Perspectives on a Common Code of Conduct for Health and Care Professionals

Qualitative Research Report

For the Professional Standards Authority for Health and Social Care

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Section 1: Executive Summary

Introduction

This exploratory qualitative research project has been commissioned as part of a scoping exercise for the Professional Standards Authority for Health and Social Care to explore perceptions, benefits and risks associated with a common code of conduct for health and care professionals. The sample was divided into two broad audiences: a cohort of the general public and users of health and care services which included patients, service users and carers across a wide variety of NHS and non-NHS services; a cohort of professionals across regulated roles, the accredited registers[1] and a small sample of non-clinical senior managers. For each audience the context and mindset that frames attitudes is examined, and then the three tiers of the concept are explored individually: the idea of a common code of conduct across regulated professionals, the extension to practitioners on accredited registers and finally to non-clinical senior managers. It is important to note that the concept of a common code was kept purposefully broad for this research, and did not define technical aspects of how it might work in practice or across the individual professions. Stimulus used within the research is shown within Appendix A[2].

Key Findings:

Context

The general public and users of health and care services typically approach the subject of codes of conduct across health and care professionals with the broad assumption that anyone working in health and care is registered or regulated in order to be allowed to practise, and therefore will be working to a code of conduct that sets out expectations of professional behaviour and clinical standards.

Across the general public and users of health and care services there is a lack of concrete understanding about how codes of conduct work, with assumptions that there might be an overarching code of conduct with common standards set by the NHS or at a Trust/setting level for all employees, or alternatively, or alongside this, different codes of conduct to allow for professional differences, set by professional bodies[3] or employers. There is a general expectation that codes of conduct would be relatively similar across professions albeit with nuances to reflect the different professional roles.

Regulated professionals, and practitioners on accredited registers, see their codes of conduct as important both to them as professionals and to their patients / those in their care and maintain that they are embedded in their practice rather than a document that is referred to day to day. They rarely consider other professions' codes, but expect that they are likely to

[1] https://www.professionalstandards.org.uk/what-we-do/accredited-registers/about-accredited-registers

[2] Examples of stimulus used, and an example discussion guide are included as appendices

[3] This is a broad term used to cover professional bodies, accredited registers or statutory regulators according to participant understanding

be relatively similar given the fact that they are all patient facing, but with important differences tailored to each profession, set by their professional body that understands their practice, roles and responsibilities. There are some reflections that suggest there may be some variability in the stringency of application of codes, and that some codes may not be considered likely to be as robust as others.

The public, users of health and care services and professionals are united in their discomfort that there are patient facing practitioners working in health and care who are not regulated or registered with a professional body and therefore do not necessarily have a code of conduct. This highlights the risks of variable practice, a lack of professionalism and no accountability. There are a range of views as to whether non-clinical senior managers within health and care settings should follow a code of conduct, and this is often linked to a desire to see true accountability in the case of mistakes.

Responses to the idea of a common code across regulated professions, practitioners on accredited registers and non-clinical senior managers

The research demonstrates there is a variable response to the idea of a common code of conduct considering all three tiers of the concept. Whilst responses at a spontaneous level can be positive, and participants across audiences can identify several potential benefits of improved consistency, there are some key concerns that emerge around the challenges of bringing together such a wide cohort of professionals under one common code. There is significant commonality in the themes raised, with variable strength of feeling and depth of understanding according to experience and role.

Typically the general public audiences are most positive overall, seeing the concept at a relatively simplistic level, whilst the users of health and care services cohort are more able to identify potential concerns given their broader experience of health and care. The professional audience are able to reflect on both potential strengths and weaknesses of the concept and their overall attitude depends on whether they view it through the lens of consistency, or the lens of difference – i.e. do they approach the concept initially considering the benefits of consistency, or having concerns about the challenges of bringing together such diverse professions. Ultimately, most participants reflect that without knowing in detail the content of codes, and how a common code would work in practice, they are unable to confidently appraise the idea, but assume that any common code would have to allow for important nuance and differences across professions.

The perceived benefits of the concept centre on consistency and everyone 'singing from the same hymn sheet'. This is perceived as potentially having patient-centred benefits in terms of improving broad standards of behaviour across all professions, providing users of health and care services with confidence that they will experience the same standards of behaviour wherever they go, which is hoped to ultimately deliver improved user experience and safety. When applied to practitioners on accredited registers, and some less well-known regulated professions, it is hoped that sharing a code of conduct will improve levels of trust and respect both from a patient and fellow practitioner perspective and potentially standards of

behaviour or care. Transparency is seen as a further benefit, particularly from a patient/service user perspective, but also across professionals – it is considered likely to be easier to identify when behaviour does not meet expected standards. This potentially could give patients/service users more confidence in complaining, and professionals more confidence in whistleblowing.

Having a common code is seen as potentially having a positive impact on workplace culture more broadly, particularly with multi-disciplinary teams working together, encouraging better communication, collaboration and common goals rather than a more siloed way of working. Whilst participants rarely specifically mention a common code impacting directly on equality, diversity and inclusion (EDI), EDI is seen as part of a more respectful, positive culture. Having common standards and therefore standardised behaviour can also be linked to equality in terms of treatment of service users.

Stimulus was shown to participants illustrating differences in wording on similar subject matter across different codes of conduct, and also providing an example of a Joint Statement signed by the statutory regulators[4]. Responses highlight how the professional audiences are engaged by the differences in wording across different codes, not having fully considered this before. Whilst the sentiment of the regulations is seen to be the same, the audience recognises that differences in wording can lead to grey areas e.g. should 'v' must are tonally different, and they can agree that if possible this would be better avoided. They welcome the clarity and communal position of the Joint Statements although most were unaware they existed.

Specifically considering the inclusion of non-clinical managerial staff, it is hoped that a common code could drive more of a focus on patient experience, safety and improve culture within the NHS, with all members of staff having the same shared focus.

Certain themes to be included in a common code of conduct appear relevant across the three tiers of the concept including standard professional behaviours that would be expected in any role (e.g. respect, not discriminating, good communication, integrity, honesty, candour) and behaviours linked to health and care and regulations (patient safety culture, GDPR, patient confidentiality and acting in the best interest of the patient).

The key challenge and concern that emerges across the sample is how to create a common code across the multiple and diverse professions that could be included. This concern strengthens as the concept moves to include practitioners on accredited registers, particularly considering roles that are felt to be furthest away from highly qualified 'medical' professions [5], and then moves to include the non-clinical senior managers. Whilst all audiences can reflect that there are some common professional behaviours there are two

[4] See stimulus in Appendix A

[5] Across the research it emerged that some roles were perceived as being more 'medical or clinical' i.e. with more clinical significance within the patient's medical journey based on factors such as length of time taken to be qualified, level of responsibility and potential impact on patient. These included roles such as, but not limited to, doctors, nurses, dentists, clinical psychologists.

issues that arise. Firstly, it is difficult to decouple conduct/behaviours from clinical interactions considering the varying levels of responsibility, contact with patients/service users, risk and training, and codes are considered likely to be tailored to the needs of each profession. Secondly, limiting a code to just purely professional behaviours can feel overly simplistic. The key concern is that in the effort to meet the needs of all professions, a common code would either be too generic, open to interpretation and lack meaning, or too stringent for other professions. There is a general perception that, to work, a common code would need to be a set of principles which allows the necessary differences across professions to shine through.

Another key concern that emerges is accountability and how a common code would work in practice. This includes how, or if it would work alongside individual professional codes and bodies, and how it would be overseen. The concern is that without accountability, it would be meaningless. This is particularly raised in relation to non-clinical senior managers who currently are not under any professional regulation and can appear to go unchallenged in a way that professionals who are regulated or on registers cannot. This is also raised in relation to practitioners who choose not to be on professional registers which is seen as a significant problem potentially leading to lower standards and variability, driving a lack of trust and respect in these professions. Arguably even with a common code this problem would still exist for practitioners on an accredited register, unless it was to become obligatory for all practitioners to adhere to it. The idea of a common code can appeal as a way of making these professionals more accountable, but for many, it is the accountability that is the real driver to interest, rather than sharing a code with other health and care professionals.

Another issue raised is potential impact. Professionals comment that their codes of conduct are already good, tailored to their needs and with no obvious weaknesses and that most health and care professionals do their best to stick to them, be professional and work at the highest levels even under significant pressure. This can raise the question of whether a common code would make a sufficient difference to be valuable. Those working in the NHS are mindful of the pressures the NHS is experiencing and can question if a common code would bring about the changes that are needed.

Final important issues identified are ensuring widespread adoption, the need for training, and for the public and users of health and care services to be aware of the code so that they can appreciate the benefits, such as identifying when behaviours do not meet acceptable common standards.

Concluding thoughts

Whilst there is an appreciation of the potential benefits of a common code centred on common professional behaviours that should be applicable to all, differences across professions feel important to professionals. The key challenge surrounds the ability to create a workable code that provides the benefits of consistency but also covers the range of

roles, necessary accountability, and delivers sufficient difference in practice to be perceived as valuable.

If the concept is to be considered further, these are some of the key areas raised by the research that would require further consideration and debate:

- How can a common code work across such a wide range of diverse professions providing the benefits of consistency with meaning and impact?
- How can a common code retain the important differences relevant to each profession's role and patient/service user interactions?
- How would a common code ensure accountability, and work alongside existing codes?
- How would non-clinical senior managers and practitioners that are not accredited be brought in and made accountable?
- How can the public be made aware of the existence of the common code?

Section 2: Background

2.1 Background

The Professional Standards Authority for Health and Social Care ('the PSA') promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and registration of people working in health and care.

The PSA oversees the work of ten statutory bodies that regulate health professionals in the UK and social workers in England. It also sets standards for organisations holding registers for people in unregulated health and care occupations, and accredits those organisations that meet their standards ('accredited registers').

Currently, each regulator and accredited register has its own code of conduct/set of standards, although there are already similarities between them. Following the publication of the report 'Safer care for all', the PSA are scoping the idea of a common code of conduct for health and care professionals. This code may extend to roles covered by the accredited registers, as well as non-clinicians in senior management positions.

To prepare for the wider scoping review in 2024/25, this qualitative research study has been commissioned to seek the views of the public, users of health and care services and registrants, on the potential value, benefits, and risks of introducing a common code of conduct.

2.2 Research Objectives

As a precursor to the forthcoming scoping review, this research aimed to identify the range of attitudes, themes and nuance that is likely to exist on the subject of a common code of conduct, across a very wide audience including the general public, users of health and care services, regulated health and care professionals, accredited practitioners and non-clinical senior managers.

The objectives of this research were to gain the views of the general public, users of health and care services, regulated professionals, accredited practitioners and non-clinical senior managers on the following:

- Levels of awareness and knowledge about codes of conduct and perceptions of the existence of a common code (public and general public/service user audiences)
- How professional codes currently impact on practice (professional/practitioner audiences)
- Responses to the idea of a common code of conduct for health and care professionals on *statutory registers*; considering the value, benefits and risks, particularly for any issues relevant to equality, diversity and inclusion (all audiences)

- Responses to the concept of extending a common code of conduct to health and care practitioners on *accredited registers* and *senior management in health and care* (all audiences)
- Key areas that the common code of conduct may cover

2.3 Research Methodology

The research programme started with a short phase of immersion including a briefing workshop and a separate stimulus development workshop between the PSA and the research team. Subsequently the research team conducted a review of existing research and documentation provided by the PSA.

Following this immersion phase, the research fieldwork was conducted. The research methodology took an iterative approach: after approximately a third of the fieldwork had been completed, emergent findings were shared with the PSA and discussion guides and stimulus were updated slightly to allow for emergent lines of enquiry.

A discussion guide and stimulus pack[6] were developed and used flexibly across the research according to responses of participants and the need to prompt further discussion after spontaneous views were collected. In each of the sessions, a broadly similar approach was taken.

- Research sessions started broadly with an understanding of the participants' context and spontaneous expectations in relation to codes of conduct/professional standards across the health and care landscape
- The sessions then explored prompted responses to how codes of conduct/professional standards work currently
- The concept of a common code of conduct for professionals on the ten statutory registers was introduced, with discussions focusing on participants' spontaneous thoughts on the concept, its strengths and weaknesses and in what ways it might make an impact. As required, participants were prompted with case studies to generate discussion around the concept and a diagram with potential areas where the concept could make an impact: culture, patient safety, equality and diversity, working across multi-disciplinary teams, workforce
- The concept of extending the common code of conduct across accredited registers was introduced, with discussions focusing on spontaneous thoughts as above, before being prompted as needed with further stimulus
- The concept of extending the common code of conduct across non-clinical senior managers in health and care was introduced, with discussions again focusing on spontaneous attitudes before prompting with further stimulus
- Participants were prompted to discuss the potential impact of a common code of conduct on historical high-profile cases including Lucy Letby, Mid-Staffordshire and Shrewsbury and Telford Maternity Services

[6] An example of one of the discussion guides, and extracts from the stimulus pack are included as appendices

- Participants were invited to draw conclusions as to their overall views on the idea of a common code of conduct and how it could work in practice

2.4 Sample Framework

The sample framework for the research was designed to provide breadth as well as depth within categories of interest given the wide scope and nature of both the audience for the research and the research objectives.

2.4.1 General Public and Users of Health and Care Services Sample

Focus groups were considered an appropriate methodology for most of the general public and higher users of health and care services sample, given their dynamic environment conducive to the exchange of views and attitudes.

All focus groups were 1.5 hours in length and held online to allow for a wide geographical sample, and to support inclusion of those who may find attending focus groups in person challenging due to location, health conditions or caring responsibilities.

Two focus groups of 5-6 participants were held with members of the general public who do not have long term health conditions and were not using health and care services particularly frequently (general public): one of these was with participants aged 18-40 and the other with participants aged 40-70.

Six smaller focus groups of 3-4 participants were held with people who have higher usage of health and care services due to their health conditions or caring responsibilities (described in this report as users of health and care services/people who use health and care services). This allowed for multiple sessions with different types of people sharing different types of experiences, but in the comfort of a discussion with like-minded others. These sessions were defined by their type of usage of health and care services including:

- People with long term health conditions that have an impact on their daily lives
- Mothers with children in the home with recent use of services such as maternity services, child services, services for children with special needs
- People who have recently undergone significant treatment e.g. cancer treatment, surgery, eye and dental treatment - in the last 12 months
- People closely involved in the care of an elderly or disabled family member who are therefore interacting frequently with professionals
- People aged 40-65 with conditions such as asthma, diabetes type 1 or type 2, mental health conditions, high blood pressure
- People aged 65 +

In addition, depth interviews were also conducted with participants with particularly sensitive or complex needs who would benefit from a private environment to express

themselves fully. Depth interviews lasted 1 hour each and were held online, with participants offered telephone or face to face interviews if required and to be accompanied if needed. These included people with mental health conditions, people with social worker contact, people with children with a learning disability (Autism, ADHD); people with hearing and sight impairments.

The sampling for the project considered the following issues:

- Frequency of usage of health and care services – including higher and lower frequency users
- Variety of use of health and care services – including a range of users of statutory regulated professions and practitioners on accredited registers
- Satisfaction with services used – including higher, average and lower levels of satisfaction
- Demographic factors including: age/lifestage, social grade, ethnicity, gender and sexual orientation
- Location across all four nations in the United Kingdom biased to England

In total 41 participants were included in the sample.

2.4.2 Health and Social Care Professional Sample

Given the wide range of professionals that are included across the 10 statutory regulators and accredited registers, the sample framework was purposefully designed to provide breadth across roles, levels of experience, working within the NHS and in private practice.

- 27 participants registered with one of the ten statutory regulators were included covering the following roles: GPs, Consultants, Practice, Community and Secondary care nurses, Midwives, Pharmacists and Pharmacy Technicians, Allied Health Professionals (Occupational Therapists, Speech and Language Therapists and Dieticians), Chiropractors, Osteopaths, Social Workers, Optometrists, Dentists
- 8 practitioners on accredited registers were included covering the following roles: Psychotherapists, CBT Therapists, High Intensity Psychological Therapists, Clinical/Oncology Counsellors, Aromatherapists, Acupuncturists
- 4 Non-clinical senior managers working across a diverse range of roles

The sampling for the project considered the following issues:

- Demographic factors including: age/lifestage, social grade, ethnicity, gender and sexual orientation
- Location across all four nations in the United Kingdom
- Working in NHS and private practice

In total 39 participants were included in the sample.

2.5 Research Ethics

This research project was carried out according to the Market Research Society's Code of Conduct and Ethics (www.mrs.org.uk/standards/code-of-conduct). The Code of Conduct was applied to all areas of the project.

Recruitment of all research participants was conducted in accordance with Market Research Society's Code of Conduct using a market research recruitment agency. All participants gave informed consent to participate and in line with standard market research practice were given a financial incentive as a thank you for their time.

2.6 Research Limitations and Considerations

Qualitative approaches are open and discursive in their exploration of project objective areas and allow for an in-depth examination of attitudes. Qualitative samples are purposive and quota-driven in nature; they are designed to reflect the range of audiences of interest to a study. They therefore do not have quantitative accuracy in terms of identifying proportions of populations holding stated views, but hold significant value in terms of understanding the depth and breadth of an audience's attitudes, feelings and beliefs. For these methodological reasons, it is not appropriate to present qualitative findings in terms of the numbers of participants expressing certain views, and the results are provided thematically with supporting verbatims.

Given the wide range of the public, users of health and care services and health and care professionals included across the research, the sample is purposefully broad and therefore attitudes are not able to be reported by sub-samples – for example profession, location or type of health condition. This is a function of the nature of the research, which was a scoping exercise and therefore required the coverage of a wide range of different participants to explore the types of responses that may occur.

Research participants were asked to discuss an abstract concept without concrete boundaries that outlined how a common code would work, or what it would contain. Stimulus was used to help them imagine how a common code might make them feel and what impact it might have on them. The research therefore provides a good understanding of participants' immediate instinctive reactions to a broad concept and what they would hope the benefits could be, and also what the concerns and watch-outs would be. Further research would be required to test concepts of how the code could work in practice given different definitive models.

2.7 Report Structure and Terminology

The following report provides a detailed review of the concept from the perspective of both the general public/users of health and care services, and professional audiences. Although

there is much commonality in opinion, there is also nuance and difference and therefore the report is structured to allow a detailed understanding of both perspectives.

Note on Terminology Used:

Accredited practitioners/practitioners on accredited registers	This term is used for practitioners on registers accredited by the PSA (accredited registers)
AHP	Allied Health Professional
EDI	Equality, diversity and inclusion
General public/general public sample:	This term is used to identify participants who were average users of health and care services and did not have long term health conditions
Users of health and care services/people who use health and care services	This term is used to identify participants who are higher than average users of health and care services in the sample
MDT:	Multi-disciplinary Team
Patients:	Patients is often used as a common term for all types of users of health and care services
Professionals/ Health and Care Professionals:	This term is used as a common term for the research sample of professionals working in health and care including regulated professionals, practitioners on accredited registers and non-clinical senior managers; it is also used as a common term encompassing people working in health and care across accredited registers, regulated roles and non-registered roles.
Professional Body:	Used as a common term to encompass professional bodies, regulators and accredited registers

PSA:	Professional Standards Authority for Health and Social Care

We would like to thank all those participants who gave their time to contribute to this research project and for the thoughtful insight they shared with us.

Section 3: Context and Perspectives on Codes of Conduct

3.1 Observations on General Public and Users of Health and Care Sample

The research sample, with its broad inclusion of both general public and users of health and care services covered a wide range of health-related experiences and usage of services. The general public sample were less-heavy users of health and care services than the user cohort, who reported high levels of interactions across a wide range of providers reflecting their care responsibilities, long term health conditions and complex medical histories. The sample overall reported contacts across a wide range of different regulated health and care professionals, primarily NHS and some private professionals, primary care, acute settings, mental health services, maternity and children's services, dentistry, and social services as well as services covered by the accredited registers.

Levels of satisfaction in the care and experience they had received from health and care providers varied across the sample, but many were appreciative of the overall care and support they had received. Accurate information and communication were valued by those with complex health conditions in the sample, as they were often seeing a number of professionals at any one time and the importance of good communication and smooth handovers was more noticeable to them. Some were less satisfied with specific elements, and in a few cases had raised formal concerns or complaints via PALs, GP practices or other routes. Others, when disappointed with services, had resorted to simply changing provider in the hope of securing improved care rather than raising a complaint. There were also examples within the sample of users of health and care services who had been unhappy with elements of the care they had received, but had not raised concerns, finding the process too complicated or difficult, or they had decided that there was no point in doing so.

Where dissatisfaction was noted, the main themes raised covered: inconsistent levels of care, lack of a personal touch, the perception that they were not being listened to and were being rushed, concerns about care of the elderly, lack of transfer of information and poor communication across health care professionals and departments. There were also comments about delays in getting appointments and treatment with some having experienced multiple cancellations. Dentistry in particular was highlighted as problematic, with difficulties accessing it and escalating costs of treatment when they had been seen. These concerns being top of mind can lead some to question later in discussions how or if a common code could potentially impact on some of these more systemic issues.

3.1.1 Spontaneous Understanding and Expectations of Codes of Conduct across Health and Care Professionals

The public and users of health and care services were asked to share their understanding of what 'codes of conduct/professional standards' meant to them within the context of health

and care services, including what their expectations were of how codes of conduct worked and what they covered.

It was clear that the subject was not one that most participants had thought about in detail before, and therefore they had very little concrete knowledge and understanding of how codes of conduct work, with expectations based mainly on assumptions. Users of health and care services typically appeared to have a better understanding, even if not based on concrete knowledge.

A small number in the sample demonstrated a good understanding of codes of conduct, typically those who had complained or who had experienced much more contact with a variety of professionals due to their underlying health issues. These participants also found it easier to talk more clearly about professional standards/codes by referencing other bodies with whom they had had contact. A small number of participants across the research had direct experience of referring to a specific practitioner's code of conduct. In these cases, they had done so either to familiarise themselves with it or to use it to raise a complaint and be clear about the specific details outlined in the code around a particular topic. Other participants reflected that the context of their own job and employer, particularly if they worked for an organisation with a governing framework, had given them a better understanding of codes of conduct overall.

I have put in a complaint, and I put a lot of effort into it and looked up the individual codes of the professional groups to make my case stronger. I wanted to give clear examples and had to go through the process. User of health and care services: mothers with children in the home

The term 'code of conduct' was consistently understood as referring to a set of standards or rules that set out expectations around professional behaviour. They were considered to be a *minimum standard* that one could expect from a practitioner. It was expected that they would also include sufficient detail to allow complaint raising when it was felt that standards fell short and were not met.

I see a code of conduct as a set of rules that outlines the rules, responsibilities and the proper practices of an individual or a group of people within any organisation. User of health and care services: long term health conditions aged up to 65

Although few participants had had cause to refer to a code of conduct, most had expectations of what they imagined they would include which were very much in line with what the professionals equally knew (or thought) was included. When discussing expectations of what codes would cover, there was a clear crossover between behaviours and clinical practice. The key themes raised spontaneously across the sample included: behaving professionally and ethically, acting with integrity, maintaining confidentiality/GDPR/data protection, safeguarding, treating others with respect and dignity, communication and standards of training and clinical practice. It was presumed that a code would cover patient safety including clinical standards, not stepping outside of clinical roles

and some level of accountability/what to do when things go wrong. When participants were shown a range of topic areas within the stimulus, that might be included in any code of conduct this fitted well with their expectations and what they thought was relevant to include.

In terms of who would be covered by a code of conduct, the general public and users of health and care services typically felt that all health and care practitioners would, and should, have a code of conduct/set of professional standards that they must abide by. This was assumed to be a prerequisite of working in a healthcare setting and being professionally qualified to practise.

Discussions about how codes of conduct work across health and care professionals revealed a lack of concrete understanding, and their expectations were largely driven by a number of assumptions. Some more knowledgeable participants were clear that codes of conduct were set by professional bodies. They reflected on how the health and care landscape is complex with a range of professional bodies, regulators, unions and also bodies such as the CQC and NICE, as well as the NHS and individual Trusts, which may all have set their own standards and codes. Others in the sample were less specific in their understanding assuming different codes across professional groups, but at the same time the potential for commonality across organisations.

There was often an expectation that there was an overarching code for all NHS employees and potentially a Trust led/GP Practice code as well.

I'm sort of thinking that when they've gone through all their training and, you know, passed all their exams and things like that…. and they get offered a job, there'd be contracts that they need to sign with codes of conduct that they'd sign… I would assume NHS, charity, private and self-employed are all governed totally differently to each other. User of health and care services: health conditions aged 40-65

However, others reflected that either in addition, or instead of this commonality, there would be different codes of conduct across professionals either set by their professional body or built into their job description.

I would think they'd each have their own specific code of conduct: one for dentists, acupuncturists will do their own thing, etc. To my mind they're not all covered under the same banner…. a CBT practitioner will have a different code of conduct in regard to confidentiality that you wouldn't have with a dentist. General Public, 40-70, C2DE

I'm not sure if it's split, so doctors have their own code of conduct, nurses have their own, and then all the others, the domestics and all the other roles have their own different, separate, codes of conduct. So, they all have one but they're all slightly different because their jobs are slightly different. General Public, 40-70, C2DE

So, there'll be nuances for certain streams of people, I guess, but stemming from an overall umbrella code of conduct which is expected of everyone. I'd imagine that the NHS has a massive one for everyone, then if there are certain other things that only certain people are responsible for then they'll be taught their own little bits. General Public, 18-40, BC1C2

Discussions revealed that there can be different expectations of conduct according to clinical role, levels of decision making and risk associated with decision making. Consideration was therefore given to the fact an overarching code within an organisation (such as the NHS) could allow for individual differences and nuances per role, but give basic standards of behaviours.

I assume within the NHS they have the same professional standards but I assume that consultants or someone high up are held more accountable for their behaviour and actions, higher up food chain, the more you get paid, therefore more responsibility you have…. after all, some roles have higher consequences. User of health and care services: social worker contact

I would assume that the codes would differ to reflect different levels of responsibility, ethical priorities, levels of patient interaction and their different roles and responsibilities and that it would be best practice to follow their own professional code as well as a code of conduct. User of health and care services: mental health condition

When considering professionals not working in NHS settings, assumptions were that there would be a code of conduct set by the workplace and embedded in their job description, or by their professional body linked to their ability to practise. Some drew a distinction between conduct within NHS and private settings and how expectations might be different.

*[*Discussing Private Care Homes*] I think they have a code of conduct to follow, there must be a regulating body or something. You'd like to think they were following a code of conduct set by someone else higher up, an organisation or whatever.* General Public, 18-40, BC1C2

3.1.2 The Regulatory Landscape and Codes of Conduct

Following discussions about spontaneous expectations of codes of conduct, participants were shown a diagram outlining the regulatory landscape across the health and care sector and this was helpful in establishing perceptions and understanding of the sector. Initial discussion highlighted that terminology such as registration, accreditation and regulation was often used interchangeably and it was not always clear what each term meant to participants, although there was a broad belief that anyone working in health and care would be registered/regulated in some way, and this drives their expectation that they are working to a code of conduct.

On prompting with information about how codes of conduct work across professional bodies, the fact that each regulator or accredited register has its own code of conduct

was not in reality considered particularly problematic and could be seen as sensible given their different roles and levels of expertise.

Although some participants were surprised to find out there was no common 'overarching code' across the professions covered by the NHS as they had anticipated, there was a broad expectation that codes of conduct across professions (both regulated and on accredited registers) would probably be similar, in line with the types of themes they had discussed, with appropriate differences according to role.

I thought everyone would follow a similar one and then branch off in different directions with a bit more added to it, but I did think there would be a standardised one. General Public, 18-40, BC1C2

Expect all the codes to be very similar, even if some of the specifics are slightly different. User of health and care services: mothers with children in the home

The bigger issue for many was the lack of registration/regulation, and in turn, code of conduct, for some health and care workers as there was a general assumption that everyone working in health and care roles would be under some form of regulation/registration to be allowed to practise.

Many across the sample were unaware of the optional basis to join an accredited register for some practitioner groups. Those working in mental health such as counsellors, psychoanalysts and child psychotherapists, were all typically seen as working with vulnerable people; the idea that they might not be registered was often described as concerning. Similarly, there was surprise and concern that roles that had physical contact with patients, and particularly where the impact of a mistake could have serious consequences for an individual, such as non-surgical cosmetic practices, did not have to be in some way registered or regulated as this could mean providers might not be held to account if something went wrong.

I think some of this is a bit concerning, counsellors can choose whether to be under a code of conduct or not. That's something in particular where clients can be taken advantage of, even cosmetic practitioners, because that can also be very damaging, so maybe I'm thinking about it too much but it's a bit concerning. General Public, 18-40, BC1C2

Most in the sample were also unaware of the fact that some clinical roles such as healthcare assistants (HCAs) were not regulated as a profession at all. This could lead to some concern, as these roles were assumed to have a considerable emphasis on hands-on, direct care of patients.

There is no overall body keeping HCAs on track and ensuring that they keep to standards, and that is worrying. User of health and care services: hearing impairment

The lack of registration/regulation of some professionals within the NHS raised questions about accountability and standards, although the common conjecture that there would be some NHS or Trust code in place was reassuring at some level.

Most in the sample had not really considered codes of conduct relating to non-clinical staff in any detail. Whilst some participants felt that anyone working in health and care had a duty of care to patients and should share common professional behaviours with their clinical colleagues which suggested regulation/registration was important, others assumed that given the lack of direct patient responsibility, there was less requirement for these roles to be regulated in the same way as clinical roles. Expectations were therefore that they would have some sort of code of conduct set by their employer or workplace for example the NHS, or their Trust, and encapsulated within their job description.

3.1.3 Response to Differences in Codes of Conduct across Professional Bodies

Stimulus which illustrated differences between a range of regulators' codes of conduct on a specific topic was useful in creating debate about the differences and the impact this might have. There were two different perspectives expressed.

For some participants the differences between the codes were seen as potentially problematic as it could lead to grey areas and ambiguity. This in turn had the potential in their view to lead to differences in how a situation might be interpreted; to different outcomes of complaints and variances in how any complaints might be treated. This grey area, in their view, had the potential to lead to less willingness to complain either on the part of patients to staff or staff to staff – it was considered potentially harder to identify if a code had been broken, and also harder to challenge if wording was different across the individual regulators.

They should all be consistent. You might need to understand the differences if you are going to complain and it complicates things having so many different versions, but I am not sure it would lead to a different outcome. User of health and care services: mental health condition

There needs to be one standard across the board – standardisation is very appealing given overall complexity of the roles. User of health and care services: recently undergone treatment

As a patient, I'd want something very clear and concise, not leaving anyone out, not leaving any details out. It needs to be clearly understood for both colleagues, patients, anyone that comes into the practice or building or whatever, there should be no discriminatory behaviour against them and it should be challenged if there is. I don't know. I'd want to see a clear-cut definition, just in case something ever happened. General Public, 18-40, BC1C2

The alternative perspective expressed was that these differences were not significant, being more semantic and about wording, and that the codes were all aiming to express and achieve the same behaviours overall. Participants who expressed this view were less likely to

be concerned that these differences would ultimately lead to different outcomes in complaints. Sometimes these differences were seen to reflect positively on the specific roles of individual professionals: for example, they appreciated the subtle tonal difference of nurses being 'advocates', and saw this as consistent with their role. Participants also noted however that any code would be open to personal interpretation and inference.

I suspect that even with slight wording differences, it will have same outcome in the end. I do feel it's down to the complaint procedure and how it is escalated in the system and the process itself, rather than the actual words themselves, but I am not convinced that it really matters. User of health and care services: aged over 65

3.2 Health and Care Professional Sample

3.2.1 Observations on Health and Care Professionals Sample

Overall, health and care professionals expressed different levels of satisfaction with their current role with some of those working in the NHS highlighting concerns about the pressures due to lack of funds, shortage of staff and other resources. Some participants returned to this theme more strongly in the latter stages of the interview, particularly when discussing the value of a common code of behaviour in the light of other issues faced.

Most health and care professionals in the sample felt that they were working in supportive and collaborative environments, which was vital as those working in larger teams felt dependent on their colleagues for practical and emotional support. They placed a premium on empathy, good communication, civility and a smooth flow of accurate information.

Everyone is looked at on a par. You come in, you have your voice, your opinion matters, nothing's off the table for discussion… some places are very doctor led, out in the community it was very much the nurses who had the voice. Regulated Professional: AHP

Despite mostly positive experiences working within teams, some participants noted elements of personality or professional clashes, some of which related to perceptions of unspoken hierarchies or challenges in dispute resolution as professionals approach situations from their own lens and skill set. Hierarchy was noted by some AHPs and practitioners on the accredited registers who commented that more established traditional medical professions could at times look down on more complementary therapies, due to a lack of understanding of the training and outcomes they could achieve, and also due to the fact that they are not regulated.

I think the perception from some medical people is that you are just a little beauty therapist. Accredited Register: Aromatherapist

I think it really depends on that line of communication, and everyone comes with their skillset and are looking at that person. Like you said earlier, a doctor might look and go,

'Nah, that's Social Care' and Social Care may look and go, 'Actually, I think there's more to it than just social care!', so I think that sometimes people come into it with their hat on.
Accredited Register: CBT Therapist/Psychotherapist

3.2.2 Role of Own Code of Conduct

Most health and care professionals in the sample claimed to be very familiar with their own code of conduct set by their professional regulator or register, even if they were not actually referring to it on a regular basis. As such they admitted to not being aware of nuances and intricacies of their code but understood it to be directed on clinical practice and ethics. For many it was embedded in their training and considered second nature in their working life. Professional codes of conduct were described as important protection for themselves as health and care professionals as well as their patients/service users.

Fundamentally they keep you safe as a practitioner… it's there in the background.
Regulated Professional: Social Worker

I don't look at it very often…. most of it is common sense for a professional person, consent, putting the safety of the person first... if there was a problem, it's the first place I would go.
Regulated Professional: Chiropractor/Osteopath

Participants described how individual codes of conduct were most often consulted during appraisals and the re-accreditation process and were used as a reference point when collating evidence for the process. Communications from their regulatory body could also prompt a professional to review the code. The codes were referenced if they had a concern they wanted to check up on, if a complaint was raised and an investigation had taken place, very much to ascertain whether the complaint was justified and identify on what grounds that was the case. There were some examples shared of referring to their codes of conduct to check on how to deal with a situation that had arisen between colleagues.

I think it's a protective factor and, also, you have to prove every year that you've done all your CPD, your training, your research and all the rest of it. Every five years you're re-accredited and you have to go through quite a long process and write reams of things, so it's something I'm always very aware of, and it's a safety mechanism really.
Accredited Register: CBT Therapist/Psychotherapist

Those professionals who were involved in training or mentoring, interviewing new members of staff, or who were in the process of job seeking themselves were looking at their code more frequently and closely.

I had to look at the code recently as one of the students was going on demonstrations and posting on social media, and we had to check this against the code of conduct as it covers how you behave professionally and personally. Regulated Professionals: Midwives and Nurse

Often during initial discussions about codes of conduct, reference was made by the audience to rules of the (NHS) Trust or setting in which they were working or what was explicitly stated in their job description. Though not confused in their minds, there was a suggestion that there may be a bit of push/pull here and some crossover with their professional body's code of conduct. Non-clinical senior managers also reflected on how regulatory bodies and NHS setting or Trust codes of conduct would work in tandem, with Trust rules focusing more on professional behaviours that were common across all those working in the Trust, and regulator/register codes of conduct focusing more on clinical standards.

For practitioners on accredited registers in private practice, there was some evidence of a code of conduct being perceived as a welcome extra which helped give their profession more status in the eyes of both other professionals as well as clients, by demonstrating that they are being held to good standards. This was significant for those who believed that their profession was not always seen to be 'clinically as important' as professions that were regulated by law. This group saw registration and abiding by a code of conduct as key to good practice and expressed concern that their industry included practitioners who were not accredited in the same way as them.

I just wanted something to basically say I work to these standards… these codes of ethics. Accredited Register: Aromatherapist.

I think some people can set themselves up as counsellors or therapists, which bothers me, and they're not regulated and I will always say, if I'm referring somebody on, to make sure they are in supervision. Accredited Register: CBT Therapist/Psychotherapist

Practitioners on accredited registers believed that having a code of conduct linked to a professional register can give a practitioner more confidence and credibility in their career and in the decisions that they make with patients. Some therapists working in the field of mental health reflected on the importance of their code given they are under constant supervision, although at times others did recognise that their code was maybe not as central to them as for other professions such as nurses.

I think it's (code of conduct) crucial. I supervise people in private practice and I'm really aware of paying a lot of attention to ethics, a lot of attention to diversity, a lot of attention to safe practice, where it's lone working, for example, and who they let into their homes. Because you've got people coming into your homes, I think I'm very aware Accredited Register: CBT Therapist/Psychotherapist

3.2.3 Expectations of Codes of Conduct across Professional Bodies

The professional audience had a good understanding of which professionals were and were not registered or regulated, in line with the diagram shared. As with the public and users of health and care services, there was a general assumption that professionals in health and social care who were regulated or registered would be covered by a code of conduct, and that those working within the NHS would be accredited if not regulated.

In common with the public and people who use health and care services, there was some disquiet (and occasional surprise) about the fact that there was choice as to whether certain professionals could decide whether to become part of an accredited register or not, and that roles such as HCAs were not professionally regulated/accredited. Again, in line with the public and users of health and care services, a concern raised was the lack of accountability for unaccredited practitioners and what this could mean in practice. This point was raised a number of times and created a continuous thread of contention as discussion about a common code was introduced.

You would say to a nurse if you do this wrong you will lose your PIN but with the HCAs there is no threat as they are not regulated so how can they work in the same way? Regulated Professional: Community Nurse

Although most appreciated that non-clinical senior managers within the NHS would not be professionally regulated, they tended to believe that managerial codes of conduct would be very closely tied to their Trust and expectations would be made clear in their job descriptions.

There were no real expressions of surprise when participants were shown the set of conducts and behaviours included in codes of conduct. The list was mostly as expected, with patient safety and the basics of professional behaviours such as record keeping, being accountable, having good communication, not discriminating, maintaining patient confidentiality and working collaboratively considered important aspects. Of note was that the inclusion of 'civility' was sometimes mentioned alongside the importance of good communication within teams. Some additional specifics were occasionally mentioned by particular practitioners such as blood consent, looking after equipment safely (e.g. sharps policy for acupuncturists), hygiene, social media policy and sustainability.

I think anyone working in the clinical setting should be expected to maintain patient confidentiality, maintain trust, work in the best interests of the patient. That's intuitive, and to work in the best interests of the practice, you would expect them to meet some minimum standards. Obviously it's not clinical care but they're dealing with patient data, patient information, accessing patient records, things like that. Regulated Professional: Dentist

Most professionals assumed that each regulator and accredited register would have its own code of conduct and presumed that the codes would cover relatively similar areas and themes, with any differences reflecting the profession and the clinical roles each perform. The fact that the codes of conduct across professions might be different did not raise any particular concerns and participants had not found themselves in situations where this had been an issue to them within clinical practice. However, there was some inference that differences in stringency of application can sometimes be evident – for example nurses were noted as being particularly careful in abiding by their code and were held to particularly high standards with little flexibility by their regulator and therefore they prioritised maintaining

their PIN. Some regulated professionals also reflected on whether all codes of conduct across accredited registers would be as robust as regulators' codes.

Each regulator will tailor their standards and requirements to the individual professions, you've got quite a wide mix on there. Pharmacists, who are involved to a lesser degree than we are and doctors are. Doctors will obviously be examining patients more intimately than we are, obviously we'll be getting a lot closer to patients than pharmacists do, so there's all those variations right across the board there. I think that as long as their standards in their field are maintained then I wouldn't particularly have a problem with them being different to what ours are. Regulated Professional: Dentist

Doctors perhaps get a slightly easier time. If a nurse was to make an error [in dispensing medication] they might be in for a really rough ride. You do see doctors making errors and perhaps they don't get the same criticism or censure. Regulated Professional: Consultant

It does feel slightly different to Nursing because in Nursing we were very aware of the code, it was spoken about a lot and it was referred to as 'The Code'. Yeah, there was almost no getting away from it. In my present role it's there in the background, I think it's probably very similar to Nursing in that sense, maybe worded differently. I've found so far there's not been as much of a reference to it. I'm aware it's there and I'm aware I work under it but it's not as in the forefront. Accredited Register: CBT Therapist/Psychotherapist

I just don't think they would be as robust [reflecting on codes of conduct of accredited registers]….I'd be thinking, because they're not as long standing as lots of the others like the GMC for example, it's that background isn't it to years of experience and trust. Regulated Professional: Social Worker

3.2.4 Response to Differences in Codes of Conduct Examples

It was evident that participants were not already aware of the differences in wording in the codes examined (General Medical Council, General Optical Council, Nursing and Midwifery Council and Health and Care Professions Council) before the research, and when they were examined they were not, on first viewing, thought to be **that** important.

Honestly, probably it doesn't really matter. Regulated Professional: Consultant

For some, the differences noted in wording across the codes of conduct reflected both the different professions they represented, and the level of patient interaction they had, and were therefore justified and correct. They argued that the language used might be indicative of their role – for example, in line with the public/users of health and care services sample the word 'advocacy' was noted as being appropriate for nursing and in line with the style and tone of their behaviour.

However, whilst there was general agreement that the *intended* outcome of the different codes was the same even if the wording was not, the audience did appreciate, on

consideration, the potential for the nuances to create differences in expectations and in actual outcomes. This was a point with which the public/users of health and care services sample agreed, as they too felt that there were potential grey areas that could be problematic. Some professionals also commented that there was perhaps a hierarchy of sorts at play with different regulators judging the same behaviours on different scales. The different use of language between the codes raised some doubt and the wording invited greyer interpretations, and could therefore be subjective.

'You should' is more encouragement whereas 'must' is more dictated and more paternalism… it's black and white… you don't have wiggle room. Regulated Professional: Pharmacist

It makes me think they should all be a certain standard to be fair because it is all down to interpretation… if it's a bit vague and they're all a bit different, it is probably hard for someone to decide what's the best course of action. Regulated Professional: Optometrist

Indirectly the slight differences may give more flexibility than intended and this, they reflected, could be problematic; being *prepared to report* and *reporting* were not seen to be the same thing. Those working in teams might be particularly impacted as they viewed behaviours through their own code's lens and without awareness of the codes others were working to, there was potential for professional disagreements. As the language is different, there were also questions raised about repercussions and how the codes were used in practice.

It can cause the different members of the team from different professions to be looking at things through different lenses, and maybe coming at things with slightly different expectations, accepted practice. So that can cause a little bit of tension sometimes. Regulated Professional: Consultant

You can imagine the way it is worded, some people could get away with things and not be held accountable. Regulated Professionals: Midwives and Nurse

The audience was therefore at times conflicted – whilst they could see rationally that the differences could technically have an impact, and consistency would probably be sensible and beneficial, they were unsure if in reality it would make a significant difference as all the codes had the same sentiment.

Most of the professional sample were unfamiliar with the Joint Statements, but they mostly provoked a positive response as they were perceived as non-hierarchical and not open to misinterpretation. They were seen as a way of streamlining expectations and raising standards across the board.

I think it's interesting… an attempt to kind of streamline things. But I guess there's always going to [be] specifics about individual professions, job roles and responsibilities and the

peculiarities of their work that are going to have to be maybe more explicit, more individualised. Regulated Professional: Consultant

It makes it easier rather than having separate rules for everyone. Regulated Professional: Pharmacy Technician

I'm glad there's a joint statement, at least that's something rather than nothing. That's an attempt at some sort of collaboration or agreement, maybe. Regulated Professional: Optometrist

Section 4: Responses to the Concept of a Common Code of Conduct across Public and Users of Health and Care Services Audiences

4.1. Overall Responses to the Common Code across the 10 Statutory Regulators

Overall, the general public groups responded well to the basic idea of a common code of conduct across all the statutory professions and tended to view it at a broad and straightforward level focusing on the benefits of consistency.

The users of health and care services sample also responded positively overall to the concept and were able to identify associated benefits in more detail based on personal experiences. However, although they often responded positively at first, they were also more able to see some of the potential challenges across the different professional roles and also identified more concerns around the practical application. They therefore appraised the concept with a more critical eye.

Generally, it was the more experienced users of health and care services who posed more questions and concerns about the concept of a common code. Some in the sample ultimately did not think the concept was a good idea and would be too challenging to implement, whilst for others their concerns and the challenges a common code would pose co-existed alongside their positive responses. Some in the sample did not raise any concerns at all and were more consistently positive and accepting of how this might work in practice, being able to anticipate how a common code could work.

A key theme that emerged when discussing the concept was that the public and users of health and care services clearly link behaviours and clinical practice together and they were often unclear of the boundaries of each of these. When reminded to focus more closely on conduct and behaviours, participants found it easier to see the value of commonality – as professional behaviours such as treating others with respect, good communication, not discriminating, maintaining patient confidentiality, and acting with integrity can be seen as relatively commonplace across health and care professionals. It was harder for them to anticipate commonality when behaviours were seen to cross over into patient interactions and clinical practice as that is where different professional roles are seen as likely to have different standards.

4.1.1 Perceived Benefits

Positive responses to the concept were typically based around the benefits of consistency and standardisation of conduct across professionals on the ten statutory regulated registers, who were all seen to share a degree of similarity in terms of some key criteria: being patient facing, medical roles, serious and ‘important’ professions.

At an intuitive level, most agreed that rules on conduct and behaviour should be the same across professions working with patients. In this respect there was strong support for the

idea of them all 'singing from the same hymn sheet' leading to common standards of behaviour across the board.

This was in some ways seen as bringing an element of simplicity so that all professionals would have the same baseline, creating uniformity and consistency which in turn would reduce any doubt or grey areas.

It creates uniformity and reduces any grey areas and doubt. General Public, 40-70, C2DE

It may seem like it will work… I don't see why they can't have a common code of conduct because they all… interact with patients in a certain kind of way, regardless of what type of role they have. So, I think it would be a good idea. User of health and care services: involved in care of elderly or disabled

This is the standard across all roles irrespective of each specific role and I don't think that will be too hard to put this together as it's all about common standards of desired behaviour. User of health and care services: hearing impairment

The perceived benefits of this consistency were noted as applying to both patients and professionals working as colleagues, and across the different health and care professions. Typically, the potential benefits perceived if a common code was working optimally focused on consistent quality of care, improvements to patient care experience and safety, the ability to identify poor behaviour and make complaints, and improvements in culture.

The potential for greater consistency of quality of care and levels of service across professionals and within multi-disciplinary teams was often identified spontaneously. This, in their view, could potentially lead to clearer expectations of behaviours across professionals as well as more cohesiveness, which they thought would be reassuring for both patients and professionals.

The idea of having a set of common goals and behaviours across MDTs was seen as having a potentially beneficial impact on patient experience and safety, as everyone would be delivering to the same (high) standards, with the same levels of communication and sharing of information. This could be very reassuring for patients.

It is actually quite comforting to know that each professional that you're seeing is going to treat you the same way and in the same manner. User of health and care services: long term health conditions aged up to 65

I like the idea of having greater equality of how you are treated for NHS and private and hope that the same practitioners who work across both sectors would treat you the same regardless. It's reassuring to know that as a patient you can expect the same service irrespective of what setting or service or professional you are using. User of health and care services: aged over 65

A case study used within the stimulus material used a scenario where a patient is being cared for by a multi-disciplinary team, and accessing both NHS and private services, all within statutory regulated roles. This was seen as an excellent working example of the benefit of a common code and the impact on MDTs with many feeling able to relate directly to this. The synergy a common code would deliver would negate the risk of 'second guessing' within the team, as all would be jointly responsible and accountable. It was also seen to ensure consistent quality of care and standards across and within NHS and private settings which could potentially improve patient safety and bring them greater reassurance. However others questioned whether in reality there would be any actual difference, given that codes of conduct currently are expected to be of a high standard.

It feels safer to me, you know what you're getting, they're all being held to the same accountability. It feels like a safety in knowing that I'm interacting with this physio and when I go to the pharmacy, I'm going to get the same level of treatment, the same consideration. General Public, 18-40, BC1C2

It was felt that a common code could, in theory, make it easier for patients and professionals to recognise behaviours that did not meet required standards. It could bring differences into focus and might therefore make it more likely that people would feel in a position to complain, knowing that everyone should have been behaving in the same way. Individuals would only need to familiarise themselves with one code rather than the multiple versions across all the different audiences. Linked to identifying poor behaviour was the potential for a common code to ultimately weed out professionals who were not very good at their job and not meeting standards.

It would be much easier to make complaints – if different people are regulated by different regulators, they might have different standards, and then if you want to raise a concern that might be different for doctors and nurses and opticians – that might put you off complaining as you don't know if someone is breaking the rules or not. User of health and care services: involved in care of elderly or disabled

This is clearer for me, as Jo Public wants to read about it and know whether my dad has received the appropriate care and they've stuck to the code of conduct – it's easier, otherwise if I'm complaining I'm going through all these different codes… now there will be just one. User of health and care services: social worker contact

It's important to be consistent and this feels as if it would be mutually beneficial. Reassuring for staff and a real bonus when dealing with complaints. General Public, 40-70, C2DE

It was also noted that professionals might hold each other to account more even across different roles as there would be no need to familiarise oneself with the multiple codes for each profession.

Professionals have their own code currently so may not understand the codes of their colleagues. A common code would mean they are not second guessing and there would be

higher levels of confidence between professionals and greater trust of the process as they are all adhering to the same guidelines. General Public, 18-40, BC1C2

There won't be people in healthcare who can fly under the radar. User of health and care services: social worker contact

Participants also anticipated a benefit in terms of culture – as with common goals and standards, they hoped it would drive a positive sense of teamwork, better communication across professionals, less sense of hierarchy across a multi-disciplinary team and treating others with respect. Although not spontaneously mentioned, on prompting this was seen by some as having the potential to impact on diversity and inclusion due to standardised levels of respectful behaviour.

It would be a lot easier to interact and know what is expected – there will be one set of expectations for everyone, so much easier to understand and it's a good leveller across professions, settings and grades of staff. User of health and care services: hearing impairment

It was also perceived that a common code could potentially bring a greater degree of fairness across the professions especially in cases when complaints were raised. It was assumed that any complaints would be judged in a 'fairer' more equitable way if everyone was measured against the common code, both NHS and private.

There shouldn't be any difference in the way they are treated or the way they treat people. There can't be one rule for one and another rule for another. General Public, 18-40, BC1C2

A final perceived benefit of having a common code was the potential to create better sharing of information and responsibility across the professions, if everyone was working to common standards in patients' best interests. Although only occasionally mentioned, this was seen as increasing the likelihood for professionals to report concerns or information about a patient, even if it was not part of their direct role, as they would feel more joint responsibility.

4.1.2 Perceived Challenges and Concerns

The two most frequently raised issues relating to having a common code of conduct across the ten statutory bodies surrounded the complexities of the different professional groups having one code, and concerns about how this code would work in practice alongside the existing, well-established codes of these regulated professions.

It's a good way to introduce consistency, but I would be worried that it will be hard to implement and will be challenging to do so. User of health and care services: mothers with children in the home

Potential differences across the codes of different professions had been noted earlier in the sessions when participants discussed their expectations of how codes of conduct currently work. Participants appreciated the nuances across professions and accepted that different professions had different training and objectives, but also different levels of responsibility, patient interaction, risk taking and decision making etc. Some participants were aware that there are different rules for example around data protection, record keeping, confidentiality and transparency depending on the profession. These differences meant that many found it very difficult to see how such a range of different roles and patient interactions could have one code of conduct that applies equally across them all. This then led them to feel that this variation should be reflected across the code, i.e. it should be non-standardised. They argued that the rules for professions are different and therefore the code would be expected to be applied differently.

You have to make a distinction between the different roles, like doctors and social workers, who have different issues around confidentiality, risk and safeguarding, versus someone like an orthodontist. It just isn't the same set of issues for the latter. General Public, 40-70, C2DE

If you have a pharmacy technician and a neurosurgeon, why should they have the same code? – their priorities and patient interactions and decision making and responsibilities are very different so how can [it be] the same code? User of health and care services: health conditions aged 40-65

For some, there was a further expectation that those professionals with more training might be held to higher standards and they wondered how would this be reflected in a common code? Would everyone be trained in the common code in the same way, given this distinction?

When reminded to focus purely on behaviours and conduct the audience can recognise that there are common professional behaviours such as acting with integrity, not discriminating, communicating well – in essence basic professionalism – that apply across all roles. However it was clear that the audience struggled to disentangle clinical roles, skills and expertise from specific behaviours and conduct and were unsure how these cross over, and this can undermine the concept. Even within themes that can at face value appear to be consistent, for example, showing empathy to patients, or maintaining boundaries, differences can be raised. One example a participant provided as an illustration of this was when discussing how different roles will have different boundaries and approaches due to their clinical focus and the lens with which they approach their client. They described how they felt a doctor, having to deliver bad news to a patient, would have a very different code to a chiropractor given their different responsibilities.

With that responsibility, to me, comes a different way to behave towards the person in front of you. There are different levels of empathy required in how you deliver your message. User of health and care services: health conditions aged 40-65

Overall, the issue of differentiation across roles raised concerns about the potential impact and validity that a common code could have compared to the individual codes, with fears that the need to apply the code in a standardised way would lead to a weakening of it overall. Essentially, they were concerned that a common code might be weaker or more lenient if it had to work at a generic level across all professions.

Some worried that it may simply become a 'rubber stamp' and lack the robustness of the more stringent professional codes which have been developed and evolved over many years to suit the specific roles and remits of the different individual professions, and would be reduced to being a meaningless 'strapline' that would not make any difference in reality.

Although less frequently voiced amongst the public and users of health and care services sample, some questions were raised around potential for confusion if the common code were implemented, especially if it was to work alongside the established professional codes of conduct. How would professionals know which code was to take priority? How would these two codes sit alongside each other?

I can see all sorts of issues... I wouldn't want them to replace the GMC and NMC codes, these are well established and good codes. But if the common code is a good code then it will have to become the standard code like the GMC, but then will they end up with 2 codes and then which one takes precedent? User of health and care services: learning disability

Some reflected that to be of value, a new common code would need to be integrated into training and induction programmes, requiring time to bed-in and allow familiarisation and ensure standardisation. It would require dedicated efforts to build awareness and to have this reinforced, for it to have real meaning in workplace settings.

You do wonder, how effective will this be in reality and actually living up to the code? And will it require more training to have a common code and to get everyone to the right levels? User of health and care services: mothers with children in the home

You will need consistent training so everyone understands it, and then how would you enforce it? You can only apply it and it's going to be very muddy water. User of health and care services: sight impairment

Much of the discussion automatically centred on NHS settings and roles. Trying to envisage how a common code would work in the private sector was more difficult for some. Some participants shared how expectations of service from a private sector provider seemed to be higher (the inference here that by paying for a service one might 'deserve' more with communication and relationships with private sector providers seen as superior). This raised the question, how would a common code work in that scenario? Given that there was some debate about the higher expectations related to private providers, some remained sceptical of the impact a common code would make.

It might give more equality across the NHS and Private, so you can still expect the same level of care and access and be treated with respect wherever you go. User of health and care services: sight impairment

I am not sure about the difference between Private and NHS, the standards vary if you are paying for healthcare and I believe you should expect a higher standard. User of health and care services: mothers with children in the home

A final consideration was whether participants felt that a common code would actually make a difference in reality and this was difficult for participants to evaluate. The question some raised was, despite the potential benefits that could be associated with a common code, after all the efforts that would be needed to embed it, would it actually have any real, visible impact on patients in the real world? The rationale given was a perception that most health and care professionals are doing their best and current codes of conduct are likely to be relatively similar, and are not identified as problematic from a patient perspective. Some participants went on to reflect that the bigger issues were ensuring the 'right' staff are recruited who will do the job well to high standards and addressing other broader issues such as resourcing. It was not clear to some how a common code could address issues relating to culture within the NHS.

I think we can all look at our own circumstances and we may have a time where we've been to a hospital and dealt with a lot of different organisations and professionals and it's gone fine. [You would] have not known that they all had a different code of conduct…. so, they've shared information and they've worked collaboratively. And so, to be honest, I don't know if it [a common code] would benefit a situation. User of health and care services: involved in care of elderly or disabled

You do think that so long as they're doing what they're supposed to be doing and behaving with certain minimum standard of humanity, then I really don't care whether they've all got the same standards or not for the professional body. I just want to know if you're doing the job and they're talking nicely to me, and really it is about hiring the right people and then why do you need this stuff? User of health and care services: health conditions aged 40-65

This feels more like behind-the-scenes difference rather than something we would actually notice as patients. User of health and care services: hearing impairment

I can't see it having any impact on workforce – this wouldn't solve this issue. This is not about resources, but it might help to change the culture and it might help strengthen diversity and inclusion. User of health and care services: learning disability

4.2 Overall Responses to the Common Code across the Accredited Registers

Although public and user of health and care services responses to extending the code to accredited registers were broadly and often initially positive, challenges and complexities around how this might work in practice were raised as the idea was discussed in more detail.

Those who were most positive about the application of a common code across statutory bodies tended to remain positive about the extension to other groups as it made natural sense to them to include all health and care professionals in the common code. The users of health and care services cohort were again more questioning and greater nuance and complexity came through their discussions, which meant they can struggle to reach a clear conclusion.

A key question that dominated discussions was how a common code could be extended across an even more varied group of practitioners, including this cohort as well as the regulated professions. Discussions highlighted how the general public and user of health and care services audiences tend to segment the roles across the accredited registers into those perceived as being 'more medical' i.e. closer to the statutory regulators, working in clinical situations with higher risk and more decision making and more accountability. This included roles that had an impact on mental and physical health directly. Then roles that were perceived to be further away from the statutory regulators: which were considered less medical with less risk, clinical input and accountability. This latter group included more complementary therapists such as aromatherapists and roles such as play therapists, which the research suggests, may not be well understood in terms of training requirements. This was a distinction/segmentation also made by some professionals.

This is trickier as it is a less cohesive group overall and the other group (regulated) would be easier. They should all come under the same headings but it will be far harder to do.
User of health and care services: sight impairment

This concept also stimulated debate about registration per se within the category of non-regulated professions and what registration might achieve in terms of creating commonality across these professional groups. Discussion readily moved to the perceived importance of mandatory registration or regulation for all non-registered health and care practitioners, particularly those in clinical roles, as the more pressing issue rather than the common code per se. There was some polarisation here between those who felt that having a common code that extended even further to non-registered practitioners could help improve standards amongst this group, and others who questioned if it would be adhered to if this group were not overseen by a governing body.

Ultimately, participants could see potential benefits, but also challenges, in applying the common code across the accredited registers as well as the statutory professions and they argued that its success would very much depend on how it was applied and what behaviours/conduct were included. Would it be a set of basic standards that just focused on

common professional behaviours, or would it be an overarching code that allowed for nuance across professions?

4.2.1 Perceived Benefits

The key perceived benefit of extending a common code of conduct across practitioners on accredited registers alongside the regulated professionals was that of reassurance and confidence in practitioners. Having a common code across both categories was seen likely to provide a guarantee of professionalism and high standards when using accredited practitioners. Those who were more positive about the concept recognised that there were a lot of shared values and behaviours that could be applied across all groups, particularly those which summed up the essence of basic professionalism.

I'd be keener to be actively looking for those who were under the same code as doctors etc., as this to me would make them more accountable. Patients will have better (more consistent) care, and when complaint handling it would give patients the reassurance that the whole team are working to the same standards. General Public, 18-40, BC1C2

I can see an opportunity for greater cohesion across the industry as a whole and might create closer working relationships. User of health and care services: social worker contact

Working to the same code of conduct as regulated professionals suggested a good level of professionalism, a standard set to which everyone should adhere. This would bring with it a sense of confidence and trust in an individual's choice of practitioner, and increased ability to identify when behaviour does not meet standards.

I would feel happier knowing there is a code of conduct as it is important in terms of how I am going to be treated and also how they will behave towards me, but the big question is how are you going to make sure that it happens? User of health and care services: aged over 65

It felt particularly natural for certain roles, including the 'more clinical' and 'closer' to the regulated professions, to fit within a common code, and made particular sense if practitioners were also working alongside NHS professionals. Having a common code was also perceived as potentially able to increase confidence and understanding in roles that sit outside the NHS, and in less well understood professions such as aromatherapy, as customers would have some basic expectations of how they would be treated. Responses to the case studies shown within this section, which provided a scenario when a patient might want to use complementary therapies and counselling to tackle stress, highlighted these particular benefits: a feeling of confidence and reassurance in the choice of practitioner outside the NHS, and the ability to recognise conduct that was below standard.

It's a good idea as they are still providing a healthcare service to public, even if there are different jobs and different levels of training; having a common code would bring consistency of behaviour, which could impact on patient safety especially in areas people don't know

very much about e.g. aromatherapy or cosmetic practice. User of health and care services: health conditions aged 40-65

In an ideal world, participants wanted the common code to be extended to all those who are not registered, and to use this as a way of encouraging those without registration to demonstrate their quality and professionalism. This was seen as likely to drive patient reassurance, a point also reflected in some of the professionals' interviews as well. Although to achieve this, participants thought it would be important that a common code could be policed and enforced for those practitioners not on accredited registers, which raised the issue of the importance of regulation.

This might help demonstrate that they are committed to high standards and have invested time and effort and commitment to their profession, and this demonstrates accountability. User of health and care services: hearing impairment

There are quite a lot of positives in that it would give you greater confidence, and the code gives added security and reassurance when you go to see someone. It's good if you needed to follow someone up or challenge, but it would need to be policed to make sure that the code was applied properly across all these professional groups. But if there was no regulatory authority then there is no one to enforce it, and it makes code less relevant. User of health and care services: aged over 65

4.2.2 Perceived Challenges and Concerns

The overall challenge, as identified earlier within the statutory professions, was the very wide range of practitioners that could be included which meant the idea of delivering one common shared code did not always make sense on reflection.

A number of potential weaknesses were identified and these highlighted the complexity of this sector overall, and the fact that many struggled to conceive the range of practitioners as a cohesive group in itself, but also a group that could share behaviours with highly qualified practitioners sitting under the ten statutory regulators.

There should be a set of standards and rules but it might conflict with professional practice and it might change to reflecting different settings. There are differences amongst them, for example aromatherapists are less accountable and less patient facing vs other roles who have more responsibility. User of health and care services: mothers with children in the home

I wouldn't want them to be behaving any differently than those who are regulated, but I am unsure how it would work considering the vastly different jobs they do like a psychologist versus an aromatherapist, so how would that work? Maybe it is about them being accredited, not about a single code of conduct. User of health and care services: mental health condition

Whilst many basic professional behaviours can be seen as likely to be common, the differences in their roles felt too stark to be able to apply the same levels of standards. Once again, how a code impacts on professional practice was at the heart of the issue.

The extent of the varied job roles, levels of training, levels of responsibility/accountability, patient interaction and associated risks, and types of information they have access to, were all cited as potentially problematic in bringing practitioners on the accredited registers in line both together and with statutory professionals within this common set of standards. Ultimately it raised the question – do individuals really expect the same behaviours from all? This group of practitioners was not seen as a 'level playing field' and whilst a common code could in theory help to bring them all in line, this lacked credibility for some.

The difference in the training and roles e.g. doctor vs a cosmetic filler person – you can do cosmetic training very quickly but not become a GP quickly. So, would a common code across all of these roles mean standards are too high for some or too low for others, so it would be ignored or just make life too difficult? User of health and care services: involved in care of elderly or disabled

I would expect some of them to have a code of conduct as you are relating to very sensitive issues, like a child psychotherapist and counsellors, but wouldn't expect an aromatherapist to have one like them – it's like chatting to your hairdresser. User of health and care services: social worker contact[7]

Having to devise a code that did encompass all these different professionals could suggest that either it would be too harsh for some – setting too high standards, or lacking robustness for others – with standards being too low. One concern was that having a common code might put some of those professions that were seen as furthest away from the statutory regulated professions under pressure to align themselves with professional groups that have much higher standards. They reflected that some of these standards might not be needed for these practitioners and that this could ultimately prove difficult for them and their businesses to achieve the standards required.

Some practitioners might not want to be covered, as it puts more pressure on them. General Public, 18-40, BC1C2

Another point raised occasionally was that there was more choice when using practitioners on accredited registers and the ability to research options, compared to the statutory professions. This ability to have free choice suggested that a common code was less necessary as patients/clients would be using other criteria such as accreditation to make their decisions.

[7] Stimulus shown highlighted aromatherapists amongst other roles on accredited registers which is why this role was specifically mentioned.

It's good that the regulated group have a common code and that is more important. It's about protecting us a patient versus us as a customer, and elective versus non-elective treatment. I am more concerned that all the practitioners are regulated and that seems like more of a priority to me. General Public, 40-70, C2DE

Occasionally participants observed that a common code felt less important for some accredited professions as practitioners are working as individuals rather than as a multi-disciplinary team. Having a common code of behaviours across colleagues was seen as having less direct impact on patients/clients overall.

Some situations, some things don't seem so bad – if you go to a cosmetic filler place and the person wasn't working collaboratively with her colleague would it bother me? Probably not as it doesn't have a patient impact, but it might do in a hospital setting where it is more professional than a salon setting. User of health and care services: involved in care of elderly or disabled

4.3 Overall Responses to the Extension of the Common Code across Non-Clinical Senior Managers

There were a variety of responses to this concept across the sample and the range of views highlight the complexity of the issues uncovered. Once again, the responses from the general public appeared more straightforward than those of users of health and care services, who were far more questioning although, often approached the issue with a positive lens.

For some, the rationale for non-clinical senior managers to be working within a common code was that managers were not regulated or registered, but were ultimately working to the same goals as health and care professionals and with the same patients. On this basis, bringing them into line with health and care professionals could generate some strong support. Others considered it a good idea at a general level but expressed little strong conviction, whilst some expressed more negativity towards the idea and foresaw many challenges in bringing it about. Ultimately those who were less positive about sharing a common code, however, did tend to feel it was more important for non-clinical senior managers to have a robust process for accountability in the event of not meeting standards.

4.3.1 Perceived Benefits

Positive responses to the concept centred on the belief that non-clinical senior managers should share the same priorities as clinical staff and that there are common behaviours such as confidentiality, data protection, professional conduct and ultimately a focus on patient safety.

Those who welcomed the concept of their inclusion focused on how important non-clinical senior managers are in the whole patient experience, and therefore how it was important

they shared common standards and goals with clinicians. It was hoped that being part of the same code would make non-clinical senior managers more accountable and more likely to listen to whistleblowers and those sounding the alarm. Furthermore, they would be held accountable in a consistent way with health and care professionals.

100% this should cover managers. They should be the people you look up to really, so I feel like they should definitely follow the same [rules] as any other health and care professional. General Public, 18-40, BC1C2

The idea of better teamwork and greater unity was seen as a potential strength of the concept, having an impact especially for staff more so than patients (although the professional sample would contend this, as they felt that better teamwork has a greater impact on patients than they might realise).

Some also suggested that sharing a common code would make non-clinical senior managers role models for other staff, setting the tone for behaviours. There were some broad assumptions expressed that managers were already sharing a code with professionals, maybe via their Trust, and that there were already standards set out around ways of working, professionalism, data security, confidentiality, etc. They also believed that sharing the same code as clinicians would mean that they would themselves be able to more easily identify poor standards in others, without having to refer to multiple codes of conduct.

There were some examples across the sample when participants had witnessed unprofessional behaviour by non-clinical senior managers. For example, managers were heard to be arguing in front of patients and this served as a reminder of potential benefits of a common code.

I heard two managers arguing once in recovery room and they gave away all sorts of personal details about the patients. It was so unprofessional, and it would have been good if they had been working to a common code. I didn't bother to complain, although in reality I wonder if I had complained would it have made any difference. User of health and care services: mothers with children in the home

Different perspectives were expressed about whether a common code could potentially make an impact on complaints handling. In some ways, sharing a common code was seen as likely to make complaints handling easier as there would be greater understanding of standards. Some participants felt it could potentially increase opportunities for patients to complain if they became aware of the shared common code and shared sense of responsibility across the entire team. Others, however, did not think it would make an impact, and occasionally expressed the view that a common code might conversely put patients off complaining as they might feel that non-clinical senior managers would be more aligned to practitioners, and they might be less inclined to take them seriously.

You (the patient) could quote code to them and challenge them in a constructive way and have more certainty about what you are saying. User of health and care services: recently undergone treatment

I think a benefit would be of giving you increased confidence and simplicity: if I complain at the GPs about a nurse, and it goes to a senior manager that's non-clinical in the practice, that would make it simpler to complain if she is governed by a common code. User of health and care services: social worker contact

4.3.2 Perceived Challenges and Concerns

The concerns and challenges expressed tended to focus on the complexity of bringing such different roles together (across all the health and care practitioners, clinical and non-clinical) and a sense that the standards would not be equally relevant and applicable at such a broad level.

This mirrors many of the arguments outlined previously around the differences in roles, and particularly in the case of managers who are non-clinical and not patient facing. The concern was that the differences in their roles would undermine the broad premise of the common code and might indeed 'dilute' the common code meaning it would have relatively little impact.

These cover such a broad range of roles, and I feel a code would have to be so different for these roles that it wouldn't be relevant for them to have the same standards as say a patient facing clinician. User of health and care services: involved in care of elderly or disabled

It's about customer service and managerial skills, not patient led skills, and somehow feels different to me. There is no reason to link with the other groups as different things apply to managers. User of health and care services: mental health condition

I think the point of a clinical code of conduct is that you have the power to really mess with someone's health…. non-clinical staff can mess with your life… they are not necessarily directly in charge of your health, and I think that should be kept separate. User of health and care services: involved in care of elderly or disabled

Some also voiced concerns around the 'power struggle' between non-clinical senior managers, senior clinicians, and patients and that a common code might not help to alleviate these tensions.

Would a middle manager really challenge a senior manager on their behaviour, as they would get fired – so you have to question, would it make a difference…? Whistleblowers get done for not challenging people in the right way, so I am not sure. User of health and care services: health conditions aged 40-65

A theme relating to non-clinical senior managers, that was also noted by professionals, was what happens when things go wrong: although senior managers would be likely to lose their jobs, there remains no further accountability that would stop them working elsewhere in the same role. Sharing a common code, however, was not necessarily seen as addressing this important issue and this undermined its role and relevance for some. For the public and users of health and care services alike, therefore, the key issue raised appeared to be more about ensuring accountability for non-clinical senior managers rather than there being a common code shared with clinical teams.

4.4 Perceived Difference a Common Code would Make: Examples of High-Profile Cases

The research highlighted how the sample of public and people using health and care services can identify both benefits and drawbacks to a common code being introduced. However, when shown stimulus that prompted them to think about high profile cases, they struggled to come to a conclusion about whether having a common code, extending across professionals and non-clinical senior managers, would have made a difference in historical high-profile cases participants were prompted to consider.

Whilst some did feel having a common code including non-clinical senior managers in place might potentially have been beneficial and saved lives via the creation of a common culture and a patient-first approach, there was no consensus that that would be the case.

Those who thought it might have made a difference considered how issues raised may have been picked up earlier, responded to faster, and potentially saved lives if a common code had been in place. When concerns were raised (whistleblowing) they might have been taken more seriously as there could potentially have been a greater sense of accountability. For some, familiarity of the rules across the wider team may have helped to create greater cohesion overall and made everyone feel more responsible for reporting.

Actually, this is a good rationale for common code as it would foster a sense of common culture, a patient first approach, and some fundamental principles to keep to and that might be very helpful. User of health and care services: social worker contact

This might mean that errors would be picked up earlier and reported sooner, and investigated sooner, and then possibly caught them easier. User of health and care services: mental health condition

If they were all under the same code of conduct, I think they'd all have had a bit more input... managers took that away for a bit... I think there might have been a bit more investigation if they're all going to be disciplined in the same way. General Public, 18-40, BC1C2

Knowing that managers have the same code of conduct might help to make a difference. If there is no code then no one will whistleblow. User of health and care services: mothers with children in the home

It was hoped that having a common code might have redressed the balance of priorities for non-clinical senior managers, encouraging a focus more aligned to the wider NHS clinical team.

Those who were not sure that a common code would have had any impact in these instances suggested that there were other issues at play such as culture of the organisation, and that this had had a bigger impact than any code of conduct could address.

In reality I don't think this would have made much difference. There are too many other complex factors and holes to be filled. User of health and care services: hearing impairment

I don't think it would make a difference as it comes back to culture of the organisation, and who is implementing rules in that particular hospital. General Public, 18-40, BC1C2

In the case of Lucy Letby, clinicians were known to have raised issues which were not examined, and having a common code was seen as unlikely to address this. This was also highlighted by some participants in the professional interviews who noted that even someone perceived as senior in the organisation was disregarded. Participants also pointed out that simply having a code is not enough when faced with an individual who will disregard it.

All the organisations had a code of conduct, but things were missed anyway, so I don't think the failings came from a lack of common ground between clinicals and non-clinicians. It was a lack of duty of care. User of health and care services: involved in care of elderly or disabled

It's one thing to have the code and another thing to make sure it is implemented properly. User of health and care services: aged over 65

Overall, participants felt that having a code that extended to non-clinical senior managers might have the effect of picking up issues and problem staff faster. However, it would take considerable time and effort to embed as part of the system and their training. Fundamentally, many felt that it came down to non-clinical senior managers having more accountability via a code of conduct and regulation rather than necessarily having a common code.

The key to success is embedding this in good practice and this will take time and will need to be a part of their training. User of health and care services: sight impairment

Section 5: Responses to the Concept of a Common Code amongst Health and Care Professionals

5.1 Overall Responses to the Common Code across 10 Statutory Regulators

The concept of a common code provoked engaging discussion across the professional interviews, with participants typically approaching it either from a lens of the benefits of commonality or the challenges of difference. Even those who did see benefits can caveat those with perceived complications due to the differences across professions and their patient interactions. Again, the level of interaction between conduct/behaviours and role complicates the issue in people's minds, with discussions moving quickly to how to account for these differences, although without detailed understanding of other codes this was seen as difficult. It was notable that many responses were equivocal i.e. 'might make a difference', 'could inspire more confidence', 'may feel more part of the team'.

This audience can also question the rationale behind the concept, and whether, despite potential benefits, it would actually make a real difference in practice, particularly given the pressures and the reality of their working lives. However, they understood that a common code could appear beneficial to patients and why the concept of consistency might appeal to them.

5.1.1 Perceived Benefits

As with the public and user of health and care services cohort, having a common code across the 10 statutory regulators was seen as having the benefit of providing simplicity and consistency across a group of similar professionals - all patient facing. It was felt to be a way to standardise behaviours and to ensure that rules would be applied equally irrespective of profession or role. For some it indicated a way of streamlining, similar to what was perceived to be the benefit of a Joint Statement signed by all the regulators, as shown within the stimulus material.

Positive responses assumed that there were already likely to be similar behaviours and standards that are present in codes of conduct that can be widely applied. They included, but were not limited to, behaviours such as treating others with respect, not discriminating, good communication, being polite, obtaining consent, working in a patient's best interests, honesty and integrity.

In principle, I don't see any problem with it. I think we all have responsibility to patients, or you know the term patient might not apply to everyone there, and no social workers don't like the term patient. But we all have those responsibilities to the people that are in our care. And I think that there are certainly lots of common themes that could apply. Regulated Professional: GP

You could have a kind of high-level set of standards, essentially, that would apply fairly easily. Like I say, things like respect for people and delivering excellence in care, but they're quite broad, slightly generalised, statements really. So, in a way because they're broad and general, they're quite easy to apply to this broad group. Regulated Professional: Consultant

The professional sample anticipated that having a common code could impact positively on workplace culture and MDTs. A common code could indicate that all regulated professions have equal standing and status. It was hoped that having a common code could drive less of a sense of hierarchy across professions and better communication across teams. This was particularly true of professionals who felt that their role was not considered as important as others. A common code could potentially deliver parity of esteem and be beneficial to those who had been made to feel lower down the healthcare hierarchy.

It puts everyone on a much more even and level playing field. Regulated Professional: AHP

If you have the common code, I think it would provide clarity… and maybe more respect for the way they work together. Everyone has the same values of communication. Regulated Professional: Social Worker

Professionally, it would help to raise the profile of professions that are undervalued. Regulated Professional: Chiropractor/Osteopath

A common code might also be a way in which to raise standards overall as weaknesses in systems, processes and individual behaviours would be more immediately apparent. With shared values and behaviours, irrespective of role, a benefit perceived was that there could be better collaboration within teams, potentially leading to better standards and patient outcomes – the belief that people work better as a team when they share values and behaviours. Currently, some participants noted, they all make assumptions that all professionals on an MDT are working to the same goals and with the same standard of behaviours. With a common code, these assumptions would be removed, making it easier and giving more confidence in working practice that everyone is working to the same standards. Occasionally participants reflected that during the Covid-19 pandemic, every profession had different rules around protective equipment, and having everyone behaving in the same way would make it easier to know what to do.

When we share [values and principles] everyone is on the same page, we work better. Regulated Professional: AHP

Participants also highlighted how it would be easier to identify where other practitioners' behaviour and conduct was not meeting standards if those standards were shared, which could help in raising concerns and more confidence in whistleblowing. It was sometimes noted on thought that there are little differences in regulations across professions that do not seem relevant e.g. differences in length of time patient records are kept.

If the standards are the same for everyone then everyone should work in the same way... and hopefully the standards are high. Regulated Professional: Pharmacy Technician

Clear, concise, structured pathway to follow. Regulated Professional: Secondary Care Nurse

I'd feel a lot more confident anyway to feel I could report someone like that, it makes it easier in the sense that a lot of the different times there can be a little bit of a power dynamic situation come into play…. so at least you'd have everyone on a level playing field, and you'd know yourself that this is the practice that we should be following. Regulated Professional: AHP

The audience suggested health and care professionals would be being judged in the same way on the same grounds, which felt fair.

We are professionals and there's that expectation that we are going to work well and professionally and effectively… I think it would be a bit unfair if I'm treated one way… if someone else did the exact same thing as me but was treated differently… if we both have done something wrong, then it should be the same rule. Regulated Professional: Social Worker

I think it would be helpful to practitioners at all levels to know that we're all working to and being judged by the same standard… knowing to what level you could challenge that, and what the potential route to challenge that, would be is helpful because I'm not sure I would know where to report an osteopath if I had to at the moment. Regulated Professional: GP

One of the non-clinical senior managers identified some additional benefits from a managerial perspective. They considered how having a common code would make it easier to share examples of good behaviour as everyone across teams and departments would be enacting the same behaviours. They believed it might be easier to spot and address issues if there were common standards, and that it could be easier to manage a wide group of different practitioners, particularly in terms of performance evaluation.

You wouldn't have to understand 10 codes if you were dealing with different types of staff, you would have just 1 for all. NHS Senior Manager

If there are any issues along the way, it's easier to deal with if everyone has the same attitude and standards. NHS Senior Manager

It was felt that a common code may lead to better communication, especially for sharing information in a timely way and ensuring that there is a shared sense of urgency and less chance of information falling through the cracks because something does not fall into their specific remit. In particular, this related to everyone taking responsibility and not assuming that it was someone else's job to do.

If I had a professional concern about a child or a vulnerable adult, I actually wouldn't know who to speak to... so if there's a common professional standard across the board, it might mean that there's more communication with people that would administrate and regulate that. Regulated Professional: Optometrist

I think that across the board it would mean there's something to hold everybody accountable to…. it's all well and good to say that chiropractors, or social workers, or whoever, document in a particular way or behave in a particular way… whereas if it was across the board, 'No, these are your professional codes of conduct across the board because you are working in this post'. It would make things easier, but I think it would start a trend where people who weren't particularly behaving like that, it would act as a way of modelling the behaviour for them in a better way. Regulated Professional: AHP

Ultimately it was anticipated that a common code should have an impact on patients and their safety. Key to improved patient safety was the perception that a common code would encourage better communication within teams but also with patients, and better data protection. Potentially it would encourage confidence in, and offer reassurance to, the patients whom they treat and an expectation of certain standards. Although only mentioned occasionally, this was noted by one participant as driving equality of experience.

It is patients who will more likely see the value in everyone having a common code. Regulated Professional: Dentist

It could put patients at ease more as they know what to expect – gives more continuity across professions. Regulated Professional: Chiropractor/Osteopath

It would provide a better structure as everyone would be working to the same goals, so patients would get a more similar service across the piece… and equality, you would be more assured that patients are being treated equally… if it is in relation to behaviours, it would have to be fairly general… it means whether you have mental health or a bad back, the patient experience would be the same. NHS Senior Manager

A final benefit highlighted occasionally was the potential for greater movement across professions, opening up careers and training. Along similar lines, some participants thought that in the case of dual qualified professionals, they would only have one code to follow which would increase simplicity, and potentially would also provide a benefit in consistent accountability – if they were 'struck off' one profession, they would not be able to practise as the other.

5.1.2 Perceived Challenges and Concerns

Professionals working in health and care were much more likely than the public and users of health and care services to quickly spot challenges in the concept of a common code as their views were less likely to be based on assumptions or suppositions. Whilst for some these

concerns co-existed alongside the potential benefits, others focused more on the challenges and how ultimately it would be too difficult to implement.

In line with concerns identified by the public and users of health and care services, the primary concern was the very disparate roles that would be covered by a common code. The differences in their view did not just apply to clinical roles but to their responsibilities in their job, the information they dealt with, and the type of patients and/or clients they might have – all of which was intertwined in their view with conduct and behaviours.

For some roles it was felt that their responsibilities towards patients demanded different behaviours and approaches. Some referenced the already noted differences in how the Nursing and Midwifery Council stipulated advocacy above challenge, which they believed implied a more nuanced approach to behaviour, and was certainly different to the stronger language of the Health and Care Professions Council code.

There was a sense that the physical and emotional boundaries between the professional and the person in their care can vary very much according to role, as well as also rules around duty of care, reporting responsibilities, data protection and handling of drugs/medication – all of which lead to different approaches depending on who they were seeing and their obligations. Physical boundaries were discussed in terms of touch, and undressing of patients, and even levels of empathy needed in consulting with patients. There was a feeling from some that they make decisions every day weighing up clinical needs and professional conduct and there was a concern that a common code could encroach on their professional judgement.

Pharmacists are obviously very exacting [in] how they behave, and rightly so in many respects because they're the custodians of all the medication. You know, I may prescribe medication, but I never have my hands on it. So, you know, a different matter if you have to be scrupulously exacting in terms of looking after the controlled medications and addictive medications and so on. Regulated Professional: Consultant

Physios don't touch people so much, so there is no need to undress. Osteopaths and chiropractors are very much hands-on, so you couldn't have something about undressing... I use my professional judgement daily… I wouldn't want anything dictating to me. Regulated Professional: Chiropractor/Osteopath

Whilst the professional audience therefore could simultaneously see the potential benefits, they also expressed concerns about feasibility, and automatically started to limit a common code to basic professional behaviours, laid out like overarching principles that would allow for nuance and individual differences per profession. Instinctively, some felt that a common code would have to be very basic and simple in order to cover all audiences, in part because they did not feel you could distance behaviour from clinical skills. This in itself led to concerns about the potential for a common code to be too generic, not specific enough to the professional needs and therefore lacking in weight and meaning, or to be too open to interpretation by individual practitioners. There was a concern that a common code might

dilute what some professionals believed to be a superior code of their own, very much tailored to their professional needs.

There is a danger that bringing us all to one level loses some of the specificity and where we have difference [that are] beneficial – the way nurses and dentists work is so different… you risk making it so general to fit that it becomes meaningless. Regulated Professionals: Midwives and Nurse

It's quite [a] disparate group of people. I mean you've got osteopaths to dental hygienists to you know surgeons and psychiatrists …. I guess the overarching principles of having respect for people and being polite and… those sort of things… they kind of apply to a civilised society. Regulated Professional: Consultant

Considerations relating to the logistics of how this could be achieved were raised. Would all the regulated professionals then come under one umbrella regulator? Would it be overlayed on the current codes? How would it work with current contracts and job descriptions? Although these questions were not in the scope of this research, they posed a considerable stumbling block to a number of those interviewed.

I can certainly see the benefit. There might be more points which branch off each individual area but overall, I can see it as a positive change. Regulated Professional: Dentist

The principle is a good idea. It strikes me that in order to accommodate all of those different positions... the danger, it might be too vague to really mean anything ultimately. Accredited Register: Therapist

[I] see it as a huge undertaking to change their current NMC [code] and how would you do this safely… would be a bit worry introducing this. Regulated Professionals: Midwives and Nurse

Another difference highlighted was language – although it was considered semantics by some, in the private sector and particularly in certain occupations, those being seen are not called patients. This differentiation led to different expectations of behaviour from the professional and potentially the public/client/patient too.

The contrast between the social and the medical model of disability. Regulated Professional: Social Worker

The danger of this is that it's a very medical model. Accredited Register: Psychotherapist

Some participants anticipated difficulties in getting buy-in across all the professions, a point alluded to above, whereby those who felt lower down the hierarchy thought that those who were perceived as more important, would not want to sign up to a common code.

The practicalities of getting agreement as to what should be included in a common code and the language used to express it was considered problematic given that they had already identified subtly different priorities in how the codes are currently written (*should* v *must*; *advocacy* v *challenge*). Occasionally a question was raised around which body would have the confidence and authority to implement such a code – and therefore would take responsibility for ensuring the wording worked across the wide range of professions and was watertight.

I'd like to see the meetings that would have to take place to try and agree those.
Regulated Professional: Consultants

Given that a common code was posited to make a positive difference to behaviours, there was some scepticism expressed about whether it would really drive sufficient change in practice. Those in positive and supportive workplaces did not think that this would add anything significant (indeed, there was a risk of causing confusion and upheaval in a time of stress and pressure). At a basic level, a common code would only be outlining the same behaviours as their individual codes did already, and they noted that there were also already in addition workplace/Trust codes that worked to achieve the same thing, just worded slightly differently. Linked to this view was that if implemented at a very basic generic level, a set of common principles based on everyday professional behaviour would not do more than current expectations. In this context, and considering the other problems faced in health and care, particularly the NHS, such as bed availability and waiting times in A&E, having a common code did not feel as if it would address the real problems faced on a day-to-day basis.

We all have to do different levels of safeguarding training, for example, or equality and diversity training or data protection training or whatever it is. So, everybody in our Trust has to do that. So, we all do the same thing, nurses, physios whatever – so there should be some kind of sort of commonality there. Regulated Professional: Consultant

I feel like the general requirement was so drilled into you from day one of training… you naturally just do it, or should be doing, a lot of the things that in those codes of conduct.
Regulated Professional: AHP

Cost implications were also mentioned, although only infrequently, with a concern being that this would be a costly exercise to achieve, and given the financial pressures already in healthcare, would the money potentially be better spent elsewhere? This point was also occasionally raised by the public/user of health and care services sample who wondered if it would be worth it in the long run.

A concern raised by some participants working in the private sector was that a common code might mean that they had harsher administrative rules imposed on them that would require more administrative resources which, compared to large organisations like the NHS, were felt to be in short supply.

Working in private practice is very different to working in the public sector, we can only do so much in inclusion and diversity. We don't have a lot of external resources to call upon, so trying to enforce things might be difficult. Regulated Professional: Chiropractor/Osteopath

Finally, there was an underlying thought that codes of conduct and behaviour were only as good as the people working under them, and there was sometimes no legislating for bad behaviour. When shown a case study relating to discriminatory practitioner behaviour, many stated that this type of behaviour should not happen at all under their current codes so they were unsure why a common code would make any difference.

5.2 Overall responses to the Common Code across Accredited Registers

There was nuance in the responses to extending a common code to practitioners on the accredited registers, often with both benefits and concerns being identified simultaneously. It did not follow that participants who thought it was a good idea for the ten regulated professions to come under one code, that the same would apply to those who are on accredited registers. Specifically, there were variable responses to the concept from participants on the accredited registers themselves, highlighting how whilst they can see potential benefits, they also recognised challenges in implementation and how it might work better for some practitioners than others.

The key benefits identified were the potential for the same high standards to be applied across all health and care professionals. The key concerns once again centred around the vast differences across professionals, with these being even more marked when discussion turned to those which were seen as furthest away from the more 'medical' regulated professions (as discussed earlier). This once again reflected discussions within the user of health and care services and public sample which suggested how these professions could be segmented into more and less 'medical/clinical' professions.

A point that was returned to frequently throughout the interviews was the need for mandatory accreditation and regulation of these practitioners more generally. The fact that there was choice as to whether one signed up to a register or not was seen as a bigger issue.

5.2.1 Perceived Benefits

The potential benefits of extending the common code to practitioners on accredited registers centred around the fact that high standards of conduct and professionalism should be applied across the board to anyone who is patient facing (a benefit identified by the public/user of health and care services sample as well). The participants assumed that there was already likely to be some commonality in expected behaviours across the patient facing professionals and their codes were likely to be similar, and this would further codify behaviours and bring reassurance inherent in having the same standards as regulated professionals.

I'd like to think if I went to an acupuncturist, they would treat me with the same common standards as a physio on the NHS. Regulated Professional: Consultant

Anyone who's going to have an impact on someone's health should be held accountable. Regulated Professional: Pharmacy Technician

A positive theme that emerged both in the interviews with participants on the accredited registers themselves and across other professions was that everyone adopting the same (assumed) high standard would benefit patients in terms of improving standards of care across all professions. This once again reflects how interlinked clinical skills and competence are with behaviour and conduct even for professionals.

I think these are all people with potentially very significant interactions with patients. And I think a common code would be helpful, and perhaps would serve to elevate some of the standards or the status of these professions. But also create a very level playing field so that they know how to interact with us, we know how to interact with them, and there's a universality to that. Regulated Professional: GP

I feel like it's a positive that anyone that has access to patients as part of our patient journey with them, it would benefit [us] to have a code wider than it is. Regulated Professional: Optometrist

I guess for some people and some professions there might be some parts that they don't see as important, so in that sense, if everyone's working under a common code, there is that standard there that this is actually how it should be. Accredited Register: CBT Therapist/Psychotherapist

If it encourages people to act in a professional manner with patients' best interest at the heart, then yes…. it's got to be fairly generic. Regulated Professional: Chiropractor/Osteopath

In addition, they thought it would provide the public with reassurance potentially driving more credibility for lesser considered professions – due to being in line with the high standards recognised across the regulated professions. Considering a case study which demonstrated referrals across statutory professions and accredited registers, it was thought that a common code could also potentially offer reassurance to practitioners when referring patients to practitioners on accredited registers, although some were keen to point out that being accredited in itself meant that this confidence would already exist. Despite this, some practitioners on the accredited registers did feel that they lacked credibility in the eyes of the statutory professions, and that sharing a code with them could help to improve their credibility not just with the public, but with other medical professionals too, and particularly the NHS.

You've got to jump through all these hoops before you can work with the NHS… if it's something standard, then [it would ease] working with the NHS, if you share common standards with them. Accredited Register: Aromatherapist

In addition, participants perceived the potential benefit of increased transparency – as everyone would be held to the same standards it might be easier to spot when behaviours and standards had slipped and be able to call it out.

Healthcare is becoming much more integrated... what happened in the past... what didn't happen well enough is the different professions on this pathway working together. NHS Senior Manager

This applies to me and to them, so it's all streamlined, and it helps with escalating things, and we all have the same knowledge. Regulated Professional: GP

5.2.2 Perceived Challenges and Concerns

The differences between roles and responsibilities already mentioned when discussing the concept working across the ten regulated professions was also noted as the key challenge when considering the extension of a common code to practitioners on accredited registers. To an even greater extent, the disparity between roles was highlighted as a potential barrier to achieving a common code. There was occasional concern amongst the regulated professions that those who had spent a considerable amount of time in education and training would be held to the same principles and standards as those who they perceived had not. When reminded to focus purely on behaviours, there was less concern raised, however discussions moved to the simplicity of common principles, still with a need for nuance per profession.

Can't compare a doctor with an aromatherapist, they have different levels of accountability and risk and consequences. Regulated Professional: Midwife

The significant differences across roles, considering physical and emotional boundaries, levels of responsibility and risk, and clinical impact were raised as particularly challenging to bridge to enable a common code. This was often hard for participants to explain clearly, as there was so much crossover between their clinical role and the behaviours and conduct expected of them in practice. The contrast was made particularly between the seriousness/medical nature of the statutory professions and with practitioners on accredited registers whose treatment of patients/clients was deemed as less life changing. For example, the role of a consultant was noted as very different in practice to that of a therapist or a cosmetic practitioner or aromatherapist, and the role of a social worker was considered very different to that of a play therapist[8], even if they might be working in the same team.

[8] As noted earlier, the research suggests the role of play therapist may not be well understood. Please note the stimulus shown outlined a variety of roles which is why these roles are particularly identified in discussions.

I just don't know whether all of what I'm bound by would need to apply to a play therapist. OK because their role is quite specific, and I imagine it to be quite structured and neat, whereas the social worker is vast, like we do all sorts. Regulated Professional: Social Worker

Attention was drawn to those making very serious decisions about patient outcomes, or who hold very sensitive information compared to those who do not, and how it would not be appropriate for them to be under the same rules. This was not lost on the users of health and care services/public sample either, as noted earlier, who struggled to see how they should have the same levels of standards – elevating or flattening perceived risk.

Some decisions are life or death… I couldn't see a complementary therapist being involved or being subject to the same level of regulation. Regulated Professional: Social Worker

Some of those on accredited registers themselves agreed with these concerns about how a code could work across such different professions, citing the differences in current rules and practices they adhered to compared to regulated professionals. Examples included levels of note taking, and patient confidentiality and boundaries.

As seen when discussing the common code in relation to the ten statutory regulators, the perception that a common code would have to be too generic to encompass such a wide range of professions and therefore would not be specific enough for each profession was again seen as problematic. This could result in standards being too high for some professions or too low for others, or too open to individual interpretation.

You would have to strip away the layers enough to make it work across the board, and a one-size-fits-all is not appropriate in healthcare. Regulated Professional: Midwife

Although the positive of it is the simplicity, that's possibly the negative in it. I'm just brainstorming something about appropriate boundaries, if that was a statement…. what does 'appropriate boundaries' actually mean for each of those professions? You know, if you're doing laser/fillers, you're probably going to be quite hands-on, that's an 'appropriate boundary', possibly, in that role and, again, sports rehabilitation, but maybe for a psychologist it might not be. So, I guess you can't leave it open for too much interpretation because, to be able to suit everyone, does it need to be broad?
Accredited Register: CBT Therapist/Psychotherapist

A little bit of overreach... there's a possibility that if you try to draw too much under one umbrella, that could become watered down. Regulated Professional: Social Worker

Practitioners on accredited registers identified some additional concerns. Although they did not see it as such a huge leap as some of the statutory professionals did, citing how the requirements placed on them were already exacting, some questioned why it was necessary and whether it would make much difference in reality given the high standards they already adhered to. Cost was raised as an issue as they considered whether this would be on top of the costs already accrued to be accredited in the first place.

The issue of language was again raised, with this having the potential to cause problems in the definition of behaviours and conduct.

If you were doing laser/fillers, you would not be using the same language as a psychoanalyst to describe the nature of how things are. A psychoanalyst would expect everything to be extremely tight and contained, and maybe three times a week being met with somebody, and no touching, absolutely, and no contact between sessions. If they're really analytical, there would be such strong boundaries around that, whereas, as a psychotherapist I would probably be looser than that but still have the boundaries on it, but I wouldn't be as tight. A cosmetic practitioner wouldn't necessarily expect people to call them in the middle of the night because they're having a crisis. Accredited Register: Therapist

Finally, another query was how the code would be administered, monitored, and how it would work alongside existing registers they were on. Specifically, whether they would still retain their own individual professional bodies, which they saw as specific to their unique professions. Retaining their professional bodies was perceived as important for providing reassurance of support specific to your profession.

Some of the discussion ultimately pointed to the importance of ensuring that all professionals should be on some sort of register rather than under a common code, and despite reminders to focus on the concept of a common code, this issue was often raised. Similarly, when discussing inappropriate behaviour and whether a common code could make this more visible or easier to report, some participants simply pointed to the fact that poor conduct should be visible within current codes of conduct.

Registration is more important than a code of conduct and making sure people are accountable. Regulated Professional: Nurse

It shouldn't matter if you're bound by the same regulation, because your own regulation should have been able to act. Accredited Register: Therapist

5.3 Responses to the Common Code across Non-Clinical Senior Managers

As with discussion around the previous layers of the concept, there was a mixed response to the idea of non-clinical senior managers being included within a common code. There were some immediate benefits identified in terms of bringing the entire health and care 'family' under one code, with one set of standards.

However, there were also participants who immediately challenged the concept and others who were more ambivalent at best. As with the inclusion of accredited practitioners, there was perceived to be lots of potential complications about how it could be implemented across an even more diverse group of people.

The small sample of non-clinical senior managers included within the research also approached the concept positively from a cultural perspective, albeit with reservations about practicalities.

5.3.1 Perceived Benefits

Participants (both clinical and non-clinical) recognised that non-clinical senior managers have a significant impact on patients, even if this is not directly obvious – by impacting on culture, decisions inputting into patient outcomes, and undertaking administrative tasks. Therefore, a key perceived benefit of bringing non-clinical senior managers into a common code was the potential for increased prioritisation of patient safety, recognising that there can be competing priorities across clinical and managerial staff. Clinical participants hoped that irrespective of targets and organisational requirements, this would encourage a more patient focused culture.

At a ward level, the managers are maybe pushing for discharge to get people out of hospital because we need the beds freed up and the medics potentially are saying well, no, I have to make sure that they're ready and well enough to be discharged. So they're competing priorities, really. Regulated Professional: Consultant

Managers have a big impact on the culture and managing outcomes… that's why they should be included. Regulated Professional: GP

(discussing if a risk to patient safety is raised with a manager) I know about the risk, it's nothing to do with me, there must be someone who is responsible and they need to know about it. The code of conduct might make people have that extra bit of thought. NHS Senior Manager

There is a really big divide in the NHS, a lot of admin roles don't understand the clinicians, we speak to them occasionally…. there is a canyon of separation and I wouldn't be surprised if clinicians say senior admin are not held to the same standards, have no risk, but something I do could really impact on them down the line… so I guess it would maybe, not bridge the divide, but it might give more awareness to both sides. If I read what clinicians have to adhere to, I might think that's a lot more serious. NHS Senior Manager

Participants also perceived the potential for there to be a positive impact on culture more broadly if everyone had the same code of conduct. Sharing the same code of conduct would make it even clearer that all were being held to the same standard and easier to spot when this was not the case. Less consideration was given to those who were not working in the NHS currently.

Our operational manager, for example – if something like that was to happen, they might not have known it was necessarily against a code of conduct because they've never had to follow a code of conduct. They don't know what clinicians are bound by in regards to the code of

conduct, so it might be dealt with but not to the extent that it needs to potentially be. Regulated Professional: AHP

Working in multi-disciplinary teams, project managers are really key to this one… especially in teams that have clinicians and administrative staff… so having a code of conduct that includes everyone would help with culture and patient safety if everyone across the board is living up to the highest standards. NHS Senior Manager

I think it would benefit non-clinical senior managers to have codes of conduct to work to, as they don't have anything at the moment… at the moment you might have pockets where they have values and nothing in others… and the places that do have values could be providing their own… it would benefit people who don't have anything at all, give them a structure and feed very well into the appraisal process… you can create a really good culture and that would help patient experience and staff retention. NHS Senior Manager

By including non-clinical senior managers, some thought it may bring their influence in the healthcare setting into more stark relief. They thought there was the potential to model good behaviour and leadership by example, and strip away any hierarchy of clinical versus non-clinical roles. They also hoped it could bring greater understanding of the challenges faced by patient facing colleagues.

You will find friction between clinicians and managers, and to have the same goals and approach can be helpful. NHS Senior Manager

It gets rid of that kind of hierarchical feel to some extent… it places the same expectations upon everyone, no matter what your rank is. Accredited Register: Therapist

A better overall patient experience… [not being faced with] 'computer says no'. Accredited Register: Aromatherapist

Occasionally participants suggested that a common code might have a positive impact on discrimination (this was in relation to patients rather than fellow colleagues) as there would be more compunction to treat everyone equally. No queue-jumping or prioritising one patient/client over another.

They could be in charge of deciding how long a patient waits for treatment. Regulated Professional: Pharmacy Technician

One key area of discussion that was frequently provoked by this concept was the fact that whereas a regulated professional could be struck off and not allowed to practise, there was not this level of accountability for non-clinical senior managers, who actually had a significant impact on patient outcomes. The audience recognised that non-clinical senior managers may have a code of conduct built into their job description or as part of the Trust they work in, but this did not preclude them working elsewhere if they lost their job.

Discussions therefore suggested that the audience was looking to see if a common code could bring more accountability.

If I did something wrong, then they did something wrong… we are going to be dealt with the same and it's fair… if somebody really high up there isn't bound by any rules or regulations… then they could just do what they want. Regulated Professional: Social Worker

It should cover them, I agree, everybody in this healthcare environment. Whether you're patient facing or not, we should all agree on the same basis as to what the level is. Some Trusts might not necessarily have a code of conduct per se, or anything they're really bound by in that sense, bar what's in the job contract. Regulated Professional: AHP

5.3.2 Perceived Challenges and Concerns

Even those who expressed positive views about the extension to non-clinical senior managers often equally appreciated how challenging it could be to implement with yet even more diversity of roles – particularly given the fact that managers are not patient facing, and therefore will not have the same requirements in terms of conduct. This for some had the potential to devalue a common code in their eyes, given their very different priorities.

I wouldn't like to have the same code of conduct as someone who's the HR business manager… it diminishes it for me. Regulated Professional: Social Worker

The challenge is finding the values and codes that apply equally to different situations and settings. NHS Senior Manager

The danger of senior management specific issues bleeding into clinicians' standards. NHS Senior Manager

A few mentioned the idea that working in healthcare is vocational – they perceived that the motivation to train to be a nurse or therapist was completely different to the motivation to be in more administrative roles and that this therefore impacted on how they thought codes should work.

Their kind of background and training and motivations [are] completely different. Regulated Professional: Consultant

Other questions raised occasionally were whether a 'patient facing' code of conduct could actually apply to staff who were 'employee/employer facing;' as they would have different priorities that therefore necessitate different conduct. Some practical concerns were raised by non-clinical senior managers such as how much would it cost, and how it would be rolled out.

A final issue returned to was the lack of accountability. Ultimately some participants questioned how much value having a common code would be if there is no regulatory body

or registration process to oversee non-clinical senior managers as part of the healthcare landscape and ensure that if, like clinicians, they were to break the code, they would be 'struck off'. Without this, sharing a common code with practitioners would just become a set of guidance, without accountability, which could easily be ignored. To that end, some argued that what was really needed was a regulator.

My first response was I can't see this getting rolled out really – I can see it being a waste of paper, nothing to uphold it. Although we have the indirect impact, it would be so hard to trace back to us… there is not just the same impact for us… but it all depends on what... admin is more tailored to bribery… that's what my big code of conduct risks are… my code of conduct wouldn't be the same as a doctor's as he's not facing the same morally grey areas as I am…. I don't know enough about what they do in their day-to-day to say exactly... there will be some crossover, but not like-for-like. NHS Senior Manager

Theoretically this was a nice inclusion to round off all those who had an impact on patients, but there was a sense that it may not really change anything or be particularly beneficial.

I can't think that it would negatively affect anything, but I also can't think of any situation in which it would be beneficial either. NHS Senior Manager

It would have a positive impact overall on the work environment, but I'm not really sure how much. Regulated Professional: Dentist

Responses to the case studies shown suggested that non-clinical senior managers sharing the same code of conduct as practitioners would not be particularly likely to encourage patients to make a complaint any more than they were now. Participants might accept that sharing a code could potentially make poor behaviour easier to evaluate and recognise, but it rarely was seen as likely to impact on patients' perceptions of making complaints.

5.4 Response to High-Profile Cases

Participants struggled to have a clear view on whether a common code would have made any difference in the high-profile cases shown, which were deemed extremely complex. Although many would like to think that having a common code of conduct across practitioners and senior management would have made a difference, there was little real confidence that it would have. Of the three cases highlighted, the most recent, that of Lucy Letby, was most understood. A problem identified was that someone did try to escalate their concerns, and in this instance a professional who was perceived as top of the hierarchy, yet Lucy Letby was still allowed to continue working even though the alarm had been raised.

Some were hopeful and thought that having a common code might have made a difference as staff would have been more confident and felt more able to whistleblow. This then raised the question of whether this type of code would not only drive better and consistent standards, but that those who called out bad behaviour would not be ignored, and would also be protected.

I would like to believe that [it] would make a difference. Regulated Professional: Pharmacist

I'd like to think that it would have been highlighted at an earlier stage… in that people would not have gone through the tragic circumstances. Regulated Professional: Social Worker

Others were far more sceptical as they felt that even with all the regulation in place now, this behaviour still went unchallenged for quite some time. They considered that it might be better to concentrate on current regulations, and identify where the gaps were and tighten them, rather than embark on a new code. Although ultimately, some argued, if someone is going to break the rules, they will do so and there is little that can be done to stop someone intent on doing so.

There are already things in place, measures in place, strategies and things that staff members should be following and we should be building on that and trying to enforce that more. Accredited Register: Private Therapist

I think you're going to get people that can sign anything and still do what they want to do. NHS Senior Manager

You're still going to get people, like Lucy Letby… going to try and do it if they're that [way] inclined… obviously people can break it. Accredited Register: Aromatherapist

Section 6: Summary of overarching themes

6.1 Overall Summary

Across the general public and users of health and care services audience, there was a mixed response to the idea of a common code of conduct considering all three strata of the concept. At a spontaneous and superficial level there was often a positive response to the concept focused on the benefits of consistency and uniformity and a belief that there are shared standards of professional conduct and behaviour, but with more concerns emerging across the users of health and care services sample.

The professional audience, although often positive in principle, were also more circumspect around the practical challenges of creating a workable code and its value in practice, therefore the concept evoked a very mixed response.

A more streamlined set of standards and codes was seen to have potential benefits in terms of consistency, with no grey areas and nuances that could be manipulated. When shown stimulus that illustrated differences in wording across different regulator codes on similar subject matter, and an example of a Joint Statement (see Appendix A), both audiences could see the value of tightening wording and descriptions within codes of conduct to ensure they are all in line and that there are no areas of doubt.

The key concern identified across the whole sample was how to create a common code across such a wide and disparate group of professional roles and clinical practice, with a fear that the more 'diluted' it might become, the less workable it would be and the less impact it could have. This concern becomes more marked the further the concept extends from regulated professions to practitioners on accredited registers and to non-clinical senior managers. A key theme was how challenging it is for the audience to isolate 'conduct and behaviours' from clinical practice, and without detailed knowledge of how codes of conduct work across professions and what other professions include, there can be reticence to give a clear answer to how workable the concept could be. Even when reminded to focus purely on behaviours and conduct, participants often instinctively return to the importance of differences. Those who responded positively overall often envisaged the common code as a set of basic principles which could be supplemented by further detail, and allow for differences per profession.

Alongside both the potential strengths and weaknesses identified, there can be an underlying concern that a common code might not bring sufficient change, in a world where professionals are already felt to have well established codes and be working to their best ability. Other issues raised are that it could be too difficult to implement to be worthwhile and would not address other fundamental issues such as workforce pressures, staffing levels, and funding. Accountability was a key issue, along with how a common code would work alongside existing tailored and good quality codes.

Considering the inclusion of non-clinical senior managers specifically, the public and users of health and care services hoped the benefits of a common code would be improving accountability in a world where managers are not currently regulated. Without some form of accountability, for example regulation/registration, it was not felt likely to have sufficient weight. It was apparent that participants often focused more on the desire for non-clinical senior managers to be more accountable for errors, rather than actually believing that introducing a common code would necessarily bring this benefit. Similarly, the inclusion of non-registered/regulated practitioners was welcomed, but primarily because this suggested adhering to good standards and there being accountability – again, it could be argued that obligatory registration or regulation would also deliver this.

When considering stimulus that highlighted some high-profile cases (Lucy Letby, Mid-Staffordshire and Shrewsbury and Telford Maternity Services), there was no clear certainty around whether having a common code across professionals and non-clinical senior managers would in fact have made a difference. In these complex situations, whilst there was the potential for a common code to support a patient first culture, these cases were known to be multi-layered and the audiences were deeply aware that there was always potential for colleagues to veer from any standards already in place.

6.2 Summary of Strengths and Weaknesses

There was significant commonality across the themes raised by the public, users of health and care services and professional audiences, albeit with differences in strength of feeling. Considering the five-point diagram shown during the research that highlighted culture, patient safety, MDT, equality, diversity and inclusion and workforce issues, the core areas where a common code was seen as having greatest potential to have some impact were identified as culture, MDT and patient safety.

The key benefits of the concept identified were typically patient centred, with the common code seen as having the potential to increase confidence, improve the patient experience and patient safety, because all professionals within the health and care system would be operating to the same high levels of conduct irrespective of roles or settings. This idea of uniformity and greater consistency was seen as enabling a more simplified, unified system where everyone was 'singing from the same hymn sheet'. When considering the accredited registers, this was seen as potentially being beneficial in terms of improving standards but also levels of respect for these roles amongst the public and amongst other professionals.

A further perceived benefit was the assumption that a shared code would give greater transparency about expected standards, and as a result it would be easier to identify when aspects of care fall short. From a patient/service user perspective this could increase confidence in complaining as they would have a benchmark against which to judge specific behaviours or expected standards. It was hoped that these complaints would all be dealt with in the same way, irrespective of whether they are raised against an individual or a

team. From a professional perspective there could be more clarity as regards when issues should be escalated.

Having a common code was felt to have potential benefits in terms of encouraging a more positive culture within health and care settings, particularly within MDTs as participants felt it could bring teams together, encourage improved communication and collaboration, and raise awareness of having common goals and principles. Participants rarely spontaneously highlighted benefits in terms of equality, diversity and inclusion, however this was intrinsic for some in an improved culture where colleagues treat each other, and patients, with respect. For the professionals, a common code was potentially considered to be a good place to start the conversation about building a shared culture which could have a positive impact across the board. Culture was the key area from which the other aspects often stemmed, including patient safety. Unlike the public and people who use health and care services, the health and care professional sample understood the different ways in which they were regulated could cause confusion and resentment at times.

Considering the extension to non-clinical senior managers, participants reflected on potential strengths, including improvements to culture, a shared prioritisation of patient safety and the patient experience, the ability to be a role model to clinicians and other staff, and the ability to identify and deal with staff who do not meet expected standards of behaviour.

However, key drawbacks and concerns were also identified across audiences. The main apprehension about the idea of a common code across all three layers of the concept was the differences across the multiple and diverse professions, all with different levels of training, responsibilities, clinical roles, levels of patient contact and risk. Whilst participants reflected that there are basic standards of professionalism and core standards that should be in place for all – such as good communication, data protection, acting with integrity, not discriminating, treating others with respect and empathy, and conflicts of interest, it was difficult to decouple conduct from clinical interactions and the audience were not sure how a common code could account for the different types of patient contact.

Concerns were that a common code, in an effort to meet the needs of all professions, would ultimately be too generic and lack robustness, especially compared to some of the existing codes that are specifically tailored to the needs of each profession. They perceived a risk that in order to embrace all the distinct roles, a common code might become a meaningless set of very simple principles designed to address the lowest common denominator, rather than the highest standards specifications to which some felt they already worked.

6.3 Themes/areas that a Common Code of Conduct might cover

Participants were shown stimulus that included a range of different topics included in codes of conduct, and the audience saw value and importance in all of the themes presented to them. However the research suggested that those topics/themes which appear to fit most closely with a common code tended to be those that encompass the

basics of professionalism including good communication, patient safety, confidentiality/GDPR, record keeping, accountability, treating others with respect and not discriminating, and having empathy, integrity and honesty. As identified earlier, how intertwined clinical practice and codes of conduct were in participants' minds was a challenge. Occasionally individuals highlighted some potential additional areas including social media policy, civility and sustainability.

6.4 Implementation and Accountability

Another theme raised across the research was accountability, including how a common code would be enforced and how, or if, it would work alongside individual regulator/register codes, or Trust codes – and whether this could cause confusion. What would happen if health and care practitioners, and in particular non-clinical senior managers, did not follow it and how would it be monitored in a consistent way across roles, teams and settings? There was some evidence of strong attachment to their own regulator/register and the depth of understanding they have individually for the profession they oversee.

This would make it all far too complicated and it might start to conflict with other existing codes, and then which ones take priority? And how is it going to be policed? User of health and care services: social worker contact

There will be a code of conduct for their profession, a common code, the NHS values and the Trust's values, and it all becomes this big swirling cloud. Regulated Professional: AHP

Concerns were raised about the process of implementation and how this would be achieved in reality. In order to be successful, most envisaged that it would need to be adopted across the board, be integrated into training right from the start, and fed into induction programmes so it became part of the culture of the sector.

It should be part of the training, or onboarding into the industry as a whole. General Public, 18-40, BC1C2

It needs good procedures in place to review and implement and good training. User of health and care services: aged over 65

It will be difficult to implement. It would take time and quite a lot of buy-in... from those range of professionals to agree... and I could see there being some disagreement in terms of how [it] would be worded. Regulated Professional: Social Worker

A question within this became who/what body would oversee a common code and make sure that it would happen. There was also awareness of the cost of both implementing and embedding these kinds of programmes, and some anxiety that a common code may not make financial sense given the other pressures on healthcare.

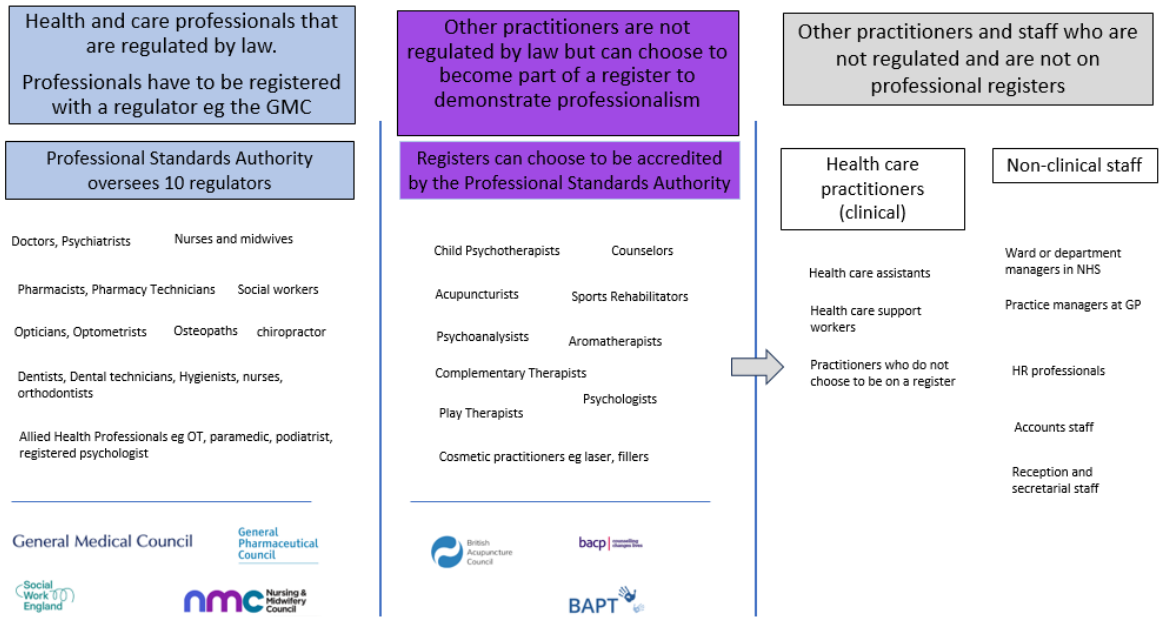
It's expensive. There are loads of overheads involved in it, administrators, managers... it's basically trying to balance the kind of affordability [of something like this] with the clinical risk and safety issues. NHS Senior Manager

There has to be a will and resourcing to make it real, not just as piece of paper. Accredited Register: Private Therapist

Participants also raised the issue of awareness and making sure there was broad awareness that a common code existed and was operational. This included awareness across users of health and care services and the general public – who would need to know about it to be able to identify any anomalies – as well as health and care professionals. Communication was therefore seen as a big task as devising an approach that could reach both audiences was considered a likely challenge.

Section 7: Appendices

Appendix A – Stimulus: Examples of stimulus deck used flexibly within research sessions



Codes of Conduct

A code of conduct is a set of professional standards that health and care practitioners must commit to to be on their professional register.

Following these standards demonstrates good practice and professionalism. If these standards are not followed professionals can face a fitness to practice investigation

Each of the Regulators and Accredited Registers that the Professional Standards Authority oversees has a different code of conduct although there are many similar themes within them

Practitioners who are not registered with a professional body do not necessarily have a code of conduct to follow

Non-clinical staff such as senior managers may not necessarily be covered by a professional code of conduct set by a regulator or register, although they will probably have standards set by their employer

What does a code of conduct cover within health and care?

For the purposes of this project we are focusing on conduct and behaviours rather than skills and competence, or any other issues relating to access to health care

This example shows how codes of conduct across different regulators can differ slightly

GMC: (doctors)

59. You must not unfairly discriminate against patients or colleagues by allowing your personal views to affect your professional relationships or the treatment you provide or arrange.

You should **challenge** colleagues if their behaviour does not comply with this guidance, and follow the guidance in paragraph 25c (see section Domain 2: Safety and quality) if the behaviour amounts to abuse or denial of a patient's or colleague's rights.

Nursing and Midwifery Council (midwives and nurses)

3.4 **act as an advocate for the vulnerable**, **challenging poor practice** and **discriminatory attitudes** and behaviour relating to their care

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

20.7 make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way

General Optical Council (Opticians)

13.9 **Challenge** colleagues if their behaviour is discriminatory and be **prepared to report** behaviour that amounts to the abuse or denial of a patient's or colleague's rights, or could undermine patient safety

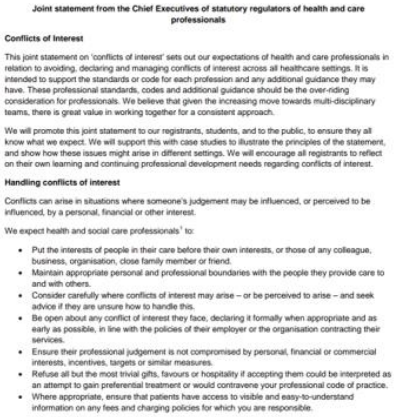
HCPC (Allied Health Professionals eg OT, Paramedics

1.5 You must not discriminate against service users, carers or colleagues by allowing your personal views to affect your professional relationships or the care, treatment or other services that you provide.

1.6 **You must challenge colleagues** if you think that they have discriminated against, or are discriminating against, service users, carers and colleagues.

Challenge? Report? Act as Advocate? Colleagues (same profession or not?)

There are some 'Joint statements' created by and signed up to across the regulators that focus on particular themes and clarify common rules



Joint statement from the Chief Executives of statutory regulators of health and care professionals

Conflicts of Interest

This joint statement on 'conflicts of interest' sets out our expectations of health and care professionals in relation to avoiding, declaring and managing conflicts of interest across all healthcare settings. It is intended to support the standards or code for each profession and any additional guidance they may have. These professional standards, codes and additional guidance should be the over-riding consideration for professionals. We believe that given the increasing move towards multi-disciplinary teams, there is great value in working together for a consistent approach.

We will promote this joint statement to our registrants, students, and to the public, to ensure they all know what we expect. We will support this with case studies to illustrate the principles of the statement, and show how these issues might arise in different settings. We will encourage all registrants to reflect on their own learning and continuing professional development needs regarding conflicts of interest.

Handling conflicts of interest

Conflicts can arise in situations where someone's judgement may be influenced, or perceived to be influenced, by a personal, financial or other interest.

We expect health and social care professionals[1] to:

- Put the interests of people in their care before their own interests, or those of any colleague, business, organisation, close family member or friend.
- Maintain appropriate personal and professional boundaries with the people they provide care to and with others.
- Consider carefully where conflicts of interest may arise – or be perceived to arise – and seek advice if they are unsure how to handle this.
- Be open about any conflict of interest they face, declaring it formally when appropriate and as early as possible, in line with the policies of their employer or the organisation contracting their services.
- Ensure their professional judgement is not compromised by personal, financial or commercial interests, incentives, targets or similar measures.
- Refuse all but the most trivial gifts, favours or hospitality if accepting them could be interpreted as an attempt to gain preferential treatment or would contravene your professional code of practice.
- Where appropriate, ensure that patients have access to visible and easy-to-understand information on any fees and charging policies for which you are responsible.

Conflicts of interest

Duty of candor

Stimulus: Introduce concept

The Professional Standards Authority for Health and Social Care is exploring responses to the idea of a **common code of conduct** for all health and care professionals who fall under the 10 statutory regulators (focusing on conduct and behaviour rather than technical aspects of professions)

Opticians, Optometrists

Doctors, Psychiatrists

Nurses and midwives

Social workers

Osteopaths

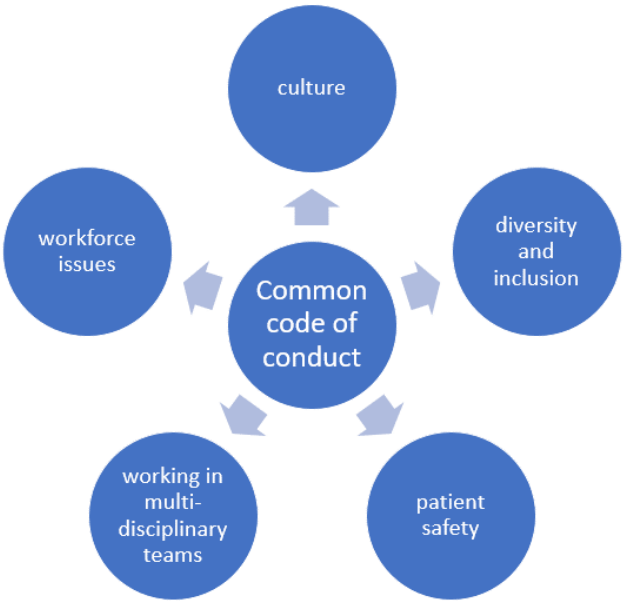
Chiropractor

Pharmacists, Pharmacy Technicians

Allied Health Professionals eg OT, paramedic, psychologist, podiatrist, registered psychologists

Dentists, Dental technicians, Hygienists, nurses, orthodontists

This could work in many different ways, but we are interested what you think about this basic idea….



Case study 1: Public and Patients

You are being treated in a busy hospital by a team of different professionals: NHS doctor/consultant, nurse, physio, and on discharge you are being linked up with a social worker. You pick up your medication from the pharmacist and… after 3 months you have decided to pay for additional physio support from a private practice

How do you feel knowing there is a common code of conduct across all these practitioners caring for you? Does this make a difference? How would you expect them to behave together as a team? And to you? What do you think the impact on your care might be?

You feel that both the doctor and the nurse looking after you are not taking your symptoms seriously enough because of your age/gender/ethnic group, which you feel is a form of discrimination. You'd like to raise a complaint against both them

How would knowing there is a common code of conduct across professionals with consistent rules about discrimination affect this situation? Does this make a difference to you in terms of likelihood to report? Could it make a difference to how professionals are investigated by their regulators if they are judged by the same standards?

Case study 1: Professionals

A team of different professionals across statutory registers are working in a busy hospital. Staff shortages means that everyone is working under pressure …. The MDT has an NHS doctor/consultant, nurse, physio, and on discharge there will be a social worker referral, and the patient is going to pay for some private physiotherapy…

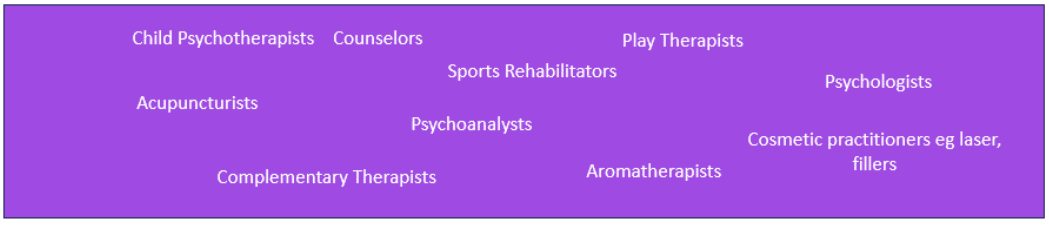
If you were working in this team, how does it feel knowing there is a common code of conduct across all these people working with you? Does this make a difference? What impact does this have on the working culture and how you work and communicate together? How do you feel about the mix of NHS and private practitioners, knowing there is a common code? Does it make a difference?

You feel that two of the professionals on the team have not taken the patient's symptoms seriously enough because of their age/gender/ethnic group, which you feel is a form of discrimination, and you decide to raise this

How would knowing there is a common code of conduct across professionals with common rules about discrimination affect this situation? Does this make a difference to you in terms of likelihood to report? Could it make a difference to how professionals are investigated by their regulators if they are judged by the same standards? How might having a common code affect issues such as discrimination either between patient/professional or professional to professional?

Stimulus: Introduce extension to accredited registers

The Professional Standards Authority for Health and Social Care are also exploring responses to whether this common code could also cover practitioners who are on their accredited registers – ie those who don't have to be regulated by law, but choose to join a register



Case study 2: Public and Patients

You have been feeling very anxious and have spoken to the GP and have decided to have some counselling, but you have decided to access this privately rather than using the NHS mental health services. You would also like to try some alternative therapies such as aromatherapy to relieve stress.

You need to choose a professional and you see that there is a practitioner local to you that is on an Accredited Register. You know this means they share a common code of conduct with other health and care professionals on the NHS

How do you feel knowing there is a common code of conduct that extends to these other practitioners too? Does this make a difference to you? To your care? To your expectations?

Case study 2: Professionals

You are working with a patient who is struggling with anxiety but is keen to avoid medication. They would like to try some therapies such as counselling or aromatherapy to relieve stress – there is a practitioner on an Accredited Register local to them that that they decide to use

Knowing that there is a common code of conduct that includes accredited registers, how does this make you feel? What would you do next?

The patient subsequently tells you that the professional they used made a sexually explicit comment to them during a session, although 'in jest' they felt uncomfortable and were not sure if it was appropriate or not.

How do you feel knowing there is a common code of conduct that also includes accredited registers? Does this make a difference?

Stimulus: Introduce extension to senior managers

The Professional Standards Authority for Health and Social Care are also exploring responses to whether if there was a common code it could be extended to also include non-clinical senior managers in health and care…

Case study 3: Public and Patients

Following on from case study 1 you decide you want to report the discrimination you have experienced to the hospital managers…

How might a common code of conduct including managers affect your decision to report the team? How does it feel to know they have the same professional standards as the clinical staff? What difference might it make in terms of how the professionals are dealt with?

A practice manager asks a patient in their surgery out on a date. If a GP asked their patient out on a date that would be breaking their code of conduct.

If there was a common code of practice, how might this affect this situation? Do all the themes apply in equal measure to different people working in health and social care?

Case study 3: Professionals

Following on from case study 1, a manager in the hospital has received a report from the patient that 2 of the professionals caring for them have not taken their symptoms seriously due to their age/gender/ethnicity.

How might there being a common code of conduct including managers affect the likelihood to report the team? What differences might this make in terms of how the professionals are dealt with knowing that the managers fall under the same common code as practitioners?

A practice manager asks a patient in their surgery out on a date. If a GP asked their patient out on a date that would be breaking their code of conduct.

If there was a common code of practice, how might this affect this situation? Do all the themes apply in equal measure to different people working in health and social care?

High Profile Cases – what influence could having a common code of conduct have made if any?

Lucy Letby

Mid-Staffordshire

Mid Staffordshire NHS trust left patients humiliated and in pain

Francis inquiry finds 'shocking' failures in care as hospital focused on cutting costs and hitting government targets

Relatives of those who have died at Stafford general hospital stand in front of a tribute wall. The hospital left patients in pain, says an inquiry. Photograph: Rui Vieira/PA

Maternity services – Shrewsbury and Telford

Five-year investigation to conclude mothers forced to suffer traumatic births because of targets for 'normal' births

Donna Ockenden's report analysed the experiences of 1,500 families at Shrewsbury and Telford hospital trust. Photograph: Jacob King/PA

Three hundred babies died or were left brain-damaged due to inadequate care at an NHS trust, according to reports.

The Sunday Times has reported that a five-year investigation will conclude next week that mothers were denied caesarean sections and forced to suffer traumatic births due to an alleged preoccupation with hitting "normal" birth targets.

There are many ways this could work….

Set of principles

More detailed guidance

Joint Statement

Code of conduct principles

Principles

The following principles set out the National Boards' expectations of the practitioners they regulate.

1. Put patients first – Safe, effective and collaborative practice

Principle 1 – Practitioners should practise safely, effectively and in partnership with patients and colleagues, using patient-centred approaches, and informed by the best available evidence to achieve the best possible patient outcomes.

2. Aboriginal and Torres Strait Islander health and cultural safety

Principle 2 – Practitioners should consider the specific needs of Aboriginal and Torres Strait Islander Peoples and their health and cultural safety, including the need to foster open, honest and culturally safe professional relationships.

3. Respectful and culturally safe practice for all

Principle 3 – Respectful, culturally safe practice requires practitioners to have knowledge of how their own culture, values, attitudes, assumptions and beliefs influence their interactions with people and families, the community and colleagues. Practitioners should communicate with all patients in a respectful way and meet their privacy and confidentiality obligations including when communicating online.

4. Working with patients

Principle 4 – Basing relationships on respect, trust and effective communication enables practitioners to work in partnership with patients. The practitioners should maintain effective and professional relationships with their patients and provide explanations that enable patients to understand and participate in their care.

5. Working with other practitioners

Principle 5 – Good relationships with colleagues and other practitioners strengthen the practitioner-patient relationship, collaboration and enhance patient care. Good relationships require health care to be free of discrimination, bullying and harassment.

6. Working within the healthcare system

Principle 6 – Practitioners have a responsibility to contribute to the effectiveness and efficiency of the healthcare system and use resources wisely.

7. Minimising risk to patients

Principle 7 – Good practice involves putting patient safety, which includes cultural safety, first. Practitioners should minimise risk by maintaining their professional capability through ongoing professional development and self-reflection and understanding and applying the principles of clinical governance, risk minimisation and management in practice.

8. Professional behaviour

Principle 8 – Practitioners must display a standard of professional behaviour that warrants the trust and respect of the community. This includes practising ethically and honestly.

9. Maintaining practitioner health and wellbeing

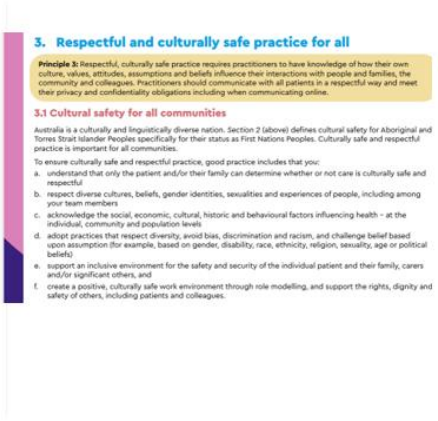
Principle 9 – It is important for practitioners to maintain their health and wellbeing. This includes seeking an appropriate work–life balance.

10. Teaching, supervising and assessing

Principle 10 – Practitioners should support the important role of teaching, supervising and mentoring practitioners and students in order to develop the health workforce.

11. Ethical research

Principle 11 – Practitioners should recognise the vital role of ethical and evidence-based research to inform quality healthcare and policy development, conduct research ethically, and support the decision-making of research participants.



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3.1 Cultural safety for all communities

Australia is a culturally and linguistically diverse nation. Section 2 (above) defines cultural safety for Aboriginal and Torres Strait Islander Peoples specifically for their status as First Nations Peoples. Culturally safe and respectful practice is important for all communities.

To ensure culturally safe and respectful practice, good practice includes that you:

a. understand that only the patient and/or their family can determine whether or not care is culturally safe and respectful
b. respect diverse cultures, beliefs, gender identities, sexualities and experiences of people, including among your team members
c. acknowledge the social, economic, cultural, historic and behavioural factors influencing health – at the individual, community and population levels
d. adopt practices that respect diversity, avoid bias, discrimination and racism, and challenge belief based upon assumption (for example, based on gender, disability, race, ethnicity, religion, sexuality, age or political beliefs)
e. support an inclusive environment for the safety and security of the individual patient and their family, carers and/or significant others, and
f. create a positive, culturally safe work environment through role modelling, and support the rights, dignity and safety of others, including patients and colleagues.

Joint statement from the Chief Executives of statutory regulators of health and care professionals

Conflicts of Interest

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- Ensure their professional judgement is not compromised by personal, financial or commercial interests, incentives, targets or similar measures.
- Refuse all but the most trivial gifts, favours or hospitality if accepting them could be interpreted as an attempt to gain preferential treatment or would contravene your professional code of practice.
- Where appropriate, ensure that patients have access to visible and easy-to-understand information on any fees and charging policies for which you are responsible.

Appendix B – Discussion Guide for public/user of health and care services sample

Below is a discussion guide used for the general public/users of health and care services provided as an example of guides used in the research. A separate guide was created for professionals working in health and care

PSA Common Code Public/Users of health and care services Phase 2 15.2.24

Focus groups (1½ hours)

Below is a moderator guide to the discussion, please note that it is used flexibly according to the discussion flow.

Outline Research Objectives:

The objectives are to understand:

1) Levels of awareness and knowledge about codes of conduct
2) Perceptions on whether they expect a common code of conduct to exist already
3) Responses to the idea of a common code of conduct for health and care professionals on *statutory registers* (all audiences); considering the value, benefits and risks
4) Responses to the concept of extending a common code of conduct to health and care professionals on *accredited registers* and *non-clinical* senior management in health and care (all audiences)
5) Key areas that the common code of conduct may cover

Introduction (5 mins)

- Welcome to Zoom! Thank you for giving us your time, we are really interested in what you have to say, and appreciate your time.
    - Explanation of research, anonymity, recording, use of data
    - Moderator introduction – independent, please share views and feelings
    - MRS explanations – confidentiality, right to withdraw, client name at end

- Today we want to talk to you about professional standards across health and care professionals
- No right or wrong answers, ideas are in early stage of development and their input makes difference in testing out whether these make sense to people etc
- Brief introduction about yourself, first name, lifestage, family, working, interactions with health services in the last 12 months

Context (5 mins)

Today we are going to be talking about codes of conduct or professional standards across health and care professions, but firstly we'd like to chat to you about the different types of health and care professionals that you interact with the most

- What health and care professionals or other people do you come into contact with when dealing with health issues? (all to shout out, moderator to note down)
- How might you group these together into different categories that go together?
    - Non-clinical ‘v’ clinical
    - Eg NHS/Private
    - Medical ‘v’ other

Spontaneous thoughts on codes of Conduct/Professional Conduct (15 mins)

- If I say code of conduct for health and care professionals….what would you expect…. What is a code of conduct and what does a code of conduct cover?
- How do you think codes of conduct work in health and social care ?
    - Who do you think of the professionals you’ve mentioned so far would be covered by a code of conduct? (refer to their map)
    - Who would you expect sets the codes of conduct?
    - Is there one code or many?
    - Do you think they are voluntary or not?
    - What might be the consequences of breaking a code of conduct?
    - Who would regulate them?

Introduce landscape (establish different types of professionals/statutory and non-statutory) (5 mins) STIMULUS

- Explore spontaneous responses to the health and care landscape in terms of regulation
- How surprised are they about this?
- Were they aware that there were regulated and non-regulated professions?
- Were they aware that there were accredited registers? And practitioners who sit outside this?
- Seeing this visual now, how do you think codes of conduct work across these different groups?
    - Do you think anything different from before in terms of who has codes of conduct, who sets them, who regulates them?

Prompted response to codes of conduct status quo (review topics included/who is covered/differences in codes) (15 mins)

What is a code of conduct: STIMULUS *briefly gauge reactions* (Moderator note: we are focusing on codes of conduct/professional standards set by professional regulator/accredited register rather than on any standards/codes set by other professional bodies e.g. Royal Colleges or Local Authorities etc)

- Have you ever thought about codes of conduct before or had occasion to use them?
- How do you feel knowing that these exist?

What does a code of conduct cover: STIMULUS

- What do you think about this information and the themes covered?

- Which do you think are the most important of these? Least important? why? (what situations come to mind when you think about these things)
- Do you think anything is missing?

Codes of conduct set by regulators/registers who do they apply to?: STIMULUS

- What do you think about this information?
- What do you think about certain practitioners not having a professional code of conduct other than one set by their workplace?
- What do you think about non-clinical staff not being included?

How do codes of conduct work (differences) STIMULUS

- What do you think about this ie that there are different codes of conduct per profession?
- How different do you expect these to be?
- Does that make a difference to you as a patient?
- What types of situations can you imagine this being problematic in?
- How you think this might make a difference to health and care professionals

Differences in code of conduct example (discrimination) STIMULUS
:

- What do you think about this information?
- How different is this to what you expected?
- What might be the challenges of this?
- How might this affect you as a patient?
- How might this affect health and care professionals?

Response to common code concept (30 mins)

Introduce concept of common code for professions covered by statutory bodies STIMULUS (moderator note: as needed remind of focus on behaviour and conduct rather than technical aspects of professions)

- All to note down on their own their immediate response
- Mark out of 10 for how 'good' an idea they think this would be
- Key reasons why they have given it this score

Share as a group and discuss in more detail:

- What 'scores' have they given it and why?
- What in their view would be the key strengths and benefits of this idea?
- What in their view might be the key problems or weakness of this idea?
- Thinking of your own experiences, when might this have made a difference?
- What do you think about these particular professionals being included?
    a. Should they all have the same code? Are there areas of conduct/behaviour that are more/less relevant so some professionals than others?
- Who do you think it might benefit the most? The least? Consider: patients, public, professionals, management

- How might it make a difference: (STIMULUS): Working culture/Diversity and inclusion/Patient safety/Working across different professional groups/Workforce *(refer back to this visual as required across discussion)*
- How do you see this as being enforced?
- How do you see this as working with each individual code of conduct for the profession?

Case study 1: STIMULUS

- What difference would having a common code make to you and why?
- A) How do you feel knowing there is a common code of conduct across all these practitioners caring for you? Does this make a difference? How would you expect them to behave together as a team? And to you? What do you think the impact on your care might be? To the culture of the workplace?

- B) How would knowing there is a common code of conduct across professionals with common rules about discrimination affect this situation? Does this make a difference to you in terms of likelihood to report? Could it make a difference to how professionals are investigated by their regulators if they are judged by the same standards?

Introduce concept of common code extension to accredited registers STIMULUS

- What do you think about these particular professionals being included?
- How would it influence how you feel about using them?
- What in their view would be the key strengths and benefits of this idea?
- What in their view might be the key problems or weakness of this idea?
- Thinking of your own experiences, where might this have made a difference?
- Who do you think it might benefit the most? The least?
- Consider: patients, public, professionals, healthcare setting
- How do you feel about whether this should extend to other practitioners eg HCAs?

Case study 2: STIMULUS

- What difference would having a common code make to you and why?
- How do you feel knowing there is a common code of conduct that extends to these other practitioners too? Why? Does this make a difference to you? To your care? To your expectations?

Introduce concept of common code extension to non-clinical senior managers STIMULUS

- What difference would having a common code make to you and why?
- What do you think about managers being included?
- What in their view would be the key strengths and benefits of this idea?
- What in their view might be the key problems or weakness of this idea?
- Thinking of your own experiences, where might this have made a difference?
- Who do you think it might benefit the most? The least?
- Consider: patients, public, professionals, healthcare setting

Case Study 3: STIMULUS

- What difference would having a common code make to you and why?
- A) How might there being a common code of conduct including managers affect your decision to report the team? How does it feel to know they have the same professional standards as the clinical staff? What differences might this make to you in terms of reporting? What difference might it make in terms of how the professionals are dealt with?
- B) If there was a common code of practice, how might this affect this situation? Do all the themes apply in equal measure to different people working in health and social care?

(High Profile Cases: if time)

- In your view, how might things have been different if there had been a common code of conduct?
- Would this have changed the outcome at all and why?

Prompted benefits and drawbacks (5 mins)

Here are some statements about what might be the benefits and drawbacks of having a common code Review statements: STIMULUS

- Which resonate most/least with you?

Review concept: (5 mins)

- Overall having discussed this, what do you think now about the idea of having a common code of conduct?
- Who would you include in it? Why? (Statutory/accredited registers/other practitioners/non-clinical manager)
- What would you cover in it? Why? (show stimulus; pick top 4) STIMULUS
- What actual differences might it make?

*There are a range of ways that this could work: eg set of principles/more detailed information about standards/joint statement on key themes (*STIMULUS*)*

- What are the ways/considerations to make a common code of conduct workable and meaningful in your view?
- Who would you want to be behind it?

Final Advice (5 mins)

- What is your final advice to the PSA about this idea?

Thank and close session