Journal of Pelvic, Obstetric and Gynaecological Physiotherapy, Spring 2015, **116,** 25–33

POGP CONFERENCE 2014

Professionalism in practice

T. Cook
Independent Practice, Upton, Norfolk, UK

Abstract
This paper provides an overview of professionalism in the context of physiotherapy practice. It introduces the reader to the ''Big Conversation'', as well as the relevant regulatory standards of the Health and Care Professions Council (HCPC), and the professional guidance provided by the Chartered Society of Physiotherapy. The author also links scope of practice to continuing professional development, and discusses several recently published high-profile reviews and reports that have made an impact on healthcare in the UK. Consideration is given to what should or could happen when ''things go wrong'' in relation to both informal and formal processes. The HCPC fitness to practise process is examined, and the author explains what happens at the various stages of the proceedings. Some relevant examples of case law and policies that guide the independent panel who hear the case are also highlighted. Finally, the author considers both recent and future developments, and outlines some key messages to support future physiotherapy practice.

Keywords: continuing professional development, fitness to practise, practice, professionalism.

Introduction

The Chartered Society of Physiotherapy (CSP) defines professionalism as ''the qualities, skills, competence and behaviours expected of individuals belonging to any given profession including physiotherapy'' (CSP 2014a).

Professional activity is complex; however, the Health and Care Professions Council (HCPC) clearly places the responsibility for ensuring that a clinician practices in a professional manner on that individual. This is documented by the HCPC in *Standards of Conduct, Performance and Ethics*, which states that, ''As an autonomous and accountable professional, you need to make informed and reasonable decisions about your practice to make sure that you meet the standards that are relevant to your practice'' (HCPC 2012b, p. 5).

The CSP expects its members to demonstrate their professionalism in several ways. These include not just working within the defined regulatory framework of personal and professional standards, but also: adhering to a moral, ethical and professional code of practice; working autonomously within one's scope of practice; both maintaining and developing one's knowledge and skills; and delivering a safe and effective service (CSP 2014a).

The regulatory framework referred to by the CSP is a statutory (i.e. legal) process implemented by the HCPC, and a breach of either the personal or professional standards can result in the initiation of fitness to practise (FtP) proceedings. The FtP process is designed to protect the public from those professionals on the HCPC Register who are not fit to practise.

Although the primary role of the HCPC is to protect the public, it should be noted that, since the title ''physiotherapist'' is protected, it is not legal to practise as a physiotherapist in the UK without HCPC registration. Therefore, a withdrawal of practice rights (by way of a suspension or striking-off order) or restriction on registration (by way of a conditions of practice order) can have implications for an individual's ability to make a living. For all of these reasons, demonstrating professionalism is an essential aspect of practice.

Correspondence: Teresa Cook, c/o Teresa Cook Physiotherapy, PO Box 1296, Upton, Norfolk NR13 6WG, UK (e-mail: tcphysio@me.com).

The Big Conversation

In February 2012, Karen Middleton, then chief health professions officer at the Department of Health (now chief executive of the CSP), encouraged us all to get involved in the ''Big Conversation'' (Middleton 2012). Her aim was that allied health professionals (AHPs) would begin talking to each other about professionalism and professional behaviour. The intention was that, both individually and collectively, AHPs would proactively address any concerns, rather than react to critical incidents that were detrimental to patient care and that could damage the reputation of the professions. By starting to talk about professionalism, it was hoped that a culture would develop in which professionalism could be discussed as normally as clinical expertise and competence. Furthermore, it was intended that these discussions would create an environment in which unprofessional behaviour would be challenged immediately and constructively.

This campaign was supported by the CSP, and was made the topic of an article in *Frontline* magazine that is still available online (CSP 2012a).

By the time that the present paper is published, it will have been 3 years since the campaign was launched. Are you aware of it, and if so, how have you been a part of it? Do you talk about professional issues with your colleagues? Are you involved with, or do you discuss the issues that arise as part of HCPC FtP hearings? Do you tackle colleagues when you see a problem? Do you discuss and share examples of good practice? There are many ways in which you can be involved, so get talking!

Health and Care Professions Council standards

Every 2 years, the HCPC asks you to make a professional declaration relating to the status of your practice. If you are a practising clinician, you are asked to confirm that:

- you continue to meet the HCPC's standards of proficiency for the safe and effective practice of your profession;
- there has been no change relating to your good character since your last registration, and no change in your health that may affect your ability to practise safely and effectively; and
- you continue to meet the HCPC's standards for continuing professional development (CPD).

Therefore, practising clinicians will be familiar with the three HCPC publications on standards that are relevant for physiotherapists: *Your Guide to Our Standards of Continuing Professional Development* (HCPC 2012a); *Standards of Conduct, Performance and Ethics* (HCPC 2012b); and *Standards of Proficiency: Physiotherapists* (HCPC 2013a).

Two of these documents are relevant for all professionals registered with the HCPC; however, the standards of proficiency (HCPC 2013a) are profession-specific. These define the ''threshold'' of standards considered to be necessary to protect members of the public, and are based on generic criteria that have been applied specifically to physiotherapy practice. In general terms, the HCPC expects registrants to make informed, reasonable and professional judgements about their practice, with the best interests of service users as their prime concern. The Council states that, if you, as a registrant, do this, and ''can justify your decisions if you are asked to, it is very unlikely that you will not meet our standards'' (HCPC 2012b, p. 5). The HCPC helpfully defines ''informed'' as having enough information to make a decision, which includes reading the standards, and taking account of any other relevant guidance or laws. It characterizes ''reasonable'' as making sensible, practical decisions about practice, taking account of all relevant information and the best interests of the people who use or are affected by the services (HCPC 2012b).

Chartered Society of Physiotherapy standards

In addition to the HCPC standards, the CSP expects members to work to its own professional standards. These include the *Code of Members' Professional Values and Behaviour* (CSP 2013a) and the *Quality Assurance Standards for Physiotherapy Service Delivery* (CSP 2012b). In addition, the Society provides guidance to members about a wide variety of practice issues and other concerns, often in the form of an information paper. Those that are particularly relevant to women's health physiotherapists address practice issues such as:

- consent (CSP 2011);
- the use of chaperones (CSP 2013b);
- CSP expectations about the development of pelvic floor examination skills (CSP 2012c); and arguably most importantly,
- scope of practice (CSP 2008).

While the CSP does not operate its own FtP processes, failure to comply with the expected standards and guidance could result in HCPC FtP proceedings being initiated.

As mentioned above, arguably the most important professional issue is that any registrant must work within their scope of practice. This is defined by the HCPC as follows: ''Your scope of practice is the area or areas of your profession in which you have the knowledge, skills and experience to practise lawfully, safely and effectively, in a way that meets our standards and does not pose any danger to the public or to yourself'' (HCPC 2013a, p. 4). Scope of practice is personal, and requires the professional to exercise their personal judgement to determine whether they have developed the knowledge and skills required for any new area of practice. Therefore, it is inextricably linked to CPD.

Continuing professional development

Continuing professional development has been defined as ''a range of learning activities through which health professionals maintain and develop throughout their career to ensure that they retain their capacity to practise safely, effectively and legally within their evolving scope of practice'' (HCPC 2012a, p. 1). This description, which was used by the HCPC in its CPD standards guidance (HCPC 2012a), is a slightly modified version of that employed by the allied health professions project on demonstrating competence through CPD (DH 2003).

The HCPC requires that registrants meet five standards in relation to CPD. These are to:

- maintain a continuous, up-to-date and accurate record of their CPD activities;
- demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice;
- seek to ensure that their CPD has contributed to the quality of their practice and service delivery;
- seek to ensure that their CPD benefits the service user; and
- upon request, present a written profile (which must be their own work and supported by evidence) explaining how they have met the standards for CPD.

There is no prescriptive guidance about what constitutes CPD, which means that individuals have autonomy to determine appropriate opportunities that will enable them to meet their personal learning needs. Continuing professional development may include attendance at formal courses. It can also include work-based learning, such as being taught experience (e.g. reflective learning and critical incident analysis), critical appraisal of the literature (e.g. a journal club), and peer support or clinical reasoning sessions. More innovative approaches can involve user feedback and professional peer review.

As well as being a statutory requirement, the role of CPD is further supported by several recent reports. These include: the Francis report on the failings of the Mid-Staffordshire National Health Service (NHS) Foundation Trust (Francis 2013); the Cavendish review of healthcare assistants and support workers in the NHS and social care settings (Cavendish 2013); the Keogh review of the quality of care and treatment in the NHS (Keogh 2013); and the Berwick report into patient safety (NAGSPE 2013).

In February 2014, the HCPC hosted a seminar involving various stakeholders as part of their ongoing work into competence and professional engagement, or more specifically, disengagement (Van der Gaag 2014). The organization has subsequently commissioned research into the factors that can lead to poor practice and why things go wrong. It is anticipated that this work, which involves a qualitative study of FtP cases, will be published in early 2015.

Van der Gaag (2014) reported previous findings by Professor Zubin Austin, who facilitated the HCPC seminar, i.e. that service users are likely to have different expectations of professional competence to professionals (Zubin 2013). In view of this, the present author suggests that clinicians need to determine and then act on what is important to their patients. While some aspects of physiotherapy practice are likely to be quite surprising to a lay person (i.e. a non-healthcare professional), the provision of accurate information that is communicated clearly should ensure that there are ''no surprises'' during any therapist–patient interaction.

Furthermore, while an engaged professional continues to be inspired by and curious about their profession, patients and practice, it appears that disengagement may increase the likelihood of a practitioner not succeeding in practice, which has an impact on patient care. Although the present paper is less likely to be read by disengaged professionals, those individuals who consider themselves to be engaged have a vital role to play in identifying and supporting their disengaging or disengaged peers.

What happens when things go wrong?

The ''post-Francis'' agenda relies on healthcare professionals to provide care that upholds patient safety and dignity, is delivered with compassion, and meets a consistently good standard. Furthermore, Francis (2013) stated that inferior care must not be tolerated or overlooked, and that everyone must take responsibility for picking up on poor care, and being open and honest if it falls short of acceptable standards.

How and where an individual raises concerns when things go wrong will depend on the nature and context of the issue encountered. However, the physiotherapist has a legal obligation in relation to both duty of care and duty to report.

The law relating to the duty of care owed to individuals is based on case law, and therefore, it is continually developing. However, the duty of care owed by physiotherapists is expressed within the regulatory standards (HCPC 2012b). This duty means that healthcare professionals must take care when treating their patients, and practise both ''reasonably'' and ''responsibly with a logical basis''. The CSP provides extensive guidance to its members with respect to duty of care, including advice about how and where to raise concerns (CSP 2013c).

The obligation to raise concerns is known as the duty to report, a responsibility that underpins the duty of care owed to a patient. As stated previously, how and where an individual raises concerns will depend on the nature and context of the concern, although there are also legal variations in an individual's duty to report, depending on where in the UK the concern arises. It is important that every clinician understands his or her obligations with regard to duty to report, and how this may link to other aspects of professionalism, such as confidentiality, data protection and safeguarding. Further information about the duty to report is available from the CSP website (CSP 2014b), which includes links to useful resources.

Anyone can raise a concern at any time. If one is broached, it could involve you if it:

- is a complaint made by a patient about you or about a colleague whom you were with at the time;
- is a complaint made by a colleague about you or another colleague whom you were with at the time;
- is about an incident that you have witnessed that causes you concern;
- involves a manager investigating a complaint about you or another colleague whom you were with at the time; or
- involves a manager investigating a complaint about a colleague whom you have been managing through a formal or informal performance/competency process.

In all of these situations, you will be reliant on any records that you made at the time. With that in mind, if you suspect that an incident may result in a complaint in the future, you should make a contemporaneous record that is dated (and/or timed) and signed. If you were with a colleague, you may want to ask him or her to make his or her own record; if you do so, document that you asked him or her to do this. Alternatively, if you are documenting a meeting with a colleague (e.g. as part of a performance management process), you should make a contemporaneous record that is dated (and/or timed) and signed. If you do this, it may be appropriate to ask your colleague to date and sign the record, and give him or her a copy. You should also keep your manager updated of any or all of the above situations, and document, date and sign another document to record that you have done so.

What do you do if a concern is raised against you?

If a concern is raised informally within the workplace, you are advised to engage with the process. You should contact your union representative (or if you do not have a workplace steward, the Employment Relations and Union Services at the CSP), who will be able to support and advise you.

If the concern is raised formally, i.e. via the HCPC, you are advised to engage with the process without delay. The Council works to specific deadlines, and some responses, particularly in the early stage of the regulatory process, are needed within a short timescale. You should seek representation from the CSP Employment Relations and Union Services, either directly or via your workplace steward. You should also read the relevant documents that explain the regulatory process (CSP 2010; HCPC 2012c).

Fitness to practise

The phrase ''fit to practise'' is used to describe someone who has the skills, knowledge and character to practise their profession safely and

effectively (HCPC 2012c). Fitness to practise procedures serve to protect service users and members of the public, maintain public confidence in the profession and the regulator, and declare and uphold proper standards of conduct and behaviour.

Fitness to practise processes are neither a general complaints resolution process, nor designed to deal with disputes between registrants and service users. However, registrants should be aware that FtP may include matters not related to your professional practice, and the consequence of such procedures, while not intended to be punitive, may have that effect.

During the 12 months covered by the *Fitness to Practise Annual Report 2013* (HCPC 2013b), 1653 complaints were made to the HCPC (i.e. cases were referred), which equates to 0.53% of all registrants. Of these 1653 grievances, 123 related to physiotherapists. At that time, there were 46 842 physiotherapists on the register. Therefore, this figure of 123 equates to approximately 0.26% of registered physiotherapists.

When a complaint is received, it triggers a specific process, which is outlined below. However, the process is fully explained by the HCPC in *What Happens If a Concern Is Raised about Me?* (HCPC 2012c).

On receipt of a complaint, a case manager at the HCPC undertakes an initial screening to ensure that the complaint is both about one of its registrants and an FtP issue. If so, the registrant will be notified that a complaint has been received. It is at this stage that the individual should contact the CSP since the complaint will have progressed to an initial investigatory phase. During this stage, the registrant will be given details of the allegation, following which he or she have at least 28 days to make a written submission. Ideally, this is formulated in conjunction with the solicitor appointed by the CSP; however, the registrant is expected to actively participate in this process in order for the CSP to provide support.

The initial investigation, including the response of the registrant, is considered in private by the Investigating Committee. Like any FtP panel, this is independent of the HCPC, and comprised of both lay and registrant members. If the Investigating Committee decides that there is no case to answer, then the case goes no further. However, if a further complaint is received within 3 years and is considered to be similar in nature, then the initial complaint may be taken into account at that time. If the Investigating Committee decides that there is a case to answer, then it is referred to a hearing. This will take place following the completion of a detailed investigation, which includes the preparation of witness statements and other evidence. The final (substantive) hearing usually takes place before the Health Committee, or the Conduct and Competence Committee. At this stage, the panel will consider the allegation(s) put before it and make a decision (i.e. a determination). Of the 123 cases referred to in the *Fitness to Practise Annual Report 2013*, only 33 (27%) progressed to a final hearing (HCPC 2013b).

Hearings follow a three-stage process. First, the panel has to determine whether the facts (i.e. the allegations) are proven. If so, the panel will consider whether the registrant's FtP is currently impaired. If impairment is found, then the panel will determine what sanction (i.e. restriction) is required to protect service users, maintain confidence in the profession, and uphold proper standards of conduct and behaviour.

The registrant is able to attend the final hearing and be represented; however, it is possible for a panel to hear the case in the absence of the registrant. Most hearings take place in public. The registrant is given the opportunity to admit any of the allegations, although the burden of proof is on the HCPC. The Council will produce evidence to prove each allegation or to give context to admitted charges. This may include evidence being given by witnesses under oath or affirmation, as in a courtroom. The registrant's representative is able to cross-examine any witnesses, and the panel may also ask questions.

Once the HCPC has put its case, the representative produces evidence on behalf of the registrant, which may include him or her giving evidence under oath or affirmation. If the registrant does give evidence, he or she may be cross-examined, and may also be asked questions by the panel. The panel then retires to make its decision on the facts of the case.

The standard of proof used at the facts stage of FtP hearings is the civil standard of proof, i.e. the balance of probabilities. This means that the behaviour or conduct contained within each allegation has to be considered more likely than not to have happened. If any fact is proved, the panel proceeds to consider whether there is current impairment, and if there is, what sanction to impose. Decisions at the impairment and sanction stages are for the panel to determine using their own professional judgement, with

impairment being considered at the time of the hearing, i.e. not as to whether the registrant's practice was impaired at when the incident(s) occurred, but at the current time.

The panel hears the case in the presence of a legal assessor, and receives advice on both process and points of law from this individual. The legal assessor's remit includes providing advice about relevant case law since many different cases are referred to in FtP proceedings. In relation to the impairment stage, some of the key cases include: *Roylance v. GMC (No. 2)* [2001] 1 AC 311; *Cheatle v. GMC* [2009] EWHC 645; *Cohen v. GMC* [2008] EWHC 581; and *CHRE v. (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

These cases are used as legal examples or guidance when a panel considers issues such as misconduct, which has been defined as "a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances" (*Roylance v. GMC (No. 2)* [2001] 1 AC 311). These may also relate to legal/regulatory process; for example, in relation to the impairment stage:

> "A panel must engage in a two-step process. First, it must decide whether there has been misconduct, deficient professional performance or whether the other circumstances set out in the section are present. Then it must go on to determine whether, as a result, fitness to practise is impaired. Thus it may be that despite a [practitioner] having been guilty of misconduct, for example, a Fitness to Practise Panel may decide that his or her fitness to practise is not impaired." (*Cheatle v. GMC* [2009] EWHC 645 [19])

For example, a panel considering issues relating to the risk of repetition will be guided by the finding of Mr Justice Silber, who said, "There must always be situations in which a Panel can properly conclude that the act of misconduct was an isolated error on the part of a [practitioner] and that the chance of it being repeated in the future is so remote that his or her fitness to practise has not been impaired" (*Cohen v GMC* [2008] EWHC 581). In relation to remediation, he went on to say, "It must be highly relevant in determining if a [practitioner's] fitness to practise is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated" (*Cohen v GMC* [2008] EWHC 581).

The following approach, which was formulated by Dame Janet Smith in the fifth report of the Shipman Inquiry (Smith 2004), and is set out at paragraph 76 of *CHRE v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin), is often adopted by Nursing and Midwifery Council panels:

> "Do our findings of fact in respect of the [registrant's] [. . .] conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:
> (a) has in the past brought and/or is liable in the future to act so as to put patients at unwarranted risk of harm; and/or
> (b) has in the past brought and/or is liable in the future to bring the [physiotherapy] profession into disrepute; and/or
> (c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the [physiotherapy] profession; and/or
> (d) has in the past acted dishonestly and/or is liable to act dishonestly in the future?"

A sanction can only be applied if impairment is found. A sanction has to be proportionate, i.e. the lowest possible that will protect the public, declare and uphold proper standards of conduct and behaviour, and maintain the reputation of the profession and confidence in the regulator. Panel members refer to the *Indicative Sanctions Policy* (HCPC 2013c), which directs the panel to consider the available sanctions in ascending order. This means that the least restrictive sanction is considered first. The available sanctions are (in ascending order):

(1) no further action;
(2) a caution order (of between 1 and 5 years);
(3) a conditions of practice order (which specifies restrictions for the registrant's practice for a period of up to 3 years);
(4) a suspension order (of up to one year, which temporarily prohibits the registrant from practice); and
(5) a striking-off order, which is the most serious sanction, as it removes the registrant's name from the register.

The sanction is not intended to be punitive, but it may have a punitive effect. Panel members are required to take into account both aggravating and mitigating factors, and they have to give clear reasons as to why a sanction is considered either appropriate or inappropriate.

Aggravating factors include:

- the period of time over which the failings took place;
- the seriousness of the failings;
- any lack of recognition of the gravity and significance of the failings;
- a continuing attribution of blame to colleagues;
- a failure to take responsibility for the failings;
- a lack of compassion for patients and patient-centred care; and
- a failure to recognize the importance of consistently maintaining appropriate standards.

With respect to mitigating factors, these include early admission in relation to the allegations, and demonstration of insight, remorse and remediation. To demonstrate insight, the registrant needs to convey an awareness of the impact of the issues – most importantly on the impact it had, or could have had, on service users and the reputation of the profession. This can help to reassure the panel that the registrant has an understanding of the significance of their actions or omissions, that he or she has learnt from the incident, and that repetition is less likely in the future. In terms of remediation, the panel will consider if the behaviour or error is remediable, whether it has been remedied, and whether it is likely to be repeated. This may include evidence of reflection and/or subsequent relevant training that has been implemented in practice, and an explanation of how, should similar circumstances present themselves in the future, the registrant would act differently. In some cases, such as dishonesty, it may be difficult to demonstrate remediation.

In relation to the 33 cases involving physiotherapists that were referred to previously as progressing to a final hearing (HCPC 2013b), the sanctions shown in Table 1 were imposed.

As well as FtP processes, there is a further HCPC procedure relating to self-referral. Registrants have a duty to inform the Council (i.e. self-refer) if they:

- are convicted of a criminal offence (other than a motoring offence, unless it involved alcohol or drug misuse, or resulted in death) or accept a police caution;
- are disciplined by any organization responsible for regulating or licensing a health or social care profession; or
- are suspended or placed under a practice restriction by an employer or similar organization because of concerns about their conduct or competence.

Table 1. Decisions made, including sanctions imposed, in the 33 cases involving physiotherapists in which complaints made to the Health and Care Professions Council (HCPC) were progressed to a final hearing (HCPC 2013b)

Decision	Number
Not well-founded	7
No further action	0
Caution	9
Conditions of practice	4
Suspension	4
Struck off	7
Voluntary removal*	2

*An agreement between the HCPC and the registrant that the individual be removed from the HCPC register.

In the first instance, this would be considered by the HCPC as a registration issue and considered by the Registration Committee, although they may refer it on as an FtP issue (CSP 2010).

Future developments

There are a number of issues that clinicians need to be aware of in relation to future professional practice, including the following:

- There is ongoing work in relation to a statutory duty of candour, as recommended by Francis (2013) in his report into the failings at the Mid-Staffordshire NHS Foundation Trust. It is proposed that the obligation would be on healthcare professionals where there is a belief or suspicion that any treatment or care provided to a patient by or on behalf of their employing healthcare provider has caused death or serious injury.
- There is a further, ongoing review by Francis into whistle-blowing processes that aims to provide independent advice and recommendations to ensure that:
  - NHS workers can raise concerns in the public interest with confidence that they will not suffer any detriment as a result;
  - appropriate action is taken when concerns are raised by NHS workers; and
  - where NHS whistleblowers are mistreated, those mistreating them will be held to account.
- There is consideration of extending the work already undertaken on safe staffing levels to include the allied health professions.
- While providing many benefits, the use of social media also presents challenges for professionals because it can blur the boundaries between personal and professional life, and have a detrimental impact on the reputation,

Box 1. Key messages: (CPD) continuing professional development

- As an autonomous professional, you are responsible and accountable for the decisions that you make.
- Ensure that you keep your CPD log up to date: it is not just a list of courses or activities, it must specify what you learned from each activity and how you applied it to your practice.
- Incorporate reflective practice into your daily activities, and keep a log so that you can demonstrate the impact of CPD on your service users.
- Keep clear and contemporaneous records: you never know when you may need to rely on these.
- Engage and be proactive.

professional status and employment prospects of health professionals (CSP 2012d).

- There is a now a mandatory requirement to have appropriate professional indemnity in place (HCPC 2014). This is a new obligation, but some employers may already provide an indemnity arrangement. Additionally, CSP members receive professional liability insurance (PLI) as part of their membership; however, it is the responsibility of individuals to ensure that the arrangement is appropriate for their needs and that they work within their scope of practice.
- It is important to consider whether the purchase of separate criminal defence cost insurance is appropriate since the CSP PLI scheme does not include cover for any criminal proceedings brought against members (CSP 2014c).

The key messages of the present paper are outlined in Box 1.

References

Austin Z. (2013) How competent are we at assessing competency? Paper presented at the CLEAR Congress on Professional and Occupational Regulation, Edinburgh, UK, 27–28 June 2013.

Cavendish C. (2013) *The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings*. [WWW document.] URL https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf

Chartered Society of Physiotherapy (CSP) (2008) *Scope of Physiotherapy Practice 2008*. Information Paper PD001. Chartered Society of Physiotherapy, London.

Chartered Society of Physiotherapy (CSP) (2010) *HCPC Investigations: A Member Guide*. Information Paper ERUS IP 40. Chartered Society of Physiotherapy, London.

Chartered Society of Physiotherapy (CSP) (2011) *Consent and Physiotherapy Practice*. Information Paper PD078. Chartered Society of Physiotherapy, London.

Chartered Society of Physiotherapy (CSP) (2012a) *Professionalism: A Focus for Topical Debate*. [WWW document.] URL http://www.csp.org.uk/frontline/article/professionalism-–focus-topical-debate-0

Chartered Society of Physiotherapy (CSP) (2012b) *Quality Assurance Standards for Physiotherapy Service Delivery*. Chartered Society of Physiotherapy, London.

Chartered Society of Physiotherapy (CSP) (2012c) *Pelvic Floor Examination – CSP Expectations: CSP Expectations of Educational Programmes in Vaginal and/or Anorectal Examination and/or Interventional Procedures for Physiotherapists*. Information Paper PD092. Chartered Society of Physiotherapy, London.

Chartered Society of Physiotherapy (CSP) (2012d) *Social Media Guidance*. Chartered Society of Physiotherapy, London.

Chartered Society of Physiotherapy (CSP) (2013a) *Code of Members' Professional Values and Behaviour*. Chartered Society of Physiotherapy, London.

Chartered Society of Physiotherapy (CSP) (2013b) *Chaperoning and Related Issues*. Information Paper PD104. Chartered Society of Physiotherapy, London.

Chartered Society of Physiotherapy (CSP) (2013c) *Duty of Care*. Information Paper PD101. Chartered Society of Physiotherapy, London.

Chartered Society of Physiotherapy (CSP) (2014a) *What Is Professionalism?* [WWW document.] URL http://www.csp.org.uk/professional-union/professionalism/what-professionalism

Chartered Society of Physiotherapy (CSP) (2014b) *Duty to report*. [WWW document.] URL http://www.csp.org.uk/professional-union/professionalism/resources/duty-report

Chartered Society of Physiotherapy (CSP) (2014c) *Insurance: Criminal Defence Costs*. [WWW document.] URL http://www.csp.org.uk/professional-union/practice/insurance/insurance-criminal-defence-costs

Cheatle v. GMC [2009] EWHC 645. [WWW document.] URL http://www.bailii.org/ew/cases/EWHC/Admin/2009/645.html

CHRE v. (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin). [WWW document.] http://www.bailii.org/ew/cases/EWHC/Admin/2011/927.html

Cohen v. GMC [2008] EWHC 581. [WWW document.] http://www.bailii.org/ew/cases/EWHC/Admin/2008/581.html

Department of Health (DH) (2003) *Allied Health Professions Project: Demonstrating Competence Through Continuing Professional Development [CPD] – Final Report*. Department of Health, London.

Francis R. (2013) *The Mid Staffordshire Foundation NHS Trust Public Enquiry*. [WWW document.] URL http://www.midstaffspublicinquiry.com/report

Health and Care Professions Council (HCPC) (2012a) *Your Guide to Our Standards of Continuing Professional Development*. Health and Care Professions Council, London.

Health and Care Professions Council (HCPC) (2012b) *Standards of Conduct, Performance and Ethics*. Health and Care Professions Council, London.

Health and Care Professions Council (HCPC) (2012c) *What Happens If a Concern Is Raised about Me?* Health and Care Professions Council, London.

Health and Care Professions Council (HCPC) (2013a) *Standards of Proficiency: Physiotherapists*. Health and Care Professions Council, London.

Health and Care Professions Council (HCPC) (2013b) *Fitness to Practise Annual Report 2013*. Health and Care Professions Council, London.

Health and Care Professions Council (HCPC) (2013c) *Indicative Sanctions Policy*. [WWW document.] URL http://www.hpc-uk.org/assets/documents/100040C7Enc14-Indicativesanctionspolicy.pdf

Health and Care Professions Council (HCPC) (2014) *Professional Indemnity and Your Registration*. Health and Care Professions Council, London.

Keogh B. (2013) *Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England: Overview Report*. [WWW document.] URL http://www.nhs.uk/nhsengland/bruce-keogh-review/documents/outcomes/keogh-review-final-report.pdf

Middleton K. (2012) Professionalism – the Big Conversation. *Allied Health Professionals Bulletin* **87** (February), 1–2.

National Advisory Group on the Safety of Patients in England (NAGSPE) (2013) *A Promise to Learn – a Commitment to Act: Improving the Safety of Patients in England*. [WWW document.] URL https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

Roylance v. GMC (No. 2) [1999] 1 AC 311. [WWW document.] URL http://www.bailii.org/uk/cases/UKPC/1999/16.html

Smith J. (2004) *The Shipman Inquiry Fifth Report: Safeguarding Patients: Lessons from the Past – Proposals for the Future*. The Stationary Office, London.

Van der Gaag A. (2014) *A Journey of a Thousand Small Steps: Thinking about Competence in a Different Way*. [WWW document.] URL http://hcpc-uk.blogspot.co.uk/2014/02/a-journey-of-thousand-small-steps.html

Teresa Cook is a women's health physiotherapy consultant and lecturer. She works both independently and as a specialist lecturer on the Postgraduate Certificate: Continence for Physiotherapists, which is part of the postgraduate physiotherapy programme at the University of Bradford. Teresa also spends a substantial proportion of her working life in healthcare regulation, predominantly as a lay panellist on the Conduct and Competence Committee of the Nursing and Midwifery Council. In addition, she is currently chair of the CSP Regulatory Board and has contributed to various professional guidance documents produced by the Society.