Council for Healthcare Regulatory Excellence

Public views on three aspects of health professions regulation

Qualitative Research Findings

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1. BACKGROUND

The Council for Healthcare Regulatory Excellence (CHRE) is accountable to Parliament for promoting good practice and harmonisation in the regulation of healthcare professions. Since its inception in 2002, CHRE's role in promoting patients' interests has been strengthened by:

- The 2007 White Paper, Trust, Assurance and Safety - the regulation of Health Professionals in the 21st Century, which called for CHRE to be an authoritative, independent voice for patients and the public on the regulation of health professionals.

- The Health and Social Care Act 2008, which gave CHRE the statutory main objective to promote the health, safety and well being of patients and other members of the public.

The *NHS Next Stage Review: A High Quality Workforce* called for 'nationally agreed standards for advanced levels of practice' by health professionals 'in order to assure the quality of outcomes and to protect the public appropriately' (p 20). Consequently, CHRE would specifically like to know more about:

– what patients and the public understand by the terms 'advanced' or 'specialist' or 'expanded' when they are being treated by health professionals

Equally, CHRE feels that it also needs to know more about two other issues:

– the public's expectations of how regulators, registrants and employers manage health issues which specifically affect health professionals

- opinions about the terminology which should be used in the following two sanctioning situations – 'cautions' or 'warnings' and 'erasure', 'striking-off' or 'removal'.

Understanding the views of patients and the public will help CHRE to deliver its statutory objectives. CHRE hopes that a better appreciation of the views of the public will help to support specific recommendations about policy in the advice supplied to ministers. The research findings will inform the advice given to ministers on these particular issues, and also provide valuable insights into the views of patients and the public for wider policy development work.

2. RESEARCH OBJECTIVES

To examine issues such as:

1. What do patients and the public understand by the terms 'advanced', 'specialist' or 'expanded' when they are being treated by health professionals? Is this taken to mean:

   - more training?
   - more experience?
   - more autonomy?
   - higher pay?
   - less supervision?
   - more senior in the organisation?
   - safer care for the individual patient?
   - fewer risks?

Specifically:

- should patients and the public (or employers on their behalf) be able to check claims of 'specialists' or 'advanced' healthcare professionals?
- do the terms have different meanings in different settings?
- can you be 'advanced' and not directly involved in the treatment of patients?

2. The public's perception of health issues amongst health professionals and its expectations of how regulators, registrants and employers manage health issues.

   Specifically:

   - public attitudes to the management and assurance regarding ongoing physical or mental health conditions of a health professional
   - what the public expects to happen so that they are assured a health professional is practising safely and effectively whilst having a disability, illness or disease
   - how would the public feel if they knew their health professional had a health condition and is managing the condition so that it does not affect the safety or effectiveness of their practice with patients?
   - if a health professional manages their work so that they meet their regulatory bodies' standards of conduct and competence, should they still have a duty to disclose their condition to their regulatory body?

3. Exploring the terminology which should be used in a number of situations:

   - 'Caution's or 'Warnings' in cases in which there is a need to indicate to a registrant, and more widely to the profession and the public, that their conduct or behaviour fell below acceptable standards, but when there is no need to take action to remove or restrict a registrant's right to practise.

– ‘Erasure’, ‘Striking Off’ or ‘Removal’ in relation to the most severe sanction, removing the registrant from the register. When a registrant is erased from a register there is a general expectation that it will normally be for life and that the registrant will not be able to practise again. (Although registrants can apply for restoration to a register after a specified period of time).

3. METHOD AND SAMPLE

A series of twelve qualitative workshop discussions (2 hours duration) were undertaken with the general public/patients. Fieldwork was conducted in Edinburgh, Brighton, Bridgend, Sutton Coldfield, Tyne and Wear, and Belfast between the 9th and 16th March 2009.

3 workshops with the ‘well’ general public:

1. Mixed sex, 26-39 years, Family stagers, young children, ABC1
2. Mixed sex, 40-59 years, Family stagers, older children C2DE
3. Mixed sex, 60+ years, Empty nesters/retired, BC1C2D

3 workshops with carers:

4. Mixed sex, 26-39 years, carers for children, C2DE
5. Mixed sex, 40-59 years, carers for older people, ABC1
6. Mixed sex, 60+ years, carers for a relative/partner with a chronic condition, BC1C2D

2 workshops with those with a recent interaction with healthcare services, either through their GP or local hospital:

7. Mixed sex, 20-39 years, Singles/Family stagers, ABC1
8. Mixed sex, 40+ years, Empty nesters/retired, C2DE

2 workshops with patients who have regular interaction with healthcare services due to ongoing, chronic conditions:

9. Mixed sex; younger patients, 20-39, C2DE, with chronic conditions (asthma, diabetes etc)
10. Mixed sex; older patients, 40+, ABC1, with chronic conditions (asthma, diabetes, arthritis, osteoporosis etc)

2 workshops with patients who have recently had experience of acute care, but are otherwise well:

11. Mixed sex; younger patients, 20-39, ABC1, who have recently had experience of acute care (hospital), but are otherwise well
12. Mixed sex; older patients, 40+, C2DE, who have recently had experience of acute care (hospital), but are otherwise well

Each workshop included a mix of those with experience of NHS, private and independent services.

4. APPROACH

A deliberative approach, focussing on specific aspects of regulation, was a highly effective way of discussing regulation.

Syndicate groups at the beginning of workshops enabled respondents to define regulation in their own terms, which helped them to engage with ideas around regulation more effectively.

Respondents were much more comfortable about focussing on specific aspects of regulation (e.g. terminology). Focussing on specific details meant that even when discussing unfamiliar topics (such as managing the health of health professionals), respondents were confident and engaged.

Case studies provided a strong platform for discussion. Respondents could identify with the scenarios and refer to their own experience.

The topic guide is appended at the rear of this report document.

5. MANAGEMENT SUMMARY

5.1 Sanction terminology

Responses to sanction terminology were consistent across all sample groups.

'Erasure' is an inappropriate choice because the term is unfamiliar and does not communicate a formal sense of control. Respondents envisage a permanent removal of the record from the register, with no record to indicate that they had been removed. Respondents became concerned that health professionals might be able to return to the record illegally.

'Struck off' is the general public's preferred term because it is familiar, impactful and communicates the most severe type of sanction. There are no other associated meanings – the term is unique to health profession regulation. However, 'struck off' fails to communicate possible restoration in the future.

'Removal' is a more flexible term. Although not as severe or impactful as 'struck off', it does communicate the possibility of restoration. Overall, 'removal' is a

more accurate term than 'striking off' in terms of communicating the possibility of restoration.

Whatever term is chosen, 'striking off' is likely to remain the dominant term in the public vocabulary. 'Striking off' summarises the general public's limited understanding of regulation, and communicates a strong message about the regulatory powers.

'Warning' is the most effective term for communicating a strong message that the professional is subject to disciplinary action. 'Warning' is also the preferred term because it is familiar (often used by employers). By comparison, 'caution' was a much softer term and was not perceived as part of a disciplinary process.

5.2 Health professionals' health issues

Patients are sympathetic and tolerant of health professionals having health issues or disabilities, however they are not comfortable with being made aware of this issue. Levels of tolerance and sympathy are much lower for mental health issues, particularly severe problems or addictions.

If professionals are employed, the professional and their employer are perceived to be responsible for managing health conditions via changes to the working environment or duties. Regulators are expected to intervene when an issue is not being managed satisfactorily (for example, when the professional is unable to perform their duties or the employer is not providing appropriate support).

Stakeholders have more responsibility for contributing to regulatory procedures if the professional is working independently or has severe mental health issues. In these circumstances, patients become implicated in raising concerns and closer interaction between the regulator and professional is also expected.

At present, patients and the public do not feel equipped to contact the regulator and are unclear where to turn for guidance if concerned about a health professional. Information about the role of regulators in the management of professionals' health issues would assist the public in raising issues themselves. This should include creating awareness:

- That patients are responsible for reporting concerns
- How regulators should be contacted
- In what situations they should be contacted (e.g. for independent practitioners)

5.3 Status terminology

The professional status terms were generally familiar to respondents, who had either personally experienced professionals describing themselves in this way or (particularly in the case of the term 'expanded') had heard about them in the news.

'Expanded' was perceived to mean 'taking on more responsibilities'. 'Specialist' was interpreted as a focus on one area of practice and inspired trust. The term 'advanced' was less clear, and although assumed to mean 'more qualified', it was largely associated with career progression. In future, 'advanced' would benefit from further explanation.

At present, patients are not taking responsibility for investigating the claims of health professionals' status. Regulators are trusted to regulate 'behind the scenes'. Employers are also expected to check the status of professionals via employment checks.

Patients are unlikely to doubt claims from NHS professionals because the

environment inspires trust and confidence. In a private setting, patients may check for certificates or name badges), but are not likely to conduct external checks.

To encourage patients and the public to take more responsibility for checking health professional claims, they need to be made aware of when to check on professionals, and how to conduct these checks. They need to understand:

- The importance of checking the status of a professional (particularly for independent practitioners)
- How to check outside of the register (for example, certificates and titles)
- When it is appropriate to check the register
- How to access the correct register if unsure

6. MAIN FINDINGS

6.1 SAMPLE COMMENTS

As in previous research, socio economic background and levels of interaction with healthcare services influenced knowledge of regulation. Overall, ABC1 respondents were considerably more knowledgeable and interested in regulation than C2DE respondents.

Parents and carers tended to be more concerned about the safety and treatment of those they cared for than themselves. Carers of older relatives were commonly very dissatisfied with the services they had encountered, with evidence of high levels of frustration and resentment:

"Time and time again. The system just can't cater for individual needs."
(Male, 60+ years, Carers for a relative/partner with a chronic condition, BC1C2D, Tyne and Wear)

By contrast, carers of children with health issues or disabilities were typically satisfied with the support they received from health services, and as a result, were more trusting of professionals.

6.2 REGULATION

As expected, understanding of regulation remained low. Known regulators included OFCOM, OFWAT, OFSTED, GMC and the FSA:

"There's all those 'off' ones. Isn't there an OFGEM somewhere or am I making that up?" (Female, 20-39 years old, patient, ABC1, Tyne and Wear)

Confusion remained between organisations who have regulatory powers and organisations whose sole purpose is to regulate. For example, some suggested that organizations such as HMRC, ombudsmen and the police were also regulators.

The purpose of regulators was perceived to be:

- Maintaining accountability
- Enforcing standards (compliance)
- Resolving issues (for example, complaints)
- Protecting the public

Knowledge of regulation was largely drawn from personal experience, but the

influence of the media was also apparent. Many respondents felt that they were regulated at work (for example, those working in the financial or public sector e.g. charities, town planning). Recent media coverage has highlighted the role of the FSA, with respondents also recollecting stories involving OFSTED and – inevitably - the GMC.

None had directly dealt with regulators and therefore views were formed via a process of thinking through hypothetical situations:

"The buck has to stop somewhere so that's why we need regulators." (Male, 60+ years, Empty nesters/retired, BC1C2D, Bridgend)

Knowledge of the regulation of health professionals was even lower. Many could not name any health regulators. Names to emerge were GMC, BMA and NICE. Once again there was confusion between organisations who have regulatory powers (e.g. the government, NHS or local trusts) who manage budgets and policy and organisations whose sole purpose is to regulate.

Overall, it was expected that regulation of health professionals would be more rigorous than regulation of other industries because health professionals deal with *"people's lives, not just tariffs and things".*

"The medical profession regulation must be more personal, not like a complaint in industry. It wouldn't be a building or an inanimate object, personal grievances would be at stake." (Male, 60+ years, Empty nesters/retired, BC1C2D, Bridgend)

"It's just like checking up on people in any other job but, because it's for treating people's health, it's more important." (Female, 40+ years, retired, C2DE, Edinburgh)

6.3 SANCTION TERMINOLOGY

6.3.1 ERASURE

'Erasure' implied that the health professional would be removed from the register. However, the term was difficult for respondents to apply to a person:

"You can't erase a person, it sounds like execution!" (Female, 20-39 years old, single/family stager, ABC1)

'Erasure' was also unfamiliar: some felt that they would not have understood the term if they came across it out of context:

"It's a funny term to use, 'erasure'? I can't honestly say I've ever heard of it." (Male, 40-59 years, carer for older people, ABC1, Brighton)

Respondents envisaged the record being *"rubbed out"* without trace. This led some to imagine that professional could return to the register illegally because there would be no record to indicate that they had been removed:

"His name's been erased but who's to say he won't come back in a couple of years and get back on. This could be his way around it."
(Female, 40-59 years, carer for older people, ABC1, Brighton)

Overall, the word 'erasure' did not communicate a sense of formality or control.

6.3.2 STRUCK OFF

This was a very familiar term. For many, 'striking off' summarises healthcare regulation. All had heard the term used in the media and clearly understood that it meant removal of the professional from the register:

"With the term 'struck off', we know what that means, we're used to 'struck off'." (Female 60+ years, Empty retired, BC1C2D, Bridgend)

"'Struck off' is better, we all know it, it's fixed in your head." (Male, 40-59 years, carer for older people, ABC1, Brighton)

'Striking off' was considered a strong, authoritative action – respondents imagined a physical 'crossing out' of the professional's record which would remain visible. All respondents expected this sanction to be 'final', with no chance of appeal. The term was considered appropriate, since it was associated with severe disciplinary action:

"You know it's a serious offence to be struck off." (Male , 60+ years, retired, BC1C2D, Bridgend)

Overall, the term 'striking off' was preferred, but did not communicate a sense of possible restoration in future.

6.3.3 REMOVAL

The meaning of 'removal' was more flexible: the term suggested movement as opposed to deletion. Only a minority interpreted a similar meaning to 'erasure' – that the record would be removed without trace.

For most, removal suggested a broader range of options. Although removed from the register, some imagined this might involve the health professional moving into a different type of involvement e.g. a demotion or a different role:

"It's like 'well she's no good there so we'll take her from that role and try her somewhere else'." (Female, 40-59 years, carer for older people, ABC1, Brighton)

Unlike 'erasure', some envisaged that the 'removed' record might be moved to another section of the register, which would allow the professional to return to the main register at a later date:

"It's the same as suspension. They've been suspended, but they might be back again." (Male, 60+ years, Carers for a relative/partner with a chronic condition, BC1C2D, Tyne and Wear)

Removal had less impact than 'struck off':

"Removal doesn't seem so serious, does it? I suppose it's just a nicer way of saying struck off." (Female patient, 20-39, C2DE, Bridgend)

Overall, 'removal' is a more accurate term than 'striking off' in terms of communicating the possibility of restoration.

6.3.4 CAUTION

A 'caution' was typically understood to be an 'official' rebuke, but where no disciplinary action has been taken. Respondents associated 'caution' with authority - for example, police cautions. Although many expected a 'caution' to be written, however a written caution was not associated with being put 'on

record'. The term conveyed a sense of a *"slap on the wrist"*, which could lead to a warning if the behaviour persisted or was repeated:

"It sounds like they've been told off but they're given the benefit of the doubt". (Female patient, 20-39, ABC1, Sutton Coldfield)

"It sounds like they've been told off and they're carrying on. 'You've been a naughty boy, you've been on the sick and earning cash on the side, we'll give you a little caution, don't do it again." (Female, 40-59 years, carer for older people, ABC1, Brighton)

6.3.5 WARNING

The term 'warning' carried more weight and implied the beginning of a formal disciplinary procedure. A warning was perceived to be more severe than a caution:

"It does seem more serious than a caution… Warnings go down on your file and it means 'do it again and you're going to be struck off.'" (Male patients, 20-39, C2DE, Bridgend)

"'Warning' just seems to have more impact." (Female, 60+ years, retired, BC1C2D, Bridgend)

The term was more familiar than 'caution' because many associated it with their employer (as opposed to the police). This meant that 'warning' was more familiar and implied a disciplinary process:

"It's like at work, three strikes and you're out." (Male patient patients, 40+, C2DE, Brighton)

Overall, 'warning' is the most effective term for communicating a strong message that the professional is subject to disciplinary action.

6.4 HEALTH OF HEALTH PROFESSIONALS

Respondents were sympathetic towards health professionals with health issues. Particularly if they shared a good rapport with an individual health professional, respondents were concerned and wanted the best for them. Many empathised with the difficulties of working as a health professional when unwell (particularly GPs):

"We think of them as superhuman. They're not like us, they can't just go off into the back office and have an 'off' day." (Female, 40-59 years, carers for older people, ABC1, Brighton)

There was also recognition that health professionals often work long hours and in stressful situations, which can lead to illness. Some were even concerned about the effect that continuing to work could have on the health professional's condition:

"If a doctor's depressed and they have to sit and listen people talk about everything that's wrong with them all day, that won't help." (Female, 40-59 years, older children C2DE, Belfast)

Although sympathetic to health professionals, there was a level of discomfort about being made aware that health professionals have health issues. For example, during the discussion of the case study, respondents were shocked about a GP admitting that they were unwell, with many feeling that this admission was 'unprofessional'. This was the point at which respondents started to question: if he can't look after himself, how can he look after patients?

"You don't want your doctor to be ill. You're going there because you're ill in some way, and they are getting paid to help you!" (Female patient, 20-39, C2DE, Bridgend)

"Their heart probably won't be in what they are doing and that's not what you need when you go to the doctor with a problem." (Female, 26-39 years, Family young children, ABC1, Edinburgh)

Respondents expected a higher level of ethical standards from health professionals than themselves when considering whether to work whilst ill:

"You would expect a professional to know their own limitations about how bad they are and when they need a day off." (Male, patient, 20-39, C2DE, Bridgend)

They expected health professionals, their peers and their employer to recognise when they were not fit to practise:

"It should never get to a point when we're noticing that the doctor isn't well enough." (Male, 26-39 years, carer for children, C2DE Sutton Coldfield)

The way of managing health issues differed in each scenario (see case studies in appendix C). MS and breast cancer raised the issue of needing time off when receiving treatment or too unwell to work. Hearing impairment and MS raised a possible requirement for employers to alter the working environment to suit the professionals' needs. Mental health and alcohol abuse were viewed similarly.

In spite of the differences between case studies and professional settings, respondents were able to create a single formula for managing health issues: firstly, the health professional is responsible for recognising that they have a problem; secondly, the employer is expected to support the professional with

appropriate alterations to working conditions.

Regulators were not perceived to be required *until this formula failed* (i.e. the professional is unable to recognise that their situation has deteriorated OR the employer is unable to manage the situation). It was hoped that in most cases, regulation would not be required.

Two instances when regulators should be informed of a health professional's health issue were identified:

- Firstly, when the health professional is judged as no longer able to comply with guidelines and standards set out by the regulator

- Secondly, when the employer is not felt to be adequately supporting the health professional to enable them to practise effectively

The perceived role of regulators was to set standards and then remove the professional from the register when unable to maintain these standards.

6.4.1 PHYSICAL AILMENTS

Dealing with physical illness was felt to be straightforward when dealing with NHS and privately employed professionals. Health professionals were trusted to inform their employer about their physical health issue:

"If the doctor thinks he or she is able to come to work then I would be happy they knew what their limits were." (Female, 60+ years, retired, BC1C2D, Bridgend)

In all cases, the employer was felt to be responsible for ensuring that the professional could work effectively. Many based this on their expectations of their own employers:

"They're just the same as anyone else. All employers are legally required to look after the welfare of their staff, and a health professional is an employee like any other." (Male, 40-59 years, carer for older people, ABC1, Brighton)

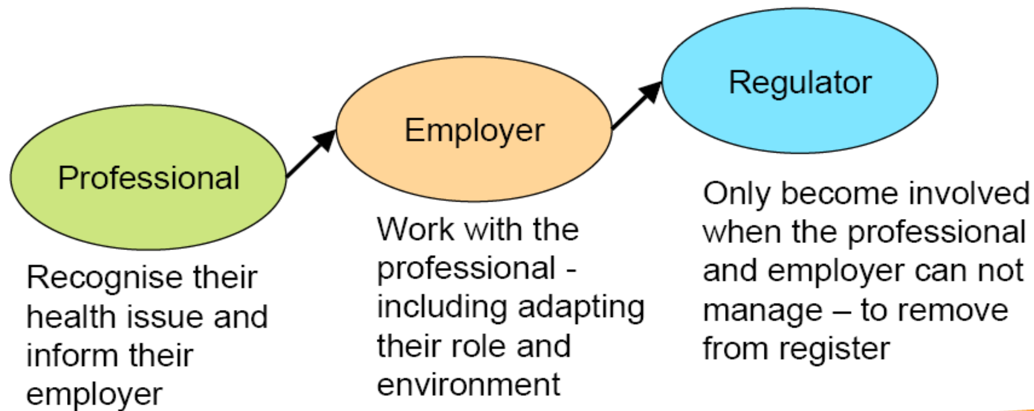
Looking after one's employees included:

- Moving the professional to a more appropriate environment (for example, a quieter department if hearing impaired)
- Offering flexible hours (for example, to allow for treatment)
- Altering or reducing duties (for example, removing duties that would be too physically demanding)

Regulation was considered to be a final step for professionals with employers – when the issue was no longer 'under control':

"The regulators wouldn't need to know about someone suffering from breast cancer. I can't see them having any involvement. It's a personal thing that they're working out themselves." (Female, 60+ years, retired, BC1C2D, Bridgend)

The way in which respondents expected employed health professionals to manage their physical health conditions is summarised below:

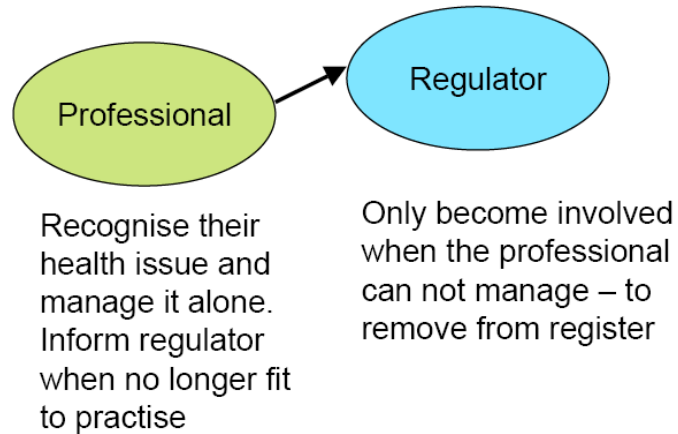


The physical health conditions of independent practitioners were considered more difficult to manage because the employer had proved so critical in the process.

In an independent setting, the professional was expected to recognise their physical condition and manage it themselves. Essentially, respondents trusted the professional to admit to the regulator that they were unfit to practice. Respondents (naively) trusted the health professional to be able to manage their illness and deal with it appropriately.

Regulators were expected to remove the professional when they became unfit to practise.

The way in which respondents expected independent health professionals to manage their physical health conditions is summarised below:



6.4.2 MENTAL HEALTH

Severe mental health issues (for example depression) were not considered to be acceptable when working as a health professional.

Although sympathetic, respondents were often alarmed about the idea of being treated by a health professional who was depressed because they imagined their judgement would be impaired. Overall, it was felt that professionals should not be allowed to work when depressed. Respondents suggested that the employer should offer treatment and enforce sick leave until the professional was well.

Alcoholism was felt to be unacceptable because there was a perception that the professional could make a decision not to drink. Respondents hoped that disciplinary action would be taken against the professional because it was viewed as an avoidable risk:

"That's a serious problem, it effects memory, judgement, and puts lives in danger. You couldn't drive if you were hung over." (Female, 60+ years, retired, BC1C2D, Bridgend)

"Imagine you're getting a nurse to take your blood but she's stinking of booze and staggering about with the needle in your arm!" (Male, 40+ years, retired, C2DE, Edinburgh)

"They should get sent home straightaway and not be allowed to see any more patients. If they come in drunk again, they get a written warning. If it happens again they should be suspended for three months, then if they do it again they should be struck off." (Male patient, 20-39, C2DE, Bridgend)

Mild mental health issues, with which professionals could still function at the required standard, were more acceptable. Mild problems (for example mild depression, stress, anxiety) were understood as potential side effects of working as a health professional. In fact, many had the impression that a majority of doctors had depression!

Respondents accepted that health professionals with mild mental health issues could work, as long as the professional was able to function and make sound judgements. Issues arose when attempting to establish *at what point* professionals should be required to inform their employer or regulator about their mental health issues.

The timeline below describes how respondents envisaged that mild mental health problems could be managed by the individual and their employer (similarly to the way in which the individual and their employer were required to manage physical conditions). Views about how serious mental health issues should be managed differed.

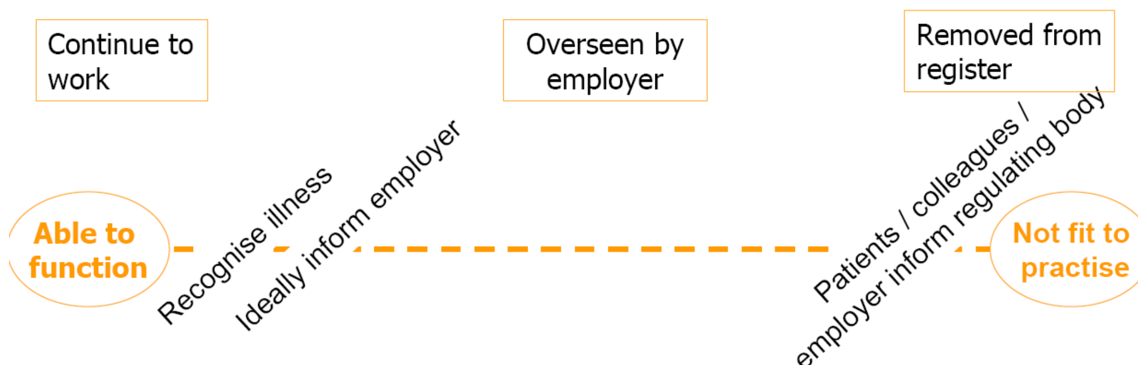
Professionals were not trusted to recognise or report serious mental health issues – therefore stakeholders were assigned more responsibility. In these circumstances, peers, colleagues and employers were responsible for observing

and acting on changes in the professionals' behaviour, appearance and performance. The employer was also expected to track performance through patient complaints and low patient retention:

"If one doctor has a big drop in patients that should show there's something wrong." (Male patient, 40+, ABC1, Belfast)

If concerned, the employer would be responsible for offering support and sick leave until the professional recovers or it becomes clear they will not recover. Eventually, the employer would need to report the professional to the regulator who would, if necessary, remove them from the register.

Mental health timeline



Mild mental health issues:

- Induced by work pressures
- Mild depression
- Stress/anxiety

Severe mental illness:

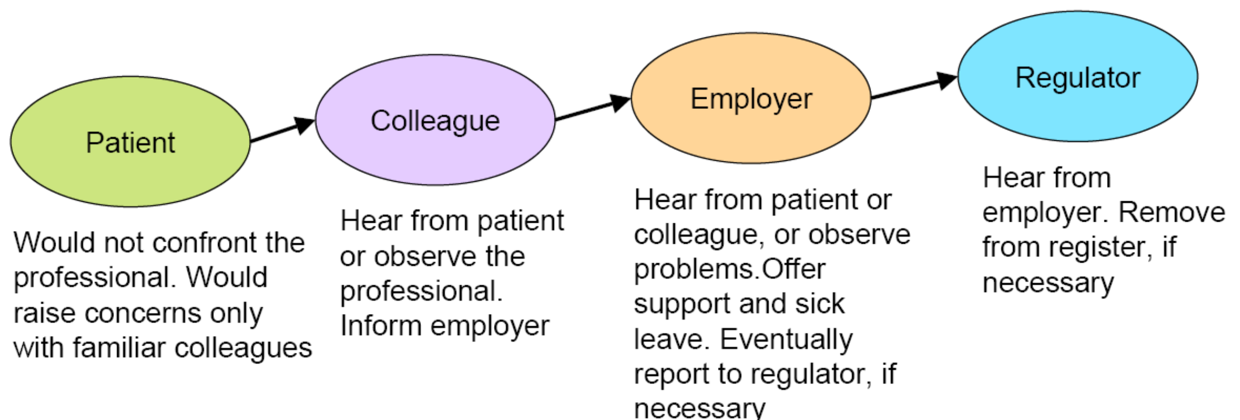
- Unable to work within guidelines
- Erratic behaviour/ appearance
- May be risk to parents
- Unable to make sound judgements

Respondents assumed more responsibility in a mental health situation. Unlike

physical illness, patients and carers expected to become involved in raising the issue of mental health issues. Within the NHS, respondents imagined speaking to reception staff who they knew and therefore would be comfortable speaking to.

However, respondents were less confident they would know how to raise the issue in a private setting because they did not expect to be as familiar with staff. In addition, respondents felt less *obliged* to raise an issue within private practice because patients had the power to walk away from unacceptable service - a luxury not possible with the NHS.

For mental health issues, NHS and private employees were perceived to have broadly the same regulation hierarchy, as described in the diagram below:



In an independent setting, respondents recognised that they were unprotected because there was no employer to oversee the professional. As a result, more responsibility was perceived to fall on the patient. However, most still wished to avoid 'prying' and did not feel equipped to deal with this kind of issue.

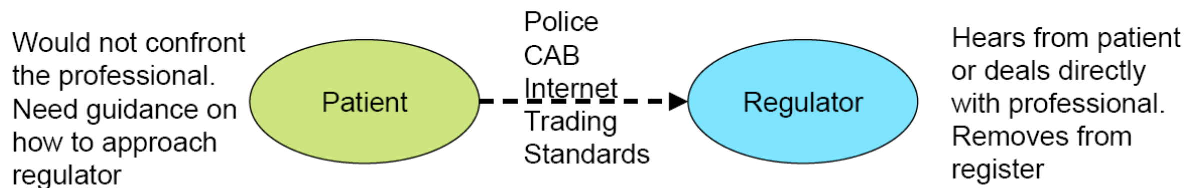
There was a sense that the regulator *should* deal with a mental health situation in an independent setting. Some hoped the regulator would be more closely involved with independent practitioners, perhaps undertaking inspections and

'spot checks' (i.e. taking on some of the role of the employer).

It emerged that all required guidance about how to raise such an issue with a regulator. When asked, respondents were clearly uncertain about who to consult: suggestions were to ask to police, Citizen's Advice, trading standards or look on the internet for advice on how to approach the regulator.

In reality, in an independent setting, most did not expect that they would report a health professional to a regulating body. It was hoped that patients would *"vote with their feet"* and word-of-mouth.

The diagram below illustrates how the general public struggled to envisage how a mental health problem would be managed in an independent setting:



6.5 STATUS TERMINOLOGY

6.5.1 EXPANDED

This term was perceived to mean 'taking on more responsibilities'. Respondents had heard of nurses becoming *"more like doctors, how they used to be"* in the media and had observed what they perceived to be increased duties (for example, putting in IVs, injecting, minor procedures).

Associations with the term 'expanded' included:

- More responsibility
- Seniority/experience
- Further training
- More qualifications

Some respondents had doubts about this status because it sounded like the professional was being given additional responsibility, potentially against their wishes: *"It's just more work, same hours, same pay".*

6.5.2 SPECIALIST

This term was interpreted as a focus on one area of practice. Many had dealt with specialist consultants, and associated the term with this type of role.

Associations with the term 'specialist' were:

- Concentrated training in one area
- Experience
- Better quality care

This status inspired trust because it implied that the professional had chosen to invest time in specializing in an area they liked. Further, they expected more skill in the specialized area:

"They have a higher level of knowledge and it fills you with confidence.
(Female, 60+ years, retired, BC1C2D, Bridgend)

"They would have more experience with a particular illness." (Male, 60+ years, retired, BC1C2D, Bridgend)

6.5.3 ADVANCED

Respondents assumed that this term meant 'more qualified'. The term was not widely liked, because its meaning was vague (i.e. More qualified in what way? More qualified than whom?

Associations with the term 'advanced' included:

- More training
- Higher qualifications
- Seniority/experience
- 'Climbing the ladder'

Some had experienced 'advanced' staff and found that it inspired confidence:

"That physio can overwrite the GP, they're the big cheese." (Male, 26-39 years, carer for children, C2DE, Sutton Coldfield)

However, those without experience of 'advanced' practitioners found that the term did not communicate a clear message about the status of the professional. The term communicated more about the professional's position in their career or hierarchy:

"It sounds like 'climbing the ladder'." (Male, 40-59 years, carer for older people, ABC1, Brighton)

6.5.4 CHECKING STATUS

Overall, there was a high level of understanding of the terms 'expanded', 'specialist' and 'advanced' – and an inherent trust in claims of these titles. Respondents were aware of each term via stories in the news or their own experience.

Respondents would not consider looking on registers to check the status of a professional – this was not considered their responsibility. As ever, the work of the regulator was expected to continue 'behind the scenes', with respondents trusting that 'someone must be doing something' to verify the claims of health professionals.

In addition to regulatory checks, employers were expected to conduct checks into the status of health professionals. Respondents trusted that the employer would check references and qualifications (which they expected to include verification of the status of the professional).

Respondents did not feel that they would need to check on claims in NHS settings because they trusted the NHS to conduct checks on their behalf:

"If you're in a pediatric ward and a nurse says she's a specialist pediatric nurse, you're not going to challenge her." (Male patient, 20-39, ABC1, Sutton Coldfield)

If paying privately (including independent practitioners) for a more qualified health professional, respondents were more likely to look for documentation internally (either in the form of certificates on display in the environment or name badges).

APPENDIX A

The purpose of the nine regulators is to protect and promote the safety of the public. They do this by setting standards of behaviour, education and ethics that health professionals must meet, and by dealing with concerns about professionals who are unfit to practise as a result of poor health, misconduct or poor performance. Regulators register health professionals who are fit to practise in the UK and can remove professionals from the register and prevent them from practising where they consider this to be in the best interests of public safety.

http://www.chre.org.uk/regulators/

APPENDIX B

CASE STUDY A: Mr A.

Outcome: **Erasure**

Notice of Allegation:

The Professional Conduct Committee finds Mr A. guilty of Serious Professional Misconduct. Mr A. has shown very little insight or fully accepted the effect his actions had. We are satisfied there is a clear risk of a repetition of this type of conduct in future.

Order:

The appropriate sanction is erasure. The Registrar will be directed to erase Mr A. from the register.

CASE STUDY B: Mrs B.

Outcome: **Struck off**

Notice of Allegation:

The Professional Conduct Committee finds Mrs B. guilty of Serious Professional Misconduct. Mr B. has shown very little insight or fully accepted the effect his actions had. We are satisfied there is a clear risk of a repetition of this type of conduct in future.

Order:

The appropriate sanction is striking off. The Registrar will be directed to strike Mrs B. off the register.

CASE STUDY C: Mr C.

Outcome: **Removal**

Notice of Allegation:

The Professional Conduct Committee finds Mr C. guilty of Serious Professional Misconduct. Mr C. has shown very little insight or fully accepted the effect his actions had. We are satisfied there is a clear risk of a repetition of this type of conduct in future.

Order:

The appropriate sanction is removal. The Registrar will be directed to remove Mr C. from the register.

APPENDIX C

CASE STUDY D: Mr Y.

Outcome: **Caution**

Notice Of Allegation:
Whilst on sick leave you carried out private work. Carrying out private practise whilst on sick leave was contrary to policy 3 (iii) of the Trust's Sickness and Absenteeism Policy and Procedure.

Order:
That the Registrar be directed to annotate the register entry of Mr Y. with a Caution which is to remain on the register for a period of two years.

CASE STUDY E: Ms Z.

Outcome: **Warning**

Notice Of Allegation:
Whilst on sick leave you carried out private work. Carrying out private practise whilst on sick leave was contrary to policy 3 (iii) of the Trust's Sickness and Absenteeism Policy and Procedure.

Order:
That the Registrar be directed to annotate the register entry of Ms Z. with a warning which is to remain on the register for a period of two years.

APPENDIX D

1. I have multiple sclerosis

MS is a condition of the central nervous system (the brain and spinal cord), which controls the body's actions and activities, such as movement and balance.

The symptoms of the condition are numerous and unpredictable, and they affect each person differently. Some of the most common conditions include problems with mobility and balance, pain, muscle spasms and muscle tightness.
MS is a life-long condition, but it is not terminal. People with MS can expect to live as long as anyone else.

http://www.nhs.uk/Conditions/Multiple-sclerosis/Pages/Introduction.aspx?url=Pages/What-is-it.aspx

2. I have a hearing impairment which means that I have difficulty following speech in a noisy environment

3. I have ongoing difficulties with depression

4. I am currently undergoing treatment (radiotherapy) for breast cancer

5. I regularly come to work hung over, having been drunk the previous night

APPENDIX E

EXAMPLE 1: Expanded

Wendy's son Jack has tonsillitis, and is admitted into the paediatric ward at their local hospital to have his tonsils removed. Before Jack goes for his operation, the nurse who has been looking after him comes to do a pre operation check. The nurse explains to Wendy that it used to be doctors that did this check, but now that she has an **expanded nurse role** she does it instead.

http://eprints.soton.ac.uk/50633/

Example 2: Specialist

Ruby is receiving treatment from breast cancer. She has an appointment with an **Oncology Specialist Nurse**, who helps Ruby to make a treatment plan by explaining the options to her. Ruby talks to the nurse about her concerns about the stress this will put on her family, and the **specialist nurse** says she will help her to speak with her family and make things as easy as possible.

http://www.tenovus.com/careAndSupport/oncologyNurseSpecialists/

Example 3: Advanced

John hurts his knee playing football. His GP refers him to have physiotherapy. When he arrives at his appointment, the physiotherapist looks at John's x-rays and discusses the pain with him. The physiotherapist explains that he is an **advanced physiotherapist**. After looking at his knee movement, the physiotherapist gives John a plan of when he can go back to work and start playing football again.

http://www.sor.org/public/pdf/adv_practitioner_Jan07.pdf

APPENDIX F - CHRE TOPIC GUIDE phase 2

1. INTRODUCTIONS AND EXPLANATIONS

- Introduce self and Research Works Limited, an independent market research agency.
- We will be discussing your views about the regulation of health professionals on behalf of Council for Healthcare Regulatory Excellence (CHRE).
- Explain confidentiality (DPA and MRS code of conduct) and ask permission to record the session.
- For filmed sessions explain to respondents that clips would be shown internally at the CHRE.

2. <u>WARM UP</u>

- Respondents to introduce themselves: Family, employment interests
- What health services have you recently accessed?
- Which health professionals treated you? (MODERATOR NOTE)
- Was this NHS, private/independent? (MODERATOR NOTE)

3. <u>UNDERSTANDING OF REGULATION</u>

Explain that this evening we are going to be talking about regulation and regulators. Let's start off with a quick brain storm …

– **Task 1: What names, words/phrases spring to mind when I say 'regulators'? What regulators are you aware of? (WRITE ON FLIP CHART)**

– What is the purpose of regulators?
– *Probe: what do they do?*

– **TASK 2: Form syndicate groups. Each group to compose a paragraph of no more than three sentences explaining "Why we have regulators". Present to the other groups, compare and contrast ideas.**

– From where does your knowledge/perceptions of regulators come?
– Have you had any experience of dealing with regulators?

4. UNDERSTANDING OF HEALTH PROFESSIONAL REGULATION

Explain that we are now going to move on to consider regulation in a healthcare context.

– Does anyone regulate health professionals? If so, whom?
– **LOOK AT TASK 1 FLIP CHART**: What health professional regulators names can we add?

– What do healthcare regulators actually do? *Probe: how do they regulate – what activities do they undertake?*
– **LOOK AT OUTPUTS FROM TASK 2**: Are there any similarities and differences between the roles of regulators and health professional regulators?
– From where have you learned what you know about health professional regulators?

- **TASK 3: Present respondents with a description of the role of healthcare regulators (Appendix A).**

– Spontaneous reactions

- To what extent does this confirm the thinking from our discussion so far? Are there any surprises?

If required, refer to appendix 1 part 2 to clarify the 9 regulating bodies and their relationships with each other and CHRE.

5. SANCTION TERMINOLOGY: ERASURE/STRIKING OFF/REMOVAL

Now the reason we have been discussing health professional regulators is because we are going to explore a how we would like healthcare regulators to communicate to us that they have concerns about a health professional. We have several 'real life' case studies to review (Appendix B).

For each case study discuss:

- What does this phrase say to you?
- What will happen to the health professional involved?
- *Probe: will they be removed from the register forever? Will they ever be able to practise again? Why/not?*

When discussed all three terms, explain to respondents what the term means (i.e. that they are removed from a register for life and not able to practise again, although registrants can apply for restoration to a register after a specified period of time):

- Given these circumstances, which term is most appropriate and why?

6. SANCTION TERMINOLOGY: CAUTIONS WARNINGS

We now have 'real life' case studies to review (Appendix C) about cautions and warnings.

For each case study discuss:

- What does this phrase say to you?
- What will happen to the health professional involved?

  Probe: will they be removed from the register forever? Will they ever be able to practise again? Why/not?

When discussed all three terms, explain to respondents what the term means (i.e. A warning or caution is given to a professional if allegations against them are found proved, but are not sufficiently serious to warrant erasure, suspension or the placing of conditions on the professional's practice. Warnings/cautions don't directly affect a professional's ability to practise but are published on the regulatory body's website and will be disclosed to anyone who asks about the professional's fitness to practise. If the actions that led to the warning/caution are repeated, this may result in further action against the professional and a more severe sanction):

- Given these circumstances, which term is most appropriate and why?

7. HEALTH AND HEALTH PROFESSIONALS

Explain that we are now going to move on to a different issue - health problems amongst health professionals and how regulators, registrants and employers might manage these situations.

TASK 4: Role play. I want you to imagine that I am your GP. You haven't seen me in a while, but when you arrive I don't look very well and I seem to have lost weight. You ask after my health and I say that I'm not very well.

- What concerns, if any, do you have about my fitness to practise?
- What questions would you like to ask me?

- What reassurance do I need to give you that I am well enough to practise?

- Would you have more/less concerns, different questions or require more/less/different reassurance in the following circumstances (review scenarios in appendix D).

  For each case study discuss:

  - What would you expect to happen, so that they are assured a health professional is practising safely and effectively? *Probe:*

    - What would you expect me to be doing about managing my work and health situation?
    - What would you expect my employer to be doing about managing my work and health situation?
    - What would you expect the regulator to be doing about managing my work and health situation?
    - How would this be different if it was a different healthcare professional?
    - How would it be different in alternative healthcare settings (e.g. different working environements, NHS Vs Private)

Imagine that, in each case, the health professional is managing the condition and adjusting the way that they work so that it does not affect the safety or effectiveness of their practise with patients. If a health professional manages their work so that they meet their regulatory bodies' standards of conduct and competence:

- Should they still have a duty to disclose their condition to their regulatory body? Why/why not?

We have discussed the idea that regulation is required to 'manage' health professionals' illness/disabilities.

- Who should be involved in managing (regulating) health professionals' health issues?

Probe: what is the hierarchy? Patients, colleagues, employers, regulators? What are their roles?

- At what point should the regulator become involved in the process of managing (regulating) health professionals' health issues?

  If regulators should be informed right at the beginning, probe:

  What types of illnesses/disabilities should they be informed about?

8. CASE STUDIES: TERMINOLOGY

Finally, we are going to look at specific terminology that may be used by health professionals we may come into contact with. Using the case studies in appendix E, discuss:

- What do you understand by this term?
- What you would expect from a health professional describing themselves in this way?
- How would this health professional differ to a health professional not describing themselves in this way?
- What does this description say about the professional's responsibility for decision making?
- What does it say about the level of autonomy with which the professional may be able to act?
- What does the description imply about of the following:
  - More training
  - Special skills

- More experience
- Less supervision,
- More senior in the organization
- Safer care for the individual patient

- What else (if anything) does the description say about the health professionals?

- Does the term mean anything different in the following situations?

  - Different healthcare professionals
  - Different healthcare settings (e.g. NHS, private, independent)

- Should patients and the public be able to check claims of 'specialists' or 'advanced' healthcare professionals?
- How would you expect to check on the status of a professional?
  Probe: ask the employer, look externally, perhaps check the register?
- How would you expect the employer to check on the status of a professional?
- *Probe: manage this internally through HR, look externally, perhaps check the register?*
- Would any other person or organization be responsible for checking on the status of a health professional? *Probe: regulators?*