Fitness to Practise Committee, 14 February 2013

Executive summary and recommendations

Introduction

The Fitness to Practise work plan for 2012-13 included a work stream looking broadly at concepts of public protection and HCPC's approach to determining whether fitness to practise is impaired. This area of work forms part of our response to recommendations previously made by the Professional Standards Authority (PSA) (formerly Council for Healthcare Regulatory Excellence) in their performance reviews and audit reports that regulators should routinely request that those registrants who are convicted of drug or alcohol related offences should undergo a health assessment

It was agreed by the Fitness to Practise Committee in October 2011, that any review of approach in this area should look more widely at our approach to the treatment of registrants who had been convicted or cautioned for an offence

The FTP team developed a work plan on this topic which included commissioning research on understanding of the concept of public protection, reviewing the approach that is taken in relation to those registrants who are convicted of drink or drug related offences, reviewing our policy of not asking for a Police National Computer check to be undertaken on receipt of a conviction certificate to determine whether there are other convictions and requesting more information from the former or current employers of registrants who are subject to a fitness to practise allegations.

Papers on each of the topics outlined above are attached to this paper as appendices.

Decision

The Committee is asked to discuss the attached and

(a) Agree with the recommendations made at paragraph 6 of the paper 'Understanding Public Protection;
(b) Agree with the next steps set out in paragraph 4 of the paper 'Multiple Allegations'; and
(c) Agree with the recommendations set out in paragraph 5 of the paper 'Requesting Further Information.'

Background information

The Committee will be aware that in July 2010, the Council approved a policy statement on the meaning of fitness to practise. That document now forms the basis of all documents referring to the topic of fitness to practise. That policy provides that the purpose of '*fitness to practise proceedings are about protecting the public. They are not*

a general complaints resolutions process. They are not designed to resolve disputes between registrants and services users.' It goes on to provide that 'Our fitness to practise process are not designed to punish registrants for past mistakes. They are designed to protect the public from those who are not fit to practise….Sometimes registrants make mistakes that are unlikely to be repeated. This means that the registrant's fitness to practise is unlikely to be impaired. People do make mistakes or have lapses in behaviour. Our processes do not mean that we will pursue every minor or isolated lapse.'

The document goes on to set the personal and public components that are taken into account when determining whether a registrants fitness to practise is impaired.

We have in place a range of documents which support panels, those appearing before them and the FTP directorate as to finding fitness to practise is impaired. Those documents include:

Allegations; Standard of Acceptance Policy - http://www.hcpc-uk.org/assets/documents/10003872Standardofacceptancepolicy.pdf

Practice Note – Case to Answer Determinations - http://www.hcpc-uk.org/assets/documents/10003874Casetoanswerdeterminations.pdf

Practice Note – Finding that Fitness to Practise is Impaired - http://www.hcpc-uk.org/assets/documents/1000289FFindingthatFitnesstoPractiseisImpaired.pdf

Resource implications

Accounted for within the FTP work plan for 2013-14

Financial implications

Accounted for within the FTP work plan for 2013-14

Appendices

Appendix 1 – Picker Institute Europe – Carol Moore, Joan Walsh, Danielle Swain, Stephen Bough and Grace Baker '*Understanding Public Protection; Exploring Views on the Fitness to Practise of Health and Care Professionals'*

Appendix 2 – Report from the Executive on the Understanding Public Protection Research

Appendix 3 – Analysis of registrants with multiple allegations

Appendix 4 – Asking for further information; PNC Checks, Employers and Drink or Drug related offences

Appendix 5 – Legal Advice - PNC Checks

Appendix 6 – Legal Advice – Wider Information

Date of paper

04 February 2013

picker Institute Europe

Making patients' views count

Understanding Public Protection

EXPLORING VIEWS ON THE FITNESS TO PRACTISE OF HEALTH AND CARE PROFESSIONALS

CAROL MOORE, JOAN WALSH, DANIELLE SWAIN, STEPHEN BOUGH, GRACE BAKER.

PICKER INSTITUTE EUROPE

JANUARY 2013

Picker Institute Europe

Picker Institute Europe is a not-for-profit organisation that makes patients' views count in healthcare. We:

- build and use evidence to champion the best possible patient-centred care
- work with patients, professionals and policy makers to strive continuously for the highest standards of patient experience.

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Making patients' views count

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We would also like to thank the Patients Association, the Patient Information Forum, Carers UK and Bliss who advertised the online survey through their networks.

1. Executive Summary

In September 2012, the Health and Care Professions Council (HCPC) commissioned Picker Institute Europe to explore public and professional views and understandings of public protection. The project was designed to examine:

- understandings of the concept of 'public protection' and of fitness to practise;
- understandings and interpretations of terms used within determinations of fitness to practise;
- views on key ongoing issues and questions pertaining to public protection and fitness to practise;
- the information about individual practitioners that participants considered relevant for the regulator to determine fitness to practise, and whether and how views differ.

The project focused particular attention on the first and last of these (as requested by HCPC) throughout each of the three stages of fieldwork:

- six focus groups with members of the public, service-users and carers
- twenty interviews with stakeholders (professional bodies, registrants, employers and educators)
- an online survey with professionals and the public to quantify the views of the earlier phases.

This report integrates the findings from each of these stages.

Understandings of public protection

Participants found it difficult to define what the public may wish to be protected from. Responding to a range of fictional scenarios about health and care professionals, people were most concerned about dishonesty and use of illegal drugs. There was however no consensus regarding any behaviours or actions that participants felt would, regardless of the particular circumstances, bring a health or care professional's fitness to practise into question.

Professional stakeholders were concerned about further defining the concept of public protection (for example by attempting to create an exhaustive list of behaviours/actions that would trigger a fitness to practise process) for fear of creating unhelpful precedents and gaps. Their view was that the risk of public harm and the need for intervention to protect patients, service users and the public is and should be determined through case-by-case examination of individual circumstances, actions and contributory factors. This

reflects the way in which fitness to practise, and impairment thereof, is presently determined within HCPC processes.

Views of the public, patients, service users and carers

Members of the public found it difficult to distinguish between the professionals regulated by the HCPC and other health or care professionals whom they came into contact with. When asked what a good experience or excellent care looked like, participants invariably described professionals who were 'person-centred' and passionate about their work. Technical competence in the absence of a genuinely personalised approach was not enough.

When people referred to poor experiences of care, they described instances when their concerns had disregarded or downplayed, laboratory specimens or personal information had been lost, having been given confusing or contradictory information and advice, and fearing inappropriate treatment because of a breakdown in communications. Members of the public had little knowledge about the regulator's work, very few knew they could approach the regulator directly with concerns about care.

When asked for their concerns about wider public protection, as opposed to individual experiences, members of the public, patients and services users readily described specific instances, widely reported in the media, of major failures care quality. These system-wide failures clearly represented participants' worst-case scenario fears

In discussing professional fitness to practise, members of the public were most concerned to explore why a (fictional) scenario may have happened and, in particular, to identify possibly mitigating factors. Many expressed a wish to assist a health professional in improving. There was no consensus on how or whether or not any given situation may impair a professional's fitness to practise – most of the scenarios elicited, on the whole, relatively relaxed views. Negative gut-reactions to some of the scenario questions typically changed or were reversed completely as discussions developed. Participants felt very strongly that a comprehensive understanding of all circumstances of any scenario would be necessary in developing a definitive response with respect to a professional's impairment and fitness to practise.

In the scenarios dealing with off-duty criminality, participants' believed that the scenarios describing possession of an illegal drug (cannabis) and shoplifting were far more likely to affect fitness to practise (or to suggest impairment) than drink-driving. The key issue here seemed to be knowledge of illegality combined with intent.

The groups were asked if a formal health assessment may be an appropriate response to any of the off-duty criminal acts described in the scenarios, to identify if there are underlying addiction or mental health issues. Participants generally felt that this was disproportionate in the case of drink-driving, and slightly less so for possessing cannabis. In the case of shoplifting, members of public were nearly unanimous in recommending

that professionals undergo a health assessment to see if there is an underlying problem. It is important to note that, even when a scenario prompted concerns about fitness to practise, participants always discussed consequences (including health assessments) in a rehabilitative context. They wanted to understand in detail the circumstances why something had occurred, and to find ways to assist the health professional to be fully fit to practise.

Views of professional stakeholders

Professional stakeholders were most likely to associate public protection with the concept of harm. They also likened it to upholding the standards of performance and ethics to which they subscribed. Detailed knowledge of these standards meant that professional stakeholders were more readily able to determine that a health or care professional's fitness to practise *might* be affected by a scenario. However, like members of the public, professional interviewees tried to seek clarification on the particular circumstances in each case before giving a definitive response.

Professional stakeholders attributed a substantive role to employing organisations in assessing fitness to practise, and in escalating issues upward to the regulator. There was consensus that most issues with professional practice could be referred internally to continuing professional development in the first instance. Failure to respond and improve when appropriately advised and supported would thus constitute an impaired fitness to practise, rather than the 'one-off' incident that triggered intervention.

When asked about off-duty criminality, some professional stakeholders questioned whether health or care professionals were ever off-duty. Others hoped there could be a distinction between an individual's professional and private life, within the confines of the expectation of 'upholding the professional standards'. Professional views reflected those the public, whereby shoplifting was seen as most serious behaviour with regard to fitness to practise and drink-driving the least, with possession of cannabis sitting in the middle of the spectrum.

When asked about health assessments, the health professionals who responded that it was disproportionate did so more strongly than members of the public. Those who did believed that health assessments would be proportionate, did not strongly endorse the idea. Rather, they felt it would not be 'too high a hurdle' for a professional who should in any case be aware that his or her fitness to practise may be impaired.

Views of online survey respondents

The majority of survey respondents fell into two categories:

- members of the public, patients, service-users and carers (48.0%);
- HCPC registrants (37.3%)

The remaining 14.7% identified themselves as health or care professionals who were not registered with the HCPC or as 'other'. Most respondents had some prior knowledge of the HCPC and the work that they do, however 30.4% of respondents had not heard of the HCPC before taking the survey. The online survey questions asked about consequences for scenarios rather than for the degree to which any scenario may affect a health or care professional's fitness to practise. However, similar thought patterns and beliefs can be inferred from the responses to the online survey as those seen in the earlier stages of the project. Each scenario elicited a wide range of opinions regarding the most appropriate course of action: different people attributed different degrees of seriousness and severity to the same actions.

In the earlier focus groups and interviews, project participants discussed whether the consequences of a professional's behaviour/act, should be taken into consideration in considering fitness to practise. In the online survey, consequences and the nature professionals' roles/relationships with patients both influenced respondents' views regarding the most appropriate course of action.

Integrating public and professional participants' views: key findings

Above all, focus group participants were clear that they would most like to be protected from consistently poor performance, by individual health and care professionals and (most particularly) across organisations. That is to say, they wish to be protected from health professionals and services who are 'repeat offenders' or whom they believe to have 'slipped through the cracks'.

When asked which of the scenarios would cause most concern about fitness to practise, those describing dishonesty and on-duty failure to adhere to core professional standards were of more concern than the off-duty criminality scenarios. In scenarios where a professional's actions raised questions about their honesty, participants were more likely to believe that escalation to the regulator would be appropriate if the professional worked in the community or in people's homes.

People generally did not support escalating 'one-off' issues or mistakes to the regulator, i.e. without any evidence to suggest that there was a pattern of poor behaviour or professional practice. They did however emphasise that it is very important for employers formally to document instances and remedial interventions, so that recurrent and ongoing problems can be identified at the earliest opportunity and escalated appropriately. Overall, professional participants' threshold for thinking that an individual's behaviour might suggest impaired fitness to practise was much **lower** than the public groups' threshold. The professional threshold for involving the regulator, however, was much **higher**.

There was a particular concern about health or care professionals moving from one employer to another and concealing a history of 'minor' issues which, taken together, might suggest impaired fitness to practise. Many people wondered if there was a role for

the HCPC in monitoring incidents that would not, in themselves, cause concern about fitness to practise but that might indicate a problem if repeated and/or if viewed as part of a pattern or bigger picture.

There was, in theory, agreement that the seriousness (or not) of a practitioner's poor behaviour or practice was independent of any adverse outcomes that might result from it. Nonetheless, focus group participants were more likely to view things more seriously, and to think that a health professional's fitness to practise should be investigated, if they were subsequently told that harm had resulted. Stakeholder interviewees agreed that actions and consequences should be viewed separately. They also, however, believed that the response of an employer or regulator should be proportionate to any harm that resulted.

This study also suggests:

- a substantial concern that professionals should be honest and trustworthy, both on and off duty;
- a complex, but relatively relaxed attitude, towards off-duty use of alcohol, including 'one-off' drink-driving;
- greater concern about possession/use of illegal drugs, attributable to intent and the choice knowingly to do something illegal;
- no consensus regarding what specifically the public would want to be protected from;
- no appetite for creating an explicit list of behaviours or acts that should trigger investigation of fitness to practise.

Overall, there was consensus that fitness to practise and impairment should be considered on a case-by-case basis, taking all relevant factors and individual circumstances into account. Blanket recommendations and fixed responses would be unpopular with the public and with professionals.

With regard to requiring 'automatic' health assessments for concerns relating to alcohol and other drug use, a slight majority of participants felt that this would be a disproportionate response. People who did support such health assessments generally did so on the grounds that 'it wouldn't do any harm', and always discussed health assessments within the context of support, rehabilitation and regaining fitness to practise. Focus group participants' were keen to emphasise that the justice system is the highest (and in some cases only) arbiter for issues of criminality, including those pertaining to the use of illegal drugs and drunk-driving. Their view was essentially that professionals should not face 'double jeopardy' through HCPC processes.

2. Background and Introduction

2.1 The Health and Care Professions Council

The Health and Care Professions Council (HCPC) is the independent professional regulator of 16 health and social care professions. Its mandate is to protect the public; its role includes setting and maintaining education, training, skills, behaviour, registration and fitness to practise standards for all the professions that it regulates, and maintaining the professional register. HCPC was first established as the Health Professions Council (HPC) in April 2002, changing to HCPC in August 2012 as its remit was extended to cover the regulation of social care workers in England by the Health and Social Care Act.

2.2 Fitness to practise and public protection

The 2012 consultation document issued as part of the ongoing Law Commission review of the regulation of health and social care professionals[1] emphasised the need for clarity of purpose and accessibility in regulation processes. HCPC's literature is clear that *"the purpose of our fitness to practise process is to protect the public from those who are not fit to practise."*

A professional's fitness to practise can be considered to be 'impaired' if there are concerns about their ability to practise safely. The key objective of the HCPC fitness to practise process is therefore to ascertain whether a health professional is fit to continue practising as usual, should continue to practise but with limited scope, or should not continue to practise.

On occasion, health and care professionals make mistakes that are minor and are unlikely to be repeated. In such circumstances HCPC takes the view that the professional's overall fitness to practise is unlikely to be considered to be impaired. Repeated mistakes, or more severe mistakes - whether or not they are likely to be repeated - may indicate an impairment for which a fitness to practise proceeding would be the appropriate response.

In determining whether a health or social care professional's fitness to practise is impaired, HCPC fitness to practise panels must take into account a range of issues which, in essence, comprise two components:

a) the 'personal' component: the current competence, behaviour etc of the individual registrant;

[1] http://lawcommission.justice.gov.uk/docs/cp202_regulation_of_healthcare_professionals_consultation.pdf last opened 19 December 2012

b) the 'public' component: the need to protect service users, and to declare and uphold proper standards of behaviour and maintain public confidence in the profession.

In 2011-12, HCPC spent just under half (46%) of its annual income on operating its fitness to practise functions. HCPC periodically reviews its fitness to practise systems and processes to ensure that they are fit for purpose and an effective use of resources. In recent years, the review process has included a study of HCPC stakeholders' expectations of the fitness to practise process and the ongoing HCPC response to the Council for Healthcare Regulatory Excellence (CHRE) performance review.

2.3 Aims and objectives

Focusing on the 'public' component of fitness to practise assessment, HCPC commissioned Picker Institute Europe to ask members of the public and HCPC professional stakeholders for their ideas and views regarding the types of actions, behaviours or practices that the public should be protected from. Essentially, HCPC was interested in identifying the stasis point between the extremes exaggerated 'health and safety' fears, and the perceived need to protect the public from harm that could be caused by HCPC registrants whose fitness to practise is, or may be, impaired.

The project was designed in order to explore with members of the public and professional stakeholders with regard to:

- their understanding of the concept of 'public protection' and of fitness to practise;
- their understanding and interpretation of terms used within determinations of fitness to practise;
- their views on the ongoing debates surrounding public protection and fitness to practise;
- what information about individuals they believe would be relevant to the regulator in determining fitness to practise, and whether there is any variance in this dependent on the profession (e.g. public facing versus non public facing professions).

The project used a four-stage developmental approach, with each stage informing the subsequent stages of the research. The first stage comprised an initial meeting with the HCPC and a review of existing research and background literature to examine key themes and areas for examination. Fieldwork in the second stage comprised a series of focus groups with members of the general public, service users and carers. Findings from the focus groups were used to design in-depth interviews with stakeholders, which in turn shaped an online survey to test public and stakeholder views against those of professionals (including HCPC registrants) and against the views of organisations representing public and patient groups.

2.4 Gathering views from patients and the public: focus groups

Six focus groups were held in early October 2012, two in Manchester, two in the Midlands and two in London.

Three focus groups were made up of the general public and three comprised members of patient and/or carer forums and networks. Forum and network members were specifically included to ensure that the project consulted individuals whom we could be confident had some (and often considerable) experience and understanding of health and care professionals regulated by HCPC, and of their roles and responsibilities.

The patient and public focus group topic guide is included as Appendix 1. It was designed to:

- develop an understanding of what the public feel they need to be protected from;
- identify minimum standards of behaviour required to maintain public confidence in professions regulated by the HCPC;
- examine reactions to scenarios which may cause concern about a health or care professional's fitness to practise.

All participants were asked for their consent to the digital recording of the focus groups. Participants were assured that what they said would be treated as confidential, and that any quotes would be anonymised within this report. Participants were offered a £50 incentive to compensate for their time and travel expenses.

Table 1: Patient and public focus groups

Group	Location	Participants
Carers UK group	London, UK	5
Carers UK group	London, UK	5
Public group	Midlands, UK	8
Parents and carers group	Midlands, UK	7
Public group	Manchester, UK	9
Public group	Manchester, UK	9

2.5 Gathering views from key stakeholders and exploring reactions: telephone interviews

The third stage of the project consisted of a series of 20 interviews with HCPC registrants, educators, employers, professional body representatives and other professional HCPC stakeholders. The interviews were conducted in October and November 2012. The interview topic guide is included as Appendix 2.

The interviews were designed to test the findings of the public focus groups, and to assess whether a deeper knowledge of professional standards and fitness to practise processes prompted different response to the scenarios. We further tested whether all professions could be held to the same standards of professional competency, or if there were more 'risks' to public protection posed by the nature of some professions in comparison to others.

Interview participants were identified by the HCPC, and from within Picker Institute Europe's network. There was a considered effort to have representation from diverse professions, roles and responsibilities, as well as geographic representation.

All participants were asked for their consent to the digital recording of their interview. Participants were assured that what they said would be treated as confidential and that quotes would be anonymised within this report.

Table 3: Stakeholder interviewees by profile

Interviewee Profile	Number
Representative of professional body	8
HCPC registrant and CHRE representatives	7
Educator	2
Employer	3
Total	**20**

2.6 Online survey

An online survey was developed for the final phase of the project. The survey was designed to:

- quantify the views of both patient and professional groups;
- share and test findings from earlier stages of the research;
- reach as wide a range of stakeholders;
- further explore differences in perspective based upon respondent characteristics, roles and responsibilities.

The Picker Institute provided a link to the survey, with an explanatory message, which HCPC distributed through its newsletter. The survey link was also distributed to patient organisations within the Picker Institute's network, including the Patient Information Forum, Bliss and the Patients Association. It was also posted on the Picker Institute's web and on social media sites.

The online survey ran from late November to mid December 2012. The explanatory message included a description of the research project aims and an assurance that all responses would remain confidential. A total of 204 respondents completed the survey, most of whom were patients, service users and members of the public (48%) or HCPC registrants (37.3%).

Table 3: Online survey respondents by profile

Respondent Profile	Number	Percentage
Patient, service-user or member of the public	98	48.0%
HCPC registered health or care professional	76	37.3%
Health or care professional not registered with HCPC	19	9.3%
Other	11	5.4%
Total	**204**	**100.0%**

3. Perceptions of public protection and fitness to practise: public, patients, service users and carers

At the outset of the focus groups, participants were asked to share their experiences of care from health and care professionals. Facilitators used this exercise to emphasise that the focus groups were concerned with professions regulated by HCPC, and specifically emphasised that this did not include doctors or nurses.

Participants were then asked to comment on a number of fictional scenarios describing potential issues relating to professional behaviour, including off-duty behaviour. Participants were asked to discuss how the behaviours and situations described may affect fitness to practise, and how they could or should be managed by employing organisations and the HCPC. This section describes the perceptions of the public, patients, service-users and carers on these topics and what the implications may be for HCPC processes.

3.1 Experiences and expectations

Integrity and trust

When asked about their experiences with, or perceptions of, health and care professionals, the groups highlighted experiences of excellent care and experiences where they received less good care. Most agreed that, overall, there is definite room for improvement in quality and/or consistency. Their view was that, due to their role, health and care professionals are given a unique type of trust by members of the public and that certain expectations of standards and behaviours inevitably sit alongside that.

Members of the focus groups had difficulty distinguishing between HCPC regulated health and care professionals and other health and care workers. They typically, though not exclusively, first thought about their experiences of health professionals with whom they had had most contact, which was often General Practitioners, nurses and dentists. This was consistent with, and perhaps reflected, participants' expectation that all health professionals, clinicians and non-clinicians, should be equally trustworthy and should adhere to the same high behavioural standards, regardless of deferring levels of clinical knowledge.

It's to do with integrity and trust is that, if somebody has a passion for what they are doing, they are unlikely to behave in a way which is contrary to what they are actually being asked to do…

Perceptions of excellence in care

The minimum expectation for health and care professionals was they would be 'competent', 'qualified' and 'passionate' about the work that they do.

When asked about what a 'good' health or care professional was like, participants described someone who was 'person-centred', who listened to them and kept them informed, and who took account of their lifestyle and needs in 'working in partnership' with them. When they spoke about excellent experiences of care, competence was not enough – it was the personalised approach that made the difference.

Someone who sees the whole picture and they don't just look at an individual problem.

Working in partnership with the patient and families

Experiences that lead to complaints or concerns about health and care professionals

Participants were asked to share any health or care experience that may have made them complain about the care they had received, or made them consider doing so. The instances that they described tended to be a contravention of the person-centred and personalised approach to working with the patient they thought were the ideal.

Experiences that participants shared also included concerns being downplayed or ignored, accusations of exaggerating their condition or pain, laboratory specimens being misplaced or lost, and health professionals working in an uncoordinated matter which meant that patients were given contradictory or confusing information and advice.

Some described being very concerned about the type of care that they or people they knew were receiving due to issues with medication, or to the health impacts of treatments received.

I've got a friend of mine who has a disabled son and I was surprised to hear of her problems is that she's had difficulty finding an appropriate home, finally she thought she had found a really good one and her son was very happy but every time she went up to visit him he'd put on weight and he's now morbidly obese and I thought goodness, you know, what sort of care service is that?

And I've experienced a few years ago with my Physiotherapist, I was telling them that I'm in pain and I needed massages, I needed some extra therapy but they turned on me, it was a young girl, probably she was poorly trained and she said to me, "You're lying," … I didn't know where to complain..

When people were asked about whether they had made a complaint, or how they would complain if they wanted to, their immediate thoughts were to complain directly to the

health or care setting they were using or visiting, or to the local council. Most did not know they could approach the regulator directly.

Patients reported that when they did complain they did not feel reassured that the complaint was heard by the individual about whom the complaint was made, or that any changes to services were made as a result.

You might be able to get a complaint form but sometimes perhaps it does not get carried through.

There seems to be a department which does the apologies for you, the people who did whatever it was that was wrong don't apologise, as far as I can tell they're not even told about it, this may only be our particular one but the investigators we called was an eye-opener because we knew that the officer concerned was dreadful but we had not realised how dreadful and she's still there.

The main reasons for deciding to complain about care quality were to improve service, or to ensure their experience was not repeated. However, some participants, particularly those with long-term health needs, reported a fear of retribution or loss of service if they were to complain about the services they received.

Or are you going to continue working with that same professional? So if you go down that complaints procedure, but actually, at the end of it, if there is only one psychologist, or one dietician, and you then make a formal complaint against them, you then might be faced with no service, or actually still having to have some form of relationship with that healthcare professional

There is a perception amongst the public, and more visibly amongst patients and carers, that both NHS management's and professional bodies' default response to a complaint is to protect the hospital or professional from liability and, in so doing, to discredit the experience of the complainant. This (perceived) response, which participants were quick to blame on the litigious nature of society, was considered counterproductive; and some participants perceived health and care professions in a more negative light because of it.

But they're there to protect the professionals, they're not there to help us. You know, if you've got a complaint that you want to take to their professional body, they suddenly circle in, you know…

But the problem is with health professionals, even when it comes to management cases they do stick up for each other and…

One final concern shared by most of the public participants was that a complaint, which could also have legal ramifications, may expose the patient to further scrutiny, particularly in the media, which may cause them not to pursue the issue or concern.

Just leave it, don't pursue it because he'll be struck off and it'll be in the papers and this and that, and she'll be named and….

The role of the media in shaping public perceptions of public protection

Participants were not directly asked what they thought they 'needed to be protected from'; rather they were asked to discuss the type of things that might cause concern about the quality of health or social care or about the staff who provide it. In considering these questions, participants generally pointed to widely reported failures of NHS and social care systems, some recent and some from years ago. Focus group members were able to recall these cases quite readily and in some detail.

The place was eventually shut down, but the machinery of managing it and the Care Quality Commission had just patently failed to do anything about it. And that is really frightening because we trust our … daughters to somebody else.

It was these systematic and system-wide failures that the public viewed as 'worst case scenario' fears. This would seem to indicate that the media has a large role to play in shaping the public's views of 'what they need to be protected from'. Group participants also pointed to a risk of adversely stereotyping entire professions on the basis of media coverage.

I think sometimes you look at these professionals and a lot of them especially on the social work side have had pretty bad press and I think generally you tarnish everybody with the same brush which is wrong, but I think that we tend to do that.

3.2 Scenario discussions

Much of the time in the focus groups was devoted to asking the public to comment on a number of brief fictional scenarios. The aim was to understand how seriously participants viewed the various issues that the scenarios raised, and whether there was agreement regarding the consequences for professionals whose behaviour fell below the generally expected standards.

All scenarios are included in Appendix 1, in the order in which they were presented to group participants.

Taking responses to all the scenarios together, there was very little consensus about how serious something was or what might cause concern about a professional's fitness to practise.

Participants were often able to give an immediate 'gut reaction' view regarding whether a scenario might cause them concern about a professional's fitness to practise. However, as discussions continued and thoughts were shared and developed, participants'

responses would often change; they often revised their initial thoughts about how serious something was, or changed their minds completely.

On the whole, participants felt that a complete and comprehensive understanding of the particular and individual circumstances would usually be needed in order to make any judgements about a health or care professional's fitness to practise, and that such information would not typically be known by the general public.

How would you know the circumstances? Surely there should be some sort of regulatory body, I'm sure there is, that looks at all of those circumstances and makes that decision on behalf of the public as to whether that affects... It's not for us to make a decision about his or her fitness to practise because we don't know the circumstances ... do you see what I mean?

Participants were however consistent in the belief that severity was increased and additional action would need to be taken if professionals repeated a behaviour or practice that contradicted the expected standards. In particular, they were more likely to consider something to be serious if it was repeated after it had been brought up with a professional, and/or previously included within a professional development plan. This was reflected in the public responses to the online survey, where only 13.7% of respondents felt a fitness to practise investigation was warranted after one incidence of a patient's record being left in an open area of a health or care setting. This percentage rose dramatically to 72.4% when the scenario indicated that this was 'not the first time'.

I mean if it was discovered the first time and they were spoken to and they're still doing it I think that's a lot more serious because then they are disobeying guidance as well as acting unprofessionally.

It follows, as some participants pointed out, that formally documenting and discussing an unacceptable behaviour or practice should happen sooner rather than later, so that future repetition can be identified as such.

Overall, the key criterion that participants seemed to use in assessing the scenarios was whether the behaviour or situation was something that they personally had done in the past, or could quite easily imagine themselves doing. Such things were generally considered to be less serious and less likely to suggest impaired fitness to practise.

Illegal behaviours were, on the whole, seen as more serious, but again people's views were tempered by whether they had done, or could imagine themselves 'inadvertently' doing, such a thing themselves. The key 'seriousness' factor seemed to be a conscious and premeditated decision to do something that 'everyone knows' to be illegal.

There was, in theory, agreement that the seriousness (or not) of a practitioner's poor behaviour or practice was independent of the consequences, if any, of that behaviour or practice. Nonetheless, participants were more likely to view things more seriously and to

think that a health professional's fitness to practise should be investigated if they were told later in the fictional scenario that harm had resulted, a view which was confirmed within the public responses in the online survey.

The following sections elaborate on the discussions and views of the participants about themes across the scenarios.

3.2.1 Scenario discussions: issues relating to record-keeping

Scenario 1: *A health professional has left a patient record in an open area of the hospital that they practise in – is this a problem?*

Scenario 2: *A health professional's record-keeping is consistently unreadable or incomplete - is this problem?*

There was a mixed initial reaction to leaving a patient's notes accessible to people who had no right to view them.

Some participants' immediate view was that patient records' inclusion of contact information alone would be enough to require that they be kept securely, because of the potential for identity theft.

Others felt that the nature of the information within health records is so personal that leaving them open and unprotected would contravene the 'privacy and respect' that they felt they ought to be afforded by health professionals.

Conversely, other members of the focus groups felt that within a health or care 'environment' there is an innate respect of confidentiality or privacy, as everyone attending that setting is in a similar situation. For these participants, the scenario it was not such a concern.

No, I wouldn't generally be bothered about looking at somebody else's notes. I mean, you very often see this, people's lives on the computer screens when you go into hospitals and things like that.

It's not a problem for me because normally they're in a folder and left on the side, you know you're in an environment where it's private and confidential. I don't know what I would gain if I picked somebody else's records up about from finding the name and address out and what was wrong with them, that wouldn't really interest me

One participant spoke of what the 'carelessness' of a health or care professional might say about how they view and value the people to whom they are providing services. Rather than being concerned about whether someone was able to read notes, her concern was whether notes, as an important archive, could be misplaced and the wealth of knowledge that would be lost with them.

It's more about the value that healthcare professional has in my notes, you know. They're very important to me and to my health and they're a very important document and it's the carelessness and what that says about how much they value me and those very, very important documents. Because, let's face it, if they were to get lost, they're irreplaceable...

Participants were quick to look for extenuating circumstances as to why a record may have been left in an open area, in order to understand why it might have happened and to react in a measured way. There was a belief that particularly in an acute health setting that perhaps records would be dropped to respond to a crisis situation.

There will be occasions where they're just going to have to drop it and run. And I do expect that, and I can sympathise with that. So, I would have to say, generally, I don't have a problem with that because I understand that there can be reasons why that can happen. But if it was just a guy who continuously, as you say, was leaving them in the cafeteria because he was, "Oh, I'll just buy a coffee,"...then yeah, I would have a problem with that.

Members of the public generally agreed that this was an issue for the employing organisation to manage, for example by providing training/updating about why patient records are kept confidential, how to ensure that they are kept confidential and ensuring that the situation was not repeated. Overall, 85% of members of the public agreed that this was an issue best resolved with an employer; but just over a third of those would want the regulator to have been notified that the health or care professional had received a warning.

I'd want to know why. I think you'd want to talk to that healthcare professional, that you re-train them, talk about why it's happening, do they understand the importance and the value of these notes? Maybe, for me, before I would, perhaps, go down a disciplinary route and then talking about how, maybe, those notes are managed.

In one group, they spoke of the significant repercussions that could occur from the loss of a record, based on the experience of a young person they knew who was accessing mental health services, and whose records had been lost in the transition between children's and adult services. In this case, the significant repercussion (and harm) included suicide attempts. This case is one area where members of the public found it more difficult to separate the consequences from the act, though initially the discussion centred around the fact that the loss of records would have the same potential for harm, regardless of whether or not any harm was caused in each case.

On this, my daughter's friend has been under the hospital for a long time, lots of issues, mental health as well as physical health and a similar thing happened to her, she turned 18, turned up for a first appointment and they had completely lost her records and they said they were left out from because she changed from being under the children's department to the adult's department and apparently these records or her records were

left out to be taken by somebody from child to adult and that girl has actually tried to commit suicide several times now because they said... ...that the history is not there, they've got to start all over again, she self-harms, it's really quite severe because they've got to now try and get all this information back again that's lost.

With regards to unreadable or incomplete records, participants mostly felt that the problem was more likely to be laziness and/or a lack of care and concern. That is to say, participants felt that this was less likely to be an 'honest mistake' than the first scenario. Participants also quickly identified negative consequences which may result from an illegible or incomplete record, such as an inappropriate treatment. Consequently, they tended to view the professional in the second scenario much more negatively than the professional in the first. The online survey indicated a similar thought process, as 6.7% of respondents would recommend a fitness to practise process in the first instance in this case, and much lower 32.6% in the case of a repeated action.

3.2.2 Scenario discussions: discussing religious views

Scenario 3: *A health professional has discussed their religious views with a patient during a consultation. Does this affect their fitness to practise?*

The views that participants shared seem broadly seemed to reflect their own personal religious views. However, all agreed that the context in which the subject religion was broached, and who initiated discussion of religious themes, were important in determining whether it was appropriate or not.

I'm sure it's quite different for someone hasn't asked for it, that's a whole different issue.

Participants who felt discussing religious views could sometimes be appropriate supported this by saying that there would be times, such as end of life care, where they would welcome a shared prayer or a conversation about religious faith.

I suppose it depends if it's done with consent. You know, if I was at end of life stage and you know, in my case you know, a Christian nurse had a strong faith and wanted to talk to me about it, I am sure I would feel a great sense of comfort from that and relief if, you know, if there wasn't somebody from the clergy on site…

Participants who themselves were not religious generally agreed that a professional discussing religious views would be inappropriate in most contexts. They did not necessarily feel that discussing religious views would always be offensive, given that patients are free to disagree or to disregard such views.

Participants were however concerned that not all patients may be confident or assertive enough to ask a professional not to share their religious views. Some felt that discussion of religious views should only occur if the patient initiated or invited it, but there was not consensus on this.

Participants strongly agreed that it would be inappropriate for religion to be discussed with reference to treatment options, because of a concern that that information or treatment availability may be biased by the professional's beliefs.

So the advice might be biased.

Especially like abortion, with some other religions they don't agree with abortion…

Yeah. I'm thinking it would only be a problem for me if they were going to withhold a certain treatment based on their religious beliefs.

…and I think that you should be able to make your own decision without being influenced by other people as to what treatment you're getting.

Participants did however agree that 'patient centred' religious discussions are acceptable, i.e. discussions about a patient's needs and requirements as these relate to religious beliefs and practices, including, for example, dietary requirements and the acceptability of treatment options.

Finally, one group's discussion focused on whether it was appropriate, in keeping with standards of professionalism, for a health or care professional to share any personal information with a patient, service-user or carer. Participants were generally not clear whether there are or should be 'rules' about this; some held surprisingly strong views. In the online survey, the majority of participants recommended that either no action should be taken in this case, or that an informal reprimand from an employer would be appropriate (86.3%).

I think it's against the code of conduct of the health professional, they're not supposed to disclose to the patient any personal information. Some disciplinary procedure, yeah, maybe he can't practise for a while or…probation or something.

3.2.3 Scenario discussions: criminal behaviours

Scenario 4: A *health professional has been charged for drink-driving after attending a party on a weekend they were off duty. They drank 4 or 5 glasses of wine – they have not shown a history of alcohol abuse – does this impact on their ability to do their job?*

Scenario 5: *A health professional has participated in a public protest and has been arrested or detained for a public order offence as they are present when some violence has broken out, but are not directly involved in violence.*

Scenario 7*: A health professional is arrested for shoplifting*.

In all the scenarios relating to criminality, participants found it difficult how to determine where the boundary lay between 'upholding the profession' and the right to a private life while off duty. This was evident in their responses to each scenario, where the cause for

concern was not the act of criminality itself, particularly if it was something they had done or could imagine themselves doing, but what that act might mean for their 'trustworthiness', 'judgement' or 'responsibility – all of which participants felt were crucial character traits of health and care professionals.

I'm very conscious of that because I don't think there's enough people in society can see the distinction between the working me and the human me that's doing whatever I want to do off duty in my spare time.

One thread in all of the last three [professional competence] questions is it actually affecting your professional activities…but if you're outside of the business I think it's a different case.

The participants also questioned the role of the fitness to practise process in relation to criminality as creating a 'double jeopardy' situation of being punished twice for the same criminal offence, or indeed being punished more harshly than other members of society.

But then you're speaking large, you punish a professional harder than you would punish another person.

It has to be a measured response doesn't it? It has to be a measured response

Some participants felt very strongly that the role of adjudicating criminality fell clearly and only within the realm of the justice system.

I think this is the lesson of professionalism, how to get that balance right, you can't lay down rigid rules because then you're taking away from sentencing policy, if ministers tell judges what sentencing policy has got to be why do you bother to have judges, you know.

My personal view is that you leave dealing with criminality to the courts, let them decide what it is.

One participant, in struggling to decide how criminality might affect a professional's ability to do their work safely and effectively, wondered whether any of these actions would make her unfit, as a parent, properly to provide care for her own children.

Well you could turn this round on its head anyway. I mean if you were to commit any of these offences or get, you know, any of these scenarios fitted with you, would that make you unfit to be a parent?

Participants disagreed regarding the point at which the regulator may need to be informed about an act of alleged criminality by one of their registrants. For some, an arrest was, on its own, enough to warrant notification to the regulator. Others did not feel that the regulator should be involved until a health or care professional was actually

convicted of a criminal offence; and even then, they were not certain that notifying the regulator should necessarily initiate a fitness to practise investigation.

Then it's a conviction and then yes, absolutely. But you know, innocent until proven guilty kind of thing. That for me would be the line was whether you were convicted.

Participants generally felt that the same behavioural standards should be adhered to by all health and care professionals, and that there should not be any distinction between the type of role that the professional in question had, i.e. whether their role was public facing or not.

However, in scenarios where a professional's actions raised questions about their honesty, participants were more likely to believe that escalation to the regulator would be appropriate if the professional worked in the community or in people's homes. Some participations suggested that professionals who do not work in direct contact with patients or service users could be treated more leniently in cases of alleged or proven dishonesty.

I'm just reflecting ... if they are working in a social environment perhaps they ought to be aware... In another profession I think it's just, should be seen as a private issue, but in the social sphere, you know, social work yes perhaps.

I think people thought that indirect contact with vulnerable people or with, you know, patients, they should probably be treated slightly differently, in laboratories they should also be treated differently.

3.2.4 Scenario discussions: use of drugs, including alcohol

Scenario 6: *A health professional is arrested at a music festival for possession of marijuana; they are not known to be a regular user of drugs.*

Facilitators also encouraged participants to refer back to Scenario 4 (drink-driving) in discussions about use of illegal drugs.

Views about possession and use of an illegal drug varied greatly within the groups, depending on the substance and its legal status. Participants were asked to comment on whether they thought a health or care professional's fitness to practise would be impaired following a drink-driving charge or by having been charged with possessing cannabis while off-duty.

Though both acts are clearly illegal, participants tended to be more lenient towards drink-driving than they were of possessing cannabis. When asked to elaborate on why there was a distinction, particularly in light of the risk of harm to others generally being higher with drink-driving, participants discussed intent. Essentially, the argument was that while drinking alcohol may cloud judgement to the extent that one is unable to recognise that

the level of impairment is too great to be driving – but a health professional would be fully aware that they are breaking the law when in possession of cannabis.

Not if they're not working.

No, drink-driving is not clever, you know. And it's illegal but it's, even if it was legal it's not clever. So you would maybe question their judgement. I wouldn't refuse to have them as my care professional, I would just say you stupid sod.

Perhaps I differ, I think that was behaving irresponsibly and I don't think he should be cut off from earning his living, he's a professional but I think there should be something...

With regard to drink-driving, participants felt that regulatory consequences should be minimal, if any at all, because:

- the act took place while the professional was off-duty and was not driving for business purposes;
- the professional would inevitably lose their driving licence – and, if required to drive in their role, this might mean that her/his job was at risk.

Respondents to the online survey answered along similar lines with only 10.5% recommending any regulator involvement at all, and only 2.4% of public respondents recommending that a charge of drink-driving should initiate a fitness to practise proceeding.

Participants were mixed on whether or not a health professional should be compelled to tell their employer or the regulator about a drink-driving conviction. Participants were also quick to develop the circumstances under which a health or care professional may have 'needed' to drive after having been drinking.

In discussions about how to 'develop' a historic record to see whether a history of alcohol was present, options suggested included notifying the regulator of a conviction of this nature. Again, participants pointed out that formal documentation would be required earlier rather than later, in order to identify potentially problematic patterns of behaviour.

it says here there's no history of it, well we're beginning the history, you know, it now changes the scenario.

Participants were very unlikely to recommend that a formal health assessment should be conducted for an act which was seen as a 'one-off'. This feeling reported in the focus groups was echoed in the online survey where 50% of respondents believed they should not undergo a health assessment and 16.4% being uncertain of whether or not it was appropriate and 33.6% recommending health assessments.

I think we're all allowed a one off. If it turned out that that was their third or fourth time or it turned out that they do have a history of alcohol abuse or whatever then yeah, I would have to consider it.

Again, some participants were more likely to prescribe more serious responses if a negative outcome were to result from the decision to drink-drive. Others pointed out that any decision to drink-drive creates the possibility (or even likelihood) of causing an accident.

But if this person has been drunk and caused a serious accident or something than you know I mean that's obviously going to be a different matter altogether...

Well the problem that you've got is that it could happen.

With regard to possession of cannabis, participants were again mixed in their opinion of how serious it was. Some were relatively relaxed about it.

I don't think it's a particular problem, I mean say if you were on three weeks holiday and you just went to this festival and say 'let's try this, see what happens', I don't think it matters.

Among other participants, the illegality of cannabis possession generated greater disapproval than drink-driving, and it also raised more questions about a professional's fitness to practise.

Although driving with over the permitted blood alcohol level and possession/use of cannabis are both illegal, participants generally felt that knowingly deciding to use an *illegal* substance was more serious - even if there was no apparent risk of harm to others – rather than the illegal act of driving a car after consuming too much of a *legal* substance. Essentially, for some participants, knowingly using an illegal substance would be an indicator of impaired judgement and poor decision-making, and so a greater cause for concern. Indeed, the public respondents to the online survey would suggest this view is representative, with 34.5% recommending regulator involvement in this instance, a difference of 24 percentage points to that shown for drink-driving.

You know when you're having a glass of wine you're not bothering anybody until you've had five or six and get in a car. But if you are handling marijuana and you're passed a spliff, whatever, you know immediately that you're breaking the law.

One reason quoted for why possessing cannabis caused such greater concern than the issue of drink-driving was the belief that if a health professional were able to abuse an illegal drug, then there may be a concern about their abusing legal drugs within the health care setting that they worked due to their 'accessibility'.

I mean if they can abuse marijuana what else can they abuse? Like as a healthcare professional you're working with a wide range of drugs and there are a lot of drugs that are legal which can have similar or you know, different effects to marijuana, well people would then go on to abuse and it does affect your integrity

Compared to the drink-driving scenario, participants were more likely (though not unanimous) to recommend a health assessment for a conviction relating to possession cannabis, and were less likely to discuss the extenuating circumstances. There were some exceptions, in which the key factor seemed to be an expectation that off-duty health and care professionals should be treated the same as other people for the same act.

And you don't know what the circumstances, someone might have asked them to hold [the cannabis] for them, it could be anything; you can't really treat the person harsher than any other person out there.

3.2.5 Scenario discussions: theft ("shoplifting")

Scenario 7: A *health professional is arrested for shoplifting.*

In this final scenario, participants were very quickly able to identify and articulate why being arrested for shoplifting might raise questions about a professional's fitness to practise. Discussions essentially focused on participants' understanding that fitness to practise is not just about competence but is also about a professional's character and suitability for the role – particularly their honesty and trustworthiness.

Shoplifting was generally viewed as an irrational act. The belief amongst some participants was that health and care professionals ought to be making a reasonable wage and as such should not be driven to acts of desperation through necessity. Shoplifting was also easily linked to theft in the workplace and the feeling was that if theft was occurring outside of work, then it was likely occurring within the workplace as well. Moreover, the trust that is placed in health professionals came under serious scrutiny if that professional was known to have a problem with theft, particularly if they worked within service-users' homes.

It's a trustworthy issue rather than being competent for their job.

If they're shoplifting and if they're not doing that while they're at work like for example going through my bag while I go and do a test in the bathroom or something like that, and I don't have a problem with that because that's outside their work life. But if it's while they're on the job and they're actually taking my possessions, they're actually stealing from me then I think that's a great misconduct.

If I'm working in a laboratory somewhere probably the fact I've been shoplifting, take your example, isn't really going to affect my work. If I am somebody who goes in

somebody else's home, well yes I think that is relevant because what's to stop them lifting things in my home.

I think we really need more information here, again if this is just one off and it's a mistake it's no problem, but if it's an ongoing thing, if they're taking things from shops, it's likely they're taking things from work.

There was also a view that shoplifting might be an act which belies a deeper-seated mental health issue, the act itself suggesting a cry for help. Participants were nearly unanimous in recommending that professionals should undergo a health assessment to identify any underlying problems that may be causing them to 'act out'. The strength of feeling within the discussions on this issue in focus groups was however not reflected in the online survey, where 36.9% recommended regulator involvement in the first instance, only slightly more than for possessing cannabis.

It is important to note that despite the fact that participants were more likely to link shoplifting with an impaired fitness to practise (than any of the other scenarios), and believed that a health assessment was appropriate, they were very careful to discuss consequences in a supportive and rehabilitative rather than punitive context. They wanted to understand the circumstances that might (fully or partially) explain what had occurred, and to find ways to assist the health professional to be fully fit to practise.

I think that is building a picture of a colleague that maybe severely struggling and perhaps does need some support, as an organisation, needs to be addressed.

On the whole, there is little consensus from the public on what they want to be protected from, and to what degree any action may impair a professional's fitness to practise. Key concerns about health professionals shared by members of the public were professionals who were consistently performing below standard, dangerously, or without consideration of patient and service-user needs. There appears to be a commonly held perception, possibly influenced by media reports of gross failures in health and care, that there exists a group of health professionals who consistently escape disciplinary procedures or fitness to practise proceedings through a lack of reporting, or moving to other roles and organisations. This is one area where members of the public felt there may be a role for the HCPC in mitigating, and one which they were clearly able to express their concerns about.

Circumstances, intent, attitude and repeated actions were all important for members of the public to consider when asked how fictional scenarios may affect fitness to practice. In some cases the role or setting of an act was also an important factor in determining the level of impairment.

4. Perceptions of fitness to practise and public protection: professional bodies, registrants, employers and educators

In the HCPC professional stakeholder interviews, we spoke to 20 stakeholders, including HCPC registrants, representatives of professional bodies, employers, educators and CHRE representatives. We sought their about their views on the role of the HCPC, fitness to practise and public protection. The interview topic guide is included in Appendix 2.

In general, the more closely that a stakeholder worked with fitness to practise processes, or indeed with the regulator, the more their responses reflected the defined statutes, standards and procedures that form the fitness to practise process. Few other trends emerged amongst the responses received from stakeholders; they varied nearly as much as responses in the public, patient and carer focus groups. On the whole, the professional stakeholder 'threshold' regarding what might bring a professional's fitness to practise into question was lower that of the public, patient and carer group participants.

4.1 Perceptions of the HCPC

All professional interviewees understood the role of the HCPC as being to protect the public. They correctly identified a wide range of roles and activities undertaken by the HCPC, including setting standards for conduct and ethics and ensuring that health professionals are competent to work safely and effectively.

Ultimately, as protecting the public.

Well public protection for me for my profession is about ensuring that we're training [professionals] to a particular standard which is mapped across to the various competencies that HCPC expect of their registrants.

... to be able to go and be treated by any registered professional and be confident that they were competent but also... honourable that they were going to work in my best interest, that they were not going to be giving me the cheapest treatment and soaking up the money, that they'd come into work having had a decent night's sleep, that they weren't on drugs or whatever.

Some interviewees emphasised the independence of the HCPC, and its ability to act in the best interest of the public without being swayed by any other group or party (including the government or professional bodies).

[The HCPC is there] to make sure that healthcare professionals are appropriately competent to do the jobs that they're doing. And as an independent body they therefore act completely independent of government, of any other sort of vested interest groups.

Two interviewees said that the HCPC's role included upholding registrants' human rights, under the relevant statutes.

4.2 Perceptions of public protection

Stakeholder participants generally defined public protection as protecting the public 'from something'; particularly through the lens of the medical 'do no harm' principle.

Interviewees working with more vulnerable populations, such as social care professionals, defined public protection as protecting people from harm within health and care settings as well as protecting them from 'abuse and exploitation' from outside sources (i.e. their homes and communities).

Other than one or two generic elements mentioned such as drugs or fraud, stakeholder participants did not believe they could comment fully or accurately on 'what the public may need to or want to be protected from'. In some cases their opinion was that it might not be useful to outline the specific acts as it may set some acts apart from others, leaving gaps and so challenging the individual assessment of circumstances in the fitness to practise process.

4.3 Scenario discussions

4.3.1 Thresholds for concern and escalation

In discussing fitness to practise and behaviours that might suggest impairment, the professional stakeholders were more prescriptive than patient, carer and public participants. They were not necessarily more punitive or more inclined to say that situations which suggested impairment inevitably required a fitness to practise investigation. Rather, being more aware of professional standards of practice and ethics, they were willing and able to give much more definitive responses.

Overall, their threshold for thinking that a professional's behaviour might suggest impaired fitness to practise was much **lower** than the public groups. Their threshold for involving the regulator, however, was much **higher**.

Like the patient, carer and public participants, they felt that, in any situation, the particular and individual circumstances would determine its relevance to fitness to practise. Similarly, they too believed that all health and care professionals should meet the same high standards of behaviour and that the consequences of unacceptable behaviour should be the same for all working in health and care, regardless of profession.

Compared to the patient, carer and public participants, professional stakeholder interviewees ascribed employers a much larger role in questioning and determining fitness to practise, as the first arbiter when situations arise and subsequently in liaising with the regulator

I think if it's within the employer's area of responsibility then it's for the employer to deal with that as they see fit through their standard disciplinary processes and it would be for the employer to decide whether they wanted to escalate that to HCPC or not.

Most of the stakeholder interviewees were employed by professional bodies or large NHS organisations. They were uncertain about whether employers in smaller organisations have the same ability and capacity to address fitness to practise issues, and wondered whether there might be (or might need be) different management, escalation and referral processes.

As in the public groups, recurrences of an unacceptable behaviour or practice were seen as much more significant and damaging than 'one offs'. Professional stakeholders in the interviews expected that people would be referred to the regulator for investigation of their fitness to practise if they did not improve after receiving a warning from their employer, and/or after completing a targeted professional development exercise.

Stakeholder interviewees further agreed with members of the public that actions and consequences should be viewed separately. They also, however, believed that the response of an employer or regulator ought to be proportionate to any harm that resulted from a mistake. As an example of this tension, stakeholders generally agreed that poor record-keeping is the same act, and equally unacceptable, regardless of whether any adverse health outcomes result. Nonetheless, they also said that the consequences for a professional whose record-keeping was unacceptable would need to be determined in proportion to any harm caused.

4.3.2 Scenario discussions: record-keeping

Scenario 1: *A health professional's record-keeping is consistently unreadable or incomplete*

Scenario 2: *A health professional's record-keeping is consistently unreadable or incomplete*

When we shared the public views with stakeholder interviewees, they were surprised to hear that patient records within a hospital were perceived as 'safer' than records that had been taken out of a health or care setting. Though they thought it was never appropriate to remove patient records from a health or care setting, and equally felt that doing so would clearly contradict professional conduct and ethics standards, they did not agree with the public view that records were 'safe' as long as they were kept within health and

care settings. Professionals were able clearly to articulate a higher threshold of confidentiality, and duty of care, with reference to patient information and records.

When asked whether a professional's fitness to practise might be affected by leaving a patient's record out in an open area of a care setting, stakeholder participants generally agreed that it might. Their view was that the circumstances under which it happened and the type of information that was in the record would affect the way in which the issue should be addressed. There was consensus that the initial response to this situation would be for an employer to assist the employee with some form of professional development to help them to correct their behaviours.

I don't think it's a regulatory matter, I think it's a management issue.

There has to be some training to ensure that the registrant understands what's expected of them in terms of legibility, what the information is that they have to record, that they have to sign it, put their registration number on, whatever, but then if they fail to do that then it would become a disciplinary matter within the organisation and that's the way that it would normally get reported up to the HCPC.

One participant made an interesting observation about the deliberate use of (arguably) disproportionate responses to one-off incidents as a management strategy.

I think there are huge differences between a one-off and routine bad behaviour, but I do wonder if sometimes, as a one-off, it's used in a way that is out of proportion to the incident because people want to fire a shot across someone's bows or whatever.

Where a professional's record-keeping is illegible or incomplete, again the stakeholder participants deferred to the employer to initiate professional development activities to bring record-keeping to standard. Again, they believed it was the employer's role to document instances and interventions (so that patterns of poor practice are identified sooner rather than later), to monitor improvement, and to report to the regulator if none is made.

In the online survey, no HCPC registrants recommended that incomplete records would require a fitness to practise investigation for a first offence, and only 3.5% recommended it for subsequent offences.

Clearly that's damaging the trust between the patient and the organisation and that would need to be addressed pretty severely and potentially reported to HCPC, especially if it was a repeat.

Participants who had assisted registrants through the fitness to practise process, or who were working for professional bodies, were more likely to discuss self-assessment of fitness to practise. They understood that it was their responsibility to report to the regulator any disciplinary action taken by an employer.

Well my understanding is if an employer takes disciplinary action against you then you need to inform the Regulator...

There was agreement amongst stakeholder interviewees that repeated instances of behaviour relating to either record-keeping scenario were more serious. There was also agreement that where records went missing or were illegible and patients suffered a negative outcome - whether through distress at their records being shared or a negative health outcome - that the response needed to be proportionate to the action and to the breach of trust that had occurred.

4.3.3 Scenario discussions: religious views

Scenario 3: *A health professional has discussed their religious views with a patient during a consultation*

Professional stakeholder interviewees answered with much more certainty than the public groups on this issue. Their view was that discussion of religious beliefs could only ever be appropriate when it was initiated/lead by a service user, within the context of a request for holistic care.

And as part of the holistic care that you are providing for the family and that person at the end of their life, it may be helpful for them to feel in some way that there is an element of understanding there, but it's being led by the client or the patient, it's never something that you would follow through...

As one interviewee pointed out, if such behaviour was reported to a complaints officer or to a professional body the professional had clearly behaved inappropriately – because the complainant felt strongly enough to mention it.

Well, if it's drawn to the employer's attention, it's obviously been a problem because someone has behaved inappropriately or in a way that has been perceived as inappropriately.

Otherwise, in most cases, professional stakeholders felt this was a failure to consider a patient's dignity and to treat them with respect. 'Inappropriate' was the term most often used, and some form of employer involvement might be required. Within HCPC registrants the clear majority of responses (78%) were for some form of informal (and in some cases formal) warning from an employer.

In most circumstances, stakeholder interviewees did not immediately recommend a fitness to practise investigation in such cases. The clear exception, which professional stakeholders said would immediately raise questions about fitness to practise, was if a professional withheld treatment or advised on treatment options based on their own religious beliefs. Stakeholder participants felt, however, that was really very unlikely to happen.

4.3.4 Scenario discussions: criminality

Scenario 4: A *health professional has been charged for drink-driving after attending a party on a weekend they were off duty. They drank 4 or 5 glasses of wine – they have not shown a history of alcohol abuse – does this impact on their ability to do their job?*

Scenario 5: *A health professional has participated in a public protest and has been arrested or detained for a public order offence as they are present when some violence has broken out, but are not directly involved in violence.*

Scenario 7*: A health professional is arrested for shoplifting*.

Stakeholder interviewees gave mixed responses to the 'criminality' scenarios with respect to fitness to practise. There were also different views about whether or not a professional would or should be required to declare arrests, charges or convictions to their employer or to the regulator.

Well I know they do in the sense that that is a requirement to inform them at the present point in time, I do feel somebody needs to know and I am not actually sure now you've raised that question, if that happened to me I don't know whether I would have to, whether I would be obliged to tell my employer.

For those who did believe that professionals had a duty to report convictions to the HCPC, they were uncertain at which point in the criminal justice process (arrest, charges or conviction) they were required to self-report. Those with more experience of the regulator and its processes had a view that it was better to report any instance from the outset, than to have the regulator discover it later on.

4.3.5 Scenario discussions: substance abuse

Scenario 4: A *health professional has been charged for drink-driving after attending a party on a weekend they were off duty. They drank 4 or 5 glasses of wine – they have not shown a history of alcohol abuse – does this impact on their ability to do their job?*

Scenario 6: *A health professional is arrested at a music festival for possession of marijuana; they are not known to be a regular user of drugs*.

Discussions about a conviction of drink-driving or possession of cannabis centred on the duty that health and care professionals have to 'uphold the standards of the profession'. Indeed, one interviewee questioned whether or not a health professional could ever be considered to be off-duty, given the position of trust they hold.

Because of the belief/understanding that professionalism extends beyond the confines of a professional's workplace and working hours, stakeholder interviewees were more likely

than public participants to believe that a conviction of this nature may affect a health or care professional's fitness to practise – but there was no consensus on this issue.

If ... they were convicted of that offence they would need to declare it and then I think a view would need to be taken both by the employer and also by HCPC as whether or not that was going to significantly affect their practise at work.

I think, you know, as a [health professional] I have to say that, you know, are you ever off duty? And the answer is probably not because even if I'm at home and this is sort of speaking personally, as a head of department here I can be phoned up for major incident at any time and I need to be able and fit enough to be able to respond to that in an appropriate way. The degree of responsibility that you need outside the workplace in order to maintain your professionalism.

Well I think whatever you do outside your place of employment always needs to uphold the standards of the profession, you know. If you are doing things which clearly are illegal then that needs to be brought to the attention of the employer if that's the case.

Where interviewees did believe that fitness to practise was impaired according to these scenarios, it was not seen as significantly impaired to the point of 'being struck-off' or removing the professional's ability to earn a living (unless the justice system effectively did so by rescinding a professional driver's licence). Rather, interviewees believed that an instance of substance abuse painted part of a picture, which may, in combination with other factors, give cause to question and investigate fitness to practise.

Stakeholder participants echoed the views of the public in asserting that possessing cannabis was more likely to affect fitness to practise than drink-driving. This again was because interviewees saw clear intent to act illegally, whereas, some argued, with drink-driving there is a 'legal' impairment in judgement which has lead to the illegal act. This belief seems to be consistent with HCPC registrant responses to the online survey, 53% of which recommended a warning from an employer and a notification to the regulator for a charge of possessing cannabis, compared to only 25% recommending the same for impaired driving charges, and the majority of other responses corresponding to 'less severe' consequences in the case of drink-driving.

They are dealing with an illegal substance and therefore to me that's a criminal offence, and that's the difference between having a few drinks more where you went, having the drink is not the criminal offence, it's having too much to drink and driving that's the criminal offence, and I would differentiate between the two.

Like members of the public groups, professional stakeholders shared a belief in supporting any professional to understand what led them to commit a criminal act, and in responding accordingly and in a rehabilitative manner to any issues relating to substance use and abuse.

4.3.6 Scenario discussions: theft ("shoplifting")

Scenario 7*: A health professional is arrested for shoplifting*.

Professional stakeholders responded to the shoplifting scenario in a similar manner to members of the public focus groups. They believed that shoplifting was an irrational act for a health professional - who should be earning a good wage - to have committed. They were also interested to know what had lead the professional to have committed the act, and were much more likely to recommend some form of assistance for the shoplifting professional than in criminality or substance abuse scenarios.

One interviewee noticed dissonance in their own thinking, which they attributed to believing that a 'cry for help' (i.e. the irrational act) was more worrying than instances of substance abuse.

Yeah. And yet we've not mentioned about assisting people with drugs problems or drink problems.

And again I would be back to saying well, you know, we need to be able to support this individual and that might actually be also a role for HCPC in supporting the individual who's doing something which is really totally unexpected with regard to the professional role that they're undertaking in their day-to-day job.

Stakeholder interviewees were also more likely to believe that shoplifting would affect a professional's fitness to practise because of the contravention of trust that such dishonesty implies.

The contravention of trust is an issue which resonated deeply with the stakeholder interviewees; it was the point at which fitness to practise really came in to question. They raised the same issues and questions that the public raised, in particular about whether shoplifting might indicate a propensity for theft within other areas, such as at work or in service users' homes. The online survey, again confirms the fact that HCPC registrants view shoplifting as serious, 46.9% of all respondents recommending a formal warning from an employer and a notification to the regulator. Only 15.6% of all respondents recommended the initiation of a fitness to practise investigation at the outset.

4.3.7 Health assessments as a response to criminal convictions

Professional stakeholders' views about requiring health assessments after criminal convictions were essentially split along two lines.

One group of interviewees, a very marginal majority, wondered if the recommendation of a health assessment was proportionate response to what was a 'one-off' activity. They could understand why it may be recommended, and appreciated that other processes

may 'miss' serious underlying problems. There were nonetheless uncomfortable with a blanket recommendation about health assessments.

The second group, slightly the minority, believed that a health or care professional's knowledge of the standards of competency and ethics would mean they would understand that they had made a mistake which had called into question their fitness to practise. A health assessment would therefore be considered a 'small-hurdle' to complete in order to have assurances for all parties that they were fit to practise.

I don't see that a health professional, either myself or a member of [professional body] would have a problem in going through such a health assessment. So I don't think for that reason we would have any objection to it.

I mean my gut instinct is that it's disproportionate, but then when you do hear of anecdotal stories in the past when people have had significant dependency problems with alcohol or drugs, and they haven't been picked up, so I very much understand where [proponents] are *coming from on that. Whether having had a couple of extra pints on a Saturday night then means you have to go to that level, I wonder whether that's proportionate.*

Stakeholder interviewees' views aligned closely with those of the public in recommending health assessments in relation to specific convictions. They were:

- most likely to recommend a health assessment after a conviction of shoplifting;
- more likely to recommend a health assessment after a conviction of possessing illegal drugs (online survey respondents 57.8% would recommend);
- less likely (and on the whole unlikely) to recommend a health assessment after a conviction of drink-driving (online survey respondents 42.2% would recommend).

Professional stakeholders were concerned about the unintended implications or precedents caused by defining public protection or outlining what members of the public may wish to be protected from. They associated public protection with the prevention of harm, both within health and care settings and in the community.

Professionals were more likely than members of the public to assign a large role to employers in the determination of impairment of fitness to practise, specifically in the role of referring health and care professionals to the regulator.

Professionals also saw a need to discuss circumstances related to any potential impairments or off duty criminality, however their threshold for suggesting a fictional incident 'might' affect one's fitness to practise was lower than that of members of the public. This was attributed, in part, to their increased knowledge of standards of practise, including 'upholding the public perception of the profession'.

5. Perspectives from respondents to the online survey

5.1 Overview

The online survey asked respondents to identify whether they were a member of the public, a HCPC registered health or care professional, non-HCPC registered health or care professional or other. The vast majority of the 204 respondents members of the public (48%) or were an HCPC registered professional (37.3%).

A further 30.4 % had not heard of the HCPC before taking the survey, meaning they would have little or no knowledge of the fitness to practise process. Interestingly, their responses reflected a very similar pattern to both members of the public who had further knowledge of the HCPC well, and of HCPC registrants themselves.

Survey questions were designed to assess the respondents' views of what constituted an appropriate response in terms of action (or inaction) to a number of scenarios of health professionals' behaviours. A number of follow up questions to each scenario were developed to further clarify respondents' opinions. It is however important to note the limitations of the survey methodology, as compared to the qualitative approaches used in earlier phases of the project. While the focus groups and interviews provided opportunities for participants to explain the reasons for their responses and to explore the 'grey areas', survey respondents were essentially limited to choosing from the response options available.

The online survey questions and full data breakdowns are provided in a separate document as Appendix 3.

The results of the online survey seem to show a slightly more lenient viewpoint on some of the scenarios, in that the threshold for notifying the regulator seemed higher than in the public focus groups.

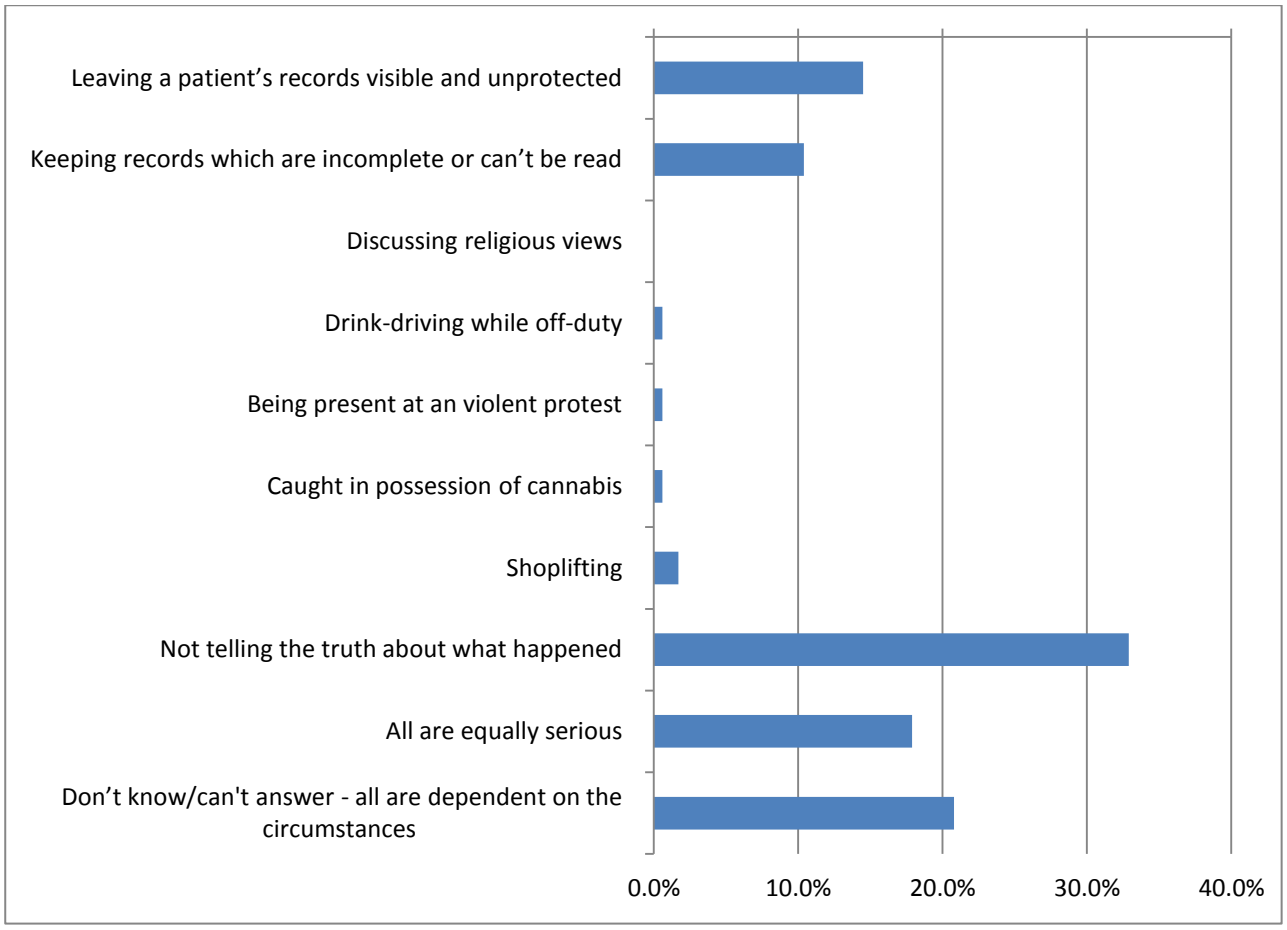
The online survey asked respondents to choose an appropriate consequence (including no action) for the professionals in each of the scenarios. The degree of concern about fitness to practise in each case can be inferred from respondents' choices, and seems slightly more lenient than views expressed in the focus groups and interviews. It may be that online survey respondents were less inclined to specify a punitive consequence based only on the minimal information presented in the scenarios.

As in the focus group and interview stage of this research, the responses from individuals vary greatly. For nearly all scenarios, there were respondents choosing 'no action' at the same time as others were recommending that a fitness to practise investigation be

initiated. There was however a clear shift towards consensus – and towards more severe consequences - for repeated actions, for dishonesty and for seeking to avoid taking responsibility for behaviours and/or adverse outcomes.

'Not telling the truth about what happened' was viewed very negatively by online survey respondents, and was the issue likely to cause most concern about fitness to practise.

Chart 1: *Of all the scenarios you have just seen, which would make you most concerned about a health or care professional's ability to do their job safely and effectively?*



Reflecting the focus group and interview findings, 20.8% of online survey respondents felt that they would need to know more about the circumstances in order to say which scenario would make them most concerned; on the information provided, 17.9% regarded all the scenarios as equally serious.

5.2 Scenarios

Online survey respondents were offered six response options to all scenario questions that reflected the potential consequences identified by participants in the earlier stages of the research:

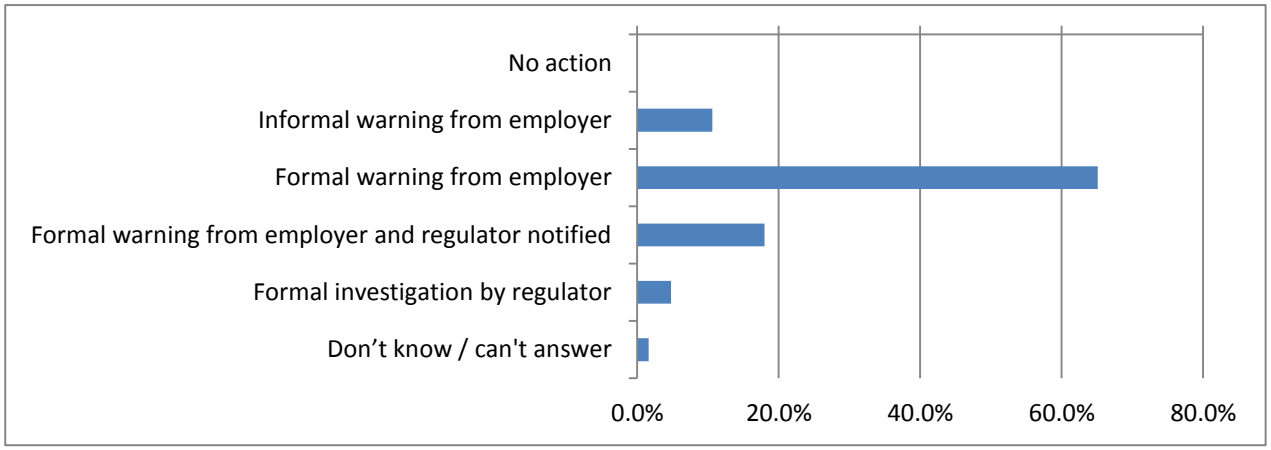
- no action;
- informal warning from employer;
- formal warning from employer;
- formal warning from employer and regulator notified;
- formal investigation by regulator;
- don't know / can't answer.

There were only two types of scenarios where no respondents chose the 'no action' category - questions about record keeping, and scenarios where health or care professionals were found to be dishonest.

5.2.1 Scenarios: record-keeping

Like the stakeholder interviewees, online survey respondents largely agreed that responsibility for addressing poor record-keeping should fall to the employer in the first instance.

Chart 2: *People working with a health or care professional report that the records they keep are difficult to read or incomplete. This is first time that they have noticed the problem. What should happen?*



When asked about records that were left out in an open area of the hospital, more respondents chose options relating to regulator notification and regulator investigation (a jump of nearly eight and just over five percentage points respectively).

More severe responses were chosen when respondents were told that personal information was seen and copied by a member of the public. Essentially, as in the focus groups and interviews, survey respondents indicated that the consequences for the professional concerned should reflect the outcome of their behaviour, as well as the behaviour itself.

Chart 3: *A health or care professional left a patient's personal records in a public area. What should happen?*

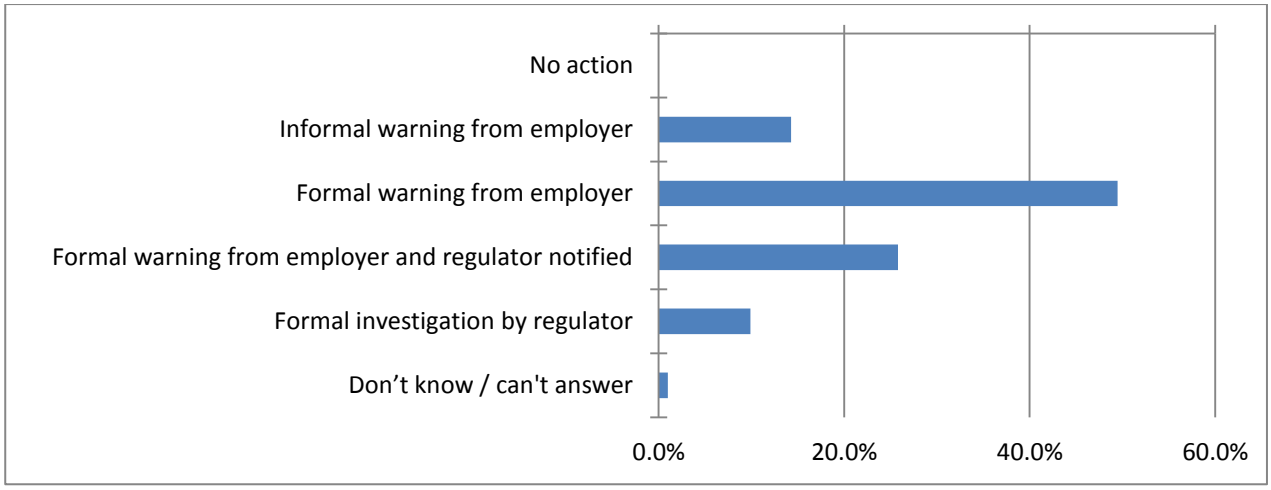
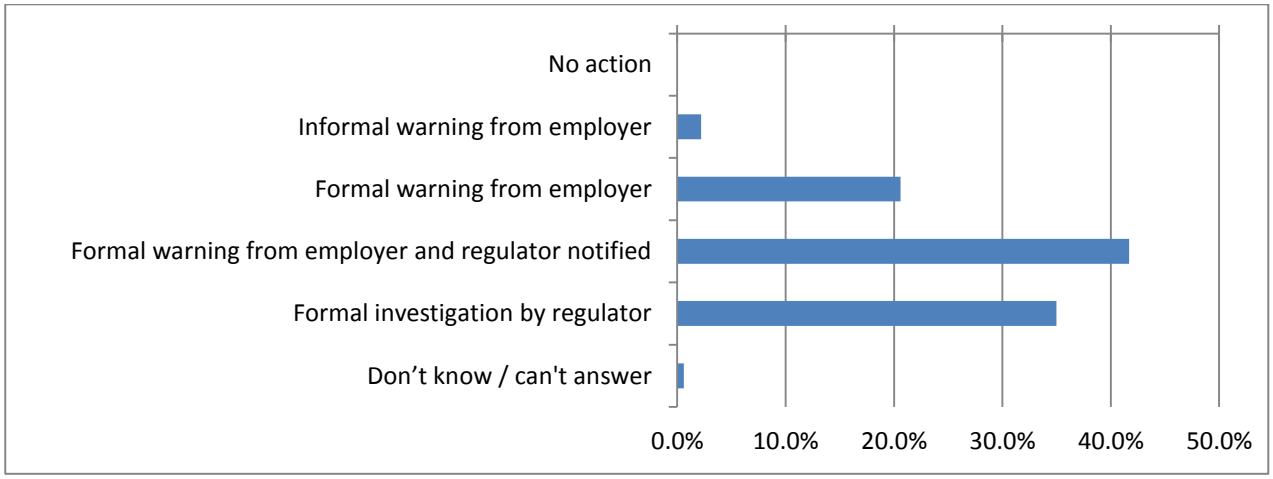


Chart 4: *The records that were left visible and unprotected contained the patient's name, all their contact details and a full medical history. A member of the public saw and copied information from them. What should happen?*



5.2.2 Scenarios: criminality

The online survey showed a variety of viewpoints regarding off-duty criminal activities. Despite the illegality of all three offences, different consequences were considered appropriate for charges of drink-driving, possession of cannabis and shoplifting. This may point to the societal views about acceptability or to the perceived importance of 'intent', as explored in the focus groups.

Notably:

- 33.9% of respondents recommended no action for a charge of drink-driving compared to 10.3% 'no action' for possessing cannabis and 16.1% for shoplifting;

- 6.8% of respondents recommended a formal investigation by the regulator for drink-driving, whereas 17.1% did so for possessing cannabis and 15.5% for charges of shoplifting.

Chart 5: *A health or care professional is charged by the police for drink-driving after attending a party on a weekend when they were off-duty. They drank four or five glasses of wine. There is nothing to suggest that they have a problem with alcohol. What should happen?*

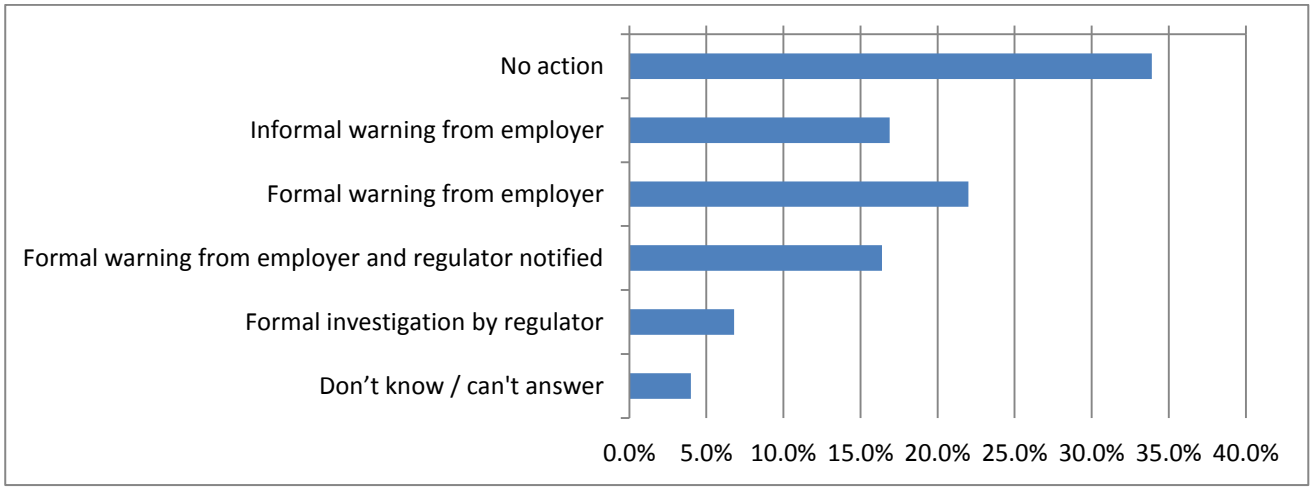


Chart 6: *A health or care professional is arrested at a music festival for possession of cannabis. They are not known to be a regular user of illegal drugs. They are charged and convicted of the offence. What should happen?*

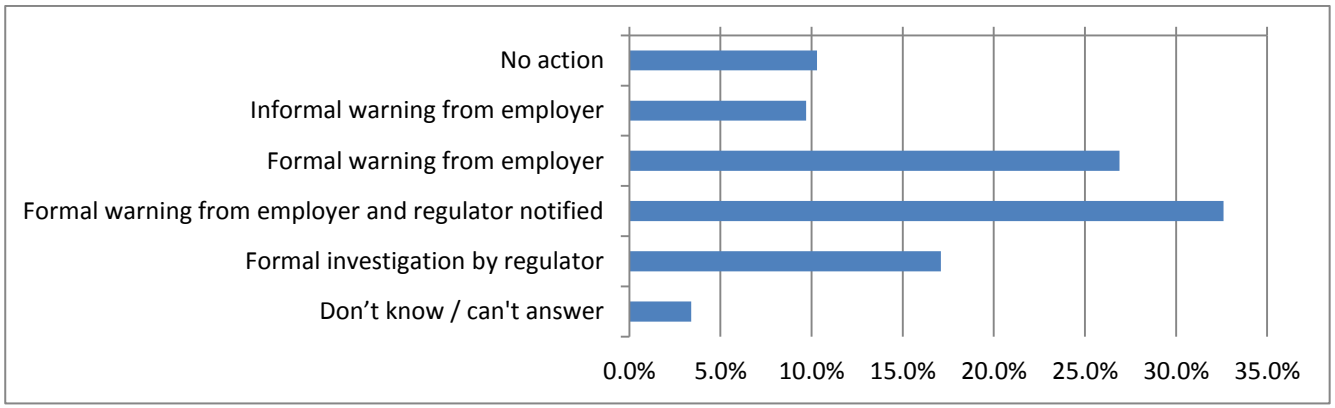
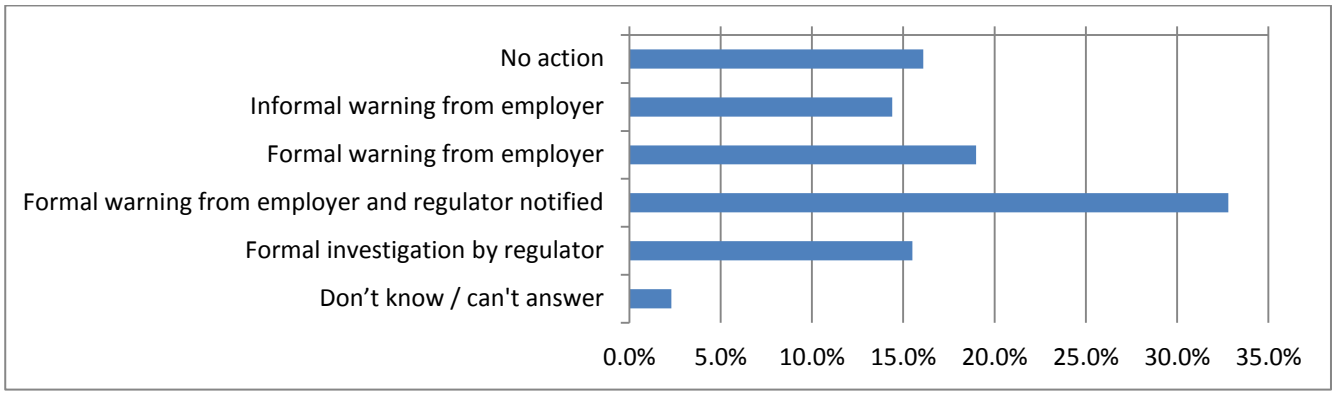


Chart 7: *A health or care professional is convicted of shoplifting. What should happen?*



Further evidence of the disconnect between drink-driving and drugs offences is seen when respondents were asked whether they thought a professional should have to take part in a formal health assessment to see if they have a problem with alcohol (or drugs) that may affect their work.

In the case of drink-driving, 36.1% felt they should, 47.5% did not think they should and 16.4% could not answer. In the case of possessing cannabis 60.6% recommended a health assessment, 25.7% felt they should not have a health assessment and 13.7% could not answer.

Chart 8: *Do you think that this professional should have to take part in a formal health assessment to see if they have a problem with alcohol that may affect their work?*

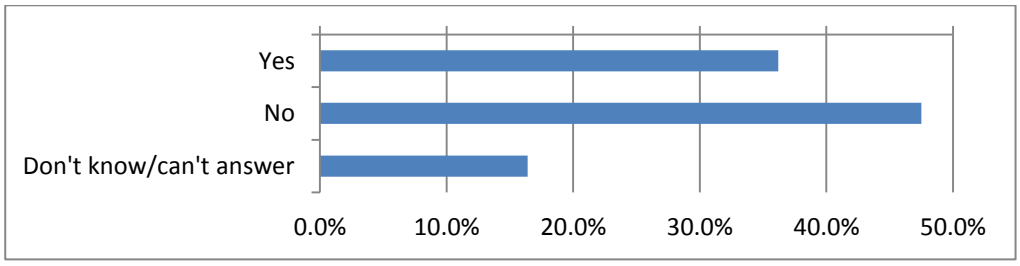
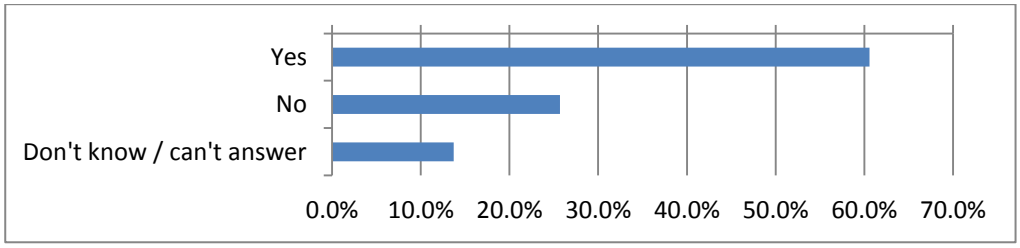


Chart 9: *Do you think that this professional should have to take part in a formal health assessment to see if they have a problem with illegal drugs that may affect their work?*



5.3 Type of profession/role in determining appropriate consequences

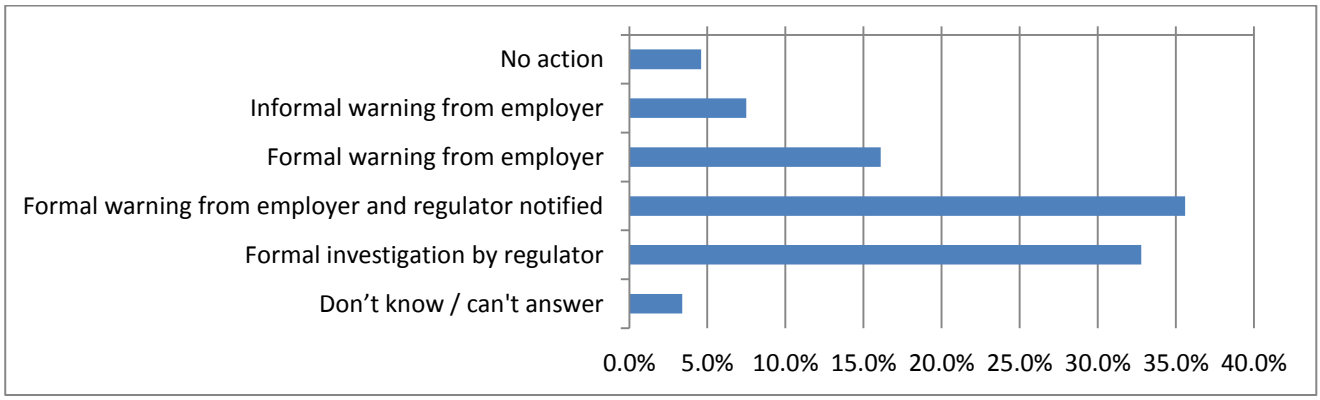
When asked about the standards for professionals, both the public focus groups and the stakeholder interviews felt that the standards of practice and ethics should be the same for all professions regulated by the HCPC regardless of whether they were public-facing or not. A very few participants added that some professions may have additional requirements in order to meet their duty of care, but on the whole most participants agreed that the nature of health and care professionals' work necessitated high standards of behaviour.

We explored this further in the online survey by providing further information on, or slightly changing, some of the scenarios.

Online survey respondents were asked what the appropriate consequence would be for a health professional who was charged with shoplifting *and who regularly worked in people's homes*. Compared to the original 'shoplifting' scenario, there was a drop of 11.5 percentage points recommending no action and an increase of 17.3 percentage point recommending a formal investigation by a regulator.

Based on the responses given in earlier phases of the project, there was a perception that though all health and care professionals hold a position of trust, that those who work within people's homes have a higher position of trust due to their place of work; as such, the contravention of that increased trust appears to be viewed more negatively with online survey respondents recommending a more severe consequence in this instance.

Chart 10: *The professional who was convicted of shoplifting regularly provides services in people's homes. What should happen?*



When asked what action might be appropriate where a health or care professional had shared their religious views but the patient was **not** distressed, 40% of respondents felt that no action would be required and 47.6% felt that an informal warning would be appropriate. No respondents recommended a formal investigation by the regulator.

When the scenario was changed to a clinical psychologist sharing their religious beliefs with a vulnerable adult, only 6.5% said no action, 15.1% said informal warning from the employer and 14% said a formal investigation by the regulator. There was a much larger group (10.2% vs. 1.0%) who responded that they didn't know or couldn't answer the question.

Chart 11: *A patient says that a health or care professional talked about their religious beliefs during a discussion about her care and treatment options. The patient did not share the professional's religious beliefs, but* ***WAS NOT*** *offended or distressed. What should happen?*

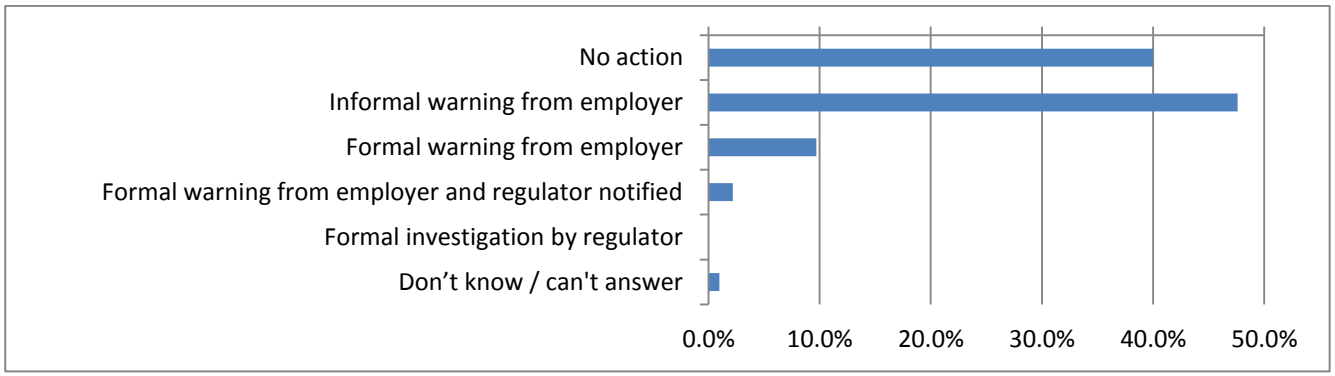
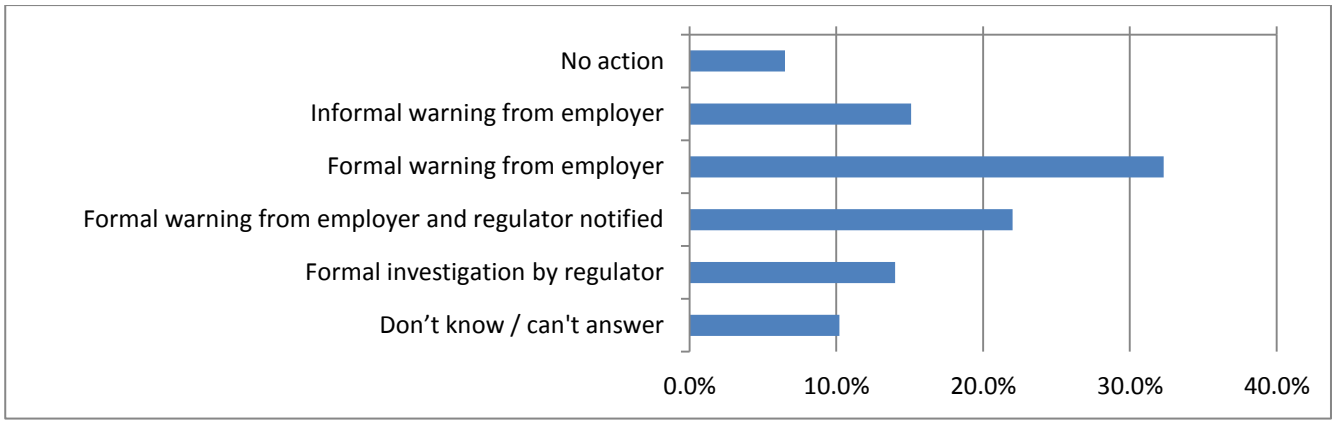


Chart 12: *If the patient was a vulnerable adult and the health professional that raised their religious beliefs was a clinical psychologist, what should happen?*



5.4 Views of male and female respondents

Participants in the online survey gave a similar pattern of responses to the scenarios regardless of gender. On most questions, male participants were however more likely to say either 'no action' or 'formal investigation by regulator' than female participants, and women were more likely than men to recommend employer involvement.

A full breakdown of male and female responses is available in Appendix 3.

Chart 13: *Male vs female responses – people working with a health or care professional report that the records they keep are difficult to read or incomplete. This is first time that they have noticed the problem. What should happen?*

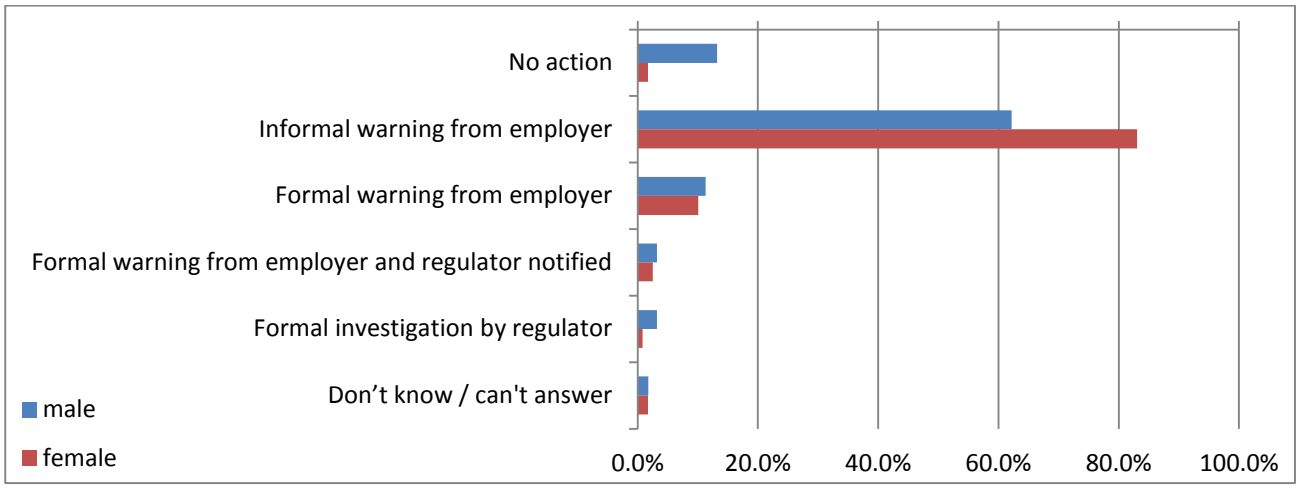
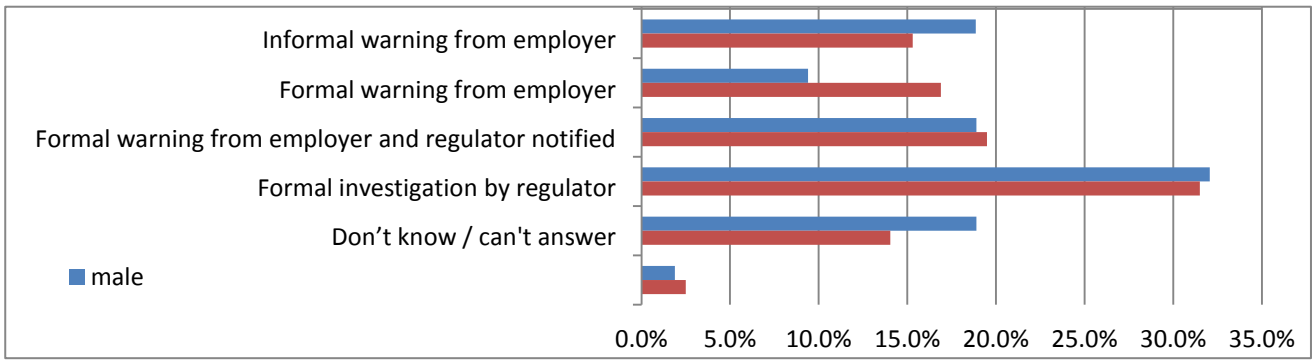


Chart 14: *Male vs female responses – a health or care professional is arrested at a music festival for possession of cannabis. They are not known to be a regular user of illegal drugs. They are charged and convicted of the offence. What should happen?*



5.5 Views of respondents by profile

HCPC registrants were less likely than members of the public or health or care professionals not registered with the HCPC to recommend a formal fitness to practise

investigation for leaving a record in a public area or similar scenario (see chart 15) but were more likely to recommend one in the case of drink-driving (see chart 16), suggesting that their awareness of self-referral of fitness to practise issues may affect their responses.

Chart 15: *Respondent profile responses: A health or care professional left a patient's personal records in a public area. What should happen?*

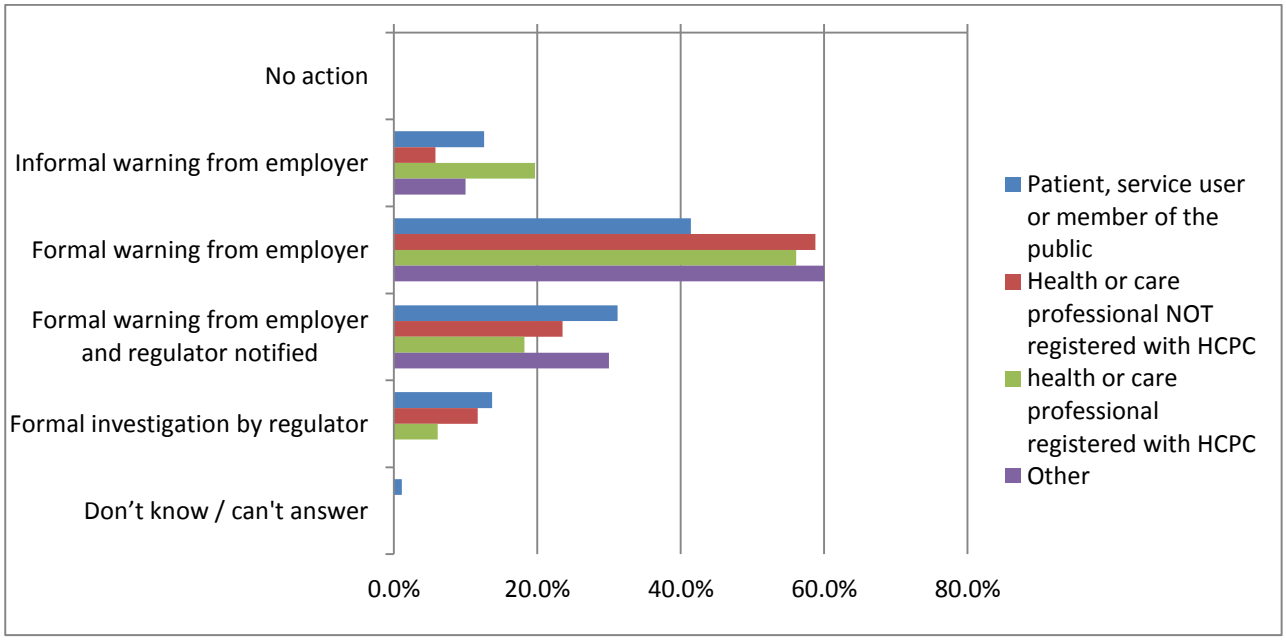
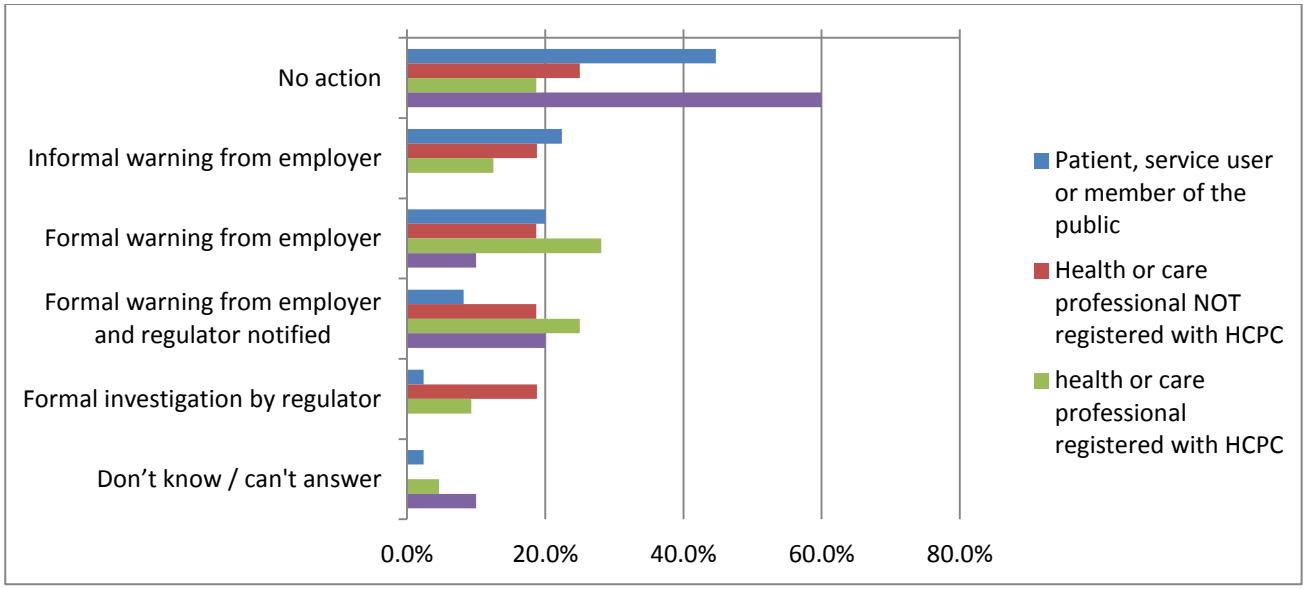


Chart 16: *Respondent profile responses: A health or care professional is charged by the police for drink-driving after attending a party on a weekend when they were off-duty. They drank four or five glasses of wine. There is nothing to suggest that they have a problem with alcohol. What should happen?*



As illustrated in the earlier stages of the study, the results of the online survey reiterate the range of views on how different actions, incidents or convictions may impair fitness to practice. The online survey questions asked about consequences for scenarios rather than for the degree to which any scenario may affect a health or care professional's fitness to practise.

The survey did highlight one crucial difference from earlier stages. Real consequences as a result of health or care professional's actions and the nature of a professional's role and relationship with patients influenced respondents' views regarding the most appropriate course of action.

Appendix 1: patient and carer focus group topic guide

Welcome and Introductions.

Introduce self and Picker Institute Europe.

Introduce Project:

The Health and Care Professions Council (HCPC) is the independent regulator of 16 health, social work and psychological professional groups across the UK and social workers in England. Its role as regulator is to set and maintain standards of the professions to include elements such as education, training, skills, behaviour, registration and fitness to practise. HCPC's fitness to practise process is centred on the desire to protect the public from harm.

More on fitness to practise:

The purpose of out fitness to practise process is to protect the public from those who are not fit to practise. If a professional's fitness to practise is impaired, it means that there are concerns about their ability to practise safely and effectively. This may mean that they should not practise at all, or that they should be limited in what they are allowed to do. Sometimes professional make mistakes that are unlikely to be repeated. This means that the person's overall fitness to practise is unlikely to be 'impaired.' Our processes do not mean that we will pursue every isolated or minor mistake.

This means that the fitness to practise process is very different from other types of complaints processes. The process is not designed, for example, to provide complainants with an explanation, an apology or compensation. It is also not designed to punish registrants for a mistake (i.e. a mistake may have been made but this might not be sufficiently serious to impair that registrant's fitness to practise).

This focus group is one of 6 that forms the first stage of a project to consult with the public, health professionals and other stakeholders on what behaviours, actions, etc. are relevant for public protection and fitness to practise.

- Arts therapists
- Biomedical scientists
- Chiropodists/podiatrists

- Clinical scientists
- Dietitians
- Hearing aid dispensers
- Occupational therapists
- Operating department practitioners
- Orthoptists
- Paramedics
- Physiotherapists
- Practitioner psychologists (e.g. Clinical psychologists)
- Prosthetists and orthotists
- Radiographers
- Social workers in England
- Speech and language therapists

Ask if anyone has any questions

Go through key points on info sheet, explain digital recording, and ask for signed consent forms.

Participant introductions

Warm up

Theme - defining health, social work and psychological professionals

If you think about the health professionals that have treated you or one of your family members – what types of things would make you decide that they were a 'good' Health Professional?

What type of a status do Health Professionals have? How do people view them? Do we think about them differently?

Why do we trust health professionals?

Status of Health, social work and psychological professionals

Do we accept certain ways of behaving, or ways of being treated from health professionals that we wouldn't from others?

Thinking about what we've just said about trust, and behaviours, do you think that health professionals have a responsibility to behave in a certain way?

- What happens if a health professional doesn't live up to that responsibility?
- At work?
- In their personal life?

Concerns about Health, social work and psychological professionals

In the last 12 months have you heard of anything concerning about health professionals? Perhaps in the newspapers, on the television, from other people- friends, family members or people in the group/forum?

Can you think about what it's like when you see a health or social care professional? Can you think about things that may make you feel unhappy, uncomfortable or unsafe when visiting a health professional?

Prompts:

- Lack of cleanliness
- Waiting time
- Poor communication
- Poor clinical skills
- Not enough information
- Bad follow up care
- Inappropriate behaviour
- Out of date equipment
- Poorly organised clinic

Scenarios for discussion: professional behaviours

We're going to talk through a number of scenarios or examples of ask a you some questions about them.

1. A health professional has left a patient record in an open area of the hospital that they practise in – is this a problem?
   Supplementary questions:

- *If this was the first time it happened?*
- *if this was a regular occurrence?*
- *If this professional had been warned about this behaviour by their employer*
- *What type of consequence would be appropriate?*

A health professional's record-keeping is consistently unreadable or incomplete, is this a problem?

Supplementary questions:

- *If it leads to inappropriate treatment by another professional does your view on this change?*
- *If the health professional's record keeping has not improved despite the issue having been addressed by their employer? Colleagues?*

A health professional has discussed their religious views with a patient during a consultation. Does this affect their fitness to practise?

Supplementary questions:

- *Does this change circumstantially – ie general discussion passing the time vs. discussing use of faith in treatment? Etc?*

Scenarios for discussion : criminality

We're going to ask a number of questions about criminal charges which have occurred while professionals are 'off duty' and see whether they have an impact on a health professional's fitness to practise.

A health professional has been charged for drink-driving after attending a party on a weekend they were off duty. They drank 4 or 5 glasses of wine – they have not shown a history of alcohol abuse – does this impact on their ability to do their job?

Supplementary questions:

- *Should a regulator be made aware of this conviction?*
- *Should there be any professional consequences, or are the justice system sanctions enough?*
- *Should the professional have to undergo a health assessment to see if they have an issue with alcohol?*

A health professional has participated in a public protest and has been arrested or detained for a public order offence as they are present when some violence has broken out, but are not directly involved in violence.

Supplementary questions:

- *Does this affect their fitness to practise?*
- *Should the regulator be made aware of the arrest/charges?*
- *What consequences, if any, should the health professional face?*

A health professional is arrested at a music festival for possession of marijuana; they are not known to be a regular user of drugs.

Supplementary questions:

- *Does this affect their fitness to practise?*
- *If they were to go on shift that evening does your opinion change?*
- *Should the regulator be made aware of the arrest/charges?*
- *Should the professional have to undergo a health assessment to see if they have an issue with drugs?*

A health professional is arrested for shoplifting.

Supplementary questions:

- *Does this affect their fitness to practise?*
- *Should the regulator be made aware of the arrest/charges?*
- *Should the professional have to undergo a health assessment to see if they have a mental health issue?*

Follow up questions which may apply to any/all of the above scenarios:

What role do employers have in resolving issues? When is a regulator required to decide?

Does it matter if this is the first time that the health professional has made this mistake? Would it concern you more if this happened regularly? How does that affect whether the public needs to be protected?

Does the type of health professional change the way you feel about the scenario or do you feel all health professionals should be held to the same standard? (might choose two specific professions for a scenario to discuss)

Are there any gray areas?

If we round up all of the scenarios we discussed today – is there one that has stuck out for you as the most serious?
Why?
Least serious?
Why?

Thanks, incentives and close

Appendix 2: professional interviews topic guide

Welcome and Introductions.

Introduce self and Picker Institute Europe.

Introduce Project:

Thank for participation in the project and for time today – explain that interview will take no more than 30-40 minutes.

Audio recording – explain rationale, emphasise confidentiality, obtain consent.

Start recording and clearly indicate that now recording (e.g. state date and interviewee name for benefit of recorder).

Introductory questions

Could you briefly tell me about your organisation and your role?

- Who do you work with/represent?

What's your knowledge of the HCPC – have you had much involvement with them?

- How do you view their role?

What does the term 'public protection' mean to you?

What do you know about the fitness to practise process?

Scenarios for discussion – professional competence

We're going to talk through a number of scenarios or examples and ask you for your reactions/responses to them.

A health professional has left a patient record in an open area of the hospital that they practise in – is this a problem?

A health professional's record-keeping is consistently unreadable or incomplete, is this a problem?

A health professional has discussed their religious views with a patient during a consultation. Does this affect their fitness to practise?

Scenarios for discussion - criminality

We're going to ask a number of questions about criminal charges which have occurred while professionals are 'off duty' and see whether they have an impact on a health professional's fitness to practise.

A health professional has been charged for drink-driving after attending a party on a weekend they were off duty. They drank 4 or 5 glasses of wine – they have not shown a history of alcohol abuse – does this impact on their ability to do their job?

Supplementary questions:

- *Should a regulator be made aware of this conviction?*
- *Should there be any professional consequences, or are the justice system sanctions enough?*
- *Should the professional have to undergo a health assessment to see if they have an issue with alcohol?*

A health professional has participated in a public protest and has been arrested or detained for a public order offence as they are present when some violence has broken out, but are not directly involved in violence.

Supplementary questions:

- *Does this affect their fitness to practise?*
- *Should the regulator be made aware of the arrest/charges?*
- *What consequences, if any, should the health professional face?*

A health professional is arrested at a music festival for possession of marijuana; they are not known to be a regular user of drugs.

Supplementary questions:

- *Does this affect their fitness to practise?*
- *If they were to go on shift that evening does your opinion change?*
- *Should the regulator be made aware of the arrest/charges?*
- *Should the professional have to undergo a health assessment to see if they have an issue with drugs?*

A health professional is arrested for shoplifting.

Supplementary questions:

- *Does this affect their fitness to practise?*
- *Should the regulator be made aware of the arrest/charges?*

- *Should the professional have to undergo a health assessment to see if they have a mental health issue?*

If we round up all of the scenarios we discussed today – is there one that has stuck out for you as the most serious?

- Why?
- Least serious?
- Why?

Priority areas for these interviews:

Testing public opinions (prompts at end of scenarios):
In the focus groups with the public, we found that they viewed the scenario of being caught with a joint in a pocket at a music festival as much more serious than the incidence of drink-driving - do you have any views on why this might be?

- Do you think your members/students/colleagues would agree with the public perception or would their perspective be different?
- What might be different and why?

In terms of criminal convictions, members of the public were almost unanimous in recommending a health assessment for shoplifting, generally in favour in recommending a health assessment for drugs related officences, but did as often believe that a health assessment would be necessary for drink-driving

- Do you think your members/students/colleagues would agree with the public perception or would their perspective be different?
- What might be different and why?

Focus group participants were less concerned about leaving a record in the open within a healthcare setting than they were about it being removed from a hospital/healthcare setting

- Do you think your members/students/colleagues would agree with the public perception or would their perspective be different?
- What might be different and why?

Bad recordkeeping was always seen as fairly negative, but was perceived as a much more serious issue than that of the health record being left out where others had access to it

- Do you think your members/students/colleagues would agree with the public perception or would their perspective be different?
- What might be different and why?

Follow up questions which may apply to any/all of the above scenarios:

What role do employers have in resolving issues? When is a regulator required to decide?

Does it matter if this is the first time that the health professional has made this mistake? Would it concern you more if this happened regularly? How does that affect whether the public needs to be protected?

Does the type of health professional change the way you feel about the scenario or do you feel all health professionals should be held to the same standard? (might choose two specific professions for a scenario to discuss)

Are there any gray areas?

Thanks and close

Stop recording

Is there anything you would like to ask me?

Thanks and close.

Appendix 3: online survey response tables

Appendix 3 is provided as a separate document. It comprises:

- responses to online survey questions, all respondents;
- breakdown by respondent role;
- breakdown by knowledge of HCPC;
- breakdown by sex of respondents.

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Institute Europe

Making patients' views count

Understanding Public Protection

1 Introduction

1.1 This paper looks at the research undertaken by Picker Institute Europe on our behalf on 'Understanding Public Protection; Exploring Views on the Fitness to Practise of Health and Care Professionals.' It sets out what, if any, action is recommended by the Executive as result of the research.

1.2 This piece of research forms part of a wider programme of work which emerged in part from the 2010-11 Council for Healthcare Regulatory Excellence (CHRE) performance review. The Review reiterated the recommendation that regulators should adopt the practice of asking registrants who are convicted or cautioned for drug or alcohol related offences to undertake a health assessment. It was agreed by the Fitness to Practise Committee in October 2011, that any review of approach in this area should look more widely at our approach to the treatment of registrants who had been convicted or cautioned for an offence, rather than adopting CHRE's more universal approach.

1.3 In recent years, a range of research has been commissioned looking at views of our fitness to practise process. It began with the Gulland Review in 2008, which identified the lack of research in relation to complaints about HCPC registered professionals compared for example with doctors and nurses (http://www.hcpc-uk.org/assets/documents/10002AACScopingreportonexistingresearchoncomplaintsmechanisms.pdf). This was followed by the IPSOS Mori research in 2010 on '*Expectations of the Fitness to Practise Process*' (http://www.hcpcuk.org/assets/documents/10003E52ExpectationsoftheFitnesstoPractiseComplaintsProcess.pdf)and in 2011 by a follow up IPSOS Mori report on Mediation. (http://www.hcpcuk.org/assets/documents/10003E51ExpectationsoftheHPCFitnestoPractiseProcessFinalReport.pdf).The 'Expectations' research included in-depth interviews with registrants, complainants and employers who had made complaints. The research found that members of the public complain for a variety of reasons and that the purpose and limitations of the fitness to practise process was not always well understood. These findings informed further work looking at ways in which we could improve and develop upon our existing processes and at exploring our approach to justice and the promotion of public protection. One of the key outcomes was a document setting out our approach to justice and a policy statement on the meaning of fitness to practise.

1.4 This research continues to pursue greater understanding in this area, and will both be used to build upon the evidence base of regulation and to increase understanding and wide dissemination and debate on the concept of public protection in health and social care settings.

2 HCPC Process

2.1 Our approach for dealing with allegations which might indicate that a registrants fitness to practise is impaired and for dealing with character issues which might prevent an applicant from admitting, readmitting or renewing to the Register, is well established. The key component to both of those processes is the management of a FTP or Health and Character case on a case by case basis, considering the circumstances of each case to determine what action is necessary. In terms of HCPC's approach to ensuring the fitness to practise of its registrants, it is perhaps worth highlighting the core principles of professional self-regulation. These include the expectation that a registrant manages his or her own fitness to practise. Subsequently, the degree of insight indicated by registrants or applicants in responding to an issue that has been raised in relation to their ability to practise their profession is key.

2.2 Fitness to Practise Process

2.3 Our fitness to practise process provides a range of opportunities for registrants to respond to an allegation that has been made against them and to assist a panel considering the case. Firstly, in determining whether there is a realistic prospect that a final hearing panel will find that registrant's fitness to practise impaired, and secondly, at a final hearing, whether that is the case. The fact that a registrant has made a mistake or even caused harm does not necessarily mean that that registrant's fitness to practise will be found impaired. We have produced a range of guidance material which sets this test out in more detail and have produced a policy statement on the meaning of fitness to practise.

2.4 Our case by case approach to our activities in the area of fitness to practise means that every case has to be judged, assessed and investigated on its merits. More detail on this approach can be found in the accompanying paper to this one, 'Requesting further information'.

2.5 Health and Character

2.6 A similar approach is taken when considering declarations by applicants' admission, readmission or renewal to the Register. When considering such declarations here and through the self-referrals process, consideration is given to the extent to which a registrant or potential registrant is managing their own fitness to practise. The Health and Character policy previously approved by the Education and Training Committee in November 2010 provides that in considering such cases

'*Panels should take account of;*

- *the nature and seriousness of the offence or misconduct;*
- *when the incident occurred; and*
- *the applicant's/registrant's conduct since the incident'*

2.7 The guidance on health and character also provides that *'if you declare a health condition to us, we will want to be sure that you have insight and understanding into your health and how that could affect your ability to practise safely and*

effectively. By insight and understanding we mean that you have a realistic, informed idea of the limits of your safe practice.' It also goes onto provide in relation to self-referrals that '*Declaring this information is part of your professional responsibility as a registrant and we believe that it shows insight and understanding.'*

3 The Standard of Conduct, Performance and Ethics

3.1 Standard 4 of the Standards of Conduct, Performance and Ethics sets out that '*We can take action against you if you are convicted of a criminal offence or have accepted a police caution. We will always consider each case individually to decide whether we need to take any action to protect the public.'* It is again important that each case, throughout the process, is considered on a case by case basis.

4 Related research by HCPC

4.1 In recent years, a programme of research to look more closely at conduct and professionalism has been undertaken. That research has included a qualitative study by researchers at Durham University looking at student and educators' perceptions of 'professionalism' (Morrow et.al, 2011). What emerged was that 'professionalism' was seen not so much as a discrete competency but a situational judgement, a set of behaviours influenced by context, rather than a fixed, defined characteristic. These behaviours were strongly influenced by the particular care group, peer group and knowledge and skills of an individual. How peers behaved, for example, could strongly influence how an individual viewed 'professional' behaviour and what was appropriate in one context might not be in another. The use of humour, calling a patient by their first name were examples of behaviours which needed to be adapted depending on the context, and the skill of professionalism was knowing what to do and when to do it. HCPC has commissioned Durham University to undertake further work looking at ways of measuring professionalism and whether and how this might add value to the measures already in place as part of registrants' performance development and review processes.

4.2 Taken together, these pieces of work support a common theme around the context sensitive nature of human behaviour and the need to consider this in any process which relates to judgements about fitness to practice.

5 The Picker study

5.1 Picker Europe were commissioned through a competitive process to undertake a study on understanding public and professional views of the concept of 'public protection.' This included looking at perceptions of fitness to practise and whether and how views differed on what information might be relevant to the regulator

5.2 There were interesting differences between the public and professionals perceptions. For example, members of the public had a higher threshold than professionals for thinking that an individual's behaviour might suggest impaired fitness to practise. However, both groups showed more tolerance for dishonesty and on-duty failure to adhere to core standards than off duty scenarios involving

use of alcohol, for example. The report observed that, above all, both public and professionals expected to be protected from consistently poor performance, 'repeat offenders', who might have continued to practice unnoticed. Other key themes which emerged from the study included:

- *an expectation that professionals should be honest and trustworthy, both on and off duty;*
- *greater concern about possession/use of illegal drugs, attributable to intent and the choice knowingly do something illegal;*
- *greater concern about serial behaviour, such as moving from one employer to another and concealing a history of 'minor' issues*
- *no consensus regarding what specifically the public would want to be protected from;*
- *no appetite for creating an explicit list of behaviours or acts that should trigger investigation of fitness to practise*

5.3 Overall, the findings support the principles which underpin the current case by case approach. They also align with some of the conclusions made by the Durham study and lend further support to our case by case approach to fitness to practise case activity taken by the HCPC . They also align with some of the conclusions made by the Durham study about the context sensitive nature of professional behaviour. Picker's Executive Summary observes that 'Overall*, there was a consensus that fitness to practise and impairment should be considered on a case-by-case basis, taking all relevant factors and individual circumstances into account. Blanket recommendations and fixed responses would be unpopular with the public and professionals (p5).'*

5.4 Comment is also made at page 4/5 of the report '*That many people wondered if there was a role for the HCPC in monitoring incidents that would, not in themselves, cause concern about fitness to practise but that might indicate a problem if repeated and/or viewed as part of a pattern.'* The accompanying paper to this one on seeking further information, sets out in more detail the provision of the 'three year rule'. As part of the Policy and Standards and Fitness to Practise Department work plan for 2013-14, new guidance for Employers on making a referral to the HCPC will be consulted upon. It is anticipated that this guidance will also include further information on the 3 year rule and dealing with patterns of behaviour. It is nevertheless, important to highlight, that each case is assessed on a case basis, but taking previous history into account.

5.5 The Executive also proposes that the outcomes of this research are taken into account in the work that is scheduled for 2013-14. This will include a review of the written literature on the purpose of the fitness to practise process, the brochures and material relating to how to raise a concern and the guidance that is provided to registrants on responding to an allegation that has been made against them (both at the investigating committee panel and final hearing stage). This work will also include the production of clearer information about how a case is investigated.

5.6 It is also planned that the outcomes from this study are taken account in the work associated with improving the experience individuals have with the fitness to practise process.

5.7 There are a number of other observations from the public and professionals in the report that may merit further investigation and dissemination. For example, page 25 of the report observes that '*There appears to be a commonly held perception, possibly influenced by media reports of gross failures in health and care, that there exists a group of health professionals who consistently escape disciplinary procedures or fitness to practice proceedings through a lack of reporting, or moving to other roles and organisations. This is one area where members of the public felt that there may be a role for the HCPC in mitigating, and one which they were clearer able to express their concerns about.'*

6 Next steps

6.1 It is proposed that the following activity is undertaken as part of the Fitness to Practise work plan for 2013-14 –

- Production of guidance for employers as to how and when to make a referral;
- Review of written literature
- Clearer guidance to registrants on responding to an allegation
- Improving the FTP experience
- Clearer information on how a case is investigated
- Dissemination of the findings through stakeholder events and regular face to face and online updates for registrants, educators and employers, and using the scenarios to generate debate and discussion on the concept of public protection

Analysis of multiple allegations against registrants

1. Introduction

As part of the public protection work plan, it was agreed that an analysis would be undertaken of registrants who had been the subject of multiple allegations. The review was to include a statistical analysis as to the number of registrants who are subject to more than one complaint and also a qualitative analysis. An analysis had therefore been undertaken of all registrants who have been subject more than one allegation from the opening of the HPC register up to the end of August 2012. The data has been broken down in a range of ways and comment is provided on this in paragraph 2. A more detailed analysis has been undertaken of a sample of cases and detail of this is provided at paragraph 3.

2. Statistical break down of cases

A total of 413 registrants were the subject of more than one case. Some of those cases may be on-going, some resulted in a 'no case to answer' decision or were not well founded and some were closed as they did not meet the standard or acceptance.

2.1. Registrants with 'no case to answer' decisions

Twenty three registrants had more than one case against them considered by Investigating Committee Panels (ICP) where a 'no case to answer' decision was made. These registrants did not have any 'case to answer' decisions made against them.

ICPs consider all cases on an individual basis and take account of the information before them. Where relevant, the panel can take account of previous 'no case to answer' decisions. Further detail is provided about this at paragraph 3.1 below.

2.2. Registrants with 'case to answer' and 'no case to answer' decisions

There were 54 registrants subject to multiple allegations, one or more of which resulted in a 'no case to answer' decision, and a further case resulting in a 'case to answer' decision.

Where a 'no case to answer' decision was made the ICP would have found that there was no realistic prospect of a final hearing panel determining that the allegation is well founded. In some of these cases it is possible that the first time the registrant came before the panel there was not significant concern, or there was limited evidence on which to refer the matter for a hearing, but a further case then came to light which formed a pattern of behaviour. As referenced above, where relevant, the ICP can take account of previous 'no case to answer' decisions. Further detail is provided about this at paragraph 3.1 below.

2.3. Registrants with more than one 'case to answer' decision

Ninety six of the 413 registrants have had a 'case to answer' decision made in more than one case. For those registrants, a breakdown of the number of cases was undertaken, for example, one registrant was the subject of seven cases and ten registrants were the subject of three cases. The table below sets out the number of cases individual registrants have been involved in.

Number of registrants with more than one case to answer decision

Number of cases	Number of registrants
2	82
3	10
4	1
5	2
7	1
Total	**96**

If a 'case to answer' decision has been made, this indicates that the allegation is not frivolous but there is a realistic prospect of the case being well founded at a final hearing. These cases may be of more interest as there is a genuine concern being raised against an individual on more than one occasion.

Where the data was available, a breakdown of the ground of allegation against each registrant was undertaken. The aim was to assess whether registrants were facing similar allegations repeatedly, or if there was no pattern in the nature of cases against them. The breakdown of these grounds of allegation is provided in the table below. Of the registrants who were subject to two or more allegations, 18 faced lack of competence allegations on both occasions. Ten registrants were subject to multiple conviction allegations.

Ground of allegation where more than one case to answer decision has been made

Number of cases against the same registrant	Misconduct	Lack of competence	Lack of competence and/or misconduct	Conviction	Conviction & other ground	Health	Health & other ground	Barring & other ground
2	16	18	16	9	15	4	1	1
3		1	7					
4			1					
5				1	1			
7	1							

3. Qualitative review

A random selection of cases from the categories set out in 2.1-2.3 above have been reviewed in more detail in order to assess whether there are any patterns emerging, or learning that can be taken forward. Between 10% and 17% of the categories of cases discussed above were reviewed. This sample size was selected to provide detailed review of a reasonable number of cases but with the resources and time available. The information that was assessed was:

- Year each allegation was received;
- The ground of each allegation;
- The outcome of the case; and
- Other factors such as reasons provided by the panel for their decision or whether the case was joined.

Tables summarising the review of each registrant are attached to this paper.

3.1. Registrants with 'no case to answer' decisions

The cases involving four of the twenty three registrants in this category were reviewed. This was a total of eight cases as each registrant was the subject of two cases. In five for the eight cases the ICP cited a lack of evidence as reason for making a 'no case to answer' decision. In the case of two of the registrants, the cases involved a conviction or caution, or failure to disclose this to an employer. In the remaining cases, the concern centred around the contact that the registrant had had with a service user. In all the cases reviewed, both allegations against the same registrant were of a similar nature.

Where a 'no case to answer' decision is made and a further allegation is received within three years, Rule 4 of the Health and Care Professions Council (Investigating Committee)(Procedure) Rules 2003 provides that:

> *'(6) Subject to paragraph (7), in determining whether there is a case to answer the Committee may take account of any other allegation made against the health professional within a period of three years ending on the date upon which the present allegation was received by the Council.*
>
> *(7) An earlier allegation in respect of which a Practice Committee previously determined that there was no case to answer may only be taken into account in accordance with paragraph (6) if, when the health professional is notified that no further action is to be taken in connection with the earlier allegation, the notification contains a statement that the case may be taken into account in the consideration of any subsequent allegation.'*

Therefore there are safeguards in place should multiple allegations be made against the same registrant. FTP operational guidance exists to advise the case management team on how to handle such cases and how to assess whether the case is of a similar nature. As part of the on-going workshops provided to the Case Management Team, refresher training will be provided on the three year rule.

3.2. Registrants with 'case to answer' and 'no case to answer' decisions

Of the 54 registrants that fell into this category, a review was undertaken of the cases relating to sample of eight registrants. This involved 21 cases as some registrants had more than two allegations against them.

In relation to five registrants, there was a 'no case to answer' decision in relation to the first allegation and 'case to answer' decisions thereafter. In two cases there were findings against the registrant at a final hearing in the first case(s) followed

by ‘no case to answer’ decisions in relation to subsequent allegations. It may be that the cases were not of a similar nature and does demonstrate that panels do consider cases on a case by case basis. The remaining case was discontinued prior to reaching a final hearing.

Where a sanction has previously been imposed and an ICP considers a further case, there are no specific provisions within the rules for the panel to made aware of this and take the previous case into account. This information is in the public domain, however, panel members may not be aware. Legal advice will be sought in this specific area, both in relation to sanctions that have expired and sanctions that are on-going.

In some cases allegations were joined and multiple allegations against the same registrant were heard at the same hearing. In joining allegations it allows similar matters to be dealt with more effectively and consistently.

Four of the eight registrants were ultimately struck off the register, perhaps demonstrating the cumulative effect of the allegations. In two cases the panel made reference to the ‘cumulative impact of successive adverse findings in separate HCPC proceedings’ and an on-going caution from a previous case when explaining their reasons for making a striking off order. An additional section is being added to the drafting fitness to practise decisions practice note on how panels should handle cases where a sanction is already in place.

In one case the second allegation was discontinued having been referred to final hearing and in one case the hearing has yet to be held.

3.3. Registrants with more than one ‘case to answer’ decision

Of the 96 registrants that fell into this category, the cases in relation to ten registrants were reviewed. This equates to 30 cases.

In one case both allegations were not well founded at the final hearing. The allegations were joined and were very similar in nature. In relation to one registrant there were seven allegations made, all of which were heard together at the same hearing and the registrant was struck off. In the remaining cases sanctions were imposed by the panel. In some cases allegations were joined and multiple allegations against the same registrant were heard at the same hearing.

The types of things panels are taking into account when deciding what action to take in relation to registrants with multiple allegations are the length of time between incidents, the likelihood of repetition and the insight demonstrated by the registrant.

In some instances a sanction was still in place at the time the second case was heard. Where a case reaches a final hearing and a sanction is already in place following a previous matter, this will be brought to the panel’s attention should they find the case well founded and when making a decision as to sanction in the current case.

4. Summary

The review of cases has been a useful exercise, however no clear conclusions can be drawn about the registrants where more than one allegation has been made. There are varying outcomes, and it remains important for panels to consider all cases on their merits, whilst taking into account previous cases where relevant. There are safeguards in place in cases where multiple allegations are made, such as the three year rule and panels being notified of on-going sanctions at final hearing.

The Executive considers it beneficial to undertake a regular six monthly review of registrants where multiple allegations have been made. This would allow for this area to be monitored on an on-going basis and for any trends to be established and add to our quality assurance framework.

In summary, the areas of work to be taken forward are:

- Legal advice will be sought in relation to panels being notified of on-going or previous sanctions at ICP stage;
- Provide refresher training to the Case Management Team on the three year rule;
- Add an additional section to the indicative sanctions policy on how panels should handle cases where a sanction is already in place; and
- Six monthly review of registrants with more than one allegation.

Registrants with 'no case to answer' decisions

Reg number	Profession	Year	Ground	Details	Outcome	Reasons / comments
1	Arts Therapist	2007	Misconduct	Manipulated client	No case to answer	Lack of evidence.
		2009	Misconduct	Behaviour towards a client	No case to answer	Lack of evidence.
2	Chiropodists / Podiatrist	2005	Caution	Battery	No case to answer	Minor in nature and took place outside work.
		2008	Caution	Assault	No case to answer	Investigating Committee informed of previous caution. Took place outside work.
3	Paramedic	2009	Conviction	Assault	No case to answer	Verbal not physical assault, outside of work.
		2010	Misconduct	Failure to disclose conviction to employer	No case to answer	No evidence that the registrant tried to cover his conviction.
4	Practitioner Psychologist	2009	Misconduct and / or lack of competence	Inappropriate assessment techniques and failure to diagnose	No case to answer	No evidence of inappropriate assessment.
		2009	Misconduct and / or lack of competence	Approach to psychological assessment	No case to answer	No evidence of inappropriate assessment.

Case to answer and no case to answer cases against same registrant

Reg number	Profession	Year	Ground	Details	Outcome	Reasons / comments
1	Paramedic	2007	Caution	Assault	No case to	Isolated incident.

					answer	
		2009	Misconduct and / or lack of competence	Failure to, Act in an emergency, Failure to, Communicate – patient, Failure to, Conduct a full/accurate assessment	Struck off	Two cases heard together as a joint allegation.
		2009	Misconduct and / or lack of competence	Failure to, Act in an emergency, Failure to, Communicate – patient, Failure to, Conduct a full/accurate assessment	Struck off	Two cases heard together as a joint allegation.
2	Biomedical Scientist	2007	Caution	possession of an offensive weapon (lock knife)	No case to answer	Dealt with via the caution not FTP issue.
		2010	Misconduct	Failure to disclose the caution	Caution	
3	Occupational Therapist	2009	Misconduct	Failure to, Collaborate with Colleagues	No case to answer	Not sufficient to amount to misconduct.
		2012	Misconduct	Dishonestly provided misleading information to employer	Awaiting final hearing	
		2012	Misconduct		Awaiting final hearing	
4	Paramedic	2008	Misconduct and / or lack of competence	Record keeping and time keeping	No case to answer	Registrant undertook retraining.
		2010	Misconduct	Unsafe Clinical Practice, Failure to, Maintain adequate records, Failure to, Provide adequate care	Struck off	No evidence to satisfy the panel that the registrant recognised any of the shortcomings.

5	Physiotherapist	2009	Conviction	Drink driving	No case to answer	
		2011	Conviction	Drink driving	Not well found	Insight and coping mechanisms put in place by registrant. Little risk of any repetition
6	Practitioner Psychologist	2012	Misconduct and / or lack of competence	Failure to, Complete adequate/accurate report, Failure to, Conduct a full/accurate assessment	No case to answer	Not sufficient evidence.
		2012	Lack of competence	Failure to, Complete adequate/accurate report	Discontinuance	
7	Radiographer	2008	Misconduct	Disclosed patient information	Caution	
		2009	Conviction	Assault	No case to answer	No evidence to suggest that the registrant's fitness to practise is currently impaired.
		2009	Misconduct	Uploaded picture of a patient to facebook without permission	Struck off	On-going caution from previous case, limited insight.
8	Speech and Language Therapist	2009	Misconduct and / or lack of competence	Failure to, Complete adequate/accurate report, Failure to, Conduct a full/accurate assessment, Failure to, Maintain adequate records	Conditions of practice	Serious deficiencies in practise. Joined with 1 other allegation.
		2009	Misconduct and / or lack of competence	Failure to, Complete adequate/accurate report, Failure to, Conduct a full/accurate assessment, Failure to, Maintain adequate records	Conditions of practice	Serious deficiencies in practise. Joined with 1 other allegation.

		2011	Misconduct	Wide ranging issues relating to speech SLT practice	Struck off	Serious nature of the misconduct and the cumulative impact of successive adverse findings in separate HCPC proceedings. Not undertaken remediation or demonstrated any insight
		2012	Misconduct and / or lack of competence	Assessment of a child	No case to answer	Insufficient evidence, registrant acting as a locum for short period.

Registrants with multiple case to answer decisions

Reg number	Profession	Year	Ground	Details	Outcome	Reasons / comments
1	Arts Therapist	2007	Misconduct	Inappropriate practice and treatment of service users	Struck off	All 7 allegations heard together. Complainants were all individual but knew of the other cases and had similar experiences.
		2007	Misconduct	Inappropriate practice and treatment of service users	Struck off	All 7 allegations heard together. Complainants were all individual but knew of the other cases and had similar experiences.
		2007	Misconduct	Inappropriate practice and treatment of service users	Struck off	All 7 allegations heard together. Complainants were all individual but knew of the other cases and had similar

						experiences.
		2007	Misconduct	Inappropriate practice and treatment of service users	Struck off	All 7 allegations heard together. Complainants were all individual but knew of the other cases and had similar experiences.
		2007	Misconduct	Inappropriate practice and treatment of service users	Struck off	All 7 allegations heard together. Complainants were all individual but knew of the other cases and had similar experiences.
		2007	Misconduct	Inappropriate practice and treatment of service users	Struck off	All 7 allegations heard together. Complainants were all individual but knew of the other cases and had similar experiences.
		2007	Misconduct	Inappropriate practice and treatment of service users	Struck off	All 7 allegations heard together. Complainants were all individual but knew of the other cases and had similar experiences.
2	Biomedical Scientist	2006	Caution	Theft	Struck off	Allegations joined
		2008	Misconduct	Failure to disclose caution to employer	Struck off	Allegations joined
3	Chiropodists / Podiatrist	2007	Conviction	Drink driving	Caution	
		2008	Conviction	Drink driving	Conditions of practice	Later revoked
4	Hearing Aid Dispenser	2010	Misconduct	Failure to, Communicate – patient Failure to, Provide adequate care	Caution	Allegations joined
		2010	Misconduct	Failure to, Communicate –	Caution	Allegations joined

				patient Failure to, Provide adequate care		
5	Occupational Therapist	2010	Health	Alcohol addiction, drink drive conviction	Suspension	Allegations joined
		2010	Health	Alcohol addiction, attending work under the influence of alcohol	Suspension	Allegations joined
6	Operating Department Practitioner	2008	Misconduct	Misappropriation of Drugs	Suspension	Revoked prior to second case being heard
		2011	Conviction	Driving, Under the influence of drink	Caution	
7	Paramedic	2010	Misconduct	Misappropriation of Drugs	Struck off	
		2011	Misconduct	Misappropriation of Drugs	Closed due to struck of decision in previous case	
8	Physiotherapist	2007	Misconduct and / or lack of competence	Failure to, Maintain adequate records	Suspension, struck off on review	Allegations joined
		2005	Misconduct	Dishonesty, Sick Leave - false claims	Suspension, struck off on review	Allegations joined
9	Practitioner Psychologist	2010	Misconduct and / or lack of competence	Failure to, Maintain adequate records, Failure to, Provide adequate care	Not well founded	Allegations joined
		2010	Lack of competence and / or misconduct	Failure to, Collaborate with Colleagues, Failure to, Maintain adequate records	Not well founded	Allegations joined

10	Radiographer	2007	Misconduct	Inappropriately accessed patient records	Caution	
		2009	Misconduct	Conducted x-rays without referral or authorisation, Failure to obtain consent, potential breach of confidentiality	Not well founded	

Requesting further information

1. Introduction

As part of the public protection research and reports published by the Professional Standards Authority (PSA) previously the Council for Healthcare Regulatory Excellence (CHRE), the HCPC has been reviewing its approach to requesting further information that may not directly relate to the allegation in hand. In particular this paper looks at obtaining Police National Computer (PNC) checks as a matter of course in cases where the HCPC is notified that a registrant has been convicted of an offence, requesting information from employers or previous employers on any issues that may have arisen which are un-related to an existing allegation and requesting health assessments where the registrant has been convicted of a drink driving offence.

2. HCPC and Police National Computer Checks

The Professional Standards Authority (PSA) previously the Council for Healthcare Regulatory Excellence (CHRE) highlighted that regulators should consider routinely obtaining PNC checks as part of its audit report on the Nursing and Midwifery Council's (NMC's) initial stage fitness to practise process in November 2011.

The PNC is a series of databases which are shared by the UK Police service. They include details of criminal records, arrests, wanted or missing persons, driver licensing, vehicle registration, certain types of stolen property and the national firearms certificate database. As such, the information held on this national computer system is vast and wide ranging. Full access to the PNC is limited to UK Police forces and law enforcement agencies and some limited access is granted to other agencies that support policing purposes.

2.1. HCPC's current process

All of HCPC's 16 professions are included in the Home Office Notifiable Occupations Scheme. This scheme ensures that information relating to professions that carry special trust or responsibility is shared by the Police with third parties, but only where the public interest in the disclosure of conviction and other information by the Police generally outweighs the normal duty of confidentiality owed to the individual. The Home Office is currently undertaking a review of the scheme and issuing revised guidance to police forces on its application and the test that should be applied.

Currently when the HCPC is notified that a registrant has been convicted of a criminal offence under the notifiable occupations scheme or otherwise, the matter is investigated in line with the HCPC's fitness to practise process. Background information relating to the circumstances of the offence are requested from the Police on a case by case basis depending on the nature of the conviction and background information may be provided upon initial referral to the HCPC.

In line with the Standard of Acceptance policy approved by Council in December 2011, minor drink drive offences will not be pursued as a fitness to practise

allegation other than in cases involving serious offences or in the case of drink drive offences, where there are aggravating circumstances. If the case meets the HCPC's standard of acceptance for allegations, the case will be pursued as a conviction allegation. Particulars of allegation will be drafted and sent to the registrant to provide observations before the matter is put to a Panel of the Investigating Committee to make a 'case to answer' decision.

During preliminary inquiries, Case Managers do not routinely ask the Police whether any other matters are known about the individual concerned. This is based on the assumption that all relevant matters will have been disclosed to HCPC under the notifiable occupations scheme and in line with public interest considerations. However, all cases are assessed on an individual basis depending on the particular circumstances of the case and as such Case Managers may request further information from the Police as well as from third parties such as the registrant's employer or previous employer (if relevant) and will liaise with the Police as necessary to ensure that the Investigating Committee has sufficient information before them to make a 'case to answer' determination. This ensures that any patterns of behaviour can be taken into account when a decision is made by the Investigating Committee.

2.2. Legal advice

Legal advice has been sought on whether the HCPC should be routinely requesting Police National Computer (PNC) checks when notified that a registrant has been convicted of a criminal offence as there is no statutory requirement for the Police to share conviction or other information about individuals with third parties, other than a common law power for the Police to share information for the purpose of the prevention and detection of crime (each case being considered in its own individual circumstances).The legal advice sets out information about the data held on the PNC, its role, remit and legal basis. A full copy of the advice is attached to this paper.

In summary, the advice received is that making the assumption that any registrant who has been convicted of an offence may have other undisclosed criminal past history amounts to little more than a 'fishing trip'.

The advice goes on to state that whilst there will always be individual cases which raise concerns or suspicions and where further inquiries would be justified, indiscriminately requesting PNC checks as a matter of routine, regardless of the nature of the offence or the circumstances in which it was committed, is unlikely to meet the 'substantial public interest' threshold.

2.3. Conclusions

In the period 1 April 2011 – 31 March 2012, a small number of cases received (12%) related to criminal convictions or Police Cautions. Since this period the HCPC has taken on the regulation of Social Workers in England and introduced the revised Standard of Acceptance policy. However, it is anticipated that numbers of referrals relating to criminal convictions and cautions will remain relatively low and in line with the overall numbers of registrants on the HCPC Register.

Based on the small proportion of cases received that relate to criminal convictions or cautions and the legal advice received, it is proposed that no further work is necessary in this area. The legal advice received is clear that routinely requesting further information from the PNC of the Police is not justified, nor is it in the public interest. In line with the HCPC's fitness to practise process Case Managers will continue to assess cases on an individual basis and take case management decisions (with the guidance of their managers) and request further information where it is appropriate and proportionate to do so depending on the particular circumstances of the case.

3. Health assessments in drink drive conviction cases

At its meeting in October 2011, the Fitness to Practise Committee considered a paper on the 2010-11 PSA (formally CHRE) performance review. In that performance review, CHRE again recommended that regulators should adopt the practice of asking registrants who are convicted or cautioned for drug or alcohol related offence to undertake a health assessment. In considering the CHRE performance review, the Committee asked the Executive to undertake further work to assess whether this practice mitigated a risk. The Committee also agreed that future work on this issue should look more widely at HCPC's approach to the treatment of registrants who had been convicted or cautioned for an offence and how it affects their fitness to practise.

The Executive provided an update paper to the Committee in February 2012, informing it that a letter had been sent to all the other health and social care regulatory bodies to ask for their policy on this topic and whether they had evaluated the approach that had been adopted. The Committee was also informed of the wider public protection research work the Department intended to undertake.

3.1. HCPC's current approach

The approach HCPC currently takes is based on the general principles of fairness and proportionality. There is no available evidence to suggest that because a registrant is convicted of an offence relating to drink or drugs, that there is an underlying health condition. It is also possible that if a registrant does have a health condition, they are able to manage their fitness to practise and it does not impact on their ability to perform their role safely.

The HCPC's standard of acceptance provides that:

> *"Drink-driving offences should be regarded as meeting the standard of acceptance if:*
>
> - *the offence occurred in the course of a registrant's professional duties, en-route to or directly from such duties or when the registrant was subject to any on-call or standby arrangements;*
> - *there are aggravating circumstances connected with the offence (including but not limited to failure to stop or only doing so following a police pursuit, failure to provide a specimen, obstructing police, etc.);*
> - *the penalty imposed exceeds the minimum mandatory disqualification from driving (12 months, with or without a fine); or*
> - *it is a repeat offence."*

If the case does meet the standard of acceptance, the Investigating Committee will be provided with information about whether the registrant was on their way to or from work, on call or on duty at the time of the offence, their blood alcohol level and the penalty imposed by the courts. This will be taken in consideration by the panel when making a case to answer decision. Furthermore, Rule 4(6) of the Health and Care Professions Council (Investigating Committee) (Procedure) Rules 2003 (known as the 'three year' rule) provides that:

> *"4(6) Subject to paragraph (7), in determining whether there is a case to answer the Committee may take account of any other allegation made against the registrant within a period of three years ending on the date upon which the present allegation was received by the Council."*

Therefore, the Investigating Committee will be made aware of any other allegations of a similar nature received within the past three years, allowing the panel to take into account any patterns in behaviour when deciding whether there is a case to answer. Should a case be referred to a final hearing, the information above will be available to the panel making a decision on whether fitness to practise is impaired and what sanction, if any, is appropriate.

The cases of ten registrants have been reviewed in detail where more than one allegation of a drink or drug related offence has been received, or a subsequent health allegation has been pursued.

In those ten cases the circumstances and outcomes varied and very much depended on the registrant's engagement and insight. For example one registrant was investigated on two occasions following drink drive convictions, however the final hearing panel took no further action following the second conviction as the registrant was able to demonstrate the action they were taking and that their alcohol dependency was not impacting on their fitness to practise. However, in another case the registrant was firstly suspended for the theft of controlled substances (the self-administration of which was known to the panel) and subsequently struck off following a second allegation of the same nature.

Where there is an underlying health issue this is often raised by the registrant themselves in mitigation or is evident on the face of the complaint. It can also come to light through communication with the employer when asking whether the registrant was travelling to or from work, on duty or on call. In much the same way, health issues also come to light in other conviction cases or cases alleged on another ground, such as shoplifting cautions or convictions, competency based allegations.

The HCPC's principle of managing cases on a case by case basis seems to be supported by this case review.

3.2. Provisions to request a medical assessment

There is no provision in the Health and Care Professions Order 2001 (the Order) to compel registrants to undergo a health assessment or produce medical documents in these types of cases. Article 25 of the Order) provides that:

'*For the purpose of assisting them in carrying out functions in respect of fitness to practise, a person authorised by the Council may require any person* ***(other than the person concerned)*** *who in his opinion is able to supply information or produce any document which appears relevant to the discharge of any such function, to supply such information or produce such a document.'*

It is important to recognise here that the only person who cannot be ordered to provide information or documents is the registrant concerned.

Any Investigating Committee panel may ask for a medical assessor to be present at the panel to give specific medical advice to the panel on the case concerned, where that panel feels they would not be able to make a decision without such advice. However, the Investigating Committee do not have any powers to ask that medical assessor to undertake a medical assessment of the registrant concerned, they can only consider the documentation alone (see Assessors and Experts Practice Note).

Only the Health and Care Professions Council (Health Committee) (Procedure) Rules 2003 allows for that Committee to invite a registrant to undergo a medical examination. The majority of fitness to practise cases involving criminal convictions or Police Cautions for alcohol or drug related offences are dealt with by the Conduct and Competence Committee due to the type of allegation. Article 22(1) of the Order sets out the types of fitness to practise allegations the HPC can consider. Specifically Article 22 (1) (a) (iii) states:

'This article applies where any allegation is made against a registrant to the effect that –
(a) his fitness to practise is impaired by reason of –
(iii) a conviction or caution in the United Kingdom for a criminal offence, or a conviction elsewhere for an offence which, if committed in England and Wales, would constitute a criminal offence'

Rule 4 of the Health and Care Professions Council (Conduct and Competence Committee) (Procedure) Rules 2003 allows for referral of a case from the Conduct and Competence Committee to the Health Committee if it appears that an allegation it is considering would be better dealt with by the Health Committee.

3.3. Feedback from other regulators

Responses were received from five other health regulators setting out their approach to requiring medical examinations in cases where the registrant has been convicted of drink or drug related offence, the number of cases where this applied and the evidence base for such an approach. Four of the regulators either did not respond to the evidence base question, or stated they did not yet have any evidence of the benefits of the approach. All but one of the regulators applied the policy in all cases, whereas one regulator applied the approach on a case by case basis.

3.4. Estimated costs

In the paper provided to the Committee in October 2010 an analysis of the case load at that time estimated that if health assessments were undertaken in all cases relating to a drink or drug offence, the likely cost would be in region of £150,000 per year. This did not take into social workers which now make up 40% of the FTP case

load. Taking into account the increase in case load, the costs could be estimated at approximately £200,000.

11.2 Proposals for future work

When the Committee has considered this issue previously it decided not to recommend a change the approach taken by the HCPC in relation to drink and drug offences. The Committee previously considered the following issues when decision whether to recommend a change in approach:

- whether it would be disproportionate to require every registrant involved in such cases to undergo a medical assessment given the potential costs involved to do so;
- that the HCPC cannot currently compel a registrant to consent to a medical assessment in such cases;
- the wider implications - for example, a conviction or Police caution for a drink drive/ drug related offence does not necessarily indicate that a registrant has an underlying health issue;
- any implications of drawing such inferences in these types of cases;
- HCPC Panels consider all allegations thoroughly, but in cases such as these, also take into account whether the evidence provided demonstrates that the registrants' ability to practice safely and effectively has been compromised. The brochure '*Managing your fitness to practise*' provides further guidance on this subject; and
- The approach that HPC takes in this area aims to be fair, balanced and proportionate.

One way in which the Executive propose some form of monitoring and further information gathering, would be to record blood or breath limits in cases for a period of time to establish the severity of the offence and seek to establish whether there are any patterns.

4. Requesting information from employers or previous employers

A further area that has been reviewed is the requesting of information from the registrant's employer or previous employer as this may raise other concerns that the HCPC was not previously aware of.

4.1. HCPC's current approach

Where a concern is raised about a registrant the current employer will often be the complainant. Where this is not the case and the complaint relates to an incident or issue relating to the workplace, the employer will be contacted and asked for any information relating to the allegation that has been made. The HCPC does not routinely ask for any other unrelated information or contact previous employers, unless there is reason to believe there may be concerns that require further investigation.

There is a need to be proportionate and fair in investigating cases and ensure that the HCPC is not 'fishing' for information, where there is no evidence or concern raised. Where there is no information or evidence presented that raises concern, it would appear to be disproportionate to attempt to find information about that registrant that had not previously warranted a referral to the regulator.

4.2. Legal advice

Legal advice was sought in relation to requesting information on any issues that sit outside the particular allegation that has been made. This advice is attached and supports the current approach. In summary it states:

> *"The nature and extent of any investigation is a balancing exercise which places public protection ahead of everything else but also takes proper account of the rights of registrants, particularly the Art 6 ECHR right to a fair hearing and the Art 8 ECHR right to privacy. A decision to widen any investigation must be proportionate, taken in respect of relevant matters and capable of being objectively justified. That simply cannot be achieved by means of a blanket instruction."*

4.3. Proposals for future work

The Executive does not propose that it changes its current approach to requesting information when investigating allegations. However, we propose to make some additions to the operational guidance provided to Case Mangers to ensure they fully understand the context and limits of their ability to request information. Equally to ensure they understand that where issues are referenced that might sit outside the knowledge of the complainant themselves, that appropriate enquiries are made with those who may be able to provide further information.

5. Recommendations

The Executive recommends that the current approach in general is maintained, that is that cases are managed on a case by case basis in a proportionate way. The principles of light touch regulation should continue to apply and recognition given to the fact that HCPC operates a fitness to practise process which differs from any criminal just or disciplinary process.

It is proposed that the following pieces of work in relation to seeking information:

- Record blood / breath alcohol levels in cases of drink related offences
- Enhance the guidance for Case Manager in requesting further information from employers and other parties.

Should the Committee consider that any further, more wide ranging, changes to the current approach are necessary, a further paper would be provided to Council as this may involve a change in policy.

Memorandum

To: Zoe Maguire, HCPC

From: Jonathan Bracken

Date: 2nd January 2013

PNC Checks

Zoe,

You asked for my advice on whether the HCPC should be routinely requesting Police National Computer (**PNC**) checks when notified that a registrant has been convicted of a criminal offence. I assume what is envisaged here is that, when the police inform the HCPC that a registrant has been convicted of an offence, the police would be asked if there is any other information about the registrant on the PNC of which the HCPC should be made aware.

The PNC is effectively a series of databases which are shared by the UK police service. They include not only criminal records but details of those arrested, wanted or missing; driver licensing and vehicle registration; a register of certain types of stolen property and the national firearms certificate database. The PNC also provides links to a number of other databases, including the Violent and Sex Offender Register (ViSOR) and the national DNA and fingerprint databases.

Full access to the PNC is limited to UK police forces and law enforcement agencies (and those in the Isle of Man and Channel Islands) and restricted access is provided to other agencies with a police business focus or that support policing purposes. These include non-police bodies such as the RSCPA (in respect of animal welfare prosecutions) and the Gun Trade Association (which has access to the firearms database).

Use of PNC information is subject to the general legal regime which applies to data, including the Data Protection Act, the Article 8 ECHR right to privacy and the common law duty of confidentiality. The PNC is also subject to a specific statutory code of practice, made by the Secretary of State under the Police Acts 1996 and 1997, the Code of Practice on the Management of Police Information 2005 (**MOPI**).

MOPI defines "police information" as information required for policing purposes, which it in turn defines as:

- protecting life and property;
- preserving order;
- preventing the commission of offences;
- bringing offenders to justice;
- any duty or responsibility of policing arising from common or statute law.

Those policing purposes provide the legal basis for the collecting, recording, evaluating, sharing and retaining police information. Consequently, the PNC can only be used for policing purposes.

For non-police users, access to the PNC is granted by the PNC Information Access Panel (**PIAP**) but only on the basis of a business case that clearly provides a policing purpose when judged against the MOPI criteria. On that basis, it is unlikely that the HCPC could obtain PNC access rights.

Obviously, the police do share information with regulators and the notification of convictions etc. under the Notifiable Occupations Scheme (**NOS**) is a good example As the guidance which supports MOPI states:

> "***6.5.2 Notifiable occupations Scheme***
>
> *The Notifiable Occupations Scheme relates to professions or occupations that carry special trust or responsibility. Here the public interest in the disclosure of convictions and other information by the police generally outweighs the normal duty of confidentiality owed to the individual.*"

NOS disclosures serve a clear and specific purpose, ensuring that regulators are routinely advised if a registrant is convicted of an offence, thus assisting in protecting the vulnerable from a known offender. Even so, NOS disclosures are not automatic. The presumption of notification for Category 1 occupations may be overridden where exceptional reasons make it appropriate to do so, such as a relatively minor offence which clearly has no bearing on the person's employment. For Category 2 occupations a test of relevance must be applied in making notification decisions.

What is being suggested here is something rather different; that when the police make a disclosure under the NOS, they would be asked to check the PNC to see if it contains any other information – other convictions or perhaps even wider information or intelligence - of which the HCPC should be made aware.

Home Office Circular 6/2006 on the NOS states (emphasis added):

> "*6. The general position is that the police should maintain the confidentiality of personal information, but legal opinion supports the view that in cases invoking* ***substantial public interest considerations*** *a presumption to disclose conviction and other information to relevant parties, unless there are exceptional reasons not to do so, is considered lawful. Areas in which it is considered there are likely to be substantial public interest considerations include:*
>
> *protection of the vulnerable, including children*
>
> *national security*
>
> *probity in the administration of justice".*

Making the vague and unfounded assumption that any registrant who has been convicted of any offence may have undisclosed criminal antecedents amounts to little more than a ‘fishing trip’. Whilst there will always be individual cases which raise concerns or suspicions and where further inquiries would be justified, indiscriminately requesting PNC checks as a matter of routine, regardless of the nature of the offence or the circumstances in which it was committed, is unlikely to meet the ‘substantial public interest’ threshold.

Further, asking police officers to conduct PNC checks on such a disproportionate basis may place them in a difficult position and potentially leave them facing disciplinary action, as it is unlikely that performing such checks would amount to a policing purpose under MOPI.

JKB

Memorandum

To: Eve Seall, HCPC

From: Jonathan Bracken

Date: 30th January 2013

Widening the scope of investigations

You asked for my advice on the extent to which case managers should be conducting more wide-ranging investigations and seeking information about registrants that goes beyond the scope of any complaint made against a registrant.

In performing its functions the HCPC must seek to protect the public and that is paramount. However public protection cannot be used as a mantra to justify what may amount to oppressive conduct towards registrants and the HCPC would certainly be at risk of challenge if it adopted a blanket policy of conducting wider inquiries on a speculative basis. The fact that a registrant is accused of X does not of itself mean that he or she must have also done Y or Z and adopting a 'no smoke without fire' approach to the investigation of allegations would be likely to amount to an improper exercise of HCPC's powers.

The starting point in investigating an allegation must be to focus upon that allegation and what may reasonably be regarded as the surrounding circumstances, including any 'train of inquiry' which arises from examining the evidence and may fairly be regarded as relevant to the case. Of course, in many instances the HCPC will know about wider issues arising from, for example:

- the registrant's prior regulatory history with the HCPC or one of its counterparts in another jurisdiction;
- information disclosed as part of a CRB check;
- information contained in disciplinary records provided by an employer.

Where there is no additional information, a decision to widen the scope of inquiry would need to be made objectively, on a case by case basis. The HCPC cannot adopt an approach of engaging in 'fishing expeditions' in the hope of finding other facts or a pattern conduct which would bolster its case when there is no credible basis for believing that such evidence exists.

A decision to widen the scope of an investigation would need to be based upon proper grounds, such as there being reasonable grounds for considering that the allegation is not an isolated incident or that an allegation does not disclose the true nature and severity of what occurred.

Often there will be no basis for forming such a view. For example, in a complaint arising from a single encounter between a service user and a sole practitioner, what further, proportionate, inquiries could be made and to whom would they be directed?

In short, there is no simple answer to this question that would apply in every case. The nature and extent of any investigation is a balancing exercise which places public protection ahead of everything else but also takes proper account of the rights of registrants, particularly the Art 6 ECHR right to a fair hearing and the Art 8 ECHR right to privacy. A decision to widen any investigation must be proportionate, taken in respect of relevant matters and capable of being objectively justified. That simply cannot be achieved by means of a blanket instruction.

JKB