Research report

Preventing small problems from becoming big problems in health and care

Contents

Foreword

I am delighted to welcome this monograph in our series on research relating to HCPC regulated professions. As with previous work in the series, it reflects our commitment to building the evidence base of regulation and bringing new thinking and empirical data to the field of professional regulation.

Our aim is that this work, like others before and after it, will contribute not only to our understanding on regulation, but also to a wider audience with an interest in this area. Previous reports have been used to generate debate and discussion and we hope that this report will provide another focus for honest conversations about professional practice.

The study of competence in health and care professionals has generated many hundreds of research papers by academics and practitioners from different disciplines. Perhaps the only area of agreement amongst the models and constructs is that competence, like professionalism, is challenging to define. Endeavours to try and capture it in a list of knowledge, skills and attributes, to produce a checklist which covers all behaviours, are likely to end in oversimplification. Competence, like professionalism, is more than the sum of its parts.

Alongside this debate, another important construct, that of engagement, has begun to take hold. The evidence is increasingly suggesting that failures in care are frequently associated with low levels of staff engagement. The questions posed by practitioners and policymakers alike are: Why does this happen? What can be done? As a regulator, the HCPC is also aware that many complaints about the professionals we regulate have little to do with their technical competence, and much more about their conduct and communication.

It is in this context that the HCPC first commissioned research on professionalism. This monograph describes the next stage of our work in this area where we have combined an independent literature review with empirical research. Both provide new insights into the triggers of disengagement and the ways in which preventive action might be implemented.

What is clear from this research is that we have a collective responsibility to address the causes of disengagement. This must involve users of services, employers, educators, professional bodies, regulators, as well as individual professionals and teams. I hope that this publication will encourage debate and raise awareness, which will help to make a difference to the way health and care is delivered in the future.

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Chair

Acknowledgements

This research report combines two pieces of work on competency and disengagement:

– a literature review by Professor Zubin Austin of the University of Toronto; and

– an empirical study of engagement and disengagement by Carol Christensen-Moore and Joan Walsh at the Picker Institute Europe.

The HCPC is grateful to Professor Zubin Austin, and Carol Christensen-Moore and Joan Walsh for their contributions to this initiative. We would also like to thank the patients, service users and professionals, union representatives, employers and professional body representatives, who contributed to the work carried out by the Picker Institute team.

Views expressed in this report are those of the authors and not the HCPC.

Executive summary

This monograph is about engagement and disengagement and its implications for our understanding of the competence of health and care professionals. It is the next stage in the Health and Care Professions Council's (HCPC) research on professionalism, exploring the critical role that professionalism plays in delivering safe and effective care to service users and patients.

The first section, from Professor Zubin Austin of the University of Toronto, provides a review of the literature, illustrating how competence in health and care has many meanings, as well as many often competing frameworks. These include traditional frameworks based on knowledge, performance, psychometrics, reflection and outcome-based approaches, all of which have contributed to our understanding of competence.

Austin demonstrates how newer, emerging constructs around teamwork, emotional intelligence and engagement may well be those which enable health and care to shift closer to a model that is fit for purpose in the twenty first century. Zubin suggests that checklist approaches may still be necessary, but are not sufficient as the complexity of health and care increases and patients and service users expect a different relationship with professionals.

The review also points to an important message about staff engagement: where staff are engaged, patient and service user outcomes are better and quality improves.

The second section describes a study of engagement and disengagement by Carol Christensen-Moore and Joan Walsh at the Picker Institute Europe. This is comprised of a retrospective analysis of a sample of HCPC fitness to practise cases, and group and individual interviews with service users, patients and professionals.

The study explored perceptions of the triggers for disengagement in health and care professionals, and the ways in which small problems may be prevented from escalating into complaints in health and care settings.

Amongst participants in the study, there was a perception that it was possible for engagement to impact on competence, and for this to have consequences for practise. Disengagement occurred on many levels, but was seen primarily as a symptom of underlying issues. The character or personal values of a professional as well as a range of personal circumstances could give rise to disengagement. However, poor levels of support and supervision and workload pressures were more frequently cited as triggers. Specifically, these included a lack of support for continuing professional development, situations where a professional's skills were being under-utilised or where there was a lack of autonomy and professional isolation.

Identifying signs of disengagement early on was possible in the right circumstances, for example where a culture of no blame was encouraged, where professional networks were strong and where managers were offering appropriate support for staff.

Improvements in these external frameworks, together with support for internalised processes such as self awareness and reflection on practise, were seen as key to better outcomes for patients, service users and professionals.

Christensen-Moore and Walsh recommend further research into the barriers and enablers to reporting concerns. Like Austin, they point to the need for better understanding of the context in which competency drift occurs and more focus on preventive methods of addressing poor practise.

1 Broadening the discourse of competence

1.1 Introduction

The purpose of this report is to review relevant literature related to competence in the context of the health and care professions. Around the world and in most professions, 'competence' has become the most commonly used word to describe the knowledge, skills and attributes of professionals. In most cases however, the word is used without further elaboration, with the assumption that everyone has the same understanding of its meaning and application. Given the ubiquity of the word itself and the sometimes contradictory ways it has been used in academic literature, it is essential that those using the term have a clear understanding of its multiple meanings and significance.

1.2 Evolution from education to regulation

It is difficult to pinpoint a moment when competence became entrenched in the academic literature, or in the thinking and work of regulators and educators. McGaghie et al (1978) and Carraccio et al (2002) have argued that the idea of competencies was a response of educational institutions, to concerns regarding the perceived inability of graduates from health and care professions to manage real-world problems and effectively deal with the needs of real-world service users and patients.

Competence-based education was initially driven by the need for greater accountability in training, the desire to demonstrate relevance to societal needs, and a desire to provide learners with reassurance that they actually were being well-prepared for a valuable role in society (McAshan, 1979). As such, competence-based education directly challenged the prevailing mid-twentieth century status quo of higher education that emphasised theory, knowledge-acquisition and a didacticism that presumed learners themselves could transl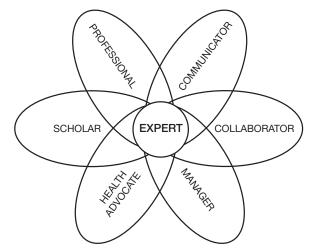ate theory into practice. This movement emerged within medical education, but subsequently spread throughout other health and care professions such as psychology (Rubin et al, 2007) and social work (Anema and McCoy, 2010), and had established itself in other professions such as engineering (Dainty et al, 2005) and teacher training (Houston, 1973).

As competence-based education became more commonplace in the training programmes of health and care professions, accreditation and regulatory bodies became more interested in this model. This further accelerated adoption of competence-based education within academic settings (Sullivan, 2011). In the context of public concerns about patient safety, disparities in access to care and the struggles of health and care professionals with increasingly ambiguous and complex practices, competence-based approaches focusing on real-world performance and doing rather than acquiring knowledge, aligned well with regulators' needs around public protection, and their interests in demonstrating social responsibility and accountability in their roles (Hodges and Lingard, 2012).

As dialogue around the notion of competence evolved between educators, regulators and employers, a key challenge emerged. Defining competencies as a series of real-world performance expectations and tasks, then using these as a foundation for curriculum purposes (as educators did), requires a certain level of accuracy, impartiality and validation. Using these competencies (as regulators wished to do) as the foundation for entry-to-practice assessment, maintenance-of-competency evaluation or fitness-to-practice decisions increased the stakes considerably. The level of definitional clarity, validity and defensibility of what competence actually means and looks like – the 'psychometric burden' – is higher within a regulatory context, due to the high-stakes nature of decisions made by regulators that directly affect the general public (Bleakley et al, 2011). The scrutiny

faced by proponents of competence-based education increased significantly as the dialogue shifted to high-stakes evaluation within regulatory and accreditation processes. Of importance, this shift towards higher stakes led to a new scrutiny around what activities should actually be measured and assessed. The need for defensibility and standardisation, due to fear of litigation, resulted in greater emphasis on the more objective, technical and visible activities of professionals, like physical assessment skills and a hesitancy to assess subjective or less visible activities, such as conflict management skills or empathy.

As interest in competence evolved from teaching and learning to assessment and evaluation, it became increasingly clear that no single or simple definition of competence could adequately capture the gestalt of professionals' work (Malone and Supri, 2010). As a result, the notion of 'competency frameworks' emerged, as a tool for describing and defining the constellation of interdependent knowledge, skills, behaviours, values and attitudes necessary for effective real-world performance. Competence frameworks typically eschew specific tasks or activities, and instead conceptualise performance as an interlaced or overlapping series of roles, each of which is necessary but by itself insufficient for effective real-world performance. One of the most widely cited, frequently emulated, and best known models is CanMEDS (Frank, 2005). CanMEDS was one of the first national competency frameworks developed for medicine, but is now used in various countries such as Australia, Canada and the Netherlands (Whitehead, 2013), and increasingly adapted for various health professions such as nursing, occupational therapy, pharmacy and physical therapy (Verma et al, 2006; Ringsted et al, 2006).

CanMEDS Competency Framework (2005)

In the CanMEDS framework, expertise as a health or care professional is conceptualised at the intersection of various other roles, such as communicator and collaborator. Role-specific competencies are further described, but do not form the actual substance of the framework, in an effort to move away from a reductionist, task-centred view of competence. This holistic, integrative, role-centred view provides both conceptual clarity and enhanced face validity and has, as a result, become an increasingly dominant mode for presenting competency frameworks across other sectors (Frank, 2005; Whitehead et al, 2011).

In the UK, individual health and care professional bodies, including physiotherapists (Chartered Society of Physiotherapy), occupational therapists (Winchcombe and Ballinger, 2005) and mental health professionals (Roth et al, 2011), have produced bespoke competency frameworks.

Competency frameworks have now become the dominant vehicle by which educators, regulators, employers and others communicate performance expectations with professionals, the public and other stakeholders (Whitehead, 2013; Simpson et al, 2002). In distilling complex and nuanced aspects of professional practice into visual forms or rubrics, they provide a

common starting point for understanding and discussing expectations and requirements of health and care professionals in practice.

1.3 Questions and critiques

Competence frameworks now underpin health and care professions training, education and regulation in many countries (Simpson et al, 2002), leading to greater scrutiny of their development and implementation. There are of course positive and productive elements in these initiatives, around achieving consistency and transparency in different contexts. However, some have argued that this approach is a 'striving for mediocrity' (Brawer, 2009) that arises when we 'focus our attention on minimum requirements only', as competency frameworks tend to do (Bleakley et al, 2010). When dealing with complex, ambiguous professional work, the whole is greater than the sum of the parts (Anderson and van der Gaag, 2005). Slavish adherence to competence as a guiding principle of teaching and assessment risks atomising professional work, overemphasising routine skills and inculcating a teaching-to-the-test mentality (Huddle and Heudebert, 2007; Malone and Supri, 2010). Frank et al (2010) note that formulaic competency frameworks or 'prescriptions', may produce a form of reductionism and utilitarianism, with an emphasis on the lowest-common-denominator, rather than an aspirational vision of professionals, to their best potential, serving the public good – 'professionalism'.

Curiously absent from much of the competency literature is discussion of professionalism, reflective practice and willingness to 'go-the-extra-mile' for patients and service users (Lingard, 2009). An emerging theme in the competency literature, this notion of 'going the extra mile', is well-understood by patients, service users and employers as an important component of health and care professionals' work. Mann et al (2009) and McGivern and Fischer (2012)

note that health and care professionals' responses to competency frameworks may tend towards reactive compliance. In complex situations, instead of asking "what does the service user or patient need me to do?" they may ask "what am I minimally required to do?"

This inherent tension between 'prescription' and 'professionalism' is perhaps best illustrated through the recent experience in the UK. The Francis Report (2013) made 290 recommendations in response to the systemic failures at the Mid Staffordshire NHS Foundation Trust, to legally enforce duties of openness, transparency and candour in the NHS. These recommendations in turn prompted criticism from some academics around the UK. Fischer and Ferlie (2013) argue that "…rules to enforce openness, transparency and candour among NHS staff can create an impetus for change, but increasing micro-regulation of clinicians and managers is likely to undermine, rather than support high-quality patient care". They further note: "…we are seeing a shift from micro-management to micro-regulation…what is needed instead is reanimation of the [health and care] professions…micro-regulation is not going to bring about [the] culture change needed".

This tension is also recognised in the Francis recommendations themselves. "1.75: The current structure of standards, laid down in regulation, interpreted by categorisation and development in guidance, and measured by the judgement of a regulator, is clearly an improvement on what has gone before, but it requires improvement".

This finding was further reinforced through the Review of Staff Engagement and Empowerment in the NHS Report (Ham, 2014). The review found evidence connecting high levels of staff engagement, from professionals who are strongly committed to their work and involved in day-to-day decision making, to better quality care and outcomes, including lower mortality rates, better patient experience and reduced staff absence and turnover. Importantly, the Report

also connected low levels of staff engagement with the type of failures demonstrated at the Mid Staffordshire NHS Foundation Trust. The Report called for all NHS organisations to prioritise staff engagement, not just competency frameworks, as a vehicle for improving delivery of safe, effective and competent care.

Historically, competence has been understood as a technical function of a profession, well-aligned to assessment through analytical checklists based on in-service performance (Witz, 1992). The mechanism by which competency frameworks and standards have evolved has been to reduce complex professional work to a checklist, then to define competencies simply because they are already codified on a checklist, then to test on these at examinations. Of significance is the notion that activities or behaviours that do not lend themselves to checklists or yes / no observations do not consequently become defined as competencies (Rogers et al, 2005). This has been illustrated recently in the UK by the Compassion in Practice campaign: a "…new vision for nurses, midwives and care-staff in England" (Department of Health, 2012). The very need to actually define 'compassion in practice' and to produce guidance around '6Cs' (six areas of action, with accompanying implementation plans), points to limitations inherent in the way in which the discourse of competence has evolved. Words such as 'care' and 'compassion' do not necessarily lend themselves to measurement through checklists, and consequently are not easily incorporated into competency frameworks as traditionally developed.

It is difficult to argue against the notion of competence underpinning our understanding of safe and effective practice in health and care professions. Competence by itself may be a necessary but insufficient construct to help shape safe and effective practices. New ways of seeing and understanding competence are evolving to address this gap.

1.4 An evolving discourse

The term 'discourse' has been used to describe the implicit meanings behind the words we use, and how these meanings shape our thoughts and ideas. Hodges (2009) has described five dominant discourses that have emerged over time in the health and care professions literature related to 'competence'.

1. **Knowledge discourse:**
   Competence is a function of ability to recall facts and basic scientific knowledge. From this perspective, competence is assessed using multiple choice tests or other methods that emphasise memorisation and rote reproduction of knowledge. As Miller (1990) has noted, this leads to book-smart professionals who lack interpersonal skills and the propensity to care is another issue.

2. **Performance discourse:**
   Competence is a function of the ability to actually behave or perform in a prescribed manner in a specified situation. From this perspective, competence is assessed using objective structured clinical examinations or other in-practice observations. We are less concerned with what people know and more interested in what they do; Norman et al (1996) have noted that this may lead to mindless reproduction of practices rather than deliberative and well-reasoned care. It may also lead to an inability to actually perform effectively in non-standardised or ambiguous situations.

3. **Psychometric discourse:**
   Competence is a function of the ability to demonstrate attainment of pro-forma standards and expectations in a statistically defensible manner. From this perspective, competence is assessed through sampling with the objective of reducing variance and ensuring reliability, validity, generalisability and defensibility

of the assessment. Schuwirth and van der Vleuten (2006) have noted that this drive for standardisation negates the actual essence of human-focused care.

4. **Reflection discourse:**
Competence is a function of mindfulness and self-assessment in practice. From this perspective, intelligent and well-intentioned individuals provided with an environment to safely reflect and self-improve will enhance their own practice. Nelson and Purkis (2004) have noted that an overemphasis on reflection may result in technical incompetence being overlooked.

5. **Production discourse:**
As health systems have become more complex, filled with 'cases to be managed' rather than 'people to be cared for', the imperative of operational efficiency has grown. There is a strong emphasis on monitoring and a culture of surveillance in the name of outcome measurement. Questions regarding the objective of efficiency at the potential expense of empathic care are challenges to the production discourse.

Over the past 30 years, these dominant discourses have produced a variety of rules, checklists, algorithms and guidelines that are meant to hold health and care professionals accountable to a clear, objective, minimal standard of practice. To Whitehead (2013), answering the question of 'accountability' by producing checklists and competence frameworks not only does not address the problem itself, it paradoxically distorts the essence of professionalism by only promoting minimal expectations. This finding has been echoed by Fischer and Ferlie (2013): "increasing micro-regulation across the NHS is likely to aggravate tensions between externally focused regulation, oriented towards transparency, accountability and external scrutiny, and locally important values of

delivering high-quality care. Paradoxically, the Francis recommendations extend regulation still further as a dominant idea, which is misguided."

No single existing competence discourse adequately captures the nuanced complexity of contemporary health and care professionals' work. Recognising that each discourse brings with it a series of assumptions (and in addition blocks or crowds out other assumptions) means that no single discourse by itself truly captures the full essence of 'competence'.

1.5 Emerging discourses

The current system of health and care professionals' education and regulation has been built upon competing and evolving discourses of competence. For some, this represents the triumph of the Production discourse: large, chaotic, complex health systems, catering to multiple needs and employing hundreds of thousands of individuals, need systems to ensure they actually function. Competence discourses that emphasise processes, utilise checklists, and rely upon centralised leadership and hierarchies, provide a comforting and recognisable structure that appears business-like and efficient (Mylopoulos, 2013).

A significant critique of existing competence discourses has emerged. After decades of work, and billions of pounds spent developing competence frameworks, why do large system failures such as Mid Staffordshire still occur? Does this suggest a problem with 'competence' itself as a safeguarding concept? How could the Mid Staffordshire tragedy, among others, have occurred given the complex, interwoven web of local, national and profession-specific competence frameworks that have existed for many years? Failure on this scale and at that level raises questions about the adequacy and sufficiency of existing frameworks for public protection. As Francis himself noted in Patients First and Foremost: The initial government response to

the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013), "[t]he system as a whole failed in its most essential duty", including the existing system of competence frameworks as a safeguard against harm.

In this spirit, several scholars have begun to point out the limits of existing competency discourses and have suggested complementary discourses of competence to broaden understanding of the term itself.

1.5.1 Competence as an inter-relational / collective construct

Care today is provided by teams. Patients with a sore elbow are referred to radiographers; biomedical scientists take blood samples; pharmacists provide medication; physiotherapists and occupational therapists restore function etc. The reality of inter-professional care delivery poses central challenges to the uni-professional and highly individualistic construct of competence as currently understood. As Lingard et al (2007) note, teamwork is mostly learned through socialisation (eg observation and experience). Below Lingard (2012) notes these realities produce important paradoxes, particularly since competence is generally seen as a quality or capacity an individual possesses or does not possess.

a. Competent individuals can come together and still form an incompetent team.

b. Individuals who perform competently in one team may not in another team.

c. One incompetent member functionally impairs some teams but not others.

Lingard suggests these three paradoxes point to the limitation of current discourses of competence. Real world experience of health care today suggests that competence is more than simply a quality that individuals acquire

and possess, free from context or location. High-profile examples of organisational and institutional failures suggest competent practitioners who find themselves in floundering systems are not as self-contained as the current discourse pre-supposes. Lingard (2012) suggests a collectivist discourse to competence must evolve, one premised on the following notions.

a. Competence is achieved through participation in authentic, real-world situations, not contrived academic settings.

b. It is distributed across a broad network of persons and artefacts.

c. It is a constantly evolving set of multiple, interconnected behaviours enacted over time.

Lingard's work examining the nuanced interpersonal interactions amongst operating theatre staff and surgeons points to the notion of the whole being greater than the sum of the parts. Building on the work of Salas et al (2007) in 'team cognition', this collectivist view of competence emerges at a time when health is increasingly recognised as a network, not a dyadic relationship between a single professional and a patient. Drawing upon the experience of other industries, notably aviation, the idea of collective competency, which includes not only practitioners but the organisational context within which they practice, requires alternative methods of understanding and assessment.

Critics of this approach note the logistical difficulty of developing and implementing team-competency assessment models. However, as Lurie et al (2009) have noted, this criticism presumes that current competence assessment systems are indeed robust and actually do what they purport to do well, when in fact, with the exception of the medical knowledge domain, few competence

assessment tools are actually simultaneously reliable, valid, generalisable and feasible.

Broadening the discourse of competence to recognise the centrality of collaboration, interdependence and teamwork in today's health system is necessary. Many system problems and errors characterised as 'communication failures' are not the result of substandard or incompetent communication skills. Instead they reflect failures to recognise that teams are the true unit of care delivery in most systems today and further work is necessary to articulate and construct discourses that recognise this reality. As Berwick observed, "[h]ealth and care professionals… want to offer safe care: in spite of that, patients get injured because of defects in the care system. Blame and accusations are not the answers. Teamwork and improvement are the answers. Commercial air travel did not get safer by exhorting pilots to please not crash. It got safer by designing planes and air travel systems that support everyone to succeed in a very, very complex environment. We can do that in healthcare too." (Berwick, 2013).

1.5.2 Competence as an emotional construct

McNaughton and LeBlanc (2012) note that, "…within the health professions, emotion sits uneasily at the intersection between objective scientific fact and subjective humanistic value". From early on health and care professionals are taught and encouraged to separate their professional and personal selves, the implication being that human emotions cloud judgement and professional effectiveness. Increasingly, there is recognition that this traditional approach may be counterproductive to the objective of safe and effective health care delivery.

Williams (2001) has noted the long-held ambivalence towards emotion within the health professions education literature. He notes that

emotion is traditionally viewed as 'the opposite' of reason, and consequently seen as uncontrollable and something that needs to be transcended. Increasingly, psychologists have grown to understand that emotion and reason are not isolated processes but interconnected dualities: without emotion, there cannot be reason and vice-versa. Kensinger (2009) has noted that emotion plays a critical role in memory function: the emotional context fundamentally shapes the way in which memory is formed and recalled. Raghunathan and Pham (1999) argue that emotion has a formidable influence in decision making. Phelps (2006) and Damasio (1994) note that emotion can influence a wide range of cognitive functions, including perception, attention, memory and decision making.

Competence as an emotional construct has been popularised through the work of Goleman (1996). His model combines skills, abilities and personality traits, and formulates a command function of 'emotional management'. The literature applying emotional intelligence (EI) to health and care professions education is broad and extensive. EI principles are now utilised in admissions interviewing (Libbrecht et al, 2014; Humphrey-Murto et al, 2014), clinical skills assessment (Stratton et al, 2005; Cherry et al, 2013; Romanelli et al, 2006) and clinical teaching (Allen et al, 2012) in health and care professions such as nursing, physiotherapy, speech and language therapy, pharmacy, medicine, midwifery and psychology.

A consensus from this literature is emerging, that empathy is the core of health and care professional practice, significantly challenging historical assumptions of the centrality of technical or cognitive skills (McNaughton and Leblanc, 2012). From this perspective, discourses of competence that focus on the technical or cognitive domains actually miss the mark. Superior technical and cognitive skills with limited empathy and emotional intelligence give rise to poor care (McNaughton

and Leblanc, 2012). This insight reinforces the work of McGivern and Fischer (2012) who note that "…rules-based regulation tends to erode values-based self-regulation, producing professional defensiveness and contradictions which undermine, rather than support, good patient care".

Human factors in patient safety are currently of significant research interest. There is a critical need to understand the distinction between 'knowing' and actually 'wanting to do' the right thing in a complex environment, particularly when doing the right thing requires the health or care professional to go beyond what might be normally expected or to overcome a system barrier (Feldman, 2001).

This link between competence and emotional intelligence has been underdeveloped, in part due to the psychometric emphasis of much of the contemporary competence literature. EI resists reduction in the form of a checklist that has historically been the approach taken in competency-based systems (Carrothers et al, 2000). Framing competence as a form of emotional intelligence or 'emotional regulation' (Phelps, 2006) is challenging due to the difficulties associated in measuring it using standard statistical tests such as reliability, validity or generalisability.

How can recent insights into emotional intelligence be integrated into a broadened discourse of competence? At a psychometric level, increased reliance on global or holistic forms of assessment may be one alternative. Conceptualising competence as a gestalt, rather than as a checklist aligns with the notion that emotion and reason are as indivisible as a dancer and a dance: change one and out of necessity the other changes. Current attempts to translate competence discourses into assessment tools suffer from an overly-rationalist bias, the belief being that measurement is quantitative, behaviour is observable and performance can be

subdivided into constituent components. Competence discourses that emphasise emotional intelligence at the core would resist these biases and instead examine ways in which the link between emotion and reason, clinical decision making and empathy, and professionalism and ethics are more explicitly acknowledged.

1.5.3 Competence as a psychological engagement construct

The work of Csikszentmihalyi (1990) and Gardner et al (2001) with respect to the psychology of positive experience provides a unique insight into the connection between motivation and performance. This model suggests that human beings are at their best when environmental challenges and opportunities align with personal skills and interests. Csikszentmihalyi (1990) coined the term 'flow' to describe a state of absorption in an activity: "…your whole being is involved and you're using your skills to the utmost".

Csikzentmihalyi's description of flow echoes the work of Schon (1983), who coined the term 'reflective practitioner' to describe the unique feature of professional work: cognitive ambiguity. If professional practice were straightforward and formulaic, it would easily be performed by machines. What makes professional work unique, and valuable to society, is that decisions must be made when information is imperfect and answers are not clear. At these times, professionals must demonstrate a psychological flexibility that allows them to recognise there may not actually be a right answer, only so-called least worst alternatives.

The work of Schon and Csikzentmihalyi raises important issues regarding the role of motivation in human behaviour. Simply because individuals can do something does not necessarily mean that, in a given circumstance, they will do it, especially when barriers including inertia, complexity, organisational culture or time constraints exist. The psychological

energy necessary to transcend routine, bureaucracy, standard operating procedures or any other form of resistance, requires 'flow' (Csikzentmihalyi, 1990).

There has been increasing interest in the notion that competency frameworks may actually be antagonistic towards 'flow' and the psychological / motivational needs of health and care professionals. As Bereiter and Scardamalia (1993) note in Surpassing Ourselves, rules-based systems, including checklists and competency frameworks, generally do not create the type of environment, or produce the psychological interest and energy, required by most people to use their skills and knowledge to their fullest abilities.

The work of McGivern and Fischer (2012) and Fischer and Ferlie (2013) have illustrated how rules-based regulation of health and care professionals erodes values-based self-regulation. They have raised concerns that any attempt to regulate or prescribe the work of professionals will compromise motivation and engagement, fundamentally changing the nature of professional work.

The need to create a psychologically engaged workforce has been identified by experts in the UK. Proposals for staff-led health and care services, with devolved decision-making have been described as a vehicle that will improve patient care. West et al (2012) have argued that development of engaged, collective leadership for health care is critical: individuals must assume responsibility for the success of their organisation, not just their own jobs. Campling (2013) presents the notion of intelligent kindness: behaviours not found in any job description, specification or competency framework, but ones that actually "…capture the essence of kind practice". This kind practice, she argues, builds a virtuous circle producing better outcomes which "…could be useful in our quest following the Francis Inquiry to transform the culture of healthcare".

This emphasis on cultural transformation is echoed by West and Dawson (2012) who note that "[i]t has long been recognised that engagement of employees with their work and organisation is a factor in their job performance." In their report Employee Engagement and NHS Performance, they conclude that staff engagement "…is linked to a variety of individual and organisational outcome measures, including staff absenteeism and turnover, patient satisfaction and mortality, and safety measures, including infection rates".

Traditional competence frameworks have focused on development of individuals' capabilities, which does not necessarily translate into organisational advancement. As described in the Review of Staff Engagement and Empowerment in the NHS (Ham, 2014), such shifts in culture and organisational administration produce the type of psychological engagement necessary to unleash health and care providers' potential. In their White Paper Delivering a Collective Leadership Strategy for Health Care (2014), Eckert et al highlight the connection between devolved decision making, staff engagement, morale and ultimately improved health care outcomes. Literature on the connection between staff engagement and outcomes in the health and care professions is emerging. Prins et al (2010), in a study in the Netherlands, noted that physicians who scored higher on professional engagement were statistically significantly less likely to make medical, diagnostic or prescribing errors. A large study involving over 8,000 hospital nurses by Laschinger and Leiter (2006) noted that those who ranked higher in terms of professional and organisational engagement had better patient safety outcomes. Boorman (2009), in the NHS Staff Health and Well-Being Report, noted that staff absenteeism cost the system over 1.75 billion pounds (equating to the loss of 45,000 full time staff positions) annually, and that absenteeism itself is linked strongly with engagement scores.

Berwick (2013) has emphasised "[t]he workforce is not the problem…they want to offer safe care. Good people get trapped into bad systems. [Safety] is not about enforcement; it's about involvement". As noted by Eckert et al (2014), disengaged professionals are disinclined from 'going the extra mile' and instead are more likely to do only that which is minimally required.

Can one be simultaneously competent and disengaged? Austin et al (2003) have noted that pharmacists in Ontario, Canada at highest risk of not meeting competence standards:

– graduated from educational programmes more than 25 years ago;

– work in sole practitioner arrangements; and

– received their professional education training outside North America.

Austin argues that these risk factors are general symptoms of isolation and professional disconnection. Grace et al (2014) identified predictors of physician performance on competence assessment and noted similar personal characteristics and practice context features, suggesting professional isolation is a risk factor for competence drift. Wenghofer et al (2014) note that attendance at, and participation in, continuing professional development activities may serve an inoculating function for those who are at risk of competence drift. Engagement with one's peers and involvement with one's professional community provides peer-benchmarking opportunities that may relate to competency. This literature suggests a connection between disengagement and competence drift.

As noted by West et al (2012) "…the more positive the experiences of staff within an NHS trust, the better the outcomes for that trust… the more engaged staff members are, the better the outcomes for patients and the organisation generally". The language of engagement has only recently been included in discussions related to competence, and has not yet been incorporated within most competency frameworks. As this discourse matures and evolves, this perspective will continue to grow in importance.

1.5.4 Competence as a cultural construct

Competence problems are identified in only a very small number of professionals within any cohort (HCPC Fitness to Practise Annual Report 2012, 2013). In these cases, including the system failures at Mid Staffordshire, organisational culture has been identified as an important potential cause (Francis, 2013). No matter how competent each individual practitioner may be in the practice of his / her profession, s / he may simply be unable to practise at an optimal level due to dysfunctional or suboptimal leadership, line management, supervision or organisational culture.

As noted by Dixon-Woods et al (2013), within the UK NHS there is "…an almost universal desire to provide the best quality care…", but "…consistent achievement of high quality care was challenged by unclear goals, overlapping priorities that distracted attention and a compliance-oriented bureaucratised management… [g]ood staff support and management were also highly variable, though they were fundamental to culture and were directly related to patient experience, safety, and quality of care." This raises the question of whether the current model of assuring competence of each individual health and care professional's competence is adequate and sufficient, or whether a new construct, such as organisational culture competence, should be developed. A consistent theme from Francis (2013), to Berwick (2013) and Ham (2014) has been the need for culture change in the NHS to prevent future tragedies.

While calls for strategic culture change within the NHS are ubiquitous, specific tactics continue to be elusive. For example, the National Advisory Group on the Safety of Patients in England, in A Promise To Learn – A Commitment to Act (2013) noted that "[w]hen responsibility is diffused, it is not clearly owned; with too many in charge, no one is". Simultaneously they call for more involvement to "engage, empower and hear patients" and "foster whole-heartedly the growth and development of all staff". The authors of Patient Centred Leadership: Rediscovering our Purpose (2014) state: "[i]t is time for the NHS to rediscover its purpose" and propose a model of shared leadership and bottom-up collaborative decision making focused on patients, which may produce conditions of diffused responsibility. Storey and Holti (2013) in Towards a New Model of Leadership for the NHS describe elements such as motivating teams and individuals, creating a positive emotional tone / climate and encouraging staff involvement and engagement, as the most effective evidence-informed tools for organisational cultural change.

Further research is ongoing to try to better understand what specific tactics to produce cultural change within organisations can actually support meaningful improvement.

1.6 Conclusions

Traditional constructs of competence have emphasised an individual health or care professional's technical and cognitive skill set. As described in this synthesis, this may be a necessary but insufficient way of thinking about competence.

Emerging notions of teamwork, emotional intelligence and engagement represent important steps in broadening the discourse of competence. The idea that organisational culture influences an individual professional's ability to demonstrate competence raises important challenges and questions. The traditional checklist approach to defining and measuring knowledge and skills, while necessary, may not

be sufficient as the complexity of health and care and service delivery increases. Broadening our understanding of competency and recognising the limitations of traditional approaches are important first steps in ensuring the best, most effective health and care possible.

Currently, there is little evidence but some discussion regarding the issue of competence drift and the mechanisms by which an individual practitioner's knowledge, skills, and attitudes may deteriorate over time. In particular, and building upon the notion of engagement or 'flow', there is interest in further examining whether it is possible to identify individuals at higher risk of competency drift earlier, and to provide more focused support and / or remediation in an attempt to prevent larger performance based problems from arising. This model of targeted interventions to address competency drift, before it translates into a practice-based issue, raises important potential roles and responsibilities for educators, regulators and employers. Further research, however, is required to establish these connections and to identify what, if any, interventions may be most useful in this context.

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2 Engagement and disengagement in health and care professionals

2.1 Introduction

The Health and Care Professions Council (HCPC) has begun exploring how and why health and care professionals become disengaged in their place of work. A range of behaviours and circumstances commonly associated with disengagement can give rise to concerns about practise and can lead to complaints. In spring 2014, Picker Institute Europe were commissioned to undertake research into this area, following on from a wide ranging review of existing literature by Professor Zubin Austin at the University of Toronto.

The Austin review provides an analysis of the relationship between competency and disengagement in a health and care context. Disengagement, it is suggested, can emerge from a complex interplay between internal and external factors. Internally, there are elements such as motivation, beliefs and values which shape the way in which people engage. There are also structural, cultural and management inputs into engagement, which can have significant impact, often over long periods of time.

The study reported is a first step in furthering the HCPC's evidence base in this area and to contribute to the ongoing debate about the origins of complaints and how more can be done to prevent them from arising in the first place.

2.2 Project aims

The project was designed to begin to explore ideas with registrants, employers, stakeholders and members of the public, including:

– perceived causes or triggers for disengagement amongst health and care professionals;

– views on to what degree disengagement affects competency;

– understanding of the competency and accountability frameworks professionals

hold themselves to, and how applicable they are to 'everyday realities';

– what interventions, if any, might prevent health and care professionals from being disengaged; and

– for those involved in fitness to practise proceedings, whether they are able to retrospectively identify when and why disengagement occurred.

2.3 Method

2.3.1 Background and development

The development stage included an overview of the reports such as the Health Foundation's 'Asymmetry of Influence' (Bilton and Cayton, 2013) thought paper and Austin's 'Continuing the competency debate: reflections on definitions and discourses' (Whitehead, Austin and Hodges, 2011). This preparatory work provided crucial context for the development of the project, particularly topic guides for both the focus groups and the individual interviews, which are included in the appendices.

2.3.2 Gathering information from fitness to practise case histories – review of case notes and interviews

The initial stage of the research was a review of fitness to practise case notes. The sample was drawn from HCPC cases that had concluded at final hearing in 2012, 2013 or 2014. Cases were selected against criteria relating to issues of competence and communication, ensuring a mix of professions were covered.

A total of 27 cases were reviewed. Each case was analysed in depth, and themes were identified. The analysis of the cases were guided by the definitions of engagement from West and Dawson (2012) and Boxall et al (2011).

Engagement: staff involvement in decision-making, or more generally, the openness of communication channels between management and staff in organisations (West and Dawson, 2012).

Engagement comprises:

– psychological state (involvement, commitment, attachment or mood);

– performance construct (effort or observable behaviour); and

– disposition (positive affect).

Engagement is characterised / evidenced by:

– psychological engagement (a positive and fulfilling work-related state of mind);

– proactivity;

– enthusiasm and initiative;

– organisational citizenship-behaviours and organisational commitment;

– involvement in decision-making; and

– positive representation of the organisation to outsiders.

Pre-conditions for engagement ('Black Box' model) (Boxall, Ang and Bartrum, 2011)

– State of engagement = involvement in one's work + commitment and positive attitudes to one's engagement

– Behaviours = making discretionary effort + personal initiative or proactivity + pro-social behaviour in organisation + advocacy in favour of organisation

– Intermediate outputs = better staff health and lower absence + higher job satisfaction / lower turnover + more efficient use of resources + higher levels of innovation

– Overall performance = higher customer satisfaction + higher profitability + greater resilience + faster growth

2.3.3 Views from members of the public – focus groups

Three focus groups were held in September 2014, two in Leeds and one in London. Two focus groups were made up of the general public and one comprised people considered as patients or service users (ie had recent experience of health or care services). Patients and service users were included to ensure that the project consulted individuals who had some experience and understanding of health and care professionals regulated by the HCPC, and of their roles and responsibilities.

Table 1 – Service user, patient and public focus groups

Group	Location	Participants
Members of the public	Leeds	9
Members of the public	Leeds	9
Service user and patient group	London	8
Total		26

The patient and public focus group topic guide is included as Appendix 2.

Participants were recruited using the services of a professional recruiter and were screened to ensure a good demographic mix. Employees of health or care providers were excluded as participants, even if not HCPC registrants. All participants were asked for their consent to the digital recording of the focus groups. Participants were assured that what they said would be treated as confidential and that any quotes would be anonymised within this report. Participants were offered a small cash incentive to compensate for their time and travel expenses.

2.3.4 Views from registrants – focus groups

Five focus groups were held with HCPC registered professionals, two in Leeds and three in London. A topic guide was developed for this discussion and is included as Appendix 2. It was designed to assess:

– what personal frameworks of competence and accountability they use to ensure they are delivering 'excellent' care;

– how formal competency frameworks resonate in everyday delivery of care;

– understanding of 'competency drift' and engagement;

– to what extent they believe engagement

can affect competency; and

– what, if anything, can employers or the HCPC do to assist them in 'feeling engaged' at work?

Participants were recruited through an email sent by the HCPC to a sample of registrants within the geographic area. All participants were asked for their consent to the digital recording of the focus groups and were assured that what they said would be treated as confidential and that any quotes would be anonymised within this report. Participants were offered a small cash incentive to compensate for their time and travel expenses.

2.3.5 Views from stakeholders

26 interviews with stakeholders, which included professional bodies, union representatives and employers (NHS and local authorities) were conducted. Stakeholder's experience in fitness to practise proceedings were drawn upon to understand their views on disengagement issues. Interview participants were identified by the HCPC and from within Picker Institute Europe's network. There was a considered effort to have representation from diverse professions, roles and responsibilities, as well as geography. All participants were asked for their consent to the digital recording of their interview. Participants were assured that what they said would be treated as confidential and that quotes would be anonymised within this report.

Table 2 – HCPC registered professionals groups

Group	Location	Participants
Mixed professionals	Leeds	6
Mixed professionals	Leeds	3
Mixed professionals	London	5
Mixed professionals	London	2
Mixed professionals	London	4
Total		20

Table 3: Stakeholder interviewees by profile

Interviewee profile	Number
Professional body representative	20
Local Authority employer	2
NHS employer	3
Union representative	1
Total	26

2.4 Results

2.4.1 Case note review

A number of themes emerged from the analysis of the 27 cases. The documents reviewed included final decision bundles, a summary decision form and the evidence contained in registrant bundles. It is worth noting the context within which the registrants were responding, which has a bearing on the evidence within the registrant bundle. Registrants were defending themselves against an allegation and as such, the evidence presented tended to be set out in order to show themselves in the best possible light. The review took the form of a qualitative analysis and, due to the small sample size, statistics have not been reported.

2.4.2 Dissonance between the individual and the organisation

There was often a conflict between organisational cultures and individual perceptions of professional codes of practice. Registrants in otherwise compatible cultures reported becoming vulnerable when they felt they were being asked to agree to compromise on standards. For example, where a department was under pressure and registrants were implicitly or explicitly expected to deviate from policies and protocols to maintain output.

Differences appeared to arise from long-standing formal and less-formal working arrangements between teams, professions and services, which led to unintended consequences. These were typically complex cases. In some, the unintended consequences appeared to flow from registrants' decisions and behaviours. For example, the choice of language used with a patient or service user, or excessive use of short forms in clinical notes. In others, there were other, arguably more influential factors that were entirely beyond the registrants' control such as workload pressures or meeting targets.

The case review pointed to a tension between professionals' attitudes and behaviours that expressed a desire to 'keep the show on the road' and the decisions and behaviours that protect an individual's registration. That is to say, registrants reported feeling that in order to achieve organisational objectives and good service user care, they were required to adopt behaviours and approaches which called their fitness to practise into question.

There was one case in which the registrant cited a poor employee-employer relationship in mitigation for misconduct. The registrant's response described the employing organisation, its culture, the registrant's manager, remuneration and terms and conditions of employment very negatively. In many cases however, it was difficult to define in any precise way the differences between registrants' commitment to, and attitude towards, their employing organisations before the event(s) that had brought their fitness to practise into question and later on in the narrative. Some had clearly not had positive relationships with their supervisors or managers but, taken together, the cases reviewed do not suggest that registrants had overtly withdrawn from their organisations, before or at the time of the alleged event.

The case review suggests that some registrants' engagement with their organisation was subsequently affected by the way in which

competence and conduct were investigated by managers, employing organisations and the HCPC, and by registrants' expectations and experience of being fairly treated and supported. Some registrants were apparently so angered, distressed or disillusioned that they disengaged from their profession and employer completely, by resigning and requesting voluntary deregistration, and asserting that they never again intended to work in that profession. For one registrant, the process seemed a foregone conclusion and decided they would not respond to the allegation, where another had self-referred for voluntary removal.

It is however not possible, from these case notes, to determine whether disengagement by these registrants resulted only from their experiences of disciplinary, competence and / or fitness to practise processes. It is possible that the investigations were in effect the 'final straw', rather than the only precipitating factor. Some registrants' decisions to 'walk away' may have reflected long-standing, though unexpressed, disengagement.

2.4.3 Competence and capability in newly appointed professionals

In West and Dawson's model of a highly engaged organisation, the pre-conditions for engagement include the conditions that people need from their roles, teams and managers. These are:

– a sense that work is meaningful and valued;

– challenges, stimulation and opportunities to learn and grow;

– authority, autonomy and influence over environment;

– manageable workloads and access to resources;

– clear objectives and well-structured appraisals;

– effective communication and co-ordination;

– a supportive work community;

– rites and rituals which celebrate success and reinforce good practice;

– managers who welcome staff views and engage their teams in decisions;

– managers who show appreciation of effort and contribution;

– managers who support staff in improving how they carry out their work and addressing problems; and

– coaching and mentoring rather than directive management (West and Dawson, 2012).

These conditions certainly characterise engagement as a two-way street and are perhaps particularly important for recently recruited staff. Registrants who perform well enough in their roles and teams are offered the role, team and management conditions for engagement. They will also have opportunities to engage themselves and to demonstrate engagement attitudes and behaviours.

Equally, employers can withhold or withdraw these conditions and opportunities, in the probationary period and subsequently, where registrants are not proficient or are not otherwise a good fit in the team.

It is not possible to determine from the cases reviewed whether withholding or withdrawing the pre-conditions for engagement directly affects registrants' state of engagement. If anything, the review suggests that there can be a two-way short-circuit between the 'pre-conditions' and 'behaviours' elements of the West and Dawson model, whereby role, team and management conditions affected

registrants' behaviours and vice-versa, without obviously influencing the registrants' internal state of engagement. In fact, some registrants seemed over-resilient, in that their sense of themselves as competent and engaged professionals was entirely at odds with colleagues' and managers' evidenced and ongoing concerns about their proficiency or conduct.

It is perhaps in no-one's best interests for employers to invite and encourage engagement from HCPC registrants where they are not meeting reasonable expectations. That is to say, expectations of positive engagement from the employer need to be managed until a registrant is proved to be competent in the role to which they have been recruited. Equally, new recruits are entitled to prove themselves and to engage with their role and organisation. Taken together, the cases reviewed suggest that registrant and supervisor relationships deteriorated, and / or became highly adversarial, when registrants felt that supervisors or managers had withheld the conditions for engagement from the outset, or had withdrawn them prematurely.

2.4.4 Competence and capability

In some cases, registrants apparently did not have the necessary skills, abilities or personal suitability to perform well in the role to which they had been appointed, and no amount of management or team support would bring their practice up to the required level and consistency. It was interesting that these registrants' responses, both their own and third party reports, typically described the registrant as highly involved in their work and cited engagement behaviours, such as making discretionary effort, taking personal initiative and attempts to be pro-social, in defence. It is possible that in many of the cases reviewed, engagement and competency were not strongly linked, and that improving engagement would not resolve a competency

impairment to fitness to practise.

In other cases, registrants had apparently been appointed to roles where, though competent to some extent, they were described by their supervisor(s) as "completely out of their depth". In particular, they had been unable to work independently and safely, sometimes in acute settings and with complex patients, as soon as their managers and colleagues had expected and needed them to.

The case review suggests that is it important for supervisors and managers to be aware of the messages that they are sending about engaging with their organisation, and to get the balance right. It could be argued that it is misleading, inappropriate and in no-one's best interests to encourage engagement when the registrant's future in the role or organisation is in the balance. On the other hand, withholding the conditions for engagement for new recruits risks isolating them. Some of the cases reviewed suggest a downward spiral of evident disappointment from managers and team members, and loss of confidence and disengaged behaviours and attitudes from the registrant.

Otherwise, in this review, 'wrong job' and 'out of depth' cases raise questions about how these individuals were recruited to the roles they were in, how they qualified, and about how training and appraisal systems could be developed to ensure that registrants are a genuinely good fit for their preferred role. They also suggest room for improvement in employers' recruitment criteria and recruitment processes, if registrants are not meeting their competencies.

2.4.5 Personal circumstances

A further theme emerged from the case review around the influence of personal circumstances. There were a number of registrants who cited bereavement, acute and chronic illness, or other significant problems and pressures (personal, familial, financial and / or professional) as mitigating factors in the case made against them.

The review found nothing to suggest that any of these registrants had any awareness that they had disengaged from their profession, from their work or from their employer. Rather, registrants had apparently tried to continue to practise as usual but had reached a point where they were overwhelmed and something had to give. Professional practice was compromised and things got worse as registrants continued to practise, but were unable to recover the situation and 'get back on track'.

These cases included registrants providing acute, community-based and domiciliary services. In all settings, the aspects of practice most likely to be both compromised and evident to colleagues were record keeping and record management. Registrants included long-serving and highly-regarded professionals who had not, or had not appropriately, for example, made contemporaneous notes, documented telephone conversations, noted all findings, completed forms, recorded consent or stored records securely.

Some cases suggest that there are structural issues that make record keeping more complicated than it might be, for example a lack of standard formats for record keeping in some service settings and clinical specialties. Multi-disciplinary and multi-agency working arrangements are complex, and there is always the potential for miscommunications and misunderstandings.

It appeared that record keeping and management became problematic, especially in cases concerning senior, very experienced and highly-respected professionals. It may be that 'paperwork' became the lowest priority when there were multiple competing pressures and priorities, and / or that it was an aspect of practice that was relatively invisible to colleagues until discrepancies came to light and prompted an investigation. Another interpretation could be that 'paperwork' being subject to audit, and clinical notes often being

shared between clinicians, was a more routinely scrutinised area of their work.

Registrants who were struggling with record keeping and management did not, apparently, voluntarily disclose their difficulties and receive support from their supervisors. These registrants appeared to conceal rather than communicate their difficulties.

2.4.6 Dysfunctional relationships

Deficits in supervision feature, in different ways, in many of the cases reviewed. These include allegedly inadequate supervision by the registrant, the registrant apparently not taking responsibility for ensuring appropriate supervision, assuming this is an expectation of HCPC registered professionals and obviously broken relationships between registrants and their supervisors and managers.

Several registrants' responses implicitly or explicitly pointed to difficult relationships between registrants and supervisors. Accepting that cases referred to the HCPC are likely to be atypical, it is notable that few of the registrants had apparently felt supported by their supervisor, or even felt able to approach their supervisor to express concerns about their own practice. From the case material, even senior registrants would not typically have been confident of a supportive and constructive response from supervisors or managers if they had sought to fulfil their professional duty to manage their circumstances, change their practice or stop practising.

Some of the cases concerned senior practitioners who had allegedly failed adequately to supervise the work of more junior colleagues, and / or to provide appropriate guidance. Again, the review does not suggest that these registrants had abdicated from their supervisory responsibility. Rather, registrants and their supervisors or managers had different understandings of the boundary between the supervisors'

responsibilities and accountabilities and those of the supervised registrant, as an autonomous practitioner in their own right. This applied, in particular, to documentation and other responsibilities that were not, strictly speaking, hands-on 'clinical' and so very obviously subject to the registrants' supervision.

2.4.7 Disengagement 'after the event'

Registrants' responses to allegations of misconduct and subsequent investigations vary widely. Some engaged fully, submitting comprehensive and carefully argued responses throughout internal and HCPC processes. At the other end of the spectrum, some registrants appeared to disengage, not replying to HCPC correspondence, resigning from their posts, requesting voluntary deregistration and asserting that they never again intend to work in the profession. There is no obvious pattern of engagement or disengagement as a response; the disengaged group, for example includes registrants working in hospital, community and social care services, more junior or recently appointed registrants and senior registrants with decades of service.

Some of the submissions to the HCPC from longer-serving registrants who disengaged after the event express clear and long-standing frustrations with their managers, their employing organisation more widely and / or with other systems, organisations and communication issues in the local health system.

Post-event disengagement could, arguably, be interpreted as evidence of pre-existing disengagement, ie that registrants had disengaged before they behaved in a way that raised questions about their fitness to practise.

The cases reviewed, however, do not suggest that registrants had previously disengaged from their work role or from their service users. In some cases, registrants' fitness to practise was questioned when they had done or not done things that they argued, sometimes

successfully, had been in the best interests of the service user. Furthermore, in some cases, it could be argued that it was certain behaviours that had put their registration at risk. For example, 'going the extra mile' and working at the edge of competence in situations that subsequently spiralled out of the registrants' and their services' control.

The case material reviewed in this study overall has limits as a source of evidence about registrants' state of engagement. Perhaps inevitably, given that they were referred to the HCPC, most of the cases describe a fitness to practise (rather than 'truth and reconciliation') approach to discovering what happened and who was responsible, with a clear focus on investigating impairment. No matter how conciliatory, registrants' statements and written responses seek to defend them against allegations and, where registrants remain engaged, to present them in the best possible light. Being both retrospective and defensive, case materials may not accurately and completely reflect registrants' state of engagement with their work or their organisation at the time of the incident(s). Furthermore, HCPC processes often began a long time after the incident(s) in question and, with regard to all witnesses and other participants, there is an obvious risk of recall bias.

Fitness to practise case material set out the facts and the implications for current fitness to practise, but the case material provided limited insight into registrants' reasoning or motivations for past (alleged) misconduct. Some cases provide a little information, offered in mitigation in respondents' responses. In a few, the rationale is self-evident (for example cases where there was a narrative around financial gain). In other cases, however, registrants had made inexplicably poor decisions that obviously contravened policies or codes of practice, or had made decisions that were not theirs to make. Without more (ideally contemporaneous) information about registrants' thought

processes, it is not possible to draw conclusions about the extent to which engagement or disengagement contributed. It is perhaps worth noting that in several cases registrants in acute services were at the very beginning or end of a shift period.

It was however striking how some registrants' reaction to allegations and investigations was to make their own situation very much worse by being untruthful or otherwise misleading by trying to disguise what they had done or not done. This included asking others to be dishonest about what had happened or what they had witnessed. This raises questions about registrants' state of mind and decision-making processes around the time of the incident(s), but may reflect the 'drift' referred to in Austin's review.

2.5 Interviews with registrants who had been the subject of a complaint

Given the low numbers of participants, the findings related to this project aim have not been reported. Recruiting registrants who had been subject to fitness to practise proceedings proved difficult given the opt-in methodology. The HCPC sent letters to 23 individuals where either a conditions of practice order or suspension order was imposed at the original hearing and had subsequently been revoked at a later review hearing. One interview was completed and two others contacted the researchers as they felt not enough time had passed since their final panel to comment.

2.6 Analysis of patients, service users and public focus groups

Three focus groups were held with patients and service users in two locations. There were 26 participants across the groups.

2.6.1 Perceptions of a 'competent' professional

Patients and service users in the sample had been in contact with a variety of HCPC registered professional groups. Members of the public had a more limited interaction with these professionals and typically were with chiropodists / podiatrists, paramedics and physiotherapists. They did, however, comment generally on doctors and nurses. Where relevant we have included these comments in the analysis, omitting anything that was clearly related specifically to the medical or nursing professions. From prior experience with similar groups, it can be difficult for patients and members of the public to comment generally on health and care professions, whilst excluding their experiences of doctors and nurses.

The groups started by defining what elements would denote to participants that a health or care professional was 'competent' or that they were 'doing a good job'. They focussed primarily on the way that they interacted with their patients or clients. Participants mentioned 'compassion' and clear, articulate or positive communication as denoting competence.

When probed about how communication can denote competence, participants pointed to a 'confidence' in delivery that let you 'know what they're doing'. They further mentioned that having the ability to reassure, meant that they were experienced in dealing with patients and service users. One participant suggested that if they understood and were able to follow a health or care professional's advice, and that resulted in a positive outcome, then they would trust that they 'knew what they were doing'.

> "A personal touch, individual care, a bit more of a tailored, kind of, approach."

> "Caring and compassion and kindness… she's very friendly towards me. It's the interpersonal skills."

> "Explain what they're doing and why they're doing it."

> "They make you feel at ease, by talking to you in a soft voice."

2.6.2 Consistency

Participants also mentioned the word 'consistency' as being linked with a competent professional. It seemed as though they were interpreting consistency as giving 'good' or 'sage' advice and not attempting to resolve a problem in as many ways as possible, as quickly as possible.

They also mentioned timing as being important in perceptions of competence. A health or care professional who rushed you, or who did not seem to have time to make the process as 'comfortable' as possible would be less likely to be a competent professional.

In terms of more 'technical' competencies, members of the public and patients and service users found it difficult to define what might comprise technical competencies. They did however, have a baseline expectation that professionals would keep up to date with their professional requirements and that various training would be expected to be undertaken on an annual or otherwise regular basis. They likened it to training within the fields that they worked, where qualifications were only valid for a year or few years at a time.

> "You don't want to feel like you're rushed, an MRI machine is scary, you want someone to talk to you and… make you feel like a person and not a thing."

> "They should be up to date with the relevant practices… They should do relevant training every year, things are changing all of the time."

2.6.3 Perceptions of factors which may affect competency

There was agreement, in general, that there might be a number of factors within a professional's life, which may affect their competency, such as their relationships with their supervisors and teams, family difficulties, training and time since qualification. This was strongly qualified by participants that it would be 'rare' or that 'you hope it wouldn't' be a factor. This belief was most often linked to the position of trust and responsibility that came with being a health or care professional. Participants viewed their role as so important that there seemed an additional burden of competency that they wouldn't expect of other professionals.

Family difficulties, such as a bereavement, family breakup, illness or other personal difficulties, were cited as examples potentially giving rise to issues with competence. In the case of a personal issue, the sense was that this would be a temporary competence issue, and their impression was that it wouldn't typically be severe or unsafe. There was also a view that one's relationship with colleagues could cause difficulties in a similar way to personal relationships. The stress of a bullying situation, for example, might cause competency problems.

There was a disagreement amongst participants on the effect that where one trained would have on their competence. Patients and the public were more likely than professionals to be convinced that the location of a professional's original training course would have a bearing on their competence. Those who thought their competence might be affected, cited a reasoning of people who go to the best universities will get the best training and be the best. This was seen from a very 'UK centric' way. However, many participants believed that competence in a health or care professional is about more than 'academics' and therefore it was less likely to impact on their competence.

There was an expectation that if a professional had been employed in the UK that their qualifications had been deemed sufficient to assure competency. That is to say, there was a belief that there is good consistency in terms of quality across training programmes in the UK and that foreign credentials, if deemed of a similar quality, should be accepted.

There were those who suggested that competence would be impaired if language skills made it difficult for patients or service users to understand the professional. Conversely, they wondered if it could impair one's competency if it was difficult for the professional to understand the nuance of information given to them by patients or service users. When thinking about 'real world' situations one participant laughed, stating that the last thing you would be thinking about when interacting with a health or care professional would be where did you train?

Though the location of people's work, such as hospital, community or social care setting, did not appear to relate to concerns about potential impacts on competence, there was a concern about lone working or isolation. A community worker would be as competent as long as they worked as part of a team, to keep their practice in check. In the participants' view, professionals who they had interacted with in a particular setting, would have worked with them to the same standard, even if the setting had changed.

There seemed to be significant value placed on the ability to confer with colleagues on cases, to reflect on a professional's practices, that isolation could make difficult. This interaction with colleagues was seen as important to the development of competency and staying up to date. The concern with lone workers was that they would become complacent.

Complacency concerns were echoed in the length of time since a professional had qualified. Patients and service users were likely to make assumptions about a health or care

professional's competency based on the length of time since someone qualified, whereas members of the public had a more balanced view. This might be due, in part, to their interaction with long serving specialists and consultants, who were viewed as paternalistic by patients. The impact for those who felt there was one, fell into two distinct camps. Some patients and service users mentioned that they viewed younger health and care professionals as more likely to 'not quite know what they're doing yet'. Others, however, believed that people who had been in the profession longer, tended to be more complacent, as though they 'can't still improve', whereas younger professionals, were more likely to be interested in innovation or trying alternative approaches. When asked, participants found it difficult to decide on particular examples of this, but rather that there may be an impact on competency in either direction.

> "Something in their personal life could be affecting them, maybe their wife has left them."

2.6.4 Views on engagement

When asked what might effect a health or care professional's engagement with their work, similar themes of difficulties in their personal life emerged. In addition, however, participants were keen to point to immediate managers as a cause of strong (dis)engagement. For most participants they perceived this as a strong link and defined it as a desire to 'do your job well'. When asked how 'wanting to do your job well' affected competence, participants were not clear that they were related, rather that health or care professionals 'may not go the extra mile'.

Another area where they felt engagement might be affected was where a health or care professional was unable to exercise all of their skills, or where they had a particularly difficult patient or service user workload. They felt that

either the boredom or stress burden in these cases may change the way that they felt about their work. They felt it possible that, without exercising different skills on a regular basis, it may affect competence.

> "Need to know they can work their way up, after ten years doing the same thing, they might get bored."

> "It might get people in a rut, they might get complacent. It's your job, you can't choose your patients."

2.6.5 Financial constraints and workload pressures

Patients and service users reported noticing the effects of the financial pressures on their appointments times, bookings and cancellations. They could tell that the professionals treating them were frustrated by the constraints they were operating under, and they thought a sense of continued frustration might impact on their engagement with their work. They also wondered if this might be an area where engagement and competence were linked, because with capacity pressures, 'something's got to give'. Similarly, there was a view that health and care professionals were increasingly spending more time with acute cases, or the 'worst cases in social care' and that they weren't always able to deliver preventative care or support. They wondered if this caused 'empathy fatigue', a sense that continually 'fighting fires' might make one less engaged.

> "They're not working in this one situation nine to five, they're living a live drama. When you've got people coming in like a conveyor belt into a building, that's where you get compassion fatigue."

2.6.6 Autonomy

Participants in one group spoke very highly of paramedics that they had come into contact with. They had found them to be extremely competent and professional. Through the discussion, they pondered whether the relative amount of autonomy given to some practitioners was related to their engagement. There was a sense that in hospital or a care setting that the targets were more evident and the audits more burdensome.

Participants described the link between disengagement with competency as definitely possible, but believed that professionals would be conscious of any disengagement and would act to rectify the situation. For example, they might raise their workload pressures with managers, or leave a job where they felt bullied. They did not believe that they would be passive in their disengagement to such an extent as to become incompetent. However, a number of the participants questioned what would you need to do to be considered incompetent? Examples, such as poor note taking or paramedic vehicle checks, were something participants thought 'you might not know how important it was until something happened', but for the most part they thought a rational professional should be able to think through the potential negative impacts of not completing all aspects of their role.

> "They have more autonomy, because of the nature of the emergencies they see, they use their initiative, they're living a live drama."

2.6.7 Preventing problems

When discussing how to prevent small problems from becoming big problems, participants wondered if it wasn't better to do more to prevent disengagement in the first place. They felt that regular team building exercises were important and that appropriate performance evaluation takes place. They

believed that employers and colleagues played a significant role in providing a guidance programme (interpreted as a preceptorship, mentorship or clinical supervision programme). Participants were also keen to suggest 'spot checks' of work, such as clinical review of cases, or of audits of certain elements of performance as an added safeguard to small problems becoming big ones.

2.7 Analysis of health and care professionals focus groups

Five focus groups were held with health or care professionals in order to gauge their views on competency, engagement and factors affecting both, as well as whether they believed there to be a link between the two. The HCPC invited a random sample of registrants who lived within the London or Leeds area where the groups were to take place, and an opt-in booking process was used. A total of 20 registrants participated. Their professions are described in the table below.

Table 4 Participants in focus groups by profession

Profession	Number of participants
Social worker	5
Physiotherapist	2
Speech and language therapist	1
Radiographer	3
Occupational therapist	4
Biomedical scientist	2
Practitioner psychologist	1
Operating department practitioner	2
Total	20

2.7.1 Notions of competency for health and care professionals

HCPC registered professionals' descriptions of the elements that made up competency indicated a type of 'fluidity' to competency, that it meant and required different things at different times. Several participants described their competencies as being not simply about the knowledge or the skill 'operating in a vacuum', but also the ability to know how, when and why they were applying a particular skill or practice in a given situation. Indeed, the ability to choose and set the appropriate skill for a good outcome for their client group was considered a crucial component of competency. Although that is not to say a poor outcome necessarily denoted a competency problem, rather in order to be competent, one would expect a professional to adjust any process or treatment that was not resulting in good outcomes.

Most professionals could describe a particular list or baseline of skills or tasks which they should be able to perform to be a competent professional. These skills and tasks were understood as what is learned during pre-registration education. They further explained that, depending on any training or specialty a professional might hold, they would have additional lists of skills, knowledge or abilities that they would need to keep up to date in order to be considered as competent.

Social workers described a much more prescribed notion of competency within their profession than reported by other participants. Capabilities for social workers, denoted what is expected of them at varying career levels, whether that was to do with length of service or seniority of management within a team. Capabilities were referred to regularly, giving a fairly clear picture as to competency for social workers in the group.

Similarly, biomedical scientists said that the framework of quality assurance within their

profession, whether that was procedures required by ISO certification for example, which meant there was little interpretation in what constituted competency. That is to say, the procedure was either carried out correctly or incorrectly. They did however note that other aspects of competency, including behaviour and ethics, were more nuanced.

> "It's an application of your knowledge to a task."

> "It's about the ability to prevent or to solve problems in your daily practice."

> "You've got different types of competencies like behavioural or skills base, but it's also about understanding the outcome of any of your activities."

> "If the intervention has been successful you can be reassured that you're competent, or if it hasn't, knowing how to reassess your approach."

2.7.2 Autonomy

The notion of autonomous practice was often referred to as an important element of competency, and was often mentioned in relation to risk. The sense was, to be competent, a professional must have the confidence to practise autonomously, or at least have the confidence to highlight their weakness in an area rather than put themselves, or indeed a service user or patient, at risk.

Competency, like expectations, changed given the characteristics of the professional. Competency for a newly-qualified professional would not be the same as that for someone who had been practising for several years, nor did professionals believe they ought to be the same. As previously mentioned, this applied for any additional training or specialities acquired by professionals.

Competency frameworks that professionals worked to varied by profession, but generally participants referred to the HCPC standards for registrants, as well as guidelines provided by employers related to particular skills or practices, or employer competency frameworks. Professionals were not certain that employer frameworks were consistent across the UK, but there was an assumption that they would cover similar elements. Social workers mentioned they had a certain number of other influences on competent practice including styles of practice, such as 'anti-oppressive practice'.

When asked whether competency frameworks informed their daily practice, professionals described having them 'in the back of their mind'. They also thought that the HCPC bi-annual review of professionals' CPD had meant they reflected on their competencies, training and abilities in a more formal or documented way.

> "The ability to work autonomously and confidently, that you're not hiding any gaps in knowledge, that you're open."

> "We have the general expectations for CPD from the HCPC, the general how you progress… once you've qualified there's nothing else, other than in your department you might have different levels and different trainings."

> "It's in the back of my mind when I'm doing anything: can this count for my CPD, can I reflect on this area – it governs which patients I can treat and what work I can do."

> "We deliver daily, we just do it. It comes natural. We do the job, but actually its very rare that a social worker will say 'I need time to develop this area', to have that reflective thinking. It's only drawn out when you have [a] formal appraisal or assessment sessions."

2.7.3 Reflective practice

Less formal ways of reflecting on competency also seemed to be routine amongst the participants in the groups. They said that it was not uncommon to reflect on one's competence, sometimes in observing a colleague's approach to a problem (ie have they done it differently and would it improve my practice if I were to adopt their approach). Similarly, professionals also described a reflective 'inner question' process. They often thought 'would another professional have acted similarly in this situation', as a way of checking themselves.

2.7.4 No blame culture

One professional found their team's approach to no error reporting as helpful in ensuring competence. Where mistakes were discussed openly and solutions or preventative measures were drawn up as a team, everyone was able to both be aware of how a mistake may have occurred, but also understand what good practice looked like.

> "Regular no blame reporting systems so we can all learn from where things go wrong and that helps."

2.7.5 Measuring competence

When asked whether it was possible to measure a professional's competency, there was consensus that it would be possible to measure certain elements of competency easily, but that others would require a much more in-depth assessment. The measurement question also brought up other thoughts on what constituted competency. For example, would behavioural competencies be weighted more than skills or vice versa?

Indeed, participants wondered if you could develop a holistic view of competence because of the numerous elements that went into deeming someone competent. There was

also a sense that the reverse might be easier. One could more clearly deem an action or behaviour as being incompetent practice.

> "Competence is dependent on so many factors it's difficult to put it all together."

> "The quality is measured by the outcomes achieved, but there's a lot of competence that requires qualitative measurement."

2.8 Factors that affect competency

2.8.1 Organisational influences

The biggest factors which health and care professionals believed impacted on competency were related to the organisation that they worked for. Several professionals reported having a workload issue, or the organisation having a capacity pressure such that expectations could threaten the competency of their practice. They often linked this to insufficient support, most likely of their immediate manager. Professionals emphasised the importance of being able to discuss their competency and whether their practice was safe with their managers. Without support, or belief of support, this could be difficult.

This concern of reporting on one's own competency, could be caused by a fear of criticism. The sense that there was a risk to discussing competency when it came to workloads because other practitioners on the team might be coping with the workload. The impression given is that managers would not always be supportive of staff members raising concerns about their own competency.

A number of participants mentioned that their NHS Trusts were no longer filling vacant posts, but there was an expectation that waiting times would remain unchanged. Many practitioners had felt pressure to do more in the time that they had and felt that they had, in some cases, compromised their practice. They

did not believe that these constraints had rendered their practice incompetent. Rather, it was not what they would promote as good and competent practice. They also thought that many of the decisions made about capacity and what can be achieved were being made by trust leaders or at a political level by people who were not practitioners, and they felt there was a fight to describe what constitutes safe and competent practice.

Professional groups were also asked to comment on a number of areas they hadn't raised independently and whether those elements may impact on a professional's competence. These included, time since qualification, where they trained, personal circumstances or difficulty and working location or style. Overall, professionals believed that these elements could impact on a professional's competence but that for the most part, they would expect that professional to identify the issue with their supervisors. Then to take some time off or make another accommodation, such as requesting specialist support, for what they believed to be, in most cases, a temporary impact on competency.

"Is there a fear of reprisal if you do raise your hand and say this isn't safe or competent practice?"

"Because posts aren't being filled there's a risk to competency because you're being asked to do so much, how can [you] be expected to achieve that? And you feel like you have to say that's not safe."

"People make big decisions who aren't practitioners, and that can cause a problem, as they don't know, necessarily how to do so and the impacts they might have on quality or competent or safe practice."

2.8.2 Time since qualification

Unlike members of the public, professionals were more likely to see people who had been in the profession for a long time as those whose competency might be affected. Their knowledge of preceptorship, and the expectation that newly qualified professionals' competency would increase over time, made them less concerned about knowledge affecting newly qualified professionals' competency. The idea that a professional could become stuck in their ways or inflexible in their practice over time was seen as one way in which competency might be impacted.

"Where people have been in a role for a long time and been denied opportunities to progress… And they're doing things in a slapdash way… They're not doing things in a thorough way… not doing the liaison with other professionals… not really engaging enough with that patient in another sense… it's not being incompetent really, but it's not doing it to the full level of your competence."

2.8.3 Professional isolation

There was concern about how isolation could impact on competency. Participants perceived isolation as either being the only qualified member of their profession within an organisation or working privately, or working in the community without the support of a team.

This concern about isolation was described in different ways. Firstly, if a professional becomes isolated they may not be reflecting on their practice in the same way that teams would do. Similarly there was a concern that if a professional was working in an isolated way it may be difficult for them to access specialist support as and when needed in order to remain competent. Finally, there was a concern that their competency might not be monitored in the same way as professionals who work in teams. However,

there were very few instances that professionals could think of where professionals were very isolated. Indeed many of the services they worked for had been set up to avoid any member of staff becoming isolated as a safeguarding process for both patients and staff.

One participant who had worked in both community and acute settings, felt as though professionals were placed in vulnerable situations by working in the community. By being asked to monitor the risks of a number of different patients in a number of different settings with little 'back up', the stress could potentially impact on their competence. Though, as the conversation continued, others wondered if perhaps the stress had made them hyper-aware, and potentially more competent when not relying on a team.

"You're much more vulnerable in the community, and from my experience I think there should be tighter monitoring of your competence and the access to specialist expertise should be easier – it could be a dangerous situation for keeping up your competency in a vulnerable situation."

"I think it would be really hard to work in isolation because you wouldn't have access to that expertise that a team has."

2.8.4 Continuing professional development

A number of participants believed there was a minimum amount of continuing professional development (CPD) required to maintain competence, but that attitudes toward CPD likely reflected other things such as what career stage they were at, what client load they had and the professional's personal circumstances. CPD was seen to supplement competency and could make a professional 'skilled', but they did not view 'skilled' and 'competent' as equivalencies.

"Competency includes your current practice and your practice as you move forward, so yes, keeping up to date is part of competency."

2.8.5 Professional networks

Professionals believed that their professional networks, on the whole, did a good job of communicating any changes in practice or guidance to the professionals. Staying up to date was seen as part of the job, and they did not believe that someone could become 'incompetent through ignorance'. However, linked to the question about the length of time since qualification, participants felt they could think of professionals within their professional network who had perhaps become set in their ways, and did not actively take up new ways of doing things. This may affect competency but, more likely, they thought it would make the overall team of professionals less competent as they were working to different methods.

"At the end of the day we're all human beings and have ups and downs in our lives and part of being professional is knowing how to cope with that or talking to your manager if you need to."

"I could see how you might make a mistake. Is a one off mistake not being competent? You might make a mistake but not be incompetent."

2.8.6 Personal circumstances

Participants thought it might be possible that the stress of a bereavement or family breakdown, for example, might 'take your eye off the ball'. But again, the professional expectation and belief was that there would be an awareness of this impact. Participants further qualified that a stressful personal life could cause someone to make a mistake, but wondered if a one-off mistake would deem a

professional incompetent. In discussion, there was an agreement that there may be some mistakes that would render one incompetent due to the severity of the mistakes, but many mistakes would be seen as less serious.

2.8.7 Place of qualification

Participants did not think that the place of qualification would impact on their competency. There were some anecdotes about particular professionals from particular countries as being very good. Some had felt that the knowledge base of some professionals differed dependent on the location of qualification, but that any induction, preceptorship or clinical supervision would bring them up to speed. Overall, they believed that, as a qualified professional, as long as someone had met the requirements of qualification and were keeping up to date as they needed, that would indicate competence. They added personal suitability to the job was much more relevant than where they trained, whether in the UK or abroad.

Personal suitability seemed very important for social workers in particular. They were concerned that there were newly qualified social workers entering the profession with very little 'life experience', and that this could cause a shock when they were faced with the problems, issues and interventions that social workers face. They thought this could cause a problem in competency, because they felt some social workers with little 'life experience' were not fully prepared for the role after their qualification.

2.9 Views on engagement

Engagement to the professional included their motivation to do the job, and this was often linked to the enjoyment of their job. They commented on reflective and mindful conduct of their practice as being engaged; that in looking for improvements in their own practice and service, they were engaged.

Others linked it to a personal responsibility to work well with teams and to develop professionally. Many mentioned keeping up to date with their profession as engaging in their work and in their practice. Much of the discussion focussed on an active form of engagement, whether it was seeking improvements or in developing their team skill set. Engagement for some was about ensuring the quality of the care delivered.

Professionals did see a certain responsibility and maturity to engagement, in that there was an expectation that professionals should attempt to not become disengaged. There seemed to be a view that disengagement might entail 'giving up'.

Relationships with managers were seen as an important influence. If there was a supportive culture that encouraged learning and team working, then professionals found themselves to be highly engaged. In a similar way, if their team functioned well and valued all members' input, and there was a feeling that 'everyone was pulling their weight', then professionals tended to feel they engaged more readily.

"Coming to work and wanting to do my job, rather than waiting for the day to end."

"Taking responsibility for your professional development, about how management were working with you."

"To be valued as part of a team make[s] you feel more engaged, and if they're not there you can become disengaged."

"It's nice to work in an organisation with a good learning culture, you keep developing and becoming a better practitioner and that helps me to feel engaged."

2.9.1 Being valued

Being valued was something that was mentioned in every group. For some, it was important for their patients or service users to value their assistance, for others it was the praise of a direct manager, and others their team valuing their input. A small number mentioned senior managers as valuing their work, and that this value could be expressed as involving them in decisions about the service.

2.9.2 Financial pressures

Financial pressures were viewed as a potential source or trigger for disengagement. Professionals reported that prolonged periods of stress associated with financial pressures within the system had caused some team members to disengage. Anxieties about putting service users at risk or compromising standards were commonly referred to. Further, they felt the focus of their employers was always on financial realities. Suggested improvements to services would always need to be justified in financial terms, which, on the whole, participants felt did not play into their engagement with work. Professionals were likely to link disengagement with 'burnout', often referring to the two interchangeably.

"Sometimes if there's a big, massive waiting list, for example, [it] can cause problems for engagement because we're putting patient care at risk, so financial implications have a role on engagement."

"They are all overridden by financial realities. If I want them to invest in my service, I need to quantify that."

2.9.3 Relationships

Professionals had engaged more when their supervisors had been supportive in developing the professional's career, or had been understanding about any concerns they may have expressed. Professionals had felt less engaged where their line manager had been perceived to be weak in managing teams, or had been relatively unsupportive or absent.

When asked about the relationship between engagement and competency, one group of participants thought that there might be cases where this could happen, but they believed it would be rare; again stating the need for professionals to be aware of their own fitness to practise. There were often a number of factors cited as leading to a professional's disengagement. For example, a combination of a poor relationship with a manager or team member as well as a stressful period at work or at home could lead the disengagement to impact on competency. However, when the discussion focussed on stressful family circumstances, participants wondered if the inevitable shift in the focus of attention from work to home life could affect a professional's engagement. They also wondered whether a professional would have the insight to know their competency was affected. A minority in the group were clear that a professional did not have to 'like' their job in order to do it competently.

Participants believed that engagement for health and care professionals could be ascribed to different parts of their work. For some, engagement seemed to be to their work, and in so doing their patient or service users. Others mentioned their engagement with their team and organisation. Some felt an engagement with their profession, that they were engaged in being a qualified professional. As a base, most professionals thought there needed to be engagement with the people that they served, but with others, this seemed to be less important in terms of competency.

"There are some things, external pressures which you can't manage, which might affect your engagement or your competency."

2.10 How to prevent small problems from becoming big problems in health and care

When asked about preventing small problems from escalating, health and care professionals felt a number of different people, roles and organisations played a part. There was a sense that sometimes small problems might be difficult to notice, unless it was related to an issue that was regularly under scrutiny, or that was audited regularly. A large role was apportioned to employers. Health and care professionals believed that managers should have sufficient structures in place to assess the competency of their staff. Further, appraisal and performance management, when done well should uncover any weaknesses in professional dynamics.

Professionals also suggested that there could be a team element to noticing the competency and practice of their team members, either in discussing and reviewing cases on a regular basis, assessing where improvements could be made or alternate approaches taken.

Indeed, professionals believed that the team review of competency, and the learning approach where all professionals' cases are reviewed in time, meant that hierarchies could be lessened and a more open culture could be created.

There was a clear consensus around the responsibility employers had to assist with engagement or competency issues. They believed that employers had a role in addressing any capability issues, or to ensure that they were a good employer creating a working environment where staff members would remain engaged.

Again, professionals were quite clear in their belief that health and care professionals, as professionals, would have a firm understanding of their own competence and the factors affecting it. The self-reflection inherent in their understanding of competency, would mean that they believed that professionals would either act to address causes of disengagement, or would change wards, units, or employers, rather than remain in a situation that may impact their competency. It is perhaps worth noting that the focus groups with professionals were both held within reasonably urban areas. As such the choice of employers were larger. Views of those within rural areas where there may only be one large health or social care provider within the local area, and a few small private providers, for example, might differ.

> "Should be picked up through robust supervision or managerial structures that should give guidance of a threshold of concern."

> "Structures for the supervision, or forums to discuss issues and challenge problems… maybe it doesn't need to be a one to one to prevent that teacher pupil dynamic."

> "There's an issue where there's a large hierarchy which prevents people entering into dialogue."

> "The employer has to be a good employer and committed to developing their staff…. They can only go as far as they are supported by senior managers."

2.11 Analysis of stakeholder interviews

Twenty six interviews were conducted with representatives of professional bodies, NHS and local authority employers as well as one union. In general, stakeholders had good experience and understanding of the fitness to practise process. Their views were remarkably similar, despite their differing relationships to HCPC registrants.

Perhaps unsurprisingly these participants had a clear idea of what they believed constituted competency. They readily described competency as having knowledge, skill and behavioural parameters applied appropriately depending on context. Competency was further defined as those elements upon which a professional's qualification were based and assessed through their education.

Stakeholders were the only group to describe an ethical construct to competency, at least directly. This was of particular importance to professional bodies who had often issued guidance or materials on the codes of ethics for their profession.

Stakeholders were also well versed on the various codes and frameworks, published or otherwise, which could be referenced as a guide to the competency of health and care professionals. These included the HCPC standards, particular guides or detailed skill frameworks published by professional bodies, trust codes of conduct, or in some cases, the job descriptions of certain levels of professionals.

"Competency is made up of a number of things including knowledge, skills and behaviours that the individual needs to have and be able to call upon and use appropriately in their workplace."

"The core competencies will have been gained from university."

"It's basically whether we are able to do the role that we are employed to do."

2.11.1 Assessing competency of health and care professionals

Stakeholders were confident that the competency of a health or social care professional could be readily assessed. They felt that there were some skills or behaviours that could be more easily measured than others. Stakeholders viewed competency

frameworks as a way of signposting professionals to areas of strength or weakness in their performance. There was also the sense that evidence-based practice had made assessing competence more straightforward than it had been previously.

Competency required interpretation in the context of the environment, the experience of a professional, the team they worked with and the complexity of the patient, client or service user that they were interacting with. One interviewee mentioned that there were shared responsibilities to assess competency, between managers and peers.

"I think you have to be careful because actually measuring competency can become too rigid so, you know, you can stifle practice really if you're measuring competency and staying rigidly within a framework. You need the space to be able to develop and try different things."

"Evidence based practice has got to be the way forward, so you don't just do things because it seems like the right thing to do, you actually check the research evidence about what's an effective intervention at the end of the day, so competent learning, nothing's ever the same."

2.11.2 Factors affecting competency

Stakeholders agreed that there were a number of influences on a professional's competency, either relating to personal characteristics of a professional or to outside influences on the professional.

Personal circumstances and workload were referenced as the main issues affecting competency for professionals. Stakeholders described stress, regardless of the source, as impacting greatly on competence. Personality and values shaped competency.

Echoing concerns from the professional focus groups, interviewees had strong concerns about professionals working in isolation, or in one, narrow form of practice. Their first concern related to the potential for the ossification of a professional's practice or to an overall deskilling. Their second concern was that it would be difficult to assess, review or enable a professional's competency when they worked in isolation.

One professional body had a particular concern which was being raised within their profession. A number of their member practitioners had dyslexia, and they had found it difficult to explain how that may impact their practice. Though the professional body did not think it necessarily impacted on competency, many managers had perceived it thus, and so they felt there could be similar issues which may or may not impact and that there could be opposing views on the impact or on what constituted competence.

> "We shouldn't delude ourselves that measuring competency gives you a full picture, everything exists within a context."

> "You have a duty to maintain yourself at a level where your competency can be maximised. You need to be in good mental and psychological and physical health. Family relationships can affect your performance, overwork can affect your performance and there's always a balance between respecting a person's exterior life and actually expecting them to deliver the requirements of the job… There has to be some give and take on both sides in that respect."

> "Reviewing an individual's competency who's working in isolation would prove to be very difficult."

2.11.3 Engagement and disengagement

The interviews with stakeholders generated a complex view of what engagement looked like in practice. They viewed engagement as 'not doing the minimum' rather than how someone felt about their role. Involvement in professional networks, engaging in debate, seeking out improvements to practice and reflecting on that practice were seen as the 'signals' of an engaged professional. Stakeholders recognised that a professional may become permanently disengaged. Sources of disengagement for stakeholders were stress, personal circumstances, workloads and overall capacity pressures.

Distinct from other views was the notion that engagement could be both negative and positive in nature. That is to say, a professional could be very engaged, but in a way, that was perhaps not productive or positive. Examples of this negative engagement came from issues with employers such as consultations on jobs and services, where professionals were engaging with their employers, but in argumentative ways. Another was where media coverage of health or care professions was particularly negative. There was a feeling that this could increase engagement, but perhaps not to the part of the job that one wanted professionals to engage with. This seemed to fit with the view that engagement was not a 'state of being' as such, but rather a symptom of underlying issues.

Professional body participants, interestingly, seemed to find it difficult to comment on disengagement and its causes, because if a professional began to disengage, it would include their relationship with the professional body. Occasionally, managers would seek advice from them where there were concerns about an individual apparently becoming disengaged.

"It's not just going in and doing the same thing on a daily basis, it's taking an interest outside of your immediate work environment. So what's the strategic environment in which you're working, what's new within your profession. So reading your magazines, the journals, being aware when new guidance is published, engaging in debate and discussion with your colleagues, reflecting on your own practice and looking to see you know, where you might need to improve. So it's a number of different indicators that would show to me that somebody's engaged."

"Engagement is a symptom rather than a cause. When people disengage it's a sign that something isn't working properly, it sort of reinforces itself."

"We don't necessarily know about them, we don't hear until something goes disastrously wrong."

"The only instance we hear about this is where an individual becomes disengaged and their managers or their supervisors ring us for advice."

"If they disengage from their role, they tend to disengage from us."

2.11.4 Link between engagement and competency

These participants were the most likely to articulate a relationship between (dis)engagement and competency. They perceived that an engaged professional would be more likely to undertake the 'active' elements required of remaining a competent professional, such as reflecting on and keeping up to date with their competencies.

Stakeholders did not see disengagement as necessarily leading to a professional being incompetent or incapable, rather that it might raise questions about a professional's competency. They were more likely to perceive that engagement could be related to the 'type' of professional or person they were. Indeed, professional body respondents were much more inclined to point to issues of personality and personal suitability. There was often a perception that a professional could disengage from some areas of the job, while remaining competent. However, interviewees did observe that just as engagement reinforced competency, so disengagement could diminish it.

"I think the more engaged you are the more likely to be competent you are, and the more likely to keep up your competencies you are."

"Well if somebody is disengaged from their profession they usually don't have very much insight into how they could better their competency…"

"If they're not engaged they may not understand nor wish to reflect on their practice."

"It's not an always relationship because I think you can be competent and disengaged. You can be disengaged because you're unhappy but it doesn't change your competency level and I think that is often a reflection of the nature of a person."

"…they probably are capable, they're not incapable, or if they were they would be going through a capability procedure, so they're more likely on the edge of incapability."

"Well yes, if becoming demoralised, not performing as well as they could do, not responding as well to supervision as they ought to do, failing to keep up with professional knowledge as it comes through. So disengagement in a sense has a negative effect of engagement and all the things that we've talked about can be weakened or diminished."

2.11.5 Preventing small problems from becoming big problems

As reflected in the case review, these participants were aware of the challenges of management and supervision. They were keen that managers and supervisors were given the time and space to be able to supervise their staff. Supervision was seen as a key component to catching small problems and being able to address them in an appropriate manner.

Good team dynamics and access to development, training and education were seen as key elements to prevent small problems in the first place. The monitoring of workloads was also mentioned, there was a feeling amongst respondents of the tendency toward a 'hero' practitioner, carrying on when things got tough. Keeping up to date on workloads and keeping expectations in check was an important factor in good management.

For some, it was difficult to determine what could be considered to be a small problem. One off mistakes could be a small issue and might not require preventative action. If competency was questioned, a small number of participants thought that usually there was a larger issue at play which may not be possible to turn around. Usually, they described a person whose personal suitability to a role was not well matched and that no matter how much support given, they might be the right person in the wrong job.

As observed in the case review, there was a sense that where small problems arose, poor management structures could exacerbate the issue, or become adversarial very quickly. The moment a process became formal, it was very difficult to prevent it from becoming adversarial as additional parties usually became involved. Participants suggested as a first step that managers ought to create an environment where good performance was enabled, and that any interventions into a professional's practice should be communicated as such.

Several participants mentioned values-based recruitment as a method of preventing small problems from occurring. They linked this to their belief that often where competency issues arose, it was due to 'the wrong person, in the wrong role'. The more that could be done to match the skills of the professional to the case load or care environment the fewer mismatches in competency would occur.

The environment for reporting concerns was also considered crucial. If an environment or management structure was such that the reporting of concerns about a professional's own, or a colleague's, competency, would be met with a heavy hand, then small problems could quickly become big problems. Implicit in the professionals need to be aware of impacts of their competency, was that employers support them in operating within their competency. 'Open' or 'no-blame' cultures, where mistakes could be deconstructed as learning experiences, were seen as a good way of using small problems positively to improve the whole team or department's working practices.

"I think the managers of the Trust need to enable the line managers to have enough time to supervise, so if there is an early sign that somebody is not achieving what they should be doing, then you actually have to go in there and spend a lot of time with them."

"In my experience it was the fact that there was always a big issue but we were hoping it would get better."

"The right people performing the right roles, it's a question of leadership and that doesn't necessarily mean management, but leadership at every level."

"Recognising the impact of hierarchies, because responsibility exists at each level…"

"Forgiveness is a powerful behaviour… not blame, but accountability."

2.12 Discussion

This study represents an initial exploration into the complex interplay between competence and disengagement in a health and social care context. It aimed to look at the causes or triggers for disengagement, and what interventions, if any, might prevent health and care professionals from becoming disengaged. It also explored participants understanding of competency and accountability, and the relationships between competency and the concept of engagement.

Perhaps surprisingly, there was considerable consensus across the three groups of stakeholders who contributed. Table 5 provides a summary of the key themes emerging on the triggers for disengagement and Table 6 highlights the consensus views on possible ways of preventing problems before they escalate towards a complaint.

The triggers for disengagement include a range of organisational and psychological dimensions. What came across was a sense that, where working relationships and organisational support were not adequate, professionals were more likely to become disengaged. Although the case review data was less clear cut, the themes around dissonance, capability issues and

dysfunctional relationships were evident here too. The impact of changes in personal circumstances, and the lack of insight that could accompany these, was also recognised across the groups.

Table 5 Consensus triggers for disengagement

Triggers for disengagement
• Workload pressures
• Operating outside scope of practice
• Under-utilising skills
• Professional isolation
• Lack of autonomy
• Lack of support for CPD
• Poor or infrequent supervision
• Poor management
• Dysfunctional relationships
• Personal circumstances (bereavement, divorce, financial pressures)
• Blame culture
• Working patterns

The groups generated a wide discussion on the mechanisms that might prevent problems from developing further. Early identification, intervention, conversation, challenge and support were all put forward. Some suggestions were about improvements in external frameworks, such as regular supervision, appraisal, buddying and mentoring schemes and team building where appropriate. Others were more focused on encouraging internalised processes such as self-awareness and reflection on practise. Creating a culture of 'no blame', one which encouraged openness and honesty was also identified as an important preventive mechanism.

Table 6 Consensus views on ways of preventing problems

Possible ways of preventing problems
• Being valued
• Good team dynamics
• Good supervision
• Regular appraisal and performance management
• Buddying schemes
• Mentoring
• Preceptorship
• Team building exercises
• Professional networks
• Reflective practice
• Self-awareness
• Keeping up to date
• No blame culture

Overall, this study has provided new insights into the nature and context for disengagement in health and care professions regulated by the HCPC. One of the constraints may have arisen from participants differing understanding of the terms 'competence' and 'engagement.' Given that this field of inquiry is very much in its infancy in empirical terms, this work should be viewed as a first step towards greater illumination.

2.13 Methodological limitations

It was disappointing that the interviews with registrants who had been the subject of a complaint proved problematic. 23 were contacted, one interview was completed and two contacted the researcher to decline,

stating they felt not enough time had passed since their final fitness to practise hearing to contribute to the study. It may be that a longer time lapse between contact and the year in which the complaint occurred should have been set. Without these first hand reflections, which might have revealed insights into registrants' thought processes, the case review analysis was only able to provide some initial observations of some of the links which were being explored in the study.

2.14 Conclusions

The data generated clear consensus around several themes, which could usefully be taken forward into further investigation. Amongst all participants in the study, there was a perception that it was possible for engagement to impact on competence and for this to have consequences for practice. The character, nature or personal values of a professional, as well as the support, supervision and workload pressures could all have an impact. Identifying triggers for disengagement early on was possible in the right circumstances, for example where a culture of no blame was encouraged, where professional networks were strong and where managers were offering support for staff.

In attempting to uncover the causes of small problems becoming bigger problems in heatlh and care settings, the following areas may provide a useful focus for future work and discussion, either for the HCPC or for others with an interest in this area.

1. The importance of appropriate supervision

Due to the reported difficulty in accessing supervision, both due to employer constraints on time, and their support of the practice, there may be a role for the HCPC in setting more detailed guidance for supervision of health and care professionals.

2. Preventive work

a. We suggest conducting further research into thresholds of concerns, barriers and enablers to reporting small problems of health and care professionals, to better understand the conditions under which small problems could be prevented from becoming big problems.

b. Guidance for professionals and their managers could be developed to assist managers in addressing issues of fitness to practise that have been self-referred. This should assist those experiencing a crisis to be given appropriate support.

c. Employers should consider additional support systems for employees to raise concerns and access support, guidance or advice without triggering disciplinary processes.

3. Building better relationships between managers and those managed

There is a widespread concern about capability procedures quickly becoming defensive and adversarial. A better understanding of supportive methods of addressing poor practice should be developed. A complementary understanding of all the factors which make the process alienating should be established, including:

a. points where the process stopped being supportive; and

b. other factors in disengagement, such as alienation from colleagues looking not to be 'tarnished by association'.

4. The importance of professional networks

Nearly all participants reiterated the importance of informal, professional networks in retaining competency and in improving practice. These networks should be encouraged and fostered.

2.15 References

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Appendix 1 – Case review summary

Profession	Year registered with HCPC	Complainant type	Incident employment status	Details of case	Outcome
Paramedic	2000	Employer	Employed within NHS	Failed to effectively supervise trainee paramedic. Dishonest by colluding person at employer to provide false report.	Struck off
Occupational therapist	2003	Employer	Employed within NHS	Failed to demonstrate appropriate knowledge and manage time.	Removed by consent
Biomedical scientist	2007	Employer	Other	Inadequate knowledge and skills for role, made malicious complaint against colleague.	Struck off
Paramedic	2001	Employer	Employed within NHS	In possession of an Entonox cylinder at ambulance station whilst signed off sick. Abused Entonox or had intended to do so.	Conditions of practice
Speech and language therapist	2009	Employer	Employed within NHS	Failed to reach satisfactory level of competencies with assessments and treatment planning.	Conditions of practice
Hearing aid dispenser	2010	Employer	Employed in private practice	Inadequate record keeping and clinical skills. Over charging service users and retaining the money.	Struck off

Profession	Year registered with HCPC	Complainant type	Incident employment status	Details of case	Outcome
Physiotherapist	Date not available ***	Employer	Employed in private practice	Inappropriate treatment of patient during treatment.	Struck off
Occupational therapist	2003	Employer	Employed within NHS	Failed to maintain records, assessments and communicate effectively with patients and colleagues.	Removed by consent
Dietitian	1984	Employer	Employed within NHS	Misuse of employer's mobile phone.	Struck off
Paramedic	2005	Article 22(6)*	Employed within NHS	Inappropriate language used to dispatcher on the phone. Left junior colleague to care for patient unsupervised.	No further action
Radiographer	1977	Employer	Employed within NHS	Failed to maintain adequate records and falsifying records.	Struck off
Speech and language therapist	2000**	Employer	Employed within NHS	Inadequate recording keeping, communication and clinical skills.	Caution
Hearing aid dispenser	2010	Employer	Not recorded	Failed to maintain patient records and provide adequate clinical care.	Suspension

Profession	Year registered with HCPC	Complainant type	Incident employment status	Details of case	Outcome
Paramedic	2000	Self-referral	Not recorded	Inadequate patient and clinical care.	Removed by consent
Dietitian	1992	Employer	Not recorded	Shared personal information with patients on Facebook. Inadequate patient care and record keeping.	Conditions of practice
Biomedical scientist	2006	Employer	Not recorded	Failed bench competency test, plagiarised colleague's work in written evidence submitted.	Conditions of practice
Paramedic	2000	Employer	Employed within NHS	Failed to maintain satisfactory timekeeping. Attending work smelling of alcohol.	Suspension
Radiographer	2010	Employer	Not recorded	Failed to meet level of competence.	Suspension
Practitioner psychologist	2010	Employer	Not recorded	Inadequate record keeping and clinical skills.	Suspension
Radiographer	2001	Employer	Not recorded	Lack of competence on clinical procedures.	Struck off
Paramedic	2004	Employer	Other	Failed to provide appropriate care for patient and identify seriousness of patients condition.	Struck off
Paramedic	2000	Employer	Not recorded	Failure to respond to emergency call, gave false information, attempted to influence witness to provide false evidence.	Struck off

Profession	Year registered with HCPC	Complainant type	Incident employment status	Details of case	Outcome
Operating department practitioner	2005	Employer	Not recorded	Self-administered Tramadol whilst on duty. Cared for patients whilst under the influence of this drug.	Struck off
Practitioner psychologist	2009	Employer	Not recorded	Rude / insulting to service user during assessment, used inappropriate language in reports.	Caution
Social worker	2012**	Professional body	Not recorded	Failed to communicate with extended family to provide alternative care for child. Falsified date on letter sent to family.	Struck off
Social worker	2012**	Employer	Not recorded	Displayed poor professional judgement and decision making. Inadequate recording keeping.	Removed by consent
Social worker	2012**	Employer	Local authority	Cautioned for common assault by beating service user.	Suspension

*Article 22(6) of the Health and Social Work Professions Order 2001 enables the HCPC to investigate a matter where a concern has not been raised in the normal way (for example in response to a media report or where information has been provided by someone who does not want to raise a concern formally).

** date of transfer to HCPC

*** registered by the Council for Professions Supplementary to Medicine, date not available

Appendix 2 – Topic guides for focus groups and interviews

Guides for members of the public, professionals and stakeholders were adapted to each group.

What constitutes 'good' or 'competent' for HCPC registered professions?

– Perception of skills / ability to help

– Way they communicate about condition / issue

– Presentation, how professional they appear

– Knowledge of issues discussed

– Whether they worked in a 'person-centred' way

– Assessment guidelines from training or specific guidance from professional bodies

– Employer or other frameworks such as job descriptions or codes of conduct

– Other personal moral frameworks

Topics tested for impact on competency

– Commitment to continuing professional development

– When and where completed qualification

– Isolation / sole practitioner

– Working in the community or in a health or social care facility

– Work-life balance (ie if facing stressful situations outside of work)

Topics covered in reference to engagement at work

– Media coverage of health sector

– Perception of how work is recognised / valued

– How involved they are in their team or decisions about their work

– The priorities of the organisation (financial, care, etc)

– Relationship with line manager (good / bad)

– Patient or case load

– Variety of work or ability to use all their skills

– Possibility of development / progression

– Your development within the profession

– Access to training

– How an organisation acts on patient and service user concerns

– How an organisation acts on their concerns

– Managing work-life balance

– Perception of senior managers

– Interaction with professional body and / or HCPC

What role do you think engagement plays in how well a health or care professional does their job?

– Can engagement mean different things (patients / profession / organisation / team)?

– Does it matter which you are engaged to, are some more important than others?

– Do you think a loss of engagement from (patients / profession / organisation / team) could have an impact on competency? What might those impacts be?

Topics covered with reference to preventing small problems

– Informal support, finding out the root of the problem

– Performance improvement / management plans

– Training and other support

– Guidance from others in their profession in the organisation

Appendix 3 – Raw data giving examples of the reasons for disengagement, competency drift and methods of prevention

Reasons behind disengagement and competency drift

Workload pressures

Because posts aren't being filled there's a risk to competency because you're being asked to do so much. How can [we] be expected to achieve that? And you feel like you have to say, 'that's not safe'. (registrant, focus group)

I think…[there] isn't a focus on constancy, as I said before, but a focus on having more people for less money. But also looking at how many patients you can see, rather than the quality of that provision. (stakeholder, interview)

As a result of a restructuring and cuts process in that area… they were left with some very high activity expectations that were difficult to meet and it made it very hard for them really to think about their work and to make time for anything else other than face-to-face clinical work. (stakeholder, interview)

I was stupid to undertake this amount of work without a break but did not wish to let anyone down. (registrant evidence, case review)

It's almost a perfect storm of not feeling valued… the refusal of a pay rise, increasing pressure, members of the public expecting more, increasing expectations both in quality and quantity of what you do. All of that together is becoming obviously quite overwhelming and is leading to some disengagement. (stakeholder, interview)

I certainly think when you look at what's happening to ambulance service paramedics, they're coming under greater time pressure. The Health Service as a body is creaking at the edges for unscheduled care. (stakeholder, interview)

Certainly in the arenas of mental health that's one of the most difficult areas that we work in and the difference to where you're going to refer someone, that can often be challenging and requires you to have a very clear head… when you're working under stress that's not always there. (stakeholder, interview)

Working Patterns

The beginning of a night shift is also a busy time for fielding queries from staff finishing their shifts and also for dealing with vehicle, drug or equipment issues that have arisen in the preceding twelve hour shift. In other words, there would more often than not, be many competing factors for my attention that would require me to prioritise, and as emphasis was placed on maintaining shift cover for the station, this would inevitably be the chief for me, to the relative exclusion of less immediate considerations. (registrant statement, case review)

Operating outside the scope of practise

There were other occasions when she would contact people in the evening and on weekends about [clinical] issues which she did not need to do... The out of hours contact appeared to be mostly by email and text message rather than by telephone. Again, I think this related to time management. (witness statement, case review)

I mean it may be that they don't have the confidence to, you know, speak up and say, actually that's not within my competence so… they kind of have a go if you like and try to do whatever it is they've been asked to do. (stakeholder, interview)

I think [record keeping] is probably the first thing that goes [when someone becomes

disengaged] and maybe the other thing that could happen is people stepping outside of their competency so… they're actually doing things that they shouldn't really be doing. (registrant, focus group)

Underutilising skills

It may be that [the practitioner] comes in and just treat[s] that corn that the patient has come in for but because they're disengaged they haven't taken into account "Well actually hang on, that person's circulation isn't as good" or "Why is that corn coming?" (stakeholder, interview)

If you have somebody who's focussing on management then they would do less and less clinical work and then there will be a tipping point over which they're not doing enough clinical work to keep up their competency. (stakeholder, interview)

Professional isolation

The concern has been where it's not just been individuals, but maybe whole services have disengaged from the rest of the profession and become like isolated little islands, and that's had quite an impact. (stakeholder, interview)

Sometimes individuals are just left, they may be employed in a different bit of an organisation, they're isolated in that way and they're not necessarily brought in to the department as such, that's going to become more difficult. (stakeholder, interview)

Often she was left on the ward working alone simply because no one else was available or they were caring for other patients. The detrimental effect of this isolation was compounded by the fact that [she] was not invited to attend multi-disciplinary team meetings for the patients she was caring for. (witness evidence, case review)

One of the issues that we had when the ambulance service started putting more and more people into single responder vehicles and

also that they were closing down ambulance stations and having people waiting for calls just sitting in their vehicles. We were saying that they're underestimating the value of people being able to chew the fat as it were and discuss work issues with colleagues because clearly sharing things and sharing experience, you know, it's one way to enhance your competency. (stakeholder, interview)

The only times [slips in competence] might not be picked up is when someone is really working in isolation with no kind of monitoring. (stakeholder, interview)

Now audit and review generally has become much more robust across the whole profession, but I think there are single-handed practitioners who now may or may not do the competency review of themselves, or get a colleague to do it. (registrant, focus group)

Lack of autonomy

I think the laissez-faire manager actually enables people to think independently and enables people to actually... feel in charge of their own progression. (stakeholder, interview)

Putting a structure of deciding in advance when you're going to end the treatment means that you can't allow space for the unexpected to come up and it's imposing a kind of constraint on the therapy that's going to limit its effectiveness, and various other things like that. (stakeholder, interview)

You're not able to take patients through to their optimum response if you like. And while that was ever there it's got much worse, so that actually is quite frustrating for a lot of physios. (registrant, focus group)

Lack of support for CPD

In prosthetics and orthotics sometimes there isn't the same opportunity for CPD time, a lot of employees would be committed to be spending between 90 and 100 per cent of their

time on a clinical basis without any sort of time set aside by their employer for their own personal development. (stakeholder, interview)

What we're very aware of, though, and very concerned about, is what we're hearing as a result of austerity, is that more and more of our members are being told they're not allowed to go to CPD opportunities even if they're free. (stakeholder, interview)

I think access in terms of personal development in the private sector is purely down to money, because obviously if you're on a course you [will] not only have to pay for the course, but you lose a day's pay. So it's a double whammy. (stakeholder, interview)

Poor or infrequent supervision

I can think of a situation this year where someone has basically had a sort of a breakdown at work and caused an issue with a patient, it was a very minor thing …but she'd been obviously… upset for quite a number of months before that and they hadn't really gone through occupational health with her… If they had done and put more processes in place to support her then her critical issues wouldn't really have ever occurred. (stakeholder, interview)

She was on a steep learning curve as far as these complex patients were concerned and matters were not helped by the sporadic, confused and unfocused nature of the support and supervision which she received from the Trust. (registrant evidence, case review)

What will often happen is people will be allowed to make mistake after mistake after mistake and nothing will be done about it. Nobody will engage with them and say, hold on here. You know, it will be overlooked so when it becomes suddenly a huge mistake… (stakeholder, interview)

Yeah, I think early identification of small issues, and certainly quite often small things are

unrecognised by the individual until they become big and that's where the airline have the use of checklists, the use of procedures and so on down to an absolute T… I sometimes think that lacks a little bit in the paramedic profession. (stakeholder, interview)

Poor management

I was always open and honest about the stresses at home but aware that there was nothing we could really do about them. At no time however did my manager sit down with me to review my workload or ask me if I was coping with my work given the pressure they knew I was under at home. (registrant evidence, case review)

No concerns were raised by my managers whenever I requested leave and I just tried to cope with everything, as I felt sympathy was lacking by this point. (registrant evidence, case review)

If you're in a team and there's bullying… [or a] management style that isn't supportive, [which] is more …suppressive of innovation, then that will make people feel undervalued. (registrant, focus group)

I think you can have weak managers in the same way you can have weak clinicians, that get focused on an objective and actually lose sight of what's happening day-to-day. (stakeholder, interview)

Yeah, there are certainly occasions where [practitioners are disciplined too soon], now sometimes it's a personality issue or there's a breakdown in relationships, but sometimes it's just there isn't somebody in post who can think of a different way of managing a situation. (stakeholder, interview)

Dysfunctional relationships (at work)

Is there a fear of reprisal if you do raise your hand and say this isn't safe or competent practice? (registrant, focus group)

There's a lot of restructuring within health and social care and I'm just thinking of some examples we've had recently where there is sort of a temporary disengagement especially with the employer where people's terms and conditions of work are either threatened or changed, and it's as if they, it's as if, I suppose they're still engaged, but they're engaged antagonistically or they're engaged in terms of they feel hurt because something that they had, that they were secure within has been changed or shifted. (stakeholder, interview)

We tend to hear of situations like bullying or when somebody is disruptive within a team so therefore the team dynamics are unhealthy shall we say and inevitably then that does affect somebody's work. (stakeholder, interview)

If you had a poor relationship with your colleagues then again that could create isolation… within your department that you work and it may limit that sharing of skills [and] knowledge between the team. (stakeholder, interview)

Staff were completely used to doing what they wanted… they were a team that were used to getting their own way and didn't like to be challenged. (registrant, focus group)

Personal circumstances (bereavement, divorce or financial pressures)

I was also under stress due to personal circumstances at that time. My ex-husband came round to tell me I had to sell the marital home… It was very stressful having buyers round, looking at other houses and contemplating moving into rented accommodation. (registrant evidence, case review)

She had an accident at work... It was a near fatal accident and she suffered from post-traumatic anxiety disorder and that's during the period where she is having to complete this portfolio… (witness evidence, case review)

At that particular time I was under a lot of pressure from three simultaneous major life events: partner being diagnosed with cancer, being treated and informed that [the] cancer was terminal; moving house and location as well as starting a new job. (registrant evidence, case review)

I think we often find when people are struggling at work… there are often elements elsewhere that are affecting their struggle at work, so it may be that there's issues at home, it may be that there's health issue and inevitably when there are too many stresses then performance goes downhill. (stakeholder, interview)

Poor support from head office and my worsening health all contributed to the events that followed. My need to support my child who had just been diagnosed with [a condition] was paramount and led to my focus being on little else. Nothing else seemed important. (registrant evidence, case review)

Blame culture

Well there can be quite a large blame culture of certain employers which is, you know, they're immediately thinking of… are we going to get sued for that, are we going to get sued for that, do we need to discipline them and make an example of them and I think, you know, sometimes that's justified, but sometimes people are treated in a punitive way where really, you know, there needs to be a bit more of a constructive approach particularly taken early on. (stakeholder, interview)

The bullying type of management culture in the NHS… stops people being as open and honest as we would want them to be, and I suppose if we wanted to have an aspiration it would be to be like the airline where they have a culture of open, honesty and putting their complaints on the table. It's not like a no blame culture because you can never really have a no blame culture. If you've done something wrong you need to take the blame for that, but they

worked really hard to get themselves on that openness. (stakeholder, interview)

Preventing problems in health and care

Being valued

If your work's not valued or you feel that… your work's not valued then it could, you could feel not as supported as others. It could be demoralising. (stakeholder, interview)

On the professional side of things you need to feel that you're valued or that you're recognised in your work, and again that could be down to rewards from your employer or based on just a discussion from your line manager or your personal development review that you're actually meeting your goals and targets you set out to achieve. (stakeholder interview)

I mean a lot of [being engaged] is about feeling valued… and that's from your employer but also the people that you're delivering a service to. (stakeholder, interview)

It will also be whether they feel valued in what they're doing, both by the patients and how they respond to them but also by their employer. (stakeholder, interview)

I think that's very important, and I don't think that always happens… I don't think there's always a culture of positive reinforcement, positive acknowledgement of the value and worth of somebody who is doing a very skilled job…and if that isn't heard then they could feel disengaged. (stakeholder, interview)

Good team dynamics

Engagement is likely to happen when people have got clarity of their own objectives and understand what the organisation is trying to achieve, a good team setting and good management and leadership. So all of those things will support engagement. (stakeholder, interview)

If there's a team you're asked "How do you think this treatment is going to help patients or how shall we implement this service?" And they feel part of the process rather than being turned round and told "Right from now on you're just going to treat in this way and you've got no voice in the matter. (stakeholder, interview)

I think if you feel that the manager has at least listened to you and your colleagues' point of view and have taken that into account then again you feel more engaged with work and with how you're being treated at work and then I think you reflect that then within the way you work. (stakeholder, interview)

[Engagement is] also working as part of a wider team to say, "Well, if we're all in it together, how do we actually make this work as a team?", because, you know, the workforce is beyond just the speech therapy profession. (stakeholder, interview)

One of the things it's important to underpin [in] your competency is decision support and it's very much about trying to say that we're part of the health team you know, paramedics that work in GP surgeries are very well supported on their decision making and they can refer back to someone when something is out with their experience. (registrant, focus group)

Good supervision

For example we do have a principle social worker for adult services and she has a competency framework and managers can choose to use that in supervision if they wish. (stakeholder, interview)

So if there's a proper management or supervision arrangement in place then these things should be picked up sooner rather than later. And one of the objectives of good management and supervision is to identify early issues and… stop them getting worse. (stakeholder, interview)

We also push for professional support in some way, supervision is very strong within occupational therapy and especially where somebody is a relatively new practitioner going into perhaps a diverse role or a lone working situation we will encourage them to seek professional support. (stakeholder, interview)

I think support structures and having infrastructure where they know they can go to for different types of supervision, whether that's clinical, [or] whether that's peer support and mentoring. (stakeholder, interview)

I mean that's part of what clinical supervision is for, and management supervision is for too, so you would hope you might be able to pick [slips in competence] up through either or both of those. (registrant, focus group)

I think it's vital, if you've got support from your line manager then you're going to feel confident about going out and doing your job, and there is a huge variety in the competence level of line managers across the NHS. (registrant, focus group)

Regular appraisal and performance management

I think the professional planning for your PDR helps to motivate professionals to achieve more or improve their skills and knowledge. (stakeholder, interview)

They should begin to pick up on issues [that might suggest a slip in competence] if they're doing proper robust professional development reviews. (stakeholder, interview)

Line managers should undertake regular supervision which would discuss clinical performance, again, that is very patchy in terms of it actually happening and so it varies. (registrant, interview)

Without [competency frameworks] you haven't got benchmarks and you haven't got a consistent standard that you apply to all of

your staff. So for me it's about consistency of standards, consistency of expectations, and fair treatment of staff, because they're all judged against the same background framework. (stakeholder, interview)

Buddying schemes, mentoring and preceptorship

I think they need support in their decision making. They need to have a culture where they can walk in and talk to a mentor or someone to go, "I'm struggling a bit", and they need to know that when action is taken on that where they're struggling, that is supportive and beneficial rather than punitive. (stakeholder, interview)

I think there's two types in my experience, there's formal mentoring which students and so on have, but there's also an informal type that goes on where they'll be people on your station or in the area where you work who are natural mentors, naturally experienced in you know, help and support. Paramedics are really good at supporting each other and the mess room culture is really quite important in that. (stakeholder, interview)

[When a mistake has been made] sending someone on a course is not necessarily the best thing for that person, it may be that they need to do some sort of shadowing or mentoring. (witness statement, case review)

Mentoring, partnering, practice supervision between individuals, there's one or two places where a few maybe getting together to provide career structure and to work together on particular projects you know, so there's different things [freelance practitioner groups are] putting in place. (stakeholder, interview)

I think peer support networks are really successful in making that type of thing happen, and I think the professional body has a role in setting up some networks that will provide that level of support. (stakeholder, interview)

Team building exercises

Having team building exercises every so often could help [with engagement], within departments or across the departments. (stakeholder, interview)

Professional networks

Now what we always suggest is that lone workers find some kind of link into others either in their field or in their region, in the locality. It's something we push very much for. (stakeholder, interview)

By interacting with other professionals it offers an opportunity to share certain new skills and knowledge between professionals. (registrant, focus group)

We're trying to strengthen those professional networks and engagements as far as we possibly can. (stakeholder interview)

Reflective practice

I wouldn't necessarily want to see someone having to be tested all the time, but you could get them to do a reflective log. They should be showing [their continued competency]. (stakeholder, interview)

Well, [competence is] understanding how their knowledge, skills and experience links to the job that they are doing and their scope of practice, and being self-reflective and aware of if they have gaps in any of that. (stakeholder, interview)

Self-awareness

We expect employers to support us in achieving our CPD, but it's our responsibility to make sure that we identify our needs. (registrant, focus group)

Because competency requires you to be continually learning, and it requires you to be alert to where the gaps might be and where the new things to learn might be. Engagement is about being awake to those things. (stakeholder, interview)

Because jobs are very difficult to get in the NHS, and I think it's certainly... since 2006 it has been, [we've] had a lot of newly qualified literally going into setting up their own practice and taking whatever patients walked through the door, with not necessarily understanding their own personal scope of work. (stakeholder, interview)

Keeping up to date

It's not just going in and doing the same thing on a daily basis. It's taking an interest outside of your immediate work environment. So what's the strategic environment in which you're working, what's new within your profession. So reading your magazines, the journals, being aware when new guidance is published, engaging in debate and discussion with your colleagues, reflecting on your own practice and looking to see, you know, where you might need to improve. So it's a number of different indicators that would show to me that somebody's engaged. (stakeholder, interview)

People who work independently of organisations tend to take their professional development and updated knowledge much more seriously because of the risk of becoming disengaged from mainstream practice. (stakeholder interviews)

It's no good just going on a course, doing the course or… getting qualified and then thinking that's it, that's the end of the process, because you soon forget what they've taught you on a course unless you're doing it all the time… So you still need to have that further engagement with either other people or reading around… to then keep on top of that information and reminding yourself why you're doing it and what you're doing it for, to keep that learning going and those competencies going. (stakeholder, interview)

No blame culture

I mean, again having no-blame... The message needs to get out to people that, you know, everybody makes mistakes… We all sometimes have off days… and encouraging people to be open about that [because] people's registration becomes more at risk, not because of the actual incident, but because of how they've behaved after it… If you've got an employer that is a very punitive… and people are afraid to admit to something they might have done wrong, then they're going to try and bury it, and that's going to cause more problems. So I think you've got to have a culture of openness and move away from the sort of blame game that a lot of employers like to play. (stakeholder, interview)

Notes

Preventing small problems from becoming big problems in health and care

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