of conduct and competence related issues (38% for paramedics and 44% for social workers), reflecting the complexity of the circumstances that often surrounded the referral. 45% of referrals about social workers related to conduct alone, compared with 31% in the paramedic sample. 10% of paramedic referrals were related to a conviction or caution, compared with 3% in the social work sample. There were also differences between the two samples in the proportion of referrals that related to competence alone – 6% of social workers compared with 20% of paramedics. Less than 1% of cases across both samples were health related, and there was no evidence of higher levels of boundary violations, drug or alcohol related referrals in either samples, as might have been predicted from previous studies (Sterud et al, 2011, Studnek et al., 2010, Beer, 2016, Strom-Gottfried, 2000, Boland Prom, 2009, GSCC, 2012). At a more granular level, 17 typologies were identified in the paramedic sample, and 25 in the social work sample. Of particular significance was the absence of a particular distinction in typology across the three stages of investigation. The typologies were peppered across all three. The variation across the stages was more evident in relation to frequency of occurrence of poor practice over time and 'severity' or 'harm' measures. There were no clear cut distinctions in typology, more a pattern of increasing complexity of factors and frequency of occurrence of error or breach of standards.

There were several exceptions to this. For example, in the paramedic cases, alleged failures to fulfil work duties and conflicts with colleagues were more common at the first two stages, than in the final hearing dataset. Allegations from members of the public that social workers had 'victimised' families occurred at the first two stages only. In the final hearing cases, the nature of the alleged misconduct tended to focus on conduct extraneous to professional competence (in the case of convictions) or misconduct on the

basis of professional competence. For example, in the final hearing cases, there were more examples of registrants who appeared to struggle to fulfil work duties due to personal health issues or technological advances in the recording and monitoring of assessments than occurred in the cases at the first two stages of investigation.

There were some clear patterns in the characteristics of referrals across both professions. Older practitioners and men were over represented. This concurs with existing studies of referrals relating to fitness to practise across different jurisdictions and various health and social work professions (for example, Frith-Cozens, 2008, Bismark et. al, 2015, Studdert et. al, 2016, GSCC, 2012). The older age of the paramedics suggests that there might be a higher number of Trust-trained professionals versus university-trained professionals in the sample, but this is inconclusive as we were unable to obtain data on type of qualification for 56% of the sample of paramedics. Data on route to qualification was also not available for the social work sample as these data were not transferred from the GSCC when the HCPC Register for social workers in England was established in 2012. There was no evidence that practitioners who qualified outside the UK were over-represented, in fact there were no paramedics in the sample who trained outside the UK and only 1% in the social work sample was identified in the database as overseas qualified.

In terms of the location in which the alleged incident took place, the majority of paramedic cases related to the acute sector (67%), and the majority of social work cases related to children's services (69%). There was no evidence that practitioners working in rural locations (assumed to be more isolated, less managed, for example see Daley and Doughty, 2006) generate higher numbers of referrals, although more information on the numbers registered in these locations would be required before any conclusions could be drawn on this. There were regional variations, for example, a higher than expected (relative to population) rate of referrals about paramedics from Northern Ireland, but the sample size was too small to draw conclusions.

The study also looked at a number of other characteristics in the referrals including registrants' engagement at work and engagement in the fitness to practise process. It was not possible to draw conclusions on engagement at work, as this information was missing in 46% of paramedic cases and 75% of social work cases. Engagement in the fitness to practise process, where relevant, appeared to be higher for paramedics (75%) than for social workers (48%). From the evidence gathered, it was not possible to determine whether or not there was a pattern of previous incidents, as found in a study of 66,000 claims against 54,000 doctors in the US (Studdert et. al, 2016), where incidents of previous claims were predictors of second or even third claims, and 32% of all claims in the sample were attributed to 1% of doctors. In this study 97% of the sample of social work cases found no previous history of complaints at local level, bearing in mind that social workers have only been regulated by HCPC since August 2012. In the paramedic sample, there were higher numbers with previous reported complaints at the local level; 17% with previous history compared with 58% who had not. Unfortunately, in 25% of the cases it was not possible to obtain data on this. An analysis of local complaints and reports of

serious incidents would be provide greater understanding of this relationship (Cawley, 2017).

The next section provides further interpretation of the findings under the four common themes; public and societal expectations, challenging practice, pressurised work environments and evolving professions, all of which emerged from multiple sources in the study.

Public and societal expectations

The Delphi exercise, interviews and focus groups all identified changes in public and societal expectations of health and care professionals as a possible explanation for the increasing number of complaints. This was also referred to in a number of sources in the literature review for both professions. HCPC's Fitness to Practise annual reports, reports from other professional regulators and other sources have reported a continuing rise in complaints to the regulators from the public (CESG, 2014, 2016, NISCC 2015, Archer et. al, 2015). The HCPC has also consistently reported a higher number of referrals about social workers from the public compared with other HCPC registered professions (HCPC, 2013, 2014, 2015). In 2014/15 this was 70% compared with 45% across all HCPC regulated professions.

The case analysis in our study also found that there was a particularly high percentage of referrals from the public (56%) about social workers. Of these, 122 (94%) did not meet the standard of acceptance, and a further seven (5%) received a finding of no case to answer at the investigating stage. Only one referral in this sample from a member of the public reached the final hearing stage, and this resulted in the social worker being struck off. This pattern of a high number of referrals and a low number reaching a final hearing or sanction reflects trends in the HCPC Fitness to Practise Annual Reports as well in the professional press and literature (Community Care 2017, Meyal et al, 2016).

Our analysis of this dataset suggests that the number of social work referrals that led to a judgement of impairment is not disproportionately high. However the proportion of referrals from the public that do not meet the threshold for acceptance of an allegation is relatively high. Further analysis of the cases suggests that there is a clear sub-category within these referrals that relates to disputes with families over residence and child contact (where a member of the family, or foster parent disagrees with the decision about where a child will live, and how much time they will spend with a parent). 58% of all referrals about children's social workers that did not meet the standard of acceptance were related to decisions of this nature. The majority of referrals relating to residence and contact disputes demonstrated a good knowledge of the system on the part of complainants and by implication the role of the social worker within it. These referrals related to disagreements over the outcome of decisions taken by the authorities and a desire to see the decisions reversed, rather than any apparent misunderstandings of the role of social workers.

For some users of services, particularly those who disagree with the decisions made about them, social workers are viewed as 'the enemy,' an advocate of the state (Jessen 2010). This is likely to be exacerbated by the negative image of social workers in the press (Leigh 2014, Warner 2013) and political and organisational pressures which have diminished their advocacy role (Bradley et al. 2010, Liljegren, 2012). In the interviews and focus groups, participants felt that social work complaints from service users or families often emerged from a feeling that all other avenues had been exhausted and there was still a need for redress. Service users who feel they have not been listened to locally, whose complaint has already been investigated at a local level and has not been upheld, may feel a need to 'fight back' against 'the state'. There were certainly cases that reflected this. Complaints were frequently about both conduct (the social worker was allegedly 'rude, aggressive, unprofessional') and competence (the social worker allegedly did not understand all the circumstances, or did not adequately assess the family context, did not keep accurate records of meetings'). Many were about more than one social worker, all of whom were described in similar ways.

The evidence suggests a relatively widespread and continuing lack of shared understanding about what referral to the regulator means, what impaired fitness to practise means, and when to refer. This reflects the findings from previous studies of public understanding of complaints handling across the UK (for example, Crerar Review, 2007, Gulland, 2009, Ipsos Mori, 2010). Similarly, the theme of awareness raising and education as an important method of prevention emerged through the Delphi exercise, interviews and focus groups. One such method which regulators might utilise to prevent complaints in the future is through nudge or behavioural insights methodologies (Thaler and Sustein, 2009, Hallsworth et al, 2016). These approaches are based on the premise that our decisions are often heavily influenced by habit, context and environment. Taking these into consideration when providing information or designing services has been shown to make a positive difference to health outcomes (Hallsworth et al., 2016). Meleyal suggests this as a methodology for more proactive engagement in conduct issues with social workers (Meleyal, 2017). A full case example is provided in the Appendix but in essence this approach could be used to refine the current guidance on the HCPC website for making a complaint, in order to improve understanding of the purpose of the fitness to practise process as well as signposting other options (see Appendix 1). Further consideration of ways in which regulators and employers can improve communication and awareness raising in this area, possibly using lessons from behavioural insights theories (Hallsworth et al, 2016) is therefore recommended.

Recommendation 1: **Engage further with the public to raise awareness of appropriate avenues for complaint and support**

Consider enhancements to the website and other signposting for the public on the criteria for making complaints to the regulator with reference to nudge theory (see Appendix 1 for specific examples of how this might be achieved).

Both social work and paramedic practice is front-facing with the public and involves challenging work. Paramedics are often dealing with people in crisis and peril – as recently witnessed in the 2017 terrorist attacks in the UK (Allen and Henderson, 2017) - and social workers often work with service users facing challenging life circumstances in a system with ever diminishing resources and ever increasing managerialism (Stewart, 2013).

The interviews and focus groups confirmed that both social workers and paramedics have a high profile in the media, are felt to be in the spotlight and are regularly and roundly criticised. Furthermore, when there are breaches of trust in these roles, they are reported as big news by the media. This is especially the case in social work cases involving children. Literature confirms that these news items have further modelled an existing discourse around health and social care which raises public anxieties about caring practices (Hutchison 2016). Conversely, media coverage which offers documentary insights into the complex working lives of social workers and health professionals can have a positive impact on public perceptions, for example, the BBC documentary about social workers (BBC, 2015) and the documentary series 'Hospital' filmed in the Emergency Department at St Marys hospital in London (BBC, 2017). The screening of 'Hospital' (Series 2) reportedly led to an 80% reduction in complaints to the Trust about St Marys hospital.

The interview and focus group data also suggest that paramedics are struggling to meet public expectations. This may be connected to public confusion about their role and remit. Paramedics often have 'hero' status, but this is aligned with an emergency model of care, which is no longer the only model through which paramedics deliver care. The interviews suggested that public perceptions have not caught up with changes in the role of the ambulance service – from a service that always takes patients to hospital, to a model of care which seeks to offer alternatives at home or in the community, away from A&E (O'Hara 2015) in order to improve outcomes for patients and reduce the negative impact of unwarranted hospitalisation. Coupled with this are gaps or uncertainties about the role and remit of other NHS provision that can leaving people feeling exposed and turning to an emergency ambulance for help. (Booker 2014, McCarvill 2017).

Public perceptions of social work are equally complex. Participants suggested that the role is often misunderstood and that service users have unrealistic expectations about what social workers can do. This is confirmed by literature suggesting the diminished status of social workers and an over expectation regarding what social workers can actually deliver for users of services (Penhale and Young, 2015). In some cases, the remit of the role is also misunderstood, for example, members of the public thinking that social workers do menial tasks and household chores (Ferguson 2017). Participants felt that complaints relating to social workers often emerged from service users or families feeling they had tried every other avenue (for example the local authority and ombudsman) but were still seeking redress.

Challenging practice

Another possible explanation from the focus groups and interviews for the higher number of complaints emerged from the narrative on the challenging day-to-day practice faced by both professions. Social workers and paramedics are often dealing with people in crisis, 'on the edge' as one social worker focus group participant put it. For paramedics, dialing 999 is often a last resort, and social workers are frequently engaging with individuals and families who are experiencing the impact of disadvantage and social exclusion. In environments of crisis and stress, ambivalence or fear about interventions can often arise. Paramedics and social workers both enter people's houses – on one hand offering care but on the other, taking control in ways which might not be expected or wanted. In addition, and in common with other emergency health and care services, these professionals are increasingly working with people with a wide range of conditions, such as mental health conditions, drug and alcohol related conditions, family conflicts and frail elderly people with multiple, complex health conditions. A BBC documentary on the work of emergency services in London provides a graphic illustration of this change (BBC 2016), and it has also been described in the literature (McCann et al 2005). These shifts in the patient profile mean that paramedics are now attending fewer patients with life threatening conditions and more patients with complex long term conditions. A number of studies suggest that the typical ratio of callouts for life threatening conditions versus non-life threatening conditions is 10:90 (Devenish, 2014). Many of those interviewed observed that older paramedics in particular had been trained primarily for this type of emergency work, and were likely to be under-utilising this skill set, and perhaps less prepared to deal with the wider range of people with long term health conditions that have become part of a routine shift.

The interviews with social workers also repeatedly highlighted the complex and unpredictable nature of everyday work highlighted in the literature (Summerson Carr, 2015, Ellis, 2011, Doel et al, 2010). Participants in the interviews and focus groups suggested that it was the complexity of relationships with service users which made this practice unusual. Previous literature has identified these relationships as particularly 'distinctive' for being 'grounded in working in partnership with service users wherever possible'; it is these collaborative relationships that help to define the social work professional role (Allen, 2014). However, the data in our study suggest that the heaviness of caseloads meant social workers were overloaded and limited in developing such collaborative relationships with often vulnerable or disadvantaged people. Relationships were also said to be disrupted by frequent use of agency workers, reflecting workforce reductions and diminishing resources.

The challenging practice identified here is confirmed by other literature showing that social work is an occupation with a high risk of stress and burnout (Moriarty et al., 2015, Beer, 2016). As mentioned earlier, the literature on paramedics also reflects the notion of a

profession under pressure (McCann et al., 2015). The number of paramedics on stress-related leave and the amount of time taken away from frontline practice has increased in the recent years (NHS Employers, 2014) which is a pattern reflected in research with other health professions too (Lemaire and Wallace, 2017).

A culture of 'fear and conflict'

A sub-theme of 'challenging practice' in the paramedic interviews and focus groups identified a culture of 'fear and conflict'. Participants frequently described paramedics who felt unsupported and fearful of their employers. This has the potential to provide fertile ground for complaints in different ways. A 'head-down get on with it' culture means paramedics might hide or cover up mistakes. Secondly, some might react to this fear by over-reporting themselves. Third, colleagues will report each other either due to historical precedent of doing so, or in order to manage disputes.

Indeed, some participants observed that paramedics worked for ambulance services where discipline was a marker of successful management. As a consequence, discipline via self-reporting might be embedded as a first reaction, rather than one which is considered, evaluated and then actioned. There was a consensus in the interviews and professional focus group that paramedics are encouraged by employers and unions to self-refer. This creates 'dichotomies' in working practice, between the autonomy of practice and employers' disciplinary, target-driven emphasis (Cooper, 2005, McCann et al 2013). A similar picture emerged from the interviews and focus groups with social workers and service users, where social workers were described as being pulled in all directions, or as Stewart describes, pulled between the dichotomies of organisational rules and professional discretion in their work (Stewart, 2013), as well as the culture of managerial control. These dichotomies of practice and the complexity of the work may offer further reasons behind the potential for complaints to arise.

Pressurised work environments

Another common theme across cases that did not reach the standard of acceptance or case to answer thresholds was evidence of poor management and support in highly demanding work environments. In the interviews, participants referred to ways in which the paramedics were experiencing unprecedented demand and multiple changes to service delivery, for example, the continuing rise in hospital emergency admissions overall, and a rise in the number of alcohol related conditions. These accounts reflect reports from across the UK in recent years. For example, data from the Nuffield Trust shows hospital admissions in England rose 2.8% to 4.3 million in 2015/16 (Nuffield, 2017). NHS Digital reports alcohol related admissions in England and Wales have risen 22% since 2006 (NHS Digital, 2017).

Along with increasing demand is a prevailing focus on measuring effectiveness primarily in terms of speed of response (Bevan and Hood 2006; Newdick 2014, HSJ, 2017). This has

meant changes in the way the service is delivered and prioritised. With not enough staff and a higher volume of calls, interview and focus group participants suggested that delivering a quick response was often difficult, and could become a cause for complaints before any individual factors were involved.

McCann et al in the UK (2015) and van der Ploeg and Kleber (2003) in the Netherlands also refer to this relationship between professional disconnect, poor supervision and unrealistic targets, all of which contribute to poorly performing practitioners and eventual burnout. Similarly, Bigham et al's study of under-reporting in pre-hospital services suggests that not enough was being done to encourage a culture of open reporting and learning from errors, where acknowledging that errors are rarely attributable to one individual is the norm rather than the exception (Bigham et al., 2012). The literature as well as the interview and focus group findings relay the notion of a profession under pressure. The number of paramedics on stress-related leave and the amount of time taken has increased in the recent years (NHS Employers, 2014, Campbell, 2017), as have reports of a higher than average incidence of bullying behaviours within ambulance services (Lewis, 2017).

With regard to social work, it would be interesting to determine whether referrals in the sample came from local authorities with poor Ofsted reports, or indeed poorly performing trusts or health boards. 70% of children's services in England subject to an inspection were deemed not to have met Ofsted standards (not including the 20 Local Authorities which received no ratings) (DfE 2016). Social workers participating in the interviews described how services felt pressured by squeezed budgets and a lack of resources as well as a lack of support staff. Some literature suggests that regulation might also increase the risk of individual social workers being held accountable for systemic or organisational failings (Leigh, 2013). Indeed, literature on ethical climate and culture supports the notion that organisational environment 'plays a critical role in encouraging or discouraging ethical acts' (Mayer 2014). Social workers – like paramedics - need support to deal with this pressurised environment, as the fear of exposure or making a mistake under pressure and scrutiny can affect practice and judgement (Garboden, 2010), akin to a form of regulatory iatrogensis (Illich, 1976) .

The box below gives an example taken from the case analysis of a social worker referred for poor performance who had been disciplined by the employer for undertaking too many assessments by phone, falsifying assessments in the electronic record system and duplicating previous assessments by clinicians. The ICP found no case to answer.

Case example 25 Referral for poor performance

From the social worker who was referred;

'I noticed that people were very stressed. I didn't feel we were getting the right support. You would send emails and not get answers from people which was really hard. When I was going on holiday and I used to dread it because of what

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I would come back to. I needed an answer to a particular question and went to my manager but never got any answers which made it harder for me. I sent a big email saying I was going on holiday and needed something sorted out but just never got an answer. That's why I left in the end, because everybody was just so despondent. It just wasn't a happy place to work.'

Written statement from a colleague of the social worker:

'A is a very caring, warm individual, and my only criticism is that [they see] 'the good in everyone', and would not be able to detect a manager who was targeting [them] as [they] had no reason to mistrust them. [The manager] used [their] power and authority to manipulate L, especially as [they were] … not always feeling well, it was a total case of 'imbalance of power'.

A is not malicious, [they are] an 'open book' and would not intentionally hurt anyone moreover, place [their] service users at risk. In fact, when A left to go on … leave, several of [their] clients relapsed. The two previous managers references speak volumes and underpin the teams view that A did not place service users at risk intentionally, only carried out tasks as requested by the Manager at the time. Staff witnessed A attempting on many occasions to try and bring forward service users appointments when they were too far away….

…'The employer's investigation concluded that neither of the social work teams were managed and this led to staff with high stress levels and going off sick. A should not be punished for this, the employer's values should also demonstrate the necessity to look after staff, especially when A has evidence from the GP that [they] was suffering with depression through this period. The team feel through this difficult period A was mismanaged and lack of supervision and clarity resulted in A being placed in this difficult situation…. robust supervision is required to regain self-confidence and be the brilliant professional [they] are capable of being'.

The common characteristics in the example above include feeling unsupported, overwhelmed by workload and pressured to follow protocols. This reflects some of the literature referred to earlier, for example, Kirwan and Malaugh (2015) describe the paradox of needing to follow rules imposed by authorities whilst at the same time becoming less responsive and creative in meeting individual needs (2015, p1055).

Evolving professions

The fourth and final theme which may provide some context for the high number of complaints as well as the complex nature of complaints relates to the evolving nature of these relatively new professions. Turning first to paramedics, the literature confirms this sense of a profession in a 'transition stage' (Cooper, 2005). Practice is continuing to

evolve (Mackway-Jones and Wankhade, 2015) with changing scope of practice and accompanying emphasis on 'upskilling' and professionalisation (NHS England 2013; HEE, 2016, McCann et al 2013).

Interview participants observed that paramedics entering the workforce as graduates were more likely to have a clearer awareness of the meaning and value of their registration than their colleagues who had not taken a university route to qualification. This awareness was thought to be one of the possible reasons behind self-referrals, which might be viewed as a marker of professionalism and good practice. It was not possible to verify this in the case analysis, as we were not able to collect information on routes to qualification.

The interviews also suggested that the generation of trust-trained paramedics were arguably less interested in the notion of professionalism and felt that changes in their way of working had been imposed on them. While participants said that this generational divide was by no means clear-cut, there was a sense that poor understanding of HCPC registration and professional responsibility, and viewing 'being accountable is a threat not an opportunity' could be a trigger for problems in practice. The interviews and focus groups also pointed to the ways in which newer graduates struggled to uphold open reporting when placed with more established colleagues not trained in that ethos, a finding which reflects other studies of under-reporting culture in pre-hospital emergency care (Bigham, et al., 2012).

Self-referrals in paramedics

As noted previously, there was an unusual pattern of self-referral by paramedics. A disproportionately high number of paramedic self-referrals was observed in the overall number of cases referred to the regulator between 2014 and 2016. In 2016, this proportion was 57% compared with an average across all 16 professions of 26%. In this sample, 46% were self-referrals, 84% of which resulted in no further action by the regulator. It does appear that some of the self-referrals in this sample relate to matters that fall outside of the requirement outlined in the HCPC's Standard of Conduct Performance and Ethics in Standard 9.5 (HCPC, 2016).

The interview and focus group data also suggest that there is some misapprehension within the profession regarding the circumstances and reasons that require self-reporting. Exploration during the interviews and focus groups revealed that some paramedics were actively encouraged by employers and unions to self-refer to the regulator. The message was that it was '*safer to refer before someone else does it for you.*' Others described a 'culture of fear' of the regulator, which was one of the reasons given as to why paramedics referred themselves – guarding themselves against the perceived 'big stick'. Indeed, paramedics may continue to work for ambulance services where discipline has traditionally been a marker of successful management. In this way, discipline via self-reporting might be embedded as a first action, rather than one which is considered, evaluated and then actioned. There did appear to be some variation in this sample across the regions.

Interestingly, those interviewed in Scotland and Wales said they were aware that the advice was changing in some ambulance services, and were aware of the variation in local guidance given by employers across the UK.

Since 84% of these self-reported cases resulted in no action by the regulator, it raises questions as to whether the regulator is inadvertently contributing to this and whether clearer communication with the profession around self-referral may be indicated. The consequences of inappropriate self-referral are significant. For the regulator, there is unnecessary time, effort, and cost incurred to actually undertake preliminary investigations of all self-referred cases prior to dismissing them. For the paramedic, there is considerable psychological distress that occurs as the self-reporting process and subsequent preliminary investigation proceeds. For the paramedic profession as a whole, there is a risk of transforming a collegial professional culture into one of mistrustful surveillance which ultimately may inhibit working practises.

Not all self-referrals in the sample resulted in no action, however. There appeared to be a higher number of out of work convictions and cautions in the paramedic sample compared with the social work sample (10% compared with 3%). This is also higher than the number reported in other HCPC professions. In the final hearing cases where there had been criminal convictions/cautions, the pattern of self-referral/employer referral is less clear-cut, with a mixture of both. It may be that a more streamlined process of considering impairment in this context could be indicated for such cases.

Some of those interviewed commented that paramedics are 'a younger profession than many others regulated by HCPC'. It was felt that although professional identity was promoted in university settings, there was less understanding about the meaning of professionalism from some ambulance service trained paramedics. These paramedics, often trained originally as ambulance drivers and from non-professional backgrounds, were used to a code of conduct based on military style, uniformed, disciplinary culture. Interview participants referred to the fact that this culture continued to 'overspill' in terms of behavioural and psychological values. The mix of this disciplinary culture and lone-working autonomy may provide fertile ground for both complaints and self-referrals. Further consideration of ways in which paramedics and ambulance services can be engaged in conversations about self-referral and what the HCPC's Standards of Conduct, Performance and Ethics (SCPE) specify is therefore recommended.

Recommendation 2: Prioritise reducing inappropriate self-referrals from paramedics

Consider revising HCPC guidance and undertaking further specific engagement work on self-referrals targeted at ambulance services and paramedics.

The interview and focus group participants suggested similar issues in the relatively newly regulated profession of social work. Participants identified differences between newer registrants and their appreciation of regulated status, and those longer in the profession who felt that registration had been imposed upon them, making them resistant to, rather

than a part of this change. Participants in these interviews felt that, despite the lengthy development of the profession, registration was a relatively new concept and more work needed to be done with social workers on embedding understanding of the meaning and purpose of regulation. In terms of self-referrals, the number by social workers in the sample was much lower, (only 12% of social work referrals compared with 46% for paramedics) of which 82% resulted in no further action by the regulator, suggesting that further enhancements to the HCPC guidance may also be valuable with social workers in England.

The interview and focus group data showed that both paramedics and social workers face issues around professional identity. Some advances in career frameworks, including the development of consultant or advanced roles, were felt to help define the profession. This is supported by literature, which suggests that qualifications can be used to affirm professional identities (Professional Standards Authority, 2016). Overall there was a sense that neither of these professions had adequate guidance and support to form and maintain their professional identity. Without this, some argue that individuals are unable to forge the 'development of a set of internal standards' and are not guided sufficiently to cultivate an 'internal compass' to regulate their work (Wald 2016). Given evidence suggests that foregrounding professional identity can have a 'broadly positive influence on the practice of healthcare', and that education helps develop professional identity (General Medical Council, 2016), the challenge is maintaining that in practice. Insights in the literature on professional identity illuminate some of the challenges which emerged from the data in this study, including the impact of internal and external (for example, public, media, employer and regulator) influences on paramedics' and social workers' valuation of their role. However, it appears that non-regulatory factors, such as peer group, culture and local leadership had more impact than the regulator on the development and sustainability of professional identity. Service users in this study suggested that forging this identity from as early a stage as possible in the educational process, and continuing to re-visit it, was an important part of preventing complaints.

The connection between identity, engagement with one's profession and maintenance of competence is an area of research interest (Smithers et al., 2005, Sargeant et al., 2008). Understanding the ways in which regulatory and workplace practices may inadvertently antagonise practitioners and cause them to become alientated from their profession is important to understanding the internal psychological motivation required to maintain competence. For example, regulatory requirements on the need for self-reflection or documentation of learning may be perceived as pointless, and burdensome administrative requirements may inadvertently drive practitioners to invent material rather than authentically engage in self reflection about their professional work (Austin and Gregory, in press). This could be construed as another example of regulatory iatrogenesis, or an unintended consequence of externally imposed processes and rules (Illich, 1976).

To return to the question of disproportionality and possible explanations for this, what is this study telling us? In terms of number of referrals, we already know that the number of

individuals referred to HCPC is very small compared to the overall numbers of professionals on the register. In 2016, this figure was less than 2%. We also know that there is a higher than average number of referrals about paramedics and social workers in England, 11 per 1000 for paramedics and 12 per 1000 for social workers in England compared with the HCPC average of 6 per 1000. What this study adds is evidence that a large number of those referrals are ultimately not about impairment. Very few cases we reviewed in this study resulted in actual harm to patients or service users. Less than 1% of those referred received a sanction. This suggests that the overall disproportionality in this sample lies not in the higher prevalence of impairment, but in the higher number of referrals that do not meet the HCPC's standard of acceptance for an allegation. For paramedics, a large number of these are self-referrals relating to one off incidents. For social workers in England, a large number are referrals by families frustrated with the decisions of their local authority about residence and contact.

Of course, not all complaints in this sample of 284 cases fall neatly into the two categories of self-referral and referrals arising from residence and contact disputes. Neither is this study suggesting that there are no cases of paramedics and social workers who cause harm to patients and service users, either deliberately or inadvertently. The final hearing cases, in the main, do demonstrate instances of serious misconduct. Some are cumulative failings of practice and others are instances of breaches of ethical standards resulting in sanction. However, across the typologies there is a large number of cases in both professions that illuminate the complex, ambiguous nature of the work, delivered in the absence of adequate employer support, supervision, emphasis on self-reflection, and a no-blame culture, all of which have been shown to underpin the delivery of high quality care (West and Dawson, 2012, West et al, 2014). The next section offers a possible theoretical framework for articulating these complex interactions.

The continuum of impact on fitness to practise

This section returns to the case analysis data, whilst continuing to draw on interpretations from the qualitative investigations and literature, and offers a model for interpreting the continuum of impairment observed in the cases we analysed. The typologies generated through the case analysis broadly reflect existing work in the literature, although these are drawn mainly from data on health professionals and not social work professionals (Spittal et al., 2016, Bismark, et al, 2016, GSCC, 2012, CESG 2014, 2016). It is noteworthy in this context that medical insurance groups such as Avant Mutual have begun to use typologies to improve understanding of risk factors in medical contexts (Maitra and Haysom, 2016), although these are commercially sensitive and therefore not yet in the public domain. The Professional Standards Authority in the UK has also explored the concept of risk in this context. Bismark and her colleagues have generated a typology from over 8000 cases referred to the Australian regulator (Bismark, et al, 2016). Our categories were very similar to those of Bismark et al., in that they fell under the two broad categories of conduct and behaviour and competence and performance. However, in our data, contrary to what might

be expected, there was no clear cut distinction between the types of complaint found in the three stages of the investigative process.

An alternative approach to interpreting this complex arena is to describe the relationship between outcome and occurrence in the pattern of referrals. Our analysis of the cases suggests that there are many 'one off' incidents where no harm has been caused to patients or service users and no sanctions are imposed, a finding which concurs with a large Australian study of 8000 health professions, where only 0.08% of the overall sample were subject to sanction (Spitall et al, 2016). Service users and professionals taking part in the interviews and group discussions also referred to this. These one-off incidents lie at what might be described as the 'yellow card' end of the continuum, to use a footballing analogy (see Figure 5 below). These referrals do not, typically, result in a sanction. For paramedics, they include speeding offences and personal disputes outside working hours. These incidents were often indicators of a period of stressful life events, which may, or may not have impacted on professional life. The Delphi and interview data also suggest that a supportive, well supervised work environment may mean that the impact of these life events on performance are minimised.

At the 'red card' end of the continuum, that is the referrals that do reach a final hearing, there is a higher likelihood of incidents characterised by poor judgement, inefficient working practices, inappropriate treatment and inconsistent use of protocols, often observed over a period of time. These are cases where there are serial errors and omissions and actual harm resulting in a sanction. From these two descriptions, we might conclude that one off incidents tend not to be sanctioned and multiple incidents are more likely to be sanctioned. Of course, the picture is not as clear-cut as this, because some one-off incidents resulted in harm or the risk of harm to patients and service users. In the final hearing cases the panels reviewed misconduct with a view to what could have happened and it was the risk associated that the panel was keen to underline in their reasons for finding impairment. In the paramedic cases the panel considered the potential impact of either actions or omissions, in an emergency situation, identifying that although the incident may have not resulted in significant harm this time in any other given set of circumstances it could have been much worse. In the social work cases the acts and omissions tended to be more systemic and continued over a longer period of time. Again the potential harm to service users was considered by the panel as crucial when considering impairment.

Figure 5

The continuum of impact on fitness to practise and the 'dark yellow card'

| Initial stage | Investigating Committee Panel (ICP) | Final hearing |

One off

- Traffic offences
- Personal disputes
- Off duty incidents
- Residence and contact disputes
- Conflicts with colleagues
- 'Unkempt' appearance
- Inappropriate use of social media
- Disputes with colleagues and service users
- Acting unprofessionally towards service user
- Delayed reporting

- Aggressive behavior towards colleague
- Failure to complete patient record form
- Failure to check vehicle
- Failure to undertake clinical checks
- Inadequate assessment and record keeping
- Delayed communication with a family member

- Repeated misdiagnosis
- Incorrect treatment
- Conviction / cautions
- Deliberate fraud
- Serial instances of inadequate care / inadequate assessment
- Sexual boundary violations

Developing this further, there is another descriptor along the continuum, between the yellow card and red card. In the centre of the continuum are cases that we might describe as 'dark yellow,' where poor patterns of conduct and performance in a number of areas emerge, for example, in relational or transactional contexts, or repeated clinical errors, inefficiencies, inappropriate verbal communication and aggressive behaviour towards colleagues. Where these are triggered by highly stressful situations, acknowledged by the registrant, and are considered 'one-off' incidents by line managers, in most cases impairment is not found and there is no sanction. Where there is evidence of deliberate harm to patients, serial offending, and lack of insight or remorse on the part of the registrant, impairment is found and sanction is a more likely outcome. We would suggest that the dark yellow card analogy reflects the complex range of influences on conduct and performance and the ambiguous nature of professional practise for both professions. This continuum relates well to Sparrow's exploration of the chronology of harm, discussed below (Sparrow, 2008). But as the case analysis demonstrates, distinctions are by no means clear-cut.
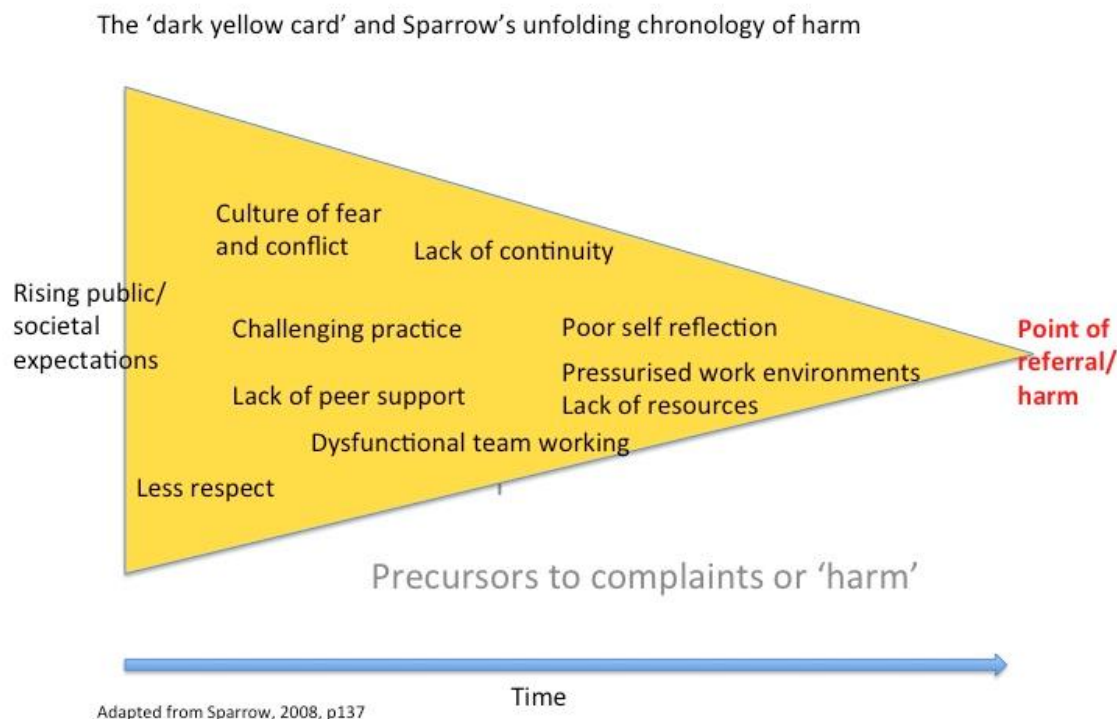
As the interview and focus group research highlighted, a critical variable in understanding practitioners' competence is the workplace within which the practitioner is expected to demonstrate competence. This concurs with observations made elsewhere in the literature (Austin et al., 2015). The broad heterogeneity of workplaces and workplace expectations in both professions suggests one size fits all definitions of competence that do not account for workplace-specific factors are problematic. Additionally, the role of employers in directly supporting and monitoring competence of practitioners requires

further exploration (Furness, 2015). In some cases, issues framed as "professional misconduct" may actually be more about workplace culture or interpersonal skills. Regulatory bodies may be seen by some as a complaint vehicle of last resort, when complaints to employers are not addressed in a satisfactory manner. Clearer delineation around employer responsibilities vs regulatory responsibilities may be required, for members of the public, professionals, and employers alike. Invoking the bludgeon of a regulatory apparatus to manage issues that are more appropriately addressed through employment-related processes is both cost and time inefficient and ultimately ineffective.

The findings also suggest that there might need to be a greater focus on understanding the individual's motivation in the fitness to practise process – not so much on what was done but why it was done. The data suggest multiple reasons, which include over-work, lack of support and supervision, stress, challenges in personal life, boredom (e.g. using a mobile phone in an ambulance) and a general sense of powerlessness in the face of overwhelming service demands.

The research has not identified a clear cut typology in the three stages of the fitness to practise process as Figure 5 above illustrates. What has become apparent is the complex mix of societal, organisational and individual precursors on both conduct and performance issues to greater or lesser degrees in the passage through to the outcome of a final hearing.

This interpretation has resonance with Malcolm Sparrow's observations on the character of harms (Sparrow, 2008). He suggests that in most scenarios there is a chronology to the unfolding of particular harms (or, in this setting concerns about practice, alleged harms, or point of referral). There is usually a complex mix of factors or variables and factors which have to come together for harm to occur (Sparrow, p.137). Sparrow argues that if we can stop any one of these from arising then there is a higher likelihood of preventing harm further down the line. Taking the themes from the literature, interviews and focus groups together with the case analysis, we would propose that this reflects the large number of precursors in the chronology of 'harms' or referrals for paramedics and social workers (see Figure 6 below). These endorse the individual, organisational and societal influences referred to in the findings from the current Delphi exercise and explored earlier by Gallagher (Gallagher et al, 2016). The model also aligns with Austin et al.'s previous work, which discussed the complex interplay between internal and external factors which shape the ways in which people engage, or disengage, in their work (Austin et al., 2015), and with the Professional Standards Authority's suggestion that regulators might provide other agencies with knowledge that can contribute to prevention, described as 'indirect frustration of harm' (PSA, 2017).

184

Figure 6 The 'dark yellow card' and Sparrow's unfolding chronology of harm

The 'dark yellow card' and Sparrow's unfolding chronology of harm

Culture of fear
and conflict   Lack of continuity

Rising public/
societal   Challenging practice   Poor self reflection   Point of
expectations   referral/
                                    Pressurised work environments   harm
                    Lack of peer support   Lack of resources

                    Dysfunctional team working

Less respect

Precursors to complaints or 'harm'

Time

Adapted from Sparrow, 2008, p137

Preventing complaints

The final research question, and one which this study addressed directly through the Delphi exercise, interviews and focus groups, is what more can be done to prevent concerns about fitness to practise?

There were a number of experts in the Delphi exercise who questioned whether or not there was a need to 'prevent' complaints at all, as they were seen as opportunities for learning rather than events which needed to be minimised. Complaints were seen as an inevitable consequence of health and care service delivery. However, the majority view across participants in the other parts of the study was that prevention was in the best interests of service users, patients and providers of services, and service users were amongst those who held this view most strongly. This was particularly the case for referrals that did not result in harm and did not indicate impairment in fitness to practise. In cases where the opposite was true, participants argued as strongly that robust action by the regulator should always be taken.

The findings from all parts of the study pointed towards the need for partnership working and collaborative strategies, involving all the key influencers and agencies. These included

inter agency efforts and awareness raising by the regulator, employers, professional bodies, unions, advocacy groups, educators and the community of practitioners themselves. The next section addresses these in turn.

Regulator

The regulator was perceived as having a significant role in educating employers and registrants about appropriate complaints handling and in improving the ways in which current processes filtered complaints. The potential for the regulator to make more use of fitness to practise case studies in pre-registration education as well as with practitioners, was one example referenced by many in the interviews and focus groups.

There were a range of specific activities suggested. These included: a filtering process on the website to reduce inappropriate referrals to the regulator (see Appendix 1 for details on how this might be implemented), further work to increase public understanding of the professions, clearer guidance for paramedics on self-referrals, engaging face to face with complainants and pursuing local resolution and mediation along with employers.

Mediation and early, local resolution

A number of those interviewed talked about the value of moving from a 'defend and deny' culture to an 'admit and apologise' approach, delivered at a local level, recognising that very often what patients and service users want is an opportunity to be listened to and their perspectives and experiences recognised. There are compelling examples of this approach in other jurisdictions, such as Denmark (Ljungberg 2012), the Netherlands (Dutch Ministry of the Interior, (2010) and the United States (Clarke, 2011). Kaiser Permenante (KP) in the United States has a HealthCare Ombudsman/Mediator (HCOM) programme which aims to resolve complaints and concerns at the earliest opportunity at local level. A team of trained mediators work with patients, families and health professionals in the immediate aftermath of an adverse event, or when there has been a complaint about poor communication. They will meet with the family and the health professional separately, communicate each viewpoint to the other, and when appropriate bring the two parties together. The role of the mediator is to understand the parties differing perspectives, find commonality, and allow both to emerge with a better understanding of what went wrong and what needs to be put in place to avoid this in the future. What is important about this approach is that it recognises that both parties may benefit from early resolution and face to face communication soon after the event. It also acknowledges that the health professional involved in a complaint also (usually) experiences distress, anguish, guilt, defensiveness, as well as questioning their own competence (Montijo et al, 2011). They can be a 'second victim' in the incident (Wu, 2000, Milner et al, 2017), and therefore creating an opportunity for an exchange of their account of the event directly to the patient or service user can result in better outcomes for both parties.

The primary focus of the HCOM team is on resolving patient disputes as rapidly as possible. The team also spend time delivering training to health professionals in how to improve listening and communication skills, appreciate a patient's perspective of an adverse event, facilitate an apology where warranted, and work to re-establish trust through more transparent communication about healthcare. It is part of Kaiser Permenante's wider programme of interventions for dealing with adverse outcomes.

The Danish and Dutch early resolution models are used across a wide range of public services, including health and social care. The model is described as 'solution driven' dialogue, using conflict management techniques, in which the patient/citizen and professional engage in a conversation about the complaint, described as 'thinking <u>with</u> the citizen instead of against them' (2012, p27). In one hospital in Denmark, the approach achieved a 90% reduction in the number of complaints forwarded for formal investigation following intervention from the 'complaints taskforce,' saving £1,509.57 per complaint (2012 data). In this setting, examples of complaints handled through this model included the handling of a deceased family member, inadequate treatment, and inappropriate medication.

One of the benefits identified in the Danish study was 'legitimising' more open dialogue about complaints, the nature of the relationship between patients and health professionals and circumstances surrounding adverse events. The evaluation also observed that the model allows for the citizen's anger to be dealt with more effectively than a formal complaints process might allow, providing that the citizen sees that changes have been implemented as a result. For the professionals, there is learning from complaints. The measurable outcomes included fewer complaints referred to a formal process, less time and reduced cost per complaint, higher levels of patient/citizen satisfaction and increased learning for the professionals.

One way of implementing local resolution more effectively is to provide training and intervention at a local level. Regional HCPC officers, trained in mediation, to train others, help to resolve low risk complaints more quickly, based on the KP model. This move would reflect wider UK policy changes towards resolution rather than litigation. For example, in March 2017, the Department of Health proposed that the NHS Litigation Authority should be re-named NHS Resolution, with a new focus on investing more resources into earlier intervention using specialist teams, trained in mediation and dispute resolution, and developing partnerships with other organisations to prevent harm. The focus of the organisation will be on continuing to give increased support for 'delivering candour in practice and sharing learning for improvement, as well as reducing the need for costly and stressful court proceedings'. (NHS Resolution, 2017, HSJ, 2017). This approach follows developments in other parts of the UK, too. For example, the Scottish Social Services Council have developed protocols for involving the Scottish Ombudsman at an early stage if there are indications that the concern relates to systemic issues, and are involving the unions in awareness raising amongst employers to improve organisational working practices. Similarly, the General Medical Council's initiative to facilitate face to face

meetings between complainants and doctors in contexts where early resolution is indicated (GMC, 2015).

Recommendation 3: Intervene at the local level in dispute resolution

Consider piloting the use of regional HCPC officers to intervene earlier, provide education and awareness raising for employers on dispute resolution and create opportunities for face to face meetings with registrants and complainants for less serious referrals. Invite dispute resolution experts to train HCPC officers and evaluate the impact of the pilot on rates and types of referrals from the region.

The economic costs of fitness to practise have been well documented (Ball and Rose, 2013, Redding and Nicodemo 2015). What is less well understood are the psychological and social 'costs' to all those involved. Research has begun to explore this in more detail. What is clear is that there are unintended consequences for complainants, registrants and for the workforce (Bismark et al, 2016, Milner et al, 2017). The impact of a protracted investigation can include physical and mental ill health, disrupted work and home life and relationships. In many of the cases considered at the initial stage and the ICP stage, the case notes documented that the registrant was signed off work, or resigned or retired due to the significant stress related to the allegation or investigation. There is also a cost to the health and care system and the taxpayer if, through the process, the practitioner leaves the profession. There were cases where, despite the finding of no case to answer, the practitioner had made this decision.

Administrative issues in the fitness to practise process

The focus of this study was to explore the reasons behind the disproportionate number of concerns about paramedics across the UK and social workers in England relative to other HCPC regulated professions. This may suggest that the focal point of concern is the point of entry to the fitness to practise process and the reasons why registrants are referred. However, through the case analysis it has become clear that the fitness to practise process itself offers a rich source of evidence through which to understand registrants' motivations and actions following referral, and there are few studies that have explored this to any great extent. One exception is Christensen-Moore and Walsh's study of 27 HCPC cases, which revealed wide variations in registrants' responses to the process, from full engagement to resignation, voluntary de-registration, and complete disengagement (see Austin, Christensen-Moore and Walsh, 2015). Whilst we found the administrative processes applied by the HCPC Fitness to Practise Department were robust and consistent, there are a number of observations and recommendations which we hope may be useful in this context.

What the current study has found is that much is made in the reasons given in the final hearing cases of the aggravating and mitigating factors in any given case. The Panel always considers these and, together with the HCPC's Indicative Sanctions Policy, the Panel is able to reach their decision as to both impairment and sanction in a structured and systematic way. It was sometimes difficult to understand from the case data how much weight the panel have placed on certain factors. For example, the panels always consider whether they should proceed in absence if the Registrant does not attend, recognising that an abuse of process is only likely if service of the notice of proceedings has not been effective. Proceeding in absence does generate problems though if witnesses are able to give oral evidence at hearing but the Registrant is not present. The Panel always confirm they take no adverse inference from the Registrant's absence but it can mean evidence of witnesses is accepted without challenge and it may be that any absence is linked to the Registrant's engagement with the process (Worsley et al, 2017). Clearly panels have to proceed but a recognition of the absence of the Registrant meaning evidence advanced has not been subject to challenge may represent a truer reflection of the panels findings.

The panels often consider, at the point of impairment, whether their decision as to sanction is proportionate. This requires the Panel to consider the following: whether the sanction is a legitimate exercise of the Panel's powers, whether the sanction secures the level of public protection required, is the sanction the least restrictive means of attaining that public protection and is the sanction proportionate in terms of public protection and the rights of the registrant. In an ordinal assessment of proportionally, the Panel would clearly consider that, for example, a failure to maintain adequate records is not as serious as a conviction for sexual assault. The more nuanced form of proportionality is cardinal where the Panel would need to be mindful of similar cases. What makes one set of circumstances more serious than another? There may be more personal mitigation in one case or clearer aggravating factors in another case but it is unclear how the Panel would respond to this dilemma in light of the existing sanctions policy. In the cases themselves the factors are clearly listed in the decision but that does not give details of how much weight is placed on each. This may have the potential to undermine or obscure the true proportionality of any sanction given. The Indicative Sanctions Policy (points 10-15) does clearly explain to Panels how insight and remorse should be considered. However, in the judgements the Panels discuss aggravation and mitigation but these are not mentioned specifically in the Policy. They may be used interchangeably but there is no sense of the weightings given. In light of these observations, some minor adjustments to the guidance for Panels may be worthy of further consideration, but as this lies outside the remit of the research questions it is not appropriate to include it under recommendations.

It was also clear from the review of cases that there were a number of instances where registrants were sanctioned for a criminal conviction/caution. It could be argued that these hearings were unnecessary given that a criminal court had already established a conviction or the police had already issued a caution. An alternative might be that where there is evidence of criminal conviction/ caution, this would result in automatic removal

from the register with a registrant then being required to apply to go back on the register once the punishment was completed (in terms of a prison or probation penalty) or in accordance with an advertised time frame. There is no expectation that convicted/cautioned registrants would never be able to apply to go back on to the register but it would appear the criminal courts/ police have put the matter to proof and therefore any further fitness to practise hearing is a duplication of effort and an unnecessary use of limited resources. There may be alternatives as to how this could be managed. For example, the regulator could automatically remove those registrants convicted of an indictable offence and leave those convicted of a summary offence or issued with a caution on the Register. On the other hand the removal process could be purely administrative and the registrant would need to apply to go back onto the Register. This could be done via an existing process or a single panel member process. Using individuals, with suitable guidance and advice, rather than a three strong panel, is becoming increasingly popular in magistrates courts. This is done via the Single Justice Process (see page 196 for references). Consideration would need to be given as to whether these processes would be possible within the current legislation governing the HCPC's fitness to practise process.

In a number of final hearing cases registrants were suspended from practice and were required to demonstrate remediation. A number did this with additional training and course attendance and the presentation of reflective logs, which were considered a year later when the suspension was reviewed. It was not always clear from the case data how much remediation was required, or what threshold might need to be reached and whether there were any attempts to evaluate the sincerity of attempts at remediation (beyond panel impression). This was not always the case, however, and in a number of cases the reviews of suspension found there had been no attempt at remediation and consequently the registrants were struck off the register. What is less clear from the data is what steps have been taken by the employer and professional body to assist with this process of remediation. Whilst the HCPC may not see it as their role to assist in any way, there may be a crucial role for the employer and/or professional body in ensuring structured and supported remediation is offered to those who are suspended. In this data set, the review hearings appeared to place the sole responsibility for remediation on the registrant. There was a sense that registrants were often unsupported post suspension and yet were required to demonstrate they had learned and had changed. If it is accepted that in some cases a range of complex and contributory factors are relevant to misconduct and impairment then the responsibility to make amends should be a shared one with a clear role for the employer and professional body.

Recommendation 4: **Enhance the fitness to practise process**

Consider whether there is scope to expedite referrals in child residence and contact cases (where the court decision rather than social work decision has resulted in disputed decisions about placements and access visiting relating to children).

Consider whether there is scope to revise the final hearing process to improve processing of conviction cases (with reference to lessons from the single justice process (see p197)).

Explore mechanisms that could proactively encourage more professional body and employer support for registrants at the post conditions of practice or suspensions stage to enhance opportunities for rehabilitation where appropriate.

Professional body and unions

Participants also highlighted the important role played by professional bodies and unions in supportive action, not only during hearings and at the post hearing stage, but also in generating preventative action. Suggestions included further work to promote professionalism, provision of continuing professional development opportunities, challenging employers to do more to support their staff, and promoting the status of the professions with the public and with the media. The role of both paramedic and social work professional bodies could be stronger, with more attention paid to variations across the four countries of the UK and how practitioners could be better supported by a local presence. The potential to disseminate good practice and to advocate and support the profession was considerable.

Educators

Preventative action by educators was a strong theme, particularly in the Delphi exercise (p54) but also for participants in the interviews and focus groups. Across all the data, there was a clear message about the responsibilities of educators to lay the foundations of professionalism. Specific recommendations included the provision of inter-professional learning in the areas of disability awareness, safety, communication, fitness to practise and record-keeping, as well as working locally with employers to provide additional training in new skill areas. There were a number of examples that went further than offering some joint education modules, with one participant suggesting that nurses and paramedics should be trained together and then opt to specialise.

In social work, there was also a view that educators should engage effectively with 'borderline students' and provide a 'reality check' so that students were adequately

prepared for the complexity and challenges of everyday practice. The Delphi participants provided further detail on suggested curriculum content that would contribute to prevention of complaints. These included; enhanced pre- and post-registration education on the subjects of professional ethics and risk management. Key topics include ethical decision making; client privacy/confidentiality; informed consent; boundaries and dual relationships; conflicts of interest; documentation; conditions surrounding termination of services; and ethical standards associated with professionals' and clients' use of digital technology. In terms of practice education, practice teachers or assessors working with students during their placements need to feel more able and be more ready to recommend fail outcomes naming their concern in terms of very specific aspects of capability and suitability. There were also suggestions that increased efforts to educate health and social care professionals about risks associated with certain practices and behaviours and what is acceptable or not may be helpful. Service users emphasised the need to provide more education and training on the origins, nature and consequences of long term conditions for social workers to equip them to work more effectively with people living with disabilities.

Recommendation 5: Develop learning and teaching materials

Work with education providers to develop learning and teaching materials based on the research for use with students on pre-registration programmes as well as for on-going learning and continuing professional development (CPD) with registrants.

Employers

Participants viewed employers as having key responsibilities in preventing concerns being escalated. Many of these centred around fostering more positive cultures – of learning from errors and complaints, and openness rather than of blame – with a focus on safety, where practitioners feel able and willing to engage in reflective practice and to learn from mistakes. Other suggestions included creating opportunities for peer support, and funding continuing professional development opportunities. More opportunities for shared learning from adverse events, and the use of senior social workers and paramedics and clinical team leaders to quality assure practice and offer informal feedback were also identified as preventive actions. The Delphi exercise highlighted that professionals should be offered 'how to look after me' programmes to minimise the risk of disengagement. There was a strong sense that employers could do much more by embedding appropriate support, mentoring and peer and clinical supervision into their structures, not as an optional 'add on' but as an essential part of maintaining good practice, ensuring that staff wellbeing as well as service delivery were prioritised.

The research found examples of services that had taken action, with positive results. Two examples of good practice are outlined below, one in social work and the other in paramedic services.

Case example 26: An example of good practice in supporting staff: The Newport Family Assessment and Support Service (FASS)

A consultant social worker in Newport described a family support service that is providing consistently high levels of support and supervision whilst at the same time delivering successful outcomes for families. This model of service emerged from the pilot of the integrated family support team model in Newport, and a commitment to create a positive work environment which actively promoted staff well being. This service was evaluated by an independent research team at Oxford Brookes University between 2013 and 2015 (IPC, 2016).

The Newport Family Assessment and Support Service (FASS) is a collaboration between Newport County Council and the UK charity, Barnardos. The service is made up of a multi-disciplinary team that includes a consultant social worker, other experienced and newly qualified social workers and experienced family support workers who together have training in systemic practice, child and family psychology, motivational interviewing techniques and solutions focused approaches. The team work with families whose experience includes what Brandon et al (2012) and Cleaver et al (2011) describe as the 'toxic trio' – domestic abuse, parental mental health issues and substance misuse, living in areas of high deprivation. 77% of the families have experience of domestic abuse, and 37% of parents in the IPC sample experienced abuse themselves.

A key feature of this consultant led service is that the senior social workers practise alongside their social work colleagues, visiting and supporting families and making assessments. There is also a strong emphasis on consistent level of support, continuing investment in stress management, and encouraging self-reflection, on the premise that support for staff has a direct impact on the quality of service they can provide.

The independent evaluation used quantitative and qualitative methods and made the following observations:

FASS had doubled the number of positive outcomes when compared with feedback on other social care interventions

FASS compares favourably in terms of cost per family compared with other social care interventions

FASS delivered a reduction in re-referral rates during the study period and the number of looked after children was reduced during the study period

Staff recruitment improved overall by 24% between 2013-2015

The number of staff leaving these teams reduced by 50% between 2013 -2015

This interviewee described a service with a focus on creating a supportive environment for staff, working alongside families, being respectful, not creating an expectation that the professionals are there to 'tell the families what to do, but there to work with them'. These were seen as key elements of success.

This view echoes Shevellar and Barringham's (2016: 191) Australian perspective, suggesting ways in which social workers can be better supported. This includes a commitment to an open culture in social work teams in which workers can feel safe, and a willingness by organisations to 'reimagine' an audit culture that is open to debate.

There are a number of papers which address the importance of adequate support and supervision to delivering high quality services (Kadushin et al.,, 1987 in: Bradley et al.,, 2010) and contributing to a social worker's motivation and resilience (Collins, 2007 in: Bradley et al.,2010, Bulbulia and Hanrahan, 2014). Bulbulia's study of resilience in social work is highlighting the ability of good practitioners to 'hold the bad along with the good, without being depleted' (Bulbulia, 2017).

Lloyd et al. (2002) found that although there are many job-related factors at play (involvement with resistant service users in emotionally-fraught and complex situations and working in impoverished environments), the most significant contributing factors were organisational: work pressure, work load, low work autonomy, lack of challenge on the job, role ambiguity, low professional self-esteem and poor relationships with supervisors. The review identified supervisory support to be a significant moderating factor. There was a similar sense from the interviews that NHS staff such as occupational therapists and psychologists, who were described as more familiar and 'comfortable' with supervision than social workers, whereas, in some social work teams, a 'macho' attitude prevailed and supervision was not deemed 'necessary.'

The FASS example in Newport provides evidence of the success of investment in supervision, particularly in the face of huge workload pressures experienced by these teams. Bradley (2010) warns against introducing supervision which focuses on administrative functions to the exclusion of building trust and confidence and providing opportunities to de-brief after managing particularly challenging service users. Roberts' observation of the importance of engagement with service users is also relevant here:

It seems to me that the challenge in today's professional world is that we risk losing the elegant and powerful simplicities of human compassion, engagement and concern – driven out by attention to process and targets. Let's not forget that these are useful and valid tools for social work but are not ends in themselves (Roberts, 2007)

The example above directly addressed three key weaknesses in service delivery identified as factors contributing to poor care and rising complaints: changing the culture, modifying the targets and increasing multi-disciplinary ways of working.

Case example 27: Working together: An example of good practice in response to changes in paramedic services

A paramedic from the Welsh Ambulance service described the approach taken by his Trust in response to this changing profile of emergency work and a high number of complaints. This involved close analysis, collective decision making and included a number of components:

An in-depth analysis of the calls over a twelve month period revealed only 6% of calls equated with life threatening situations (for example, obstetrics, cardiac arrests, road traffic accidents). As a result of this finding, the Trust moved away from an overall target for all response times, and re-set the 8 minute target to focus only on these calls, in effect, changing the response model. In addition, there is what is described as a 'stretch' target for patients who require emergency treatment which is not life threatening.

There is now a Paramedic Quality Service Group, which is looking closely at concerns raised by the public, and how the service could be improved, for example, in relation to older people who have falls at home. These are classified as low acuity calls but with high risk of complications or co-morbidities. In addition, the Trust has started working more closely with other agencies such as social services and fire service, with clinicians on call at the call centre who can provide advice and support to their paramedic colleagues. This has had positive results, not only in terms of response times but also in terms of moving towards a 'productive' ambulance service, and reducing the flow of complaints.

The Trust have also changed their strategy on support for staff. They provide an ongoing leadership skills programme, which promotes mentoring and support, and regular analysis and feedback of calls and actions. This has had a positive impact on reporting, as well as on behaviour. Staff are now 'identifying their own problems' and are able to discuss clinical issues more readily with paramedic and nurse colleagues. The emphasis is on learning 'what could we have done differently' rather than punishment. 'Within this type of supportive feedback and mentoring – we are seeing change'.

This example illustrates how the collective wisdom of a team came together through the reflective 'safe' space (McGivern et al, 2015) within which to find solutions and share the responsibility for improvement rather than attribute blame (for further examples of valuing complaints data, see SPSO, 2017). This aligns with a report from the Nuffield Trust which describes how health services in Scotland have been underpinning this approach through consistent quality improvement initiatives, building trust and focus on intrinsic ethical and professional motivations rather than external rules (Dayon and Edwards, 2017). It also reflects the findings and recommendations of the Lewis report, an independent study of the impact of negative culture on ambulance staff (Lewis, 2017).

> **Recommendation 6: Proactive engagement with employers to enhance support and supervision for registrants**
>
> Consider producing guidance and undertaking specific engagement work with employers and registrants on the critical role of supervision and support in maintaining standards and preventing complaints.

Joint working

During interviews and discussions in relation to both professions, the benefits of joint agency working were repeatedly highlighted. No one agency was responsible for change. It was seen as a collective responsibility. Specific preventative initiatives included: the provision of inter-professional education and training; the utilisation of fitness to practise scenarios as educational tools; input on patient safety and human factors; values-based recruitment; and much greater emphasis on open and supportive cultures. Working more closely with systems regulators, for example, the Care Quality Commission in England, Health Improvement Scotland, Scottish Public Services Ombudsman, Healthcare Inspectorate Wales and the Regulation and Quality Improvement Authority in Northern Ireland, as well as with other professional regulators across the UK was also seen as a crucial part of inter-agency work in this area.

> **Recommendation 7: Partner and collaborate with systems regulators**
>
> Consider how the HCPC might work with systems regulators and others on raising awareness of interventions to address the impact of negative cultures on professional behaviours and competence, for example, through a UK-wide consensus conference event.

Practitioners

Perhaps surprisingly, given regulators' focus on individual accountability, there was less focus in the interviews and focus groups on the role and responsibilities of registrants in preventing complaints. The qualitative data highlighted the value of reflection in practice, learning from service user feedback and the importance of self-care and resisting the 'macho' culture of 'just keep doing it'. There was also reference to encouraging more honest feedback amongst peers about aspects of their competence and behaviour, a strategy acknowledged to be challenging and counter intuitive when working closely in teams, but nonetheless a powerful preventive action. More focus on discussing the meaning of professionalism, both inside and outside work, was referred to, particularly by paramedics. Offering opportunities for conversations about the inevitable 'messiness' of

professional practice (Ingram, 2015), and validating the ambiguities of effective practice and of the need for intuition, trial and error and the application of common sense are emerging as central to ways of working that deliver high quality care for patients and service users and sustain professionals (Shevellar and Barrington, 2016). The work of Jenny Bulbulia on building and sustaining resilience amongst practitioners provides another rich source of expertise for engaging with practitioners in the pursuit of self care and personal well being (Bulbulia and Hanrahan, 2015, Bulbulia, 2016).

Rasmussen observed that '*Although there are no easy answers to maintaining emotional health in the face of the significant challenges posed by providing care to others, I suggest that our first order of business ought always to be ensuring our own optimal care. Only then can we optimally care for others.*' (Rasmussen, 2012).

It falls within the responsibilities of employers, professional bodies, unions and regulators as well as practitioners to ensure that this principle is not overlooked.

Recommendation 8: Proactively engage with registrants

Use case examples from the study at registrant events, meetings with professional bodies and trade unions to further improve awareness of the fitness to practise process and the grounds for referral to the regulator.

Strengths, limitations and lessons from the study

This study has successfully addressed the possible reasons behind the disproportionately high number of referrals about paramedics and social workers, and offered a detailed description of complaints at different stages of the fitness to practise process. No previous study has undertaken such a detailed description of cases that do not proceed to a final public hearing. This methodology has provided fresh insights into the complex interplay between precursors to a referral, as well as examples and narratives with the potential to educate and engage. It has also generated a wealth of other material on possible preventative actions that might be taken in order to reduce the number of referrals made in the future.

What this study has not been able to address is the wider question of why there is a disproportionate number of complaints compared to other professions. This can only be achieved by examining similar variables in other health and care professions. The data we have collected and the interpretations we have made for these professions might well be replicated for other professions, including those with low fitness to practise referral rates. However, this does not alter the fact that there are higher rates of complaining in these professions than we might expect solely from the numbers on the register. This was the original motivation behind the commission, seeking to understand more about the themes

and characteristics of the referrals that are made and what might be done to prevent them arising in the first place.

Another limitation of this study is that it only looked at a 10% sample of cases over a two year period, and only 44 cases at the final hearing stage. This points to the need for further analysis of a larger sample of cases at the final hearing stage. This could consider other possible measures of disproportionality compared with other professions, such as the rate and nature of sanctions.

The study was unable to obtain complete data on potentially key variables such as type and date of qualification and ethnicity, which limited the descriptive data we were able to generate. Despite best efforts we were unable to obtain data on our 'engagement at work' category as this was not clearly identifiable in 70% of the cases we reviewed, despite being recognised in the literature as a key influence on competence. There were also a small number of categories in the HCPC case management system that appeared to have limited utility, such as incident location. We would suggest that consideration might be given to adding some of the categories we devised to the system in future, (for example, categorisation of harm and alleged harm, number of previous complaints received locally, and more specificity on employer and work setting). These might usefully be reviewed prior to any in-house follow up work, as they have the potential to provide insights into the possible precursors referred to earlier.

Finally, we obtained rich feedback from the two user groups and from a number of individual interviews, but recognise that this was 18% of the overall sample of stakeholders. Future studies might want to include a high proportion of users versus providers of services.

Application to other professions

There are a number of ways in which this study might contribute to collective understanding of complaints about other health and care professions. First, it would be possible to replicate the methods used here to examine the pattern of complaints about other professions, using the learning from the case review set out above and amending some of the variables to take account of their relative utility. It might be particularly valuable to use the case review methodology to identify characteristics and to generate profession specific case studies for learning and teaching purposes.

Secondly, the 'swampy lowlands' of professional practice, where 'problems are messy and confusing' (Schon, (1983, p.42), are of course not the exclusive domain of paramedics and social workers. The contexts in which these professions work, for example the pressurised working environments and challenging practice that are described here as precursors to referral or harm, could equally be applied to other practitioners who work in health and care. Many of the recommendations aimed at reducing referrals in the future could well be applied across a broader range of professions.

Concluding reflections

This study of paramedics from across the UK and social workers in England has thrown new light on the number and nature of complaints and concerns raised about their practice, as well as offering a range of narratives and actions that might help to reduce these in the future.

It was the first study of its kind to look at a relatively large sample of cases at all three stages of the investigative process. Older, male practitioners were over-represented relative to their numbers on the register. Social workers employed by children's services had a higher representation in relation to referrals from members of the public than their counterparts in adult social services. However, only 1 of these progressed to a final hearing investigation. In contrast, paramedics had a low number of referrals from members of the public overall but a high number of self-referrals at all three stages of the investigative process. Six of these self-referrals progressed to a full investigation and 1 was struck off the register. We did not find a disproportionate number of cases of impairment in the sample of cases we reviewed. Instead, we found a disproportionate number of self-referrals by paramedics and referrals from members of the public about social workers in England that resulted in no further action by the regulator. For paramedics, a large number of these are self-referrals relating to one off incidents. For social workers in England, a large number are referrals by families frustrated with the decisions of their local authority about residence and contact.

Regulators play a unique role within the life of any profession: unlike employers, academic institutions, unions or professional associations, every practising member of a profession must connect to the regulator. As a result, the regulator's reach is unparalleled and so too is its potential to help shape and influence the culture and practice of a profession. Given the findings of this study exposed negative aspects of professional culture in both professions, questions about what opportunities might exist for the regulator to work proactively with other agencies to address this issue, whilst remaining mindful of its primary responsibility to ensure safe and effective practice.

Finding this balance is complicated for many reasons. The practice of professions in general has become more complex with technological and social evolution. In a world of instantaneous communication, twitter-feeds, Instagram and unlimited information, professionals are under scrutiny as never before, as observed by participants in this study. In addition to this, the work of professionals has increasingly moved away from technical/procedural complexity towards interpersonal/psycho-social complexity. As noted by paramedics in this study, a growing proportion of their day-to-day work involves conflict resolution, negotiation, and interpersonal risk management rather than technical activities such as intubation and resuscitation. For social work, the evolution of their role as advocates for service users versus 'agents of state intervention' gives rise to similar tensions. The inherent ambiguity of these activities makes challenges and complaints more likely – and potentially more difficult to defend against.

The final reason is that we live in ever more litigious times, where individuals are more ready and willing to use existing processes and systems to try and resolve their concerns – and an expectation that these systems will put them first. Ensuring safe and effective professional practice requires a balance: the rights of patients and service users and the needs and realities of practitioners engaged in day to day practice must both be valued and respected. Failure to explicitly acknowledge this balancing act risks alienating and disengaging one or both of these groups. Regulators do not exist to unquestioningly advocate on behalf of either; instead they exist to judiciously apply principles and processes in ways that encourage and promote best practice, and to recognise that their work is not a zero-sum game in which one side "wins" and the other "loses".

The second focus of this study was on prevention. There was a strong consensus from users of services as well as professionals that this was an important aspiration, in the interests of the public as well as the professions and the services that employed them. A wide range of actions and interventions were offered, with a clear emphasis on partnership and collaboration between different agencies and agents.

The importance of preventive action and the complexity of the regulatory balancing act is increasingly being recognised within the broader regulatory community across the UK and around the world (Sparrow, 2008, Bilton and Cayton, 2013, McGivern et al., 2015, PSA, 2016, SPSO, 2017). The concept of "right touch" regulation, promoted by the Professional Standards Authority has been acknowledged internationally as a key guiding principle for regulators, with its focus on prevention and reduction of harm (PSA, 2015). The English Department of Health's review of professional regulation further endorsed the need for reforms which would allow regulators to become more proactive, proportionate and efficient in their ways of working (DH, 2015). Likewise, Sparrow suggests that regulators are increasingly focused on preventive strategies, rather than just reactive ones, important though these are. One of the challenges is that these preventive interventions are much more difficult to measure in terms of success than reactive interventions.

This study has highlighted some potential opportunities to consider the application of these regulatory principles to address some of the issues identified here. For example, one of the core principles states that regulation should be used only when it is actually necessary (PSA, 2015). The disproportionate number of referrals about social workers that are dismissed at the first stage of investigation suggests that members of the public may be using regulatory mechanisms to express their feelings and frustrations because they have found no resolution through other, local mechanisms. Considering use of different, non-regulatory tools – for example, alternative dispute resolution, nudge theory or community engagement strategies – might reduce the regulatory burden on users of services and practitioners alike, while providing more meaningful avenues to facilitate expressions of concern from the public. Similarly, this study identified a disproportionate number of self-reported cases from paramedics which would have been better addressed through employer-led engagement processes rather than through regulatory channels.

Practitioners are central to the delivery of safe and effective practice and regulators are charged with the responsibility of setting and monitoring standards for them. Recognising these nuances in no way diminishes the regulator's primary responsibilities to the public. However, it is important to recognise that deliberate malfeasance by practitioners is, in most professions, a small proportion of cases, and yet a significant regulatory apparatus is applied to the vast majority of practitioners whose day to day work is of a very high standard, in spite of all the challenges documented in the literature and confirmed by the findings of this study. When one-off errors or disagreements in professional judgment result in regulatory processes that produce psychological or decisional paralysis for practitioners, it is important for those in authority to consider how "right" the "touch" of their regulation really is.   As this study has highlighted, the lines between individual and collective responsibility are rarely clear-cut. There are, however, significant opportunities to change the architecture of listening, and to develop new systems to engage employers, professional bodies, practitioners, educators and others more fully in the regulatory process, rather than framing it as an antagonistic, zero-sum game.

Recommendations

1. **Engage further with the public to raise awareness of appropriate avenues of complaint and support**

   Consider enhancements to the website and other signposting for the public on the criteria for making complaints to the regulator with reference to nudge theory (see Appendix 1 for specific examples of how this might be achieved).

2. **Prioritise reducing inappropriate self-referrals from paramedics**

   Consider revising HCPC guidance and undertaking further specific engagement work on self-referrals targeted at ambulance services and paramedics.

3. **Intervene at the local level in dispute resolution**

   Consider piloting the use of regional HCPC officers to intervene earlier, providing education and awareness-raising for employers on dispute resolution and creating opportunities for face to face meetings with registrants and complainants for less serious referrals. Invite dispute resolution experts to train HCPC officers and evaluate the impact of the pilot on rates and types of referrals from the region.

4. **Enhance the fitness to practise process**

   a. Consider whether there is scope to expedite referrals in child residence and contact cases (where the court decision rather than social work decisions have resulted in disputes about placements and access visiting relating to children).
   b. Consider whether there is scope to revise the final hearing process to improve processing of conviction cases (with reference to lessons from the single justice process).[3]
   c. Explore mechanisms that could proactively encourage more professional body and employer support for registrants at the post conditions of practice or suspensions stage to enhance opportunities for rehabilitation where appropriate.

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   [1] http://www.counsel.direct/news/2016/6/14/single-justice-procedure-notice
   https://www.magistrates-association.org.uk/sites/magistrates-association.org.uk/files/Single%20justice%20procedure%2014%2004%2015.pdf
   Section 46 of the Criminal Justice and Courts Act 2015 introduces trial by single justice on the papers. This provision is for summary, non-imprisonable offences only and for the most part has been used to deal with minor road traffic offences where the defendant has pleaded guilty and there is no need for them to attend court. The magistrate sits with a legal adviser in a non-traditional court room and decides on the penalty in line with published guidelines.

5. **Develop learning and teaching materials**

   Work with education providers to develop learning and teaching materials based on the research for use with students on pre-registration programmes as well as for on-going learning and continuing professional development (CPD) with registrants.

6. **Proactively engage with employers to enhance support and supervision for registrants**

   Consider producing guidance and undertaking specific engagement work with employers and registrants on the critical role of supervision and support in maintaining standards and preventing complaints.

7. **Partner and collaborate with systems regulators**

   Consider how the HCPC might work with systems regulators and others on raising awareness and interventions to address the impact of negative cultures on professional behaviours and competence through a UK-wide consensus conference event.

8. **Proactively engage with registrants**

   Use case examples from the study at registrant events, meetings with professional bodies and trade unions to improve further awareness of the fitness to practise process and the grounds for referring concerns to the regulator.

Areas of further research

1. **Follow up research with a greater focus on user perspectives on preventing complaints in the future**.
   Consider a further investigation with a large sample of service users, including those who have been involved in making complaints.

2. **Further investigation of a larger sample of final hearing cases to test the framework proposed in this study.**
   One of the limitations of this study was the relatively small sample of final hearing cases considered in the case review. Consider looking at a larger sample of final hearing cases using the methodology applied in this study to test the framework proposed here.

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(For additional references contained in the paramedic and social work literature review, see separate additional Appendix document)

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Appendix 1

Applying behavioural insights to the issue of self-referral in paramedics and referrals from members of the public in social work

1.   Self-referral by paramedics

What do we know?

- Over the last 5 years, the rate at which paramedics self refer is disproportionately high compared to other HCPC regulated professions.
- In 2016, the rate was 56% compared with 13% across social workers and 6% for all other HCPC regulated health professions
- In the sample of cases examined in this study, 75% of self referrals did not reach a final hearing.
- Feedback from interviews and focus groups suggests that there is a 'culture of fear' of the regulator, and a common belief that it is better to self report 'before someone else does'

What problem are we trying to solve?

- Paramedics and their employers who have a misunderstanding of what incidents need to be reported to the regulator and what should be addressed locally.
- HCPC already has guidance on this on the website, but this may be insufficient to guide practice..

How could behavioural insights help?

- Behaviour is more likely to occur if it is made **Easy, Attractive, Social** and **Timely** (EAST) (Hallsworth et al., 2016)
- Making the desired behaviour visible via role models, peer behaviour and stories may be more likely to have impact.
- This would mean HCPC finding a new way of engaging with the profession and employers.
- Using a targeted social media campaign to clarify when to refer/not refer, using the case studies in this report
- Revising information on the HCPC website to include a step by step guide to referral, for example;.
  Step 1 clear account of what HCPC can and cannot do.
  Step 2 Is this something you should raise with your employer?
  Step 3 if self referral is appropriate, here is what you need to provide us with
  Step 4 complaint form (can only be completed when the previous steps have been completed)

This step by step approach, (following the principles of EAST) gives information in a way that is more accessible (using language like when to refer/not refer, what we can and cannot do). Use case studies from the research, showing which referrals did not reach the standard of acceptance.

The relationship between policy tools, nudges and behavioral insights
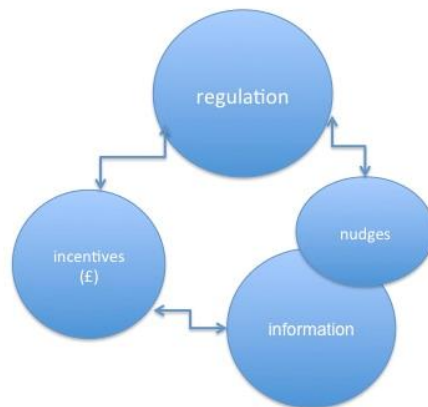
Hallsworth et.al,2016

Applying behavioural insights to the problem of over-referral by members of the public in social work

What do we know?

- There is a disproportionate number of referrals about social workers in England that do not reach the standard of acceptance.

What problem are we trying to solve?

- A high number of these referrals are from members of the public who are dissatisfied with the outcome of a court decision (eg court order on residence and custody of a child) and are seeking redress.
- Dissatisfaction with a court decision is better dealt with a local level.
- Unlike paramedics (and self-referral) this target group will only come into contact with the regulator when they are looking for redress.
- However, they will come into contact with social workers, their managers and social work organisations, all of whom might be able to give better advice and support regarding complaints.

How could behavioural insights work with members of the public?

- Revise the information on the HCPC website so that it is **EASY**. For example provide a step by step process designed specifically for members of the public. Each step has a drop down menu which ensures that the information is read before moving forward. Use stories to illustrate what is and is not an appropriate referral and give reasons and alternative options. The complainant is asked to go through each of these before completing the online form. For example,

- Step 1 Make sure we are the right organisation to complain to
- Step 2 Read about what we can and cannot do
- Step 3 What to think about when raising a concern
- Step 4 This is what you need to raise a concern
- Step 5 Complete our complaints form

How could behavioural insights work with social workers and social work agencies?

- Consider how they could communicate differently with service users who are unhappy with decisions.
- Direct complaints initially to internal systems, dealing with them promptly and with respect.