# People like us?

# Understanding complaints about paramedics and social workers[1]

# Additional Appendices

## Contents



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

## Appendix A –Literature review references

### Paramedic literature references

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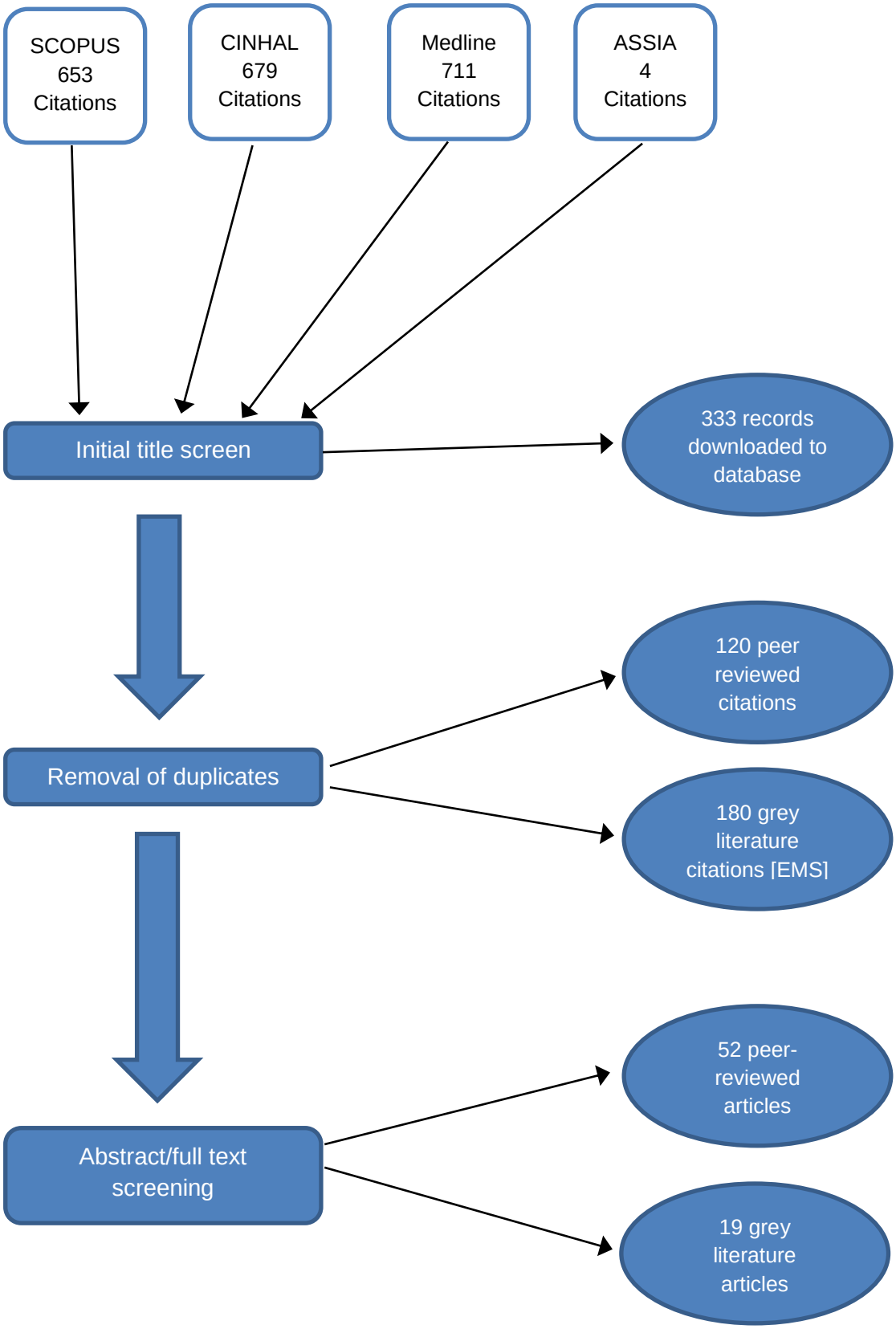
## Literature review search terms

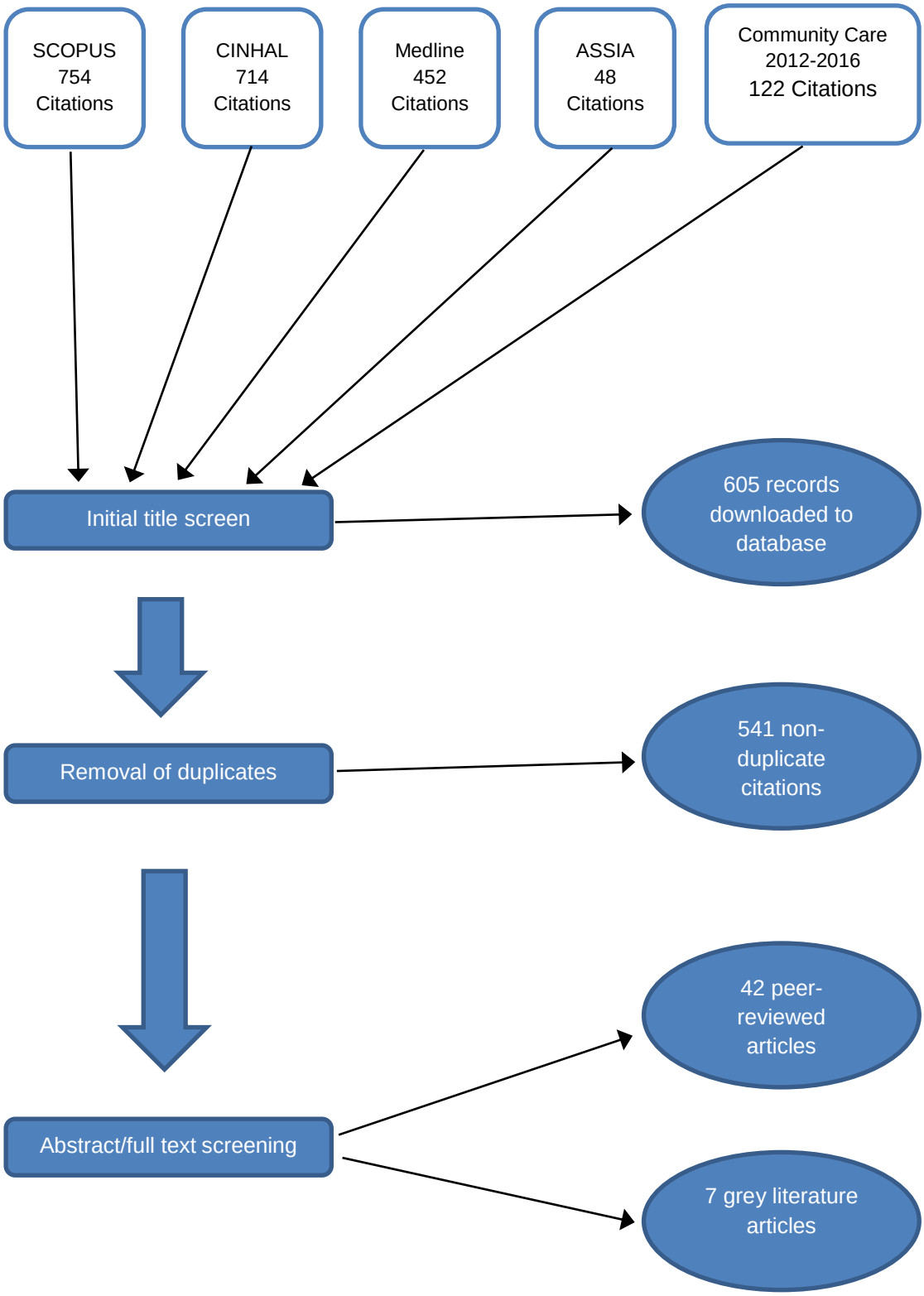
In searching for both paramedic and social work literature the following search terms were used in line 1: “fitness to practi*” OR “conduct hearing*” OR *disciplinary hearing*” OR “disciplinary action*” OR misconduct OR malpractice OR “professional conduct” OR “professional discipline” OR “professional boundar*” OR professionalism OR “quality assurance” OR complain* OR unethical OR Illegal OR unprofessional. Line 2 of the paramedic literature search consisted of: paramedic OR ems OR emergency medical service OR prehospital OR pre-hospital OR ambulance OR emergency medical technician OR emt. Line 2 of the social work literature search consisted of: “social work*”. Additional criteria were used to narrow down both searches to publications from 2000-2016 and written in English.

## Appendix B – Literature review flow diagrams

### Paramedics



**Social Work**


SCOPUS
754
Citations
CINHAL
714
Citations
Medline
452
Citations
ASSIA
48
Citations
Community Care
2012-2016
122 Citations
Initial title screen
605 records downloaded to database
Removal of duplicates
541 non-duplicate citations
Abstract/full text screening
42 peer-reviewed articles
7 grey literature articles

## Appendix C – Literature sources

### Paramedics

| Authors | Title | Date | Journal | Method | Participants | Country | Publication |
|---|---|---|---|---|---|---|---|
| Aasa et al. | Work-related psychosocial factors, worry about work conditions and health complaints among female and male ambulance personnel. | 2005 | Scandinavian Journal of Caring Sciences | Survey | 1500 | Sweden | PR |
| Aasa et.al | Stress monitoring of ambulance personnel during work and leisure time | 2006 | In Archives of occupational and environmental health | Observational | 26 | Sweden | PR |
| Bevan and Hood | Hitting and missing targets by ambulance services for emergency calls; effects of different systems of performance measurement within the UK | 2006 | Journal of the Royal Statistical Society | Literature review | | UK | PR |
| Bigham | Patient safety in emergency medical services; a systematic review of the literature | 2012 | Pre hospital Emergency Care | Systematic review | | US | PR |

| Authors | Title | Date | Journal | Method | Participants | Country | Publication |
|---|---|---|---|---|---|---|---|
| Blau | Exploring the impact of sleep related impairments on the perceived general health and retention intent of an EMS sample | 2011 | Career Development International | Survey | 288 | US | PR |
| Broniecki et al. | Musculoskeletal disorder prevalence and risk factors in ambulance officers | 2010 | Journal of Back and MSK Medicine | | | Australia | PR |
| Burford et al. | Professionalism education should reflect reality: findings from three health professions. | 2014 | Medical Education | Focus groups | 112 | UK | PR |
| Christmas & Millward | New Medical Professionalism: A scoping report for the Health Foundation | 2011 | The Health Foundation | Policy paper | | UK | GL |
| Clohessy, & Ehlers | PDST symptoms, response to intrusive memories and coping in ambulance service workers. | 1999 | British Journal of Clinical Psychology | Survey, interviews | | UK | GL |
| Coffey et al. | A physical demands description of paramedic work in Canada | 2016 | | Observational | 14 | Canada | PR |

| Authors | Title | Date | Journal | Method | Participants | Country | Publication |
|---|---|---|---|---|---|---|---|
| Colwell et al. | Complaints against an EMS system. | 2003 | Journal of Emergency Medicine | Retrospective case analysis | 286 | US | PR |
| Department of Health | See PEEP report | 2008 | | Policy paper | | UK | GL |
| Dick | • Professional etiquette: how you show your respect for people.<br>• EMS reruns. Fox in the henhouse: when the accused is a caregiver.<br>• What people say: fielding and responding to customer complaints.<br>• Front-line leadership. Leadership tips. Listening later: can some complaints really wait?<br>• The lesson. Why do some of us become cynical?<br>• Flexibility: making systems serve people.<br>• That whining sound: accept complaints, but expect suggestions. | 2004-2010 | EMS Magazine | Narrative | | US | GL |

| Authors | Title | Date | Journal | Method | Participants | Country | Publication |
|---|---|---|---|---|---|---|---|
| | • Witch hunt: supporting caregiver's authority to think.<br>• What's that smell? Your partner, the drunk.<br>• Tricks of the trade. Professional etiquette: stuff a pro does. | | | | | | |
| Fitzgerald | Defining a regulatory framework for paramedics; a discussion paper | 2007 | Journal of Emergency Primary Health Care | Review | | Australia | PR |
| Gallagher et al. | Experts' perspectives on professionalism in paramedic practice: findings from a Delphi process. | 2016 | British Paramedic Journal | Delphi | 12 | UK | PR |
| Gallagher et al. | Professionalism in paramedic practice: the views of paramedics and paramedic students | 2016 | British Paramedic Journal | Interviews | 16 | UK | PR |
| Gilbert | How to Respond to Complaints. | 2012 | EMS World | Narrative | | US | GL |
| Harkins | Managing risk in Emergency Care | 2001 | Emergency | Narrative | | US | GL |

| Authors | Title | Date | Journal | Method | Participants | Country | Publication |
|---|---|---|---|---|---|---|---|
| | Services | | Medicine Journal | | | | |
| Heightman | Are foxes gurding your henhouse? | 2007 | Journal of Emergency Medicine | Narrative | | US | GL |
| Ho | Apathy is not welcome here | 2003 | Prehospital Emergency Care | Narrative | | US | GL |
| Iacobucci | NHS111 is blamed for the large increase in complaints against ambulance trusts | 2014 | British Medical Journal | Editorial | | UK | PR |
| Jennings & Stella | Barriers to incident notification in a regional prehospital setting. | 2011 | Emergency Medicine Journal | Ethnography | | Australia | PR |
| Jonsson | Post traumatic stress amongst Swedish ambulance personell. | 2003 | Emergency Medicine Journal | Survey | 362 | Sweden | PR |
| Kilner | Educating the ambulance technician, paramedic, and clinical supervisor: using factor analysis to inform the curriculum. | 2004 | Emergency Medicine Journal | Delphi | | UK | PR |

| Authors | Title | Date | Journal | Method | Participants | Country | Publication |
|---|---|---|---|---|---|---|---|
| Knowles et.al. | Patient experiences and views of an emergency and urgent care system | 2012 | Health Expectations | Survey | 1000 | UK | PR |
| Knox | Regulation and registration as drivers for continuous professional competence for Irish prehospital practitioner; a discussion paper | 2004 | Irish Journal of Medical Science | Literature review | | Ireland | PR |
| Lovegrove, & Davis | *Paramedic Evidence Based Education Project (PEEP) End of Study Report* | 2013 | | Policy paper | | UK | GL |
| Lu et.al. | Disclosure of harmful medical errors in out of hospital care | 2013 | Annals of Emergency Medicine | Literature review | | US | PR |
| Mason et al. | Effectiveness of emergency care practitioners working within existing emergency service models of care | 2007 | Emergency Medicine Journal | Observational | 524 | UK | PR |
| Mason et al. | Safety of paramedics with extended skills. | 2008 | Academic Emergency Medicine | Retrospective case analysis | 2025 | UK | PR |

| Authors | Title | Date | Journal | Method | Participants | Country | Publication |
|---|---|---|---|---|---|---|---|
| McCann et al. | Where Next for the Paramedic Profession? An Ethnography of Work Culture and Occupational Identity. | 2015 | Emergency Medicine Journal | Ethnography | | UK | PR |
| McCann et al. | Still blue-collar after all these years? An ethnography of the professionalization of emergency ambulance work, | 2013 | Journal of Management Studies | Interviews | 10 | UK | PR |
| McDonnell | The search and development of professionalism in ‘ambulance’; a multidisciplinary journey | 2009 | Journal of Emergency Primary Health Care | | | Australia | PR |
| Newdick | From Hippocrates to commodities- 3 models of NHS governance | 2014 | Medical Law Revuew | Narrative | | UK | PR |
| O’Meara | Paramedics marching toward professionalism. | 2009 | Journal of Emergency Primary Health Care | Narrative | | Australia | PR |
| Page | Excrement happens | 2016 | EMS World | Narrative | | US | GL |

| Authors | Title | Date | Journal | Method | Participants | Country | Publication |
|---|---|---|---|---|---|---|---|
| Panchal | The impact of professionalism on transfer of care to the Emergency Department | 2015 | Journal of Emergency Medicine | Observation | 1091 | US | PR |
| Paterson | Association between poor sleep fatigues and safety outcomes | 2012 | Prehospital Emergency Care | Survey | 547 | US | PR |
| Paterson | What paramedics think about when they think about fatigue: contributing factors. | 2014 | Emergency Medicine Australasia | Survey | 49 | Australia | PR |
| Perry | Collaborating on Safety | 2016 | EMS World | Narrative | | US | GL |
| Petzall et.al | Threats and violence in the Swedish pre-hospital emergency care service | 2011 | International Emergency Nursing | Survey | 143 | Sweden | PR |
| Porter | Accepting complaints | 2004 | EMS | | | US | GL |
| Reynolds | Beyond the front line: An intepretative ethnography of an ambulance service. | 2008 | Ph.D thesis | Ethnographic study | | Australia | GL |
| Risavi | Analysis of complaints in a rural | 2013 | Prehospital and | Retrospective | 110 | US | PR |

| Authors | Title | Date | Journal | Method | Participants | Country | Publication |
|---|---|---|---|---|---|---|---|
| | emergency medical service system. | | Disaster Medicine | case analysis | | | |
| Rollert | Coping with violent people | 2007 | EMS Magazine | Narrative | | US | GL |
| Seddon | Systems thinking In the public sector | 2009 | Book | | | UK | |
| Shojania | Bad apples – time to redefine as a type of system problem? | 2013 | BMJ Qual & Safety | Narrative | | Canada | PR |
| Sili | Organisational health and quality of life; survey among ambulance nurses in pre hospital emergency care | 2011 | La Medicina del Lavoro | Survey | 411 | Italy | PR |
| Simmonds | Professionalism and care; the daily bread and butter of a paramedic attending patients who fall | 2015 | Journal of Emergency Medicine | Interview | 12 | UK | PR |
| Smith | Beyond the books. It's care with a capital "C." | 2005 | EMS | Narrative | | US | GL |
| Smith | Beyond the books. Show Me the Professionals. | 2013 | EMS World | Narrative | | | GL |
| Sofianopolous | Paramedics and the effects of shift | 2012 | Journal of | Literature | | Australia | PR |

| Authors | Title | Date | Journal | Method | Participants | Country | Publication |
|---|---|---|---|---|---|---|---|
| et al. | work on sleep: a literature review. | | Emergency Medicine | review | | | |
| Sterud et al. | Health status in the ambulance services: A systematic review. | 2006 | BMC Health Services Research | Literature review | | Norway | PR |
| Sterud et al. | Suicidal ideation and suicide attempts in a nationwide sample of operational Norwegian ambulance personnel. | 2008 | Journal of Occupational Health | Survey | 1180 | Norway | PR |
| Sterud et al. | A comparison of general and ambulance specific stressors: predictors of job satisfaction and health problems in a nationwide one-year follow-up study of Norwegian ambulance personnel. | 2011 | Journal of Occupational Medicine and Toxicology | Survey | | Norway | PR |
| Streger | Professionalism | 2003 | EMS | Narrative | | US | GL |
| Strzemecka | The factor harmful to the quality of human life - Shift-work. | 2013 | Annals of agricultural and environmental | Survey | 700 | | |

| Authors | Title | Date | Journal | Method | Participants | Country | Publication |
|---|---|---|---|---|---|---|---|
| | | | medicine | | | | |
| Studnek et al. | An assessment of key health indicators among emergency medical services professionals. | 2010 | Prehospital Emergency Care | Survey | 19,960 | US | PR |
| Studnek et al. | Back problems among emergency medical services professionals: the LEADS health and wellness follow-up study. | 2010 | American Journal of Industrial medicine | Survey | 470 | US | PR |
| Togher | Reassurance as a key outcome valued by emergency ambulance service users: a qualitative interview study. | 2014 | Health Expectations | Interviews | 30 | UK | PR |
| Torjesen | BMA and ambulance service call on government to delay roll out of non emergency number 111 | 2012 | British Medical Journal | Narrative | | UK | PR |
| Touchstone | Professional development. Part 2: subordinating your interests. | 2010 | EMS | Narrative | | US | GL |
| Trede | Becoming professional in the 21st | 2011 | Journal of Emergency | Narrative | | Australia | PR |

| Authors | Title | Date | Journal | Method | Participants | Country | Publication |
|---|---|---|---|---|---|---|---|
| | century | | Primary Health Care | | | | |
| Turner et al | The costs and benefits of implementing the new Ambulance service response time standards. Report to DH, University of Sheffield. | 2006 | DH | Review | | UK | GL |
| Tunaligil | Determinants of general health, work related strain and burnout in public versus private emergency medical technicians in Istanbul | 2016 | Workplace Health Safety | Survey | 824 | Turkey | PR |
| van der Ploeg & Kleber | Acute and chronic job stressors amongst ambulance personell; predictors of health outcomes. | 2003 | Occupational and Environmental Medicine | Survey | 123 | Netherlands | PR |
| Vike | Paramedics self reported medication errors. | 2006 | Prehospital Emergency Care | Survey | | US | PR |
| Velloso | Mobile Emergency Care services; | 2014 | Referencia | Qualitative | 31 | Brazil | PR |

| Authors | Title | Date | Journal | Method | Participants | Country | Publication |
|---|---|---|---|---|---|---|---|
| | the work on display | | | study | | | |
| Wang et al | Tort claims and adverse events in emergency medical services. | 2008 | Annals of Emergency Medicine | Survey | | US | PR |
| Williams | Is the Australian paramedic discipline a full profession? | 2010 | Journal of Emergency Primary Health Care | Survey | 63 | Australia | PR |
| Williams | Are paramedic students ready to be professional? An international comparison | 2015 | Journal of Emergency Primary Health Care | Survey | 479 | NZ/Australia | PR |
| Wollard | The Role of the Paramedic Practitioner in the UK. | 2009 | Journal of Emergency Primary Health Care | Review | | UK | PR |
| Zhao | Shift work and work related injuries among health care workers; a systematic review | 2010 | | Systematic review | | Australia | PR |

**Social Work**

| Authors | Title | Date | Journal | Method | Participants | Country | Publication |
|---|---|---|---|---|---|---|---|
| Banks | Ethics, Accountability and the Social Professions, | 2004 | Book | | | | |
| Banks | Ethics in an age of austerity: Social work and the evolving New Public Management | 2011 | Journal of Social Intervention: Theory and Practice | Narrative | | UK | PR |
| Banks | Negotiating personal engagement and professional accountability: professional wisdom and ethics work. | 2013 | European Journal of Social Work | Narrative | | | PR |
| Banks | Everyday ethics in professional life: social work as ethics work | 2016 | Ethics and Social Welfare | Narrative | | | PR |
| Bates et al. | “Baptism of Fire”: The First Year in the Life of a Newly Qualified Social Worker. | 2009 | Social Work Education | Survey and Interviews | 37 | England | PR |
| Bates et al. | Exploring boundary attitude. | 2013 | Journal of Adult Protection | Survey and interactive | 409 | UK | PR |

| Authors | Title | Date | Journal | Method | Participants | Country | Publication |
|---|---|---|---|---|---|---|---|
| | | | | training events | | | |
| Beer | Predictors of and Causes of Stress Among Social Workers: A National Survey. | 2016 | Thesis publication | Survey and interviews | 427 | England | GL |
| Boland-Prom et al. | Sanctioning Patterns of Social Work Licensing Boards, 2000–2009. | 2015 | Journal of Human Behavior in the Social Environment | Retrospective Case Analysis | 2,607 | USA | PR |
| Bradley et al. | Supervision: A force for change? Three stories told. | 2010 | International Social Work | Narrative | | South Africa, England and Sweden | PR |
| Burns | Professional Decision Making in Social Work Practice. | 2011 | Child & Family Social Work | Book review | | | PR |
| Carey | The quasi-market revolution in the head: ideology, discourse, care management. | 2008 | Journal of Social Work | Ethnomethodology | 44 | UK | PR |
| Clark | Professional Responsibility, | 2007 | Ethics and Social | Narrative | | | |

| Authors | Title | Date | Journal | Method | Participants | Country | Publication |
|---|---|---|---|---|---|---|---|
| | Misconduct and Practical Reason | | Welfare | | | | |
| Clarke | Transfer of training: the missing link in training and the quality of adult social care. | 2013 | Health & Social Care in the Community | Systematic review | | | PR |
| Daley & Doughty | Ethics Complaints in Social Work Practice: A Rural-Urban Comparison. | 2006 | Journal of Social Work Values and Ethics | Retrospective case analysis | 594 | USA | PR |
| Doel et al. | Professional boundaries: crossing a line or entering the shadows? | 2010 | British Journal of Social Work | Survey | 504 | UK, Ireland, USA, Canada, Australia, New Zealand, South Africa, Sweden, Germany | PR |
| Ellis | “Street-level Bureaucracy” Revisited: The Changing Face of Frontline Discretion in Adult Social Care in | 2011 | Social Policy and Administration | Observation and interviews | | UK | PR |

| Authors | Title | Date | Journal | Method | Participants | Country | Publication |
|---|---|---|---|---|---|---|---|
| | England | | | | | | |
| Evans | Organisational Rules and Discretion in Adult Social Work. | 2013 | British Journal of Social Work | Interviews | 12 | England | PR |
| Foster & Wilding | Whither welfare professionalism? | 2000 | Social Policy and Administration | Narrative | | | PR |
| Furness | Conduct Matters: The Regulation of Social Work in England. | 2015 | British Journal of Social Work | Retrospective case analysis | 265 | England | PR |
| Garboden | Lessons of baby P are not being learned, SCR author complains. | 2010 | Community Care | Narrative | | England | GL |
| General Social Care Council | Regulating social workers (2001-2012) | 2012 | Report | | | England | GL |
| Gibson | Constructing pride, shame, and humiliation as a mechanism of control: A case study of an English local authority child protection service. | 2016 | Children and Youth Services Review | Ethnography | 21 | England | PR |
| Ingram | Exploring Emotions within Formal and Informal Forums: Messages | 2015 | British Journal of Social Work | Survey and interviews | 112 | Scotland | PR |

| Authors | Title | Date | Journal | Method | Participants | Country | Publication |
|---|---|---|---|---|---|---|---|
| | from Social Work Practitioners. | | | | | | |
| Jessen | Trust and recognition: a comparative study of client attitudes and workers' experiences in the welfare services. | 2010 | European Journal of Social Work | Survey | 1146 professionals and 5442 members of the public | Norway | PR |
| Juhila, Raitakari, & Hall (eds) | Responsibilisation at the margins of welfare services | 2017 | Book | | | | |
| Katsavdakis et al. | Profiles of impaired health professionals. | 2004 | Bulletin of the Menninger Clinic | Retrospective case analysis | 334 | USA | GL |
| Kirwan & Melaugh | Taking Care: Criticality and Reflexivity in the Context of Social Work Registration. | 2015 | British Journal of Social Work | Retrospective case analysis | 72 | UK | PR |
| Leigh | The process of professionalisation: Exploring the identities of child protection social workers. | 2013 | Journal of Social Work | Interviews | 8 | UK | PR |
| Leigh | The story of the ppo queen: The development and acceptance of a | 2014 | Child & Family Social Work | Auto-ethnography | 1 | UK | PR |

| Authors | Title | Date | Journal | Method | Participants | Country | Publication |
|---|---|---|---|---|---|---|---|
| | spoiled identity in child protection social work. | | | | | | |
| Liljegren | Pragmatic professionalism: micro-level discourse in social work. | 2012 | European Journal of Social Work | Individual and focus group interviews | 30 | Sweden | PR |
| Lloyd et al. | Social work, stress and burnout: A review. | 2002 | Journal of Mental Health | Literature review | | | PR |
| McLaughlin | The social worker versus the General Social Care Council: an analysis of care standards tribunal hearings and decisions. | 2010 | British Journal of Social Work | Retrospective case analysis | 14 | England | PR |
| Mclaughlin et. al | The State of Regulation in England : From the General Social Care Council to the Health and Care Professions Council. | 2016 | British Journal of Social Work | Narrative | | England | PR |
| Moriarty et al. | A depth of data: research messages on the state of social work education in England. | 2010 | Research, Policy and Planning | Multi-method longitudinal study | Includes 25,490 student records, 3,944 | England | PR |

| Authors | Title | Date | Journal | Method | Participants | Country | Publication |
|---|---|---|---|---|---|---|---|
| | | | | | survey responses, 290 interviews | | |
| Murray | “Mission impossible on a daily basis” – the real effect of spending cuts on social work. | 2015 | The Guardian Social Care Network | Survey | 1,420 | UK | GL |
| O’Leary et al. | The boundaries of the social work relationship revisited: Towards a connected, inclusive and dynamic conceptualisation. | 2013 | British Journal of Social Work | Narrative | | | PR |
| Parry et al. | “The tip of the ice berg”: children’s complaints and advocacy in Wales -- an insider view from complaints officers. | 2008 | British Journal of Social Work | Interviews | 122 | Wales | PR |
| Payne | The Origins of Social Work | 2005 | Book | | | | |
| Reamer | Social Workers’ Management of Error: Ethical and Risk Management Issues. | 2008 | Families in Society: The Journal of Contemporary | Narrative | | USA | PR |

| Authors | Title | Date | Journal | Method | Participants | Country | Publication |
|---|---|---|---|---|---|---|---|
| | | | Social Services | | | | |
| Roberts | 'Complaints stem from failure to listen...'. | 2007 | Community Care | Letter | | UK | GL |
| Seebohm Report | Report of the Committee on Local Authority and Allied Personal Social Services | 1968 | | | | | |
| Shevellar & Barringham | Working in Complexity: Ethics and Boundaries in Community Work and Mental Health. | 2016 | Australian Social Work | Narrative | | | PR |
| Siebert | Denial of AOD use: An issue for social workers and the profession. | 2003 | Health and Social Work | Survey | 751 | USA | PR |
| Stevenson | Social worker sanctioned over Facebook posts reflects on feeling abandoned amidst a media storm. | 2014 | Community Care. | Narrative | | | GL |
| Stewart | Resolving social work value conflict: Social justice as the primary organizing value for social work. | 2013 | Journal of Religion & Spirituality in Social Work: Social Thought | Narrative | | | PR |

| Authors | Title | Date | Journal | Method | Participants | Country | Publication |
|---|---|---|---|---|---|---|---|
| Strom-Gottfried | Ethical vulnerability in social work education: an analysis of NASW complaints. | 2000 | Journal of Social Work Education | Retrospective case analysis | 894 | USA | PR |
| Strom-Gottfried | Understanding adjudication: origins, targets, and outcomes of ethics complaints. | 2003 | Social Work | Retrospective case analysis | 894 | USA | PR |
| Summerson Carr | Occupation bedbugs: Or, the urgency and agency of professional pragmatism | 2015 | Cultural Anthropology | Ethnography | | USA | PR |
| Walter | Toward a third space: improvisation and professionalism in social work. | 2003 | Families in Society | Narrative | | | PR |
| Warner | Social work, class politics and risk in the moral panic over Baby P. | 2013 | Health, Risk & Society | Qualitative documentary analysis | 420 | UK | PR |
| Wilberforce et al. | Revisiting the causes of stress in social work: Sources of job demands, control and support in personalised adult social care. | 2014 | British Journal of Social Work | Survey and interviews | 297 | England | PR |

## Appendix D – Delphi Process Summary Table: All statements

Consensus statements over 70% highlighted (Rounds 2 and 3).

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

| | Round 3 - % CONSENSUS | MEAN Round 2 | MEAN Round 3 |
|---|---|---|---|
| **Public attitudes/expectations** | | | |
| 1. There are changing attitudes towards what health and social services should deliver to the public and an increasing belief in what the public's rights to help are. | 100% | 1.7 | 1.6 |
| 2. The public's lack of knowledge of what is feasible or realistic in terms of level of or type of treatment or care. | 62.5% | 3.0 | 2.5 |
| 3. The increase may be more related to a better-informed public than an increase in misconduct or incompetence of professions. | 100% | 1.8 | 1.8 |
| 4. There is a reduction in deference to professions by society generally | 100% | 2.2 | 1.9 |
| 5. The public is more exacting about standards of care and levels of professionalism and not as willing to accept poor communication or below par standards. | 100% | 1.7 | 1.6 |
| 6. The public has less trust in the infallibility of professional expertise; | 100% | 2.1 | 1.9 |
| 7. This perhaps reflects a broader shift in social attitudes – a temptation to blame others for problems (for example, part of phenomenon that has led to Brexit & Trump). | 62.5% | 2.4 | 2.4 |
| 8. The public has increased access to information - about legal provisions, services, health indicators etc - and so a more | 100% | 1.9 | 1.8 |

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| questioning, even challenging, approach is inevitable. | | | |
| 9. There is an increasing willingness on the part of members of the public to raise a complaint. | 77.5% | 2.1 | 2.0 |
| Awareness of complaint process | | | |
| 10. There is greater public awareness of how to make a complaint resulting in their filing complaints in increasing numbers. | 77.8% | 2.0 | 2.1 |
| 11. The public is becoming increasingly more aware of the role of the regulator in receiving complaints. | 75% | 2.4 | 2.3 |
| 12. Complaints are often made as a precursor to the initiation of court proceedings - it is often considered an inexpensive way of flushing out the case and the details. | 25% | 3.2 | 3.0 |
| **Pressure on services** | | | |
| 13. Health and social care services are under pressure to deliver 'cost effective' care resulting in hard prioritisation of what type and level of care is delivered. | 100% | 2.3 | 1.6 |
| 14. Even if better options are available in a given situation, professionals' guidelines dictate them to deliver 'good enough' care, not 'best' care. | 50% | 3.1 | 2.8 |
| 15. There is a more complex environment within which professionals work which means more can go wrong. | 87.5% | 2.0 | 2.1 |
| 16. Resources are stretched to the limits following the global economic crisis and many posts are not being filled which puts increased pressure on professionals. | 100% | 2.1 | 1.5 |
| 17. Professions charged with operating at the juncture between private and public interests are inherently under the spotlight and exposed to a close scrutiny of what might be 'good' | 75% | 2.3 | 2.0 |

| | | | |
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| behaviour. | | | |
| 18. Reduced amount of emotional support from organisations under pressure. | 50% | 2.3 | 2.3 |
| 19. Professionals are feeling increasing pressure mainly around the lack of support offered at a systems/organisational level. | 62.5% | 2.3 | 2.1 |
| 20. Many, many complaints/concerns involve apparent poor practice when it is actually the lack of resources (time, supervision, inordinately high workloads) that is as much, if not more, the problem. | 75% | 2.3 | 2.1 |
| **Workforce factors** | | | |
| 21. Fatigue amongst health care professionals. | 62.5% | 2.6 | 2.6 |
| 22. Insufficient professional development opportunities offered to staff contributing to increasing fatigue, decreasing employee loyalty and reducing the moral commitment of the health care professionals. | 75% | 2.5 | 2.3 |
| 23. A disillusioned workforce. | 50% | 2.4 | 2.5 |
| 24. Pay is not commensurate with work expectations. | 37.5% | 2.8 | 2.5 |
| **Media & political factors** | | | |
| 25. Bad press coverage - TV and newspapers - may impact on the perception of the services being offered. | 75% | 1.9 | 2.0 |
| 26. The media is largely responsible for this as is the risk society that has steadily been created over past decades. | 75% | 2.5 | 2.4 |
| 27. Any actual or perceived number of complaints and concerns is about the wider social and political circumstances and the interrelationship between state and media | 62.5% | 2.7 | 2.1 |

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| constructions of risk. | | | |
| 28. Social media (e.g. twitter and facebook) make it easy for the public to complain and spread stories about poor service. | 75% | 2.2 | 1.9 |
| **Regulatory factors** | | | |
| 29. Regulator initiatives focused on public outreach, education and communication have informed the public about what they should expect form regulated health and care professionals, and more importantly, what they should do if their expectations are not met. | 50% | 2.3 | 2.6 |
| 30. There is greater awareness of the regulator and its role. | 50% | 2.5 | 2.5 |
| 31. There are better system linkages between regulators and other quality assurance mechanisms which means that poor practice is being detected earlier. | 62.5% | 2.3 | 2.4 |
| 32. Employers and regulatory authorities have taken accountability much more seriously and practitioners are more likely to be reported by colleagues for inappropriate behaviour or conduct that is of concern | 87.5% | 2.3 | 1.9 |
| 33. In jurisdictions where a registration process has been more recently introduced, this may contribute to heightened awareness of regulatory options for complaints procedures. | 62.5% | 2.2 | 2.3 |
| 34. From a standards perspective, there is a heightened awareness both within and outside of the professions, in terms of ethics, integrity and appropriate behaviour, and a concomitant emphasis on making complaints/grievance procedures transparently available. | 75% | 1.9 | 1.9 |
| 35. Maybe we are doing a good job at telling people that they are able to complain, rather than assuming that any increase in the number | 50% | 2.1 | 2.3 |

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| of complaints indicates a greater level of (e.g.) alleged misbehaviour on the part of the practitioners. | | | |
| **Nature of practice** | | | |
| 36. Nature of the work certain groups such as social workers - dealing with tough situations, having to make very tough decisions with unhappy parties no matter what. | 75% | 1.6 | 1.9 |
| **Education/training** | | | |
| 37. Professional training programs have become less selective at the time of admissions and today's practitioners are, on average, less competent. | 0% | 3.8 | 3.9 |
| 38. The quality of ethics education is not strong enough. | 25% | 3.3 | 3.1 |
| Questioning the increase | | | |
| 39. I am not convinced that there has been a significant increase in unethical conduct. | 87.5% | 2.3 | 2.3 |
| *40. The norms for what we accept as unethical have shifted over time [number change from here] | 87.5% | | 1.9 |

**Question 1A: Are there any particular reasons that apply to paramedics? Please describe.**

| | | | |
|---|---|---|---|
| **Public attitudes/expectations** | | | |
| 41. If there is a discrepancy between expectations of high level of care (or just a specific, but unnecessary type of care), and what the ambulance service or paramedics can or wish to give, there will be a conflict. | 85.7% | 2.3 | 2.0 |

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| 42. A psychological situation which affects paramedics specifically is the 'my home is my castle' situation. From the resident's standpoint, subconsciously, the resident is the king - and therefore also has some kind of right to dominate. So even if one should expect a trained health care professional to be high up in the hierarchy of the local group, this is not always so. If care offered is not aligned with expectations, conflict may arise. | 100% | 2.9 | 2.6 |
| 43. The public has the expectation when they call an ambulance that they will be taken to hospital and seen by a Doctor. When this does not happen they may feel that they are being denied access to hospital care and vent their frustration at the paramedics. | 71.4% | 2.1 | 2.3 |
| 44. There is an increased tendency for the public to be aggressive towards paramedics and firemen so complaints may arise from this. | 85.7% | 2.6 | 2.9 |
| 45. There is a high level of public expectation about the effectiveness of medical/emergency intervention, and less acceptance that people are going to die/be damaged as a result and possibly a greater sense of litigation and individual rights here. | 71.4% | 2.3 | 2.3 |
| **Pressure on services** | | | |
| 46. There are too few human resources. | 42.9% | 2.6 | 2.3 |
| **Workforce factors** | | | |
| 47. Paramedicine can attract fast thinking but comparatively low reflective-type individuals. This reactive persona might cause paramedics to be more likely to make decisions that have negative outcomes. | 14.3% | 3.6 | 3.3 |
| 48. Paramedics not caring for themselves personally, or poorly trained in self-care strategies with evidence of emotional | 42.9% | 3.0 | 2.7 |

| | | | |
|---|---|---|---|
| dysregulation. | | | |
| 49. Lack of clarity to paramedics as to what they can and cannot do, in relation to additional roles. | 14.3% | 3.2 | 3.0 |
| 50. Expanding scope of practice means paramedics are doing a lot more than they have in the past, with more invasive procedures and access to restricted drugs, | 57.2% | 2.2 | 2.3 |
| 51. Paramedics work away from communities of other professions who appreciate the strain everyone is under. While supervision may be provided from their own professionals the lack of other health and social care professions working alongside them, could be isolating the cultural behaviour of paramedics. | 57.2% | 2.3 | 2.1 |
| **Nature of practice** | | | |
| 52. Paramedics work in situations of extremis (at times) and in heightened situations of emotional and physical distress. | 85.7% | 1.7 | 1.6 |
| 53. The move to treat patients at home and to have on-scene discharge. | 57.2% | 2.3 | 2.3 |
| 54. As first responders to medical emergencies that can go ‘either way’, paramedics would be either commended or complained against-depending on the outcome. | 57.2% | 2.2 | 2.4 |
| 55. Paramedics provide their services in less than ideal circumstances, for example, on the side of the road, in tight spaces in homes, off a cliff or on a beach. By the nature of the calls to emergency services, patients do die or may not have the expected outcome, compared to if the illness had occurred in hospital. | 71.5% | 2.0 | 2.0 |
| 56. Paramedics may be called out on behalf of others and thus the relationship may not be one of a person's own choosing which can lead to | 57.2% | 2.4 | 2.3 |

| | | | |
|---|---|---|---|
| contempt. | | | |
| 57. Paramedics are on the front line of crisis, trauma and emergency services. They are under the watchful eye of a range of people as they go about their jobs. Family and significant others are often involved in emergency situations, and the heightened emotion at times of crisis can result in misperceptions and miscommunication. This can result in complaints. | 71.5% | 1.9 | 1.9 |
| 58. When patients are acutely sick in the pre-hospital environment, tasks have to be prioritised. This gives priority to medical tasks, instead of good communication with patient, next of kin and members of the public. | 56.2% | 2.6 | 2.4 |
| **Education/training** | | | |
| 59. Paramedics being educated quite separately from other health and social care professions could add to professional isolation. | 57.2% | 2.5 | 2.1 |
| *60. We need more inter-professional training and education | 85.7% | | 1.6 |

**Question 1B: Are there any particular reasons that apply to social workers? Please describe.**

| | | | |
|---|---|---|---|
| **Awareness of complaint process** | | | |
| 61. Social workers work with vulnerable client groups who traditionally have not had much of a voice and have tended not to complain. It may be that having a multi-profession regulator makes public education a lot more effective - maybe people know where to go to complain more than they used to, and we may be getting better at making our complaints systems more accessible. | 62.5% | 2.3 | 2.4 |
| **Workforce factors** | | | |

| | | | |
|---|---|---|---|
| 62. Social workers are primarily employed in local authority and do not have the links with other health and social care professions who are dealing with people facing extreme difficulties and are separated from the full involvement of the multi-disciplinary teams. | 50% | 2.7 | 2.6 |
| 63. While social workers are increasingly part of care teams they often work or interface with clients on their own which can make them more susceptible to complaints which are harder to defend as it often comes down to the clients word or the social workers word. | 50% | 2.5 | 2.5 |
| **Organisational factors** | | | |
| 64. Professional reflective supervision space is being hijacked by management structures and utilised more as a case management opportunity. | 50% | 2.3 | 2.4 |
| 65. Organisational factors can exacerbate burnout and secondary traumatic stress and can lead to poor professional performance. | 62.5% | 2.3 | 2.0 |
| **Nature of practice** | | | |
| 66. Social workers work often at and with the marginalised. They work in situations that are often characterised by fractured families, substance abuse, mental health issues, physical, sexual, emotional abuse and harm. They are part of making and implementing decisions that have the most profound effect on people's lives; lives that are already often dislocated and fractured. Complaints about the social worker are an immediate way of channelling that frustration. | 50% | 2.1 | 2.4 |
| 67. There is an increased likelihood of 'vulnerability' among the clientele that social workers assist and given the tenuous balance of power that exists between many health and care professionals and their clients, this may increase the chances of conduct or competence | 50% | 2.2 | 2.4 |

| | | | |
|---|---|---|---|
| complaints | | | |
| 68. Social Workers are involved with very challenging family situations on behalf of society often having to make very unpalatable decisions, or in the case of not making those decisions, making very difficult risk assessments about safety of some children. Whatever decisions they make, others are unhappy and will complain. | 50% | 2.0 | 2.1 |
| 69. The often involuntary nature of the relationship between social workers and clients is a very important feature (with notable exceptions such as in the case of a family wishing to adopt etc.). | 50% | 1.8 | 2.3 |
| 70. Social workers are often involved in cases where there are other state actors or agencies involved such as the courts. The circumstances are never easy and social workers find themselves part of a complex relationship - for example between parents and children. These relationships are often dislocated and chaotic in nature | 50% | 1.9 | 2.1 |
| 71. Social workers can and do cause harm to vulnerable people. When complaints are made they are often either on the serious end of the extreme, or the vexatious end. | 37.5% | 2.9 | 2.8 |
| 72. There are few absolutes and much exercise of judgement, expertise and balancing of risk. All of this occurs under the public spotlight. | 62.5% | 2.3 | 2.1 |
| 73. Social workers do not appear to have as high a rate of complaints made about them, unless they are involved in statutory child protection work and then they are prime targets. | 37.5% | 2.6 | 2.6 |
| **Education/training** | | | |

| | | | |
|---|---|---|---|
| 74. Social workers are educated away from other health and social care professions. This may prevent collegiality among the professions working with challenging groups. | 50% | 2.8 | 2.8 |
| **Regulatory factors** | | | |
| 75. The advent of a publicly available Code of Professional Practice, together with the more visible and transparent competence-based nature of social work training at both pre- and post-qualifying levels. | 50% | 2.8 | 2.4 |
| *76. Because social workers are not part of health services they could potentially be isolated and unsupported | 12.5% | | 2.9 |

**Question 2: What preventative actions could be taken to respond to the increasing number of conduct and competence complaints and concerns about health and social care professionals?**

| | | | |
|---|---|---|---|
| **Selection and training/education of workforce** | | | |
| 1. Provide education on team work, communication, cultural care and self-care. | 100% | 1.4 | 1.4 |
| 2. There should be assessment of communication skills both at entry into the professional and as continuing competency assessment as many complaints relate to communication deficits. | 87.5% | 1.7 | 1.5 |
| 3. Awareness about appropriate levels of empathy and compassion should be explored as part of communication training. | 100% | 1.7 | 1.4 |
| 4. Make increased efforts to educate health and social care professionals about risks associated with certain practices and behaviours and what is acceptable or may not be helpful. | 100% | 1.7 | 1.3 |
| 5. Engage more with the student cohort to educate them about the role of the regulator and | 87.5% | 2.4 | 1.9 |

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| how to avoid getting into strife. | | | |
| 6. Providing knowledge and awareness of occupational hazards such as burnout and secondary traumatic stress in itself is a preventative measure. | 100% | 1.7 | 1.4 |
| 7. Target continuing professional development requirements to specific areas of concern in the profession. | 75% | 1.4 | 1.8 |
| 8. Rigorous admission protocols and criteria at the time of admission to training programmes. | 71.4% | 2.3 | 1.7 |
| 9. Enhanced pre- and post-registration education on the subjects of professional ethics and risk management. Key topics include ethical decision making; client privacy/confidentiality; informed consent; boundaries and dual relationships; conflicts of interest; documentation; termination of services; consultation; referral; ethical standards associated with professionals' and clients' use of digital technology. | 100% | 1.9 | 1.4 |
| 10. Ethics should be taught as an inter-professional course so that all health professionals are aware of the codes of ethics and conduct requirements of others. | 62.5% | 1.8 | 2.0 |
| 11. Codes of ethics needed to be reviewed for currency every three years. | 50% | 2.3 | 2.1 |
| 12. Professional education has a responsibility to select and screen out students with demonstrated unethical behaviour. | 87.5% | 2.0 | 1.6 |
| 13. The curriculum needs to emphasise reflective practice. | 100% | 1.6 | 1.3 |
| 14. Analysis of the data about the nature of the problems identified by the complaints should be fed that back into the training of practitioners - both undergraduate and post-graduate, and to professional associations to better inform the | 100% | 1.5 | 1.6 |

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|---|---|---|---|
| profession about the sorts of matters that are leading to complaints. | | | |
| 15. Monitoring student experiences in clinical placements and data from a variety of sources including employers, professional bodies, insurers and third party payers to detect where the problems are. | 75% | 2.0 | 2.1 |
| **Educate the public/Manage expectations** | | | |
| 16. Educate the public about the different channels of complaints and when it is appropriate to make a complaint to the regulator or when it is a complaint against a system. | 75% | 1.8 | 2.0 |
| 17. Better guidance to the public on airing concerns is needed so that this is more likely to occur at an earlier stage while the situation may be more easily remediable. | 75% | 2.2 | 1.8 |
| 18. Attempt to target public expectations to emergency medical services, and giving the public alternatives when conditions are non-emergent. | 62.5% | 1.9 | 1.9 |
| 19. Professional bodies have responsibility for explaining the social work role to the public with the odd 'good news' story occasionally. | 87.5% | 1.9 | 1.5 |
| **Organisational support/improve work conditions** | | | |
| 20. Provide better organisational support towards each employee, especially support from leadership and coaching programs. | 85.8% | 1.8 | 1.7 |
| 21. Allow greater flexibility of work place, leave, co-workers, shift cycle & duration. | 87.5% | 2.2 | 1.9 |
| 22. Create opportunities for peer support and appropriate professional supervision/reflection. | 100% | 1.4 | 1.3 |
| 23. Employers have workplace responsibility to provide effective supervision and stress | 87.5% | 1.7 | 1.5 |

| | | | |
|---|---|---|---|
| management support | | | |
| **Research to deepen our understanding of complaints** | | | |
| 24. Categorise the types of complaints so there is a better idea as to what remedial action needs to be taken. | 100% | 1.7 | 1.6 |
| 25. Identify the specific types of concerns and practice settings - analyse data and look for patterns - what role have employers got in addressing concerns? What role can professional associations and educational bodies play? Is there a specific role for the HCPC Council? | 75% | 1.8 | 2.1 |
| 26. Spotting trends and potential career flashpoints is important. | 62.5% | 1.8 | 2.3 |
| 27. We should get better at distinguishing between resource availability and practice standards | 87.5% | 2.0 | 1.5 |
| 28. Obtain a better understanding required of why patients and fellow professionals do not raise concerns in order to address these reasons. | 62.5% | 2.2 | 2.3 |
| 29. We need to link data from a variety of systems to detect patterns & deteriorating clinical governance in health and social care services. | 75% | 1.8 | 2.1 |
| **Regulatory strategies** | | | |
| 30. Appoint an ombudsman to help identify common complaints and allow management the opportunity to develop strategies to reduce these complaints. | 87.5% | 3.0 | 2.6 |
| 31. Implement solid principles and processes related to Alternate Dispute Resolution- where the client and professional are both engaged in a mediated process to determine what went | 62.5% | 2.3 | 2.1 |

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| wrong and what needs to happen to ensure better outcomes going forward. | | | |
| 32. Regulators should work with paramedics and social workers on such matters as maintaining resilience with multi-professional groups. | 87.5% | 2.3 | 1.9 |
| 33. Regulators have a role in opening up the discussion with the professionals themselves and invite them to be part of the preventative action. The regulator has a leadership opportunity here in promoting debate and understanding. | 100% | 1.5 | 1.6 |
| 34. Provision of better guidance to professionals on airing concerns so that this is more likely to occur at an earlier stage while the situation may be more easily remediable. | 87.5% | 1.8 | 1.9 |
| 35. Develop information materials to support employers and supervisors, professional associations and educators in recognising and responding to areas of concern. | 100% | 2.1 | 1.5 |
| 36. Publish case studies of disciplinary matters. | 87.5% | 1.9 | 1.5 |
| **Questioning the increase** | | | |
| 37. Do we need to take preventative action? The increase in complaints and concerns can be seen as a positive thing if poor practice is highlighted and the avenues for the expression of public/service user/ concerns are more visible. | 100% | 2.1 | 1.8 |
| 38. Service users need to know their rights and have their concerns listened to. | 100% | 1.6 | 1.3 |
| *39. Targeted training that focuses on isolated risk avoidance does not instil holistic attitudes and life habits of professional practice | 87.5% | | 1.9 |
| *40. Regulators should be members of the particular profession understanding the work | 50% | | 2.5 |

| | | | |
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| and values and not bureaucrats divorced from front-line practice | | | |
| *41. We need better data collection about complaints so all of this can be better understood. | 100% | | 1.3 |
| *42. Categories of complaints should be very specific and not general so data can be interpreted more accurately. | 87.5% | | 1.9 |
| *43. There should be focus on what the registrant is doing to protect themselves from burnout. | 87.5% | | 2.0 |
| *44. Professionals need 'how to look after me' programmes to minimise the risk of disengagement. | 87.5% | | 1.8 |
| *45. Employers should run courses along the lines of 'thank you, let's support you in the next phase of your career'. | 75% | | 2.0 |

**Question 3: What strategies would you suggest to support health and social care professionals to deliver high quality health and social care?**

| **Staff training/education and assessment** | | | |
|---|---|---|---|
| 1. Staff should be trained in patient safety issues | 87.5% | 1.6 | 1.6 |
| 2. Staff should be trained in customer relationship management. | 87.5% | 2.0 | 1.6 |
| 3. Continuing medical education type programmes can be offered to provide additional training to professionals to reduce the number of complaints (e.g. how to communicate effectively, manage cultural diversity, gender issues, etc.) | 100% | 1.9 | 1.6 |
| 4. Practitioners need to be equipped with the requisite skills to be able to diffuse conflict situations, for example, being blamed for poor | 87.5% | 1.7 | 1.5 |

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|---|---|---|---|
| response times. | | | |
| 5. Rostered time off should be provided for practitioners to undertake targeted training, workshops, retreats etc to focus on growing skills to deliver high quality care. | 87.5% | 1.8 | 1.6 |
| 6. Continuing professional development (CPD) focussed on area of practice but also elective CPD that gives practitioners the opportunity to expand their training to include training pursuant to alternative future career pathways. | 87.5% | 2.0 | 1.8 |
| 7. Best practices would suggest training at the under-graduate level be focused less on book knowledge and more on competencies needed to deliver high quality care. | 75% | 2.3 | 2.3 |
| 8. Exams and assessments at both the entry and on a continuing basis should be done on health and care professionals using competency -based assessments that involve Objective Structured Clinical Examinations using standardized patients | 75% | 2.6 | 2.3 |
| 9. CPD to value resilience and supports registrants to look at work/life balance - why not have mindfulness training or stress management and relaxation acceptable as part of CPD? | 62.5% | 2.3 | 2.1 |
| 10. Ensuring that undergraduate and ongoing professional training reflects on the nature of complaints and the hazards associated with this work. | 87.5% | 1.8 | 2.0 |
| 11. Educators should not assume that concepts such as emotional resilience or work engagement are easily understood concepts that can be taught - a lot of work needs to be done still around understanding these concepts and how they may be fostered and supported. Importantly they need to be looked at in terms of outcomes. | 87.5% | 1.9 | 1.9 |

| | | | |
|---|---|---|---|
| 12. Taking the very real life lessons learned from the complaints made and filtering this back into the professions at undergraduate level and continuous professional development. | 100% | 1.4 | 1.6 |
| 13. Sound education that covers relational skills and critical reflection, need to be supported by employment environments that provide scope for continuing professional development. | 100% | 1.7 | 1.4 |
| 14. Practice teachers or assessors working with students during their placements need to feel more able and be more ready to recommend fail outcomes naming their concern in terms of very specific aspects of capability and suitability. | 100% | 1.8 | 1.6 |
| 15. Even in an under resourced system opportunities for reflection are not costly and can bring great value. | 100% | 1.6 | 1.3 |
| **Ethics education** | | | |
| 16. Empowering professionals to understand the nature of what it means to be an ethical professional rather than someone who must adhere to guidelines. Space needs to be created to explore what this in fact means. | 100% | 1.5 | 1.5 |
| 17. Instilling value and a sense of self-compassion back into the professionals themselves. | 75% | 2.0 | 1.9 |
| 18. Ongoing professional development in ethics and professional practice. | 100% | 1.8 | 1.5 |
| 19. Training in ethical decision making processes. | 100% | 1.5 | 1.5 |
| 20. In-depth, sustained, rigorous ethics and risk-management education.. | 87.5% | 1.6 | 1.8 |
| 21. It is important to introduce practitioners to key ethics concepts, provide rich examples of complex ethical dilemmas, and discuss ways to manage these dilemmas (applying relevant ethics concepts standards and using practical | 100% | 1.6 | 1.3 |

| | | | |
|---|---|---|---|
| decision-making protocols). | | | |
| **Time and space** | | | |
| 22. Create time and a safe space for discussion. | 87.5% | 1.8 | 1.6 |
| 23. Make space for reflection and acknowledgement of both strengths and development needs. | 87.5% | 1.7 | 1.4 |
| **Organisational factors** | | | |
| 24. Be aware of fatigue cultures developing amongst colleagues. | 75% | 1.9 | 1.8 |
| 25. Health professionals need to feel that they are supported as often the complaints are not related to the individual practitioner's skills and competence but rather broader system and resource constraints. The practitioner is the face of the organisation and often is blamed by the public for general system failures. | 75% | 1.8 | 2.3 |
| 26. Active and open peer support networks. | 100% | 1.6 | 1.6 |
| 27. Supportive and accessible managers. | 100% | 1.4 | 1.5 |
| 28. Organisations must be quick to respond to complaints posted on social media. | 87.5% | 1.9 | 1.6 |
| 29. Organisations should use social media to share good stories. | 75% | 1.9 | 1.8 |
| 30. Onsite chaplaincy should be available. | 75% | 3.3 | 3.4 |
| 31. Better support from colleagues and employers in workplaces, and identifying barriers to this. | 87.5% | 2.0 | 1.9 |
| 32. Professional supervision for all health and social care workers. | 75% | 1.8 | 1.6 |
| 33. Implement workload controls. | 87.5% | 2.1 | 1.9 |

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|---|---|---|---|
| 34. Pay attention to inter-professional team dynamics and conflict resolution. | 75% | 1.9 | 1.8 |
| 35. Management in organisations needs to recognise the sensitivities of the relational nature of the work and to support the workers rather than taking on a punitive role because of their funding streams. | 87.5% | 1.8 | 1.8 |
| 36. Leadership needs to have an emphasis on ethics and values as well as outputs. | 87.5% | 1.4 | 1.4 |
| 37. Highly trained professionals should work in pairs (e.g. two paramedics on an ambulance instead of one paramedic and one assistant) so they can support each other in decision making and increase patient safety. | 50% | 2.3 | 2.3 |
| **Regulatory approaches** | | | |
| 38. Regulators should have a humane approach. | 100% | 1.5 | 1.3 |
| 39. Regulators should emphasise the responsibilities of the employers. | 87.5% | 1.8 | 1.4 |
| 40. Implement a code of conduct for employers. | 87.5% | 2.3 | 1.4 |
| 41. Create a greater interface between the systems regulator, the professional bodies (including unions), educators and client/advocate groups. | 100% | 1.7 | 1.4 |
| 42. While fitness to practise/conduct cases are about individuals, the findings can be utilised to highlight bigger issues. The regulator has a role in appropriately disseminating this information. | 87.5% | 1.5 | 1.8 |
| 43. There needs to more effective professional publicity regarding complaints/concerns that enables the prospective complainant to identify whether it is the availability (or lack of) resources OR the professional practice in delivering these that is the problem. | 75% | 2.4 | 2.0 |

| | | | |
|---|---|---|---|
| | | | |
| **A holistic response** | | | |
| 44. Interventions are needed at every level - in student selection, undergraduate training, post graduate training and monitoring compliance with professional standards, using data to detect risky practitioners and deteriorating clinical governance, targeting of continuing professional development requirements, revalidation, use of performance assessment powers targeted to at risk groups. | 88.8% | 1.9 | 1.7 |
| 45. Rather than just targeting individuals, target the systems within which they work - employers, managers, professional bodies, insurers and governments. | 77.8% | 1.8 | 2.0 |
| **Questioning the strategies** | | | |
| 46. The vast majority of health and social care professionals genuinely deliver services of the very best quality that they can and no amount of berating them with the possibility of complaints or conduct investigations is going to improve this. It's only going to lead to ever more defensive practice. | 85.8% | 2.5 | 1.7 |

## Appendix E – Example of Participant Information Sheet

### Study title: Understanding the prevalence of fitness to practise cases about paramedics and social workers in England

#### Participant Information Sheet: Interviews and Focus groups

**Introduction**

We would like to invite you to take part in this research project. Before you decide you need to understand why the research is being done and what it will involve for you. Please take the time to read the following information carefully and ask questions about anything you do not understand.

**What is the purpose of the study?**

This project explores the reasons for, and action to prevent the disproportionate number of fitness to practise cases about paramedics and social workers in England.

The research project uses several research methods to address these issues and includes a literature review, an international Delphi process, in-depth review of 10% of fitness to practise cases in each profession, observation of fitness to practise hearings, 30 in-depth interviews and 6 focus groups with stakeholders from across the UK.

**Why have I been invited to take part in the study?**

You have been invited to take part in an interview/focus group because we would like to hear your views on the prevalence of fitness to practise cases about paramedics and/or social workers in England and strategies for prevention. We aim to carry out 6 focus groups in a range of locations around the UK.

**Do I have to take part?**

No, you do not have to participate. There will be no adverse consequences if you decide not to participate or withdraw at a later stage. You can withdraw your participation at any time.

**What will my involvement require?**

If you agree to take part, we will ask you to sign a consent form. We would like you to participate in a focused group discussion which will take about 1.5 hours.

**What will I have to do?**

We will invite you to talk about your views on paramedic and social work practise, why you think there are high numbers of referrals to the regulator, and what you think could be done collectively to address this.

**What will happen to data that I provide?**

Please be assured that any information we receive from you will be looked after. Research data are stored securely for at least 10 years following their last access in line with the University of Surrey policies. Personal data will be handled in accordance with the UK Data Protection Act (1998).

**What are the possible disadvantages or risks of taking part?**

There are no anticipated risks or disadvantages to taking part in this study

**What are the possible benefits of taking part?**

The benefits are that you will help us explore the reasons for, and action to prevent the disproportionate number of fitness to practise cases about paramedics and social workers in England. The project offers you the opportunity to influence the future of practice, education and training and standards for these professions.

**What happens when the research study stops?**

At the end of the study, we will hold a meeting with those who have ben involved in the study to discuss the findings and following this we will write a report and produce materials that will be used by the HCPC to inform their future work.

**What if there is a problem?**

Any complaint or concern about any aspect of the way you have been dealt with during the course of the study will be addressed; please contact Anna van der Gaag, Principal Investigator at a.vandergaag@surrey.ac.uk in the first instance. You may also contact XXXXX, Head of School of Health Sciences, University of Surrey on 01483 XXXX @surrey.ac.uk.

**Will my taking part in the study be kept confidential?**

Yes. Your details will be held in complete confidence and we will follow ethical and legal practice in relation to all study procedures. Personal data will be handled in accordance with the UK Data Protection Act 1998 so that unauthorised individuals will not have access to them.

Your personal data will be accessed, processed and securely destroyed by members of the research team. In order to check that this research is carried out in line with the law and good research practice, monitoring and auditing can be carried out by independent authorised individuals. All will have a duty of confidentiality to you as a participant and we will do our best to meet this duty. The data you provide will be anonymised  your personal data will be stored securely.

You will not be identified in any reports/publications resulting from this research and those reading them will not know who has contributed to it. With your permission we would like to use anonymised verbatim quotations in reports.

**Full contact details of Principal Investigator:**

**Anna van der Gaag**

School of Health Sciences

Faculty of Health and Medical Sciences

University of Surrey

Guildford, Surrey GU2 7TE

Email: a.vandergaag@surrey.ac.uk

**Who is organising and funding the research?**

This research is organised by the University of Surrey and funded by the Health and Care Professions Council.

The funder has no conflict of interest

**Who has reviewed the project?**

*This research has been looked at by an independent group of people, called an Ethics Committee, to protect your interests. This study has been reviewed by and received a favourable ethical opinion from University of Surrey Ethics Committee.*

**Thank you for taking the time to read this Information Sheet.**

## Appendix F – Example of consent form

**Study title: Understanding the prevalence of fitness to practise cases about paramedics and social workers in England**

**Consent form for interviews and focus groups**

**Please initial each box**

- I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. ☐
- I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result. ☐
- I agree to comply with the requirements of the study as outlined to me to the best of my abilities. ☐
- I give consent to my interview / participation in focus group to be audio recorded ☐
- I give consent to anonymous verbatim quotation being used in reports ☐
- I understand that all research data will be held for at least 10 years in accordance with University policy and that my personal data is held and processed in the strictest confidence, and in accordance with the UK Data Protection Act (1998). ☐
- I understand that I am free to withdraw from the study at any time without needing to justify my decision, without prejudice and without any adverse effect. ☐
- I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation. ☐

Name of participant (BLOCK CAPITALS)

.....

Signed .....

Date .....

Name of researcher …….....

Signed .....

Date .....

## Appendix G – Topic guide – interviews and focus groups

### Topic Guide for interviews and focus groups

**Introduction**

"We want to find out about your views on social work/paramedic practice.

We are interested in the reasons why there are more complaints about this/these professions than others in the health and care sector. We are also interested in exploring ways in which concerns and complaints can be prevented in the future.

The interview/discussion will take about 1 hour/1.5 hours. We will be analysing your responses along with those of others and drafting a report for the HCPC. There will be further opportunities to have input into the recommendations towards the end of the project when we will hold a meeting for stakeholders.

Nothing you tell us will be attributed directly to you and all personal information will be stored securely in line with requirements on data protection".

**Topic Guide and Interview Schedule Questions**

1. Number of complaints

What is your understanding of the number of complaints and concerns about social workers/paramedics?

2. Nature of complaints

What is your understanding of the nature of complaints and concerns about social workers/paramedics?

*Prompts: highest number of referrals: Paramedics and self referral, SW referrals from members of the public Prompts: Specific contextual factors/ themes or characteristics of concerns about paramedics/social workers*

3. Preventative strategies

How do you think we can work together to prevent complaints and support professionals in delivering high quality health and care? What new strategies and ways of working might be put in place; For the profession? For the professional bodies? For the regulator? For educators? For employers?