Council for Healthcare Regulatory Excellence

Safeguards in healthcare

Qualitative Research Findings

February 2009

Prepared for:

CHRE
11 Strand
London
WC2N 5HR

Prepared by:

Research Works Limited
Regency House
219a Hatfield Road
St Albans
Herts, AL1 4TB

Tel: 01727 893159
Fax: 01727 893930

all@researchworks.co.uk

CONTENTS

1. BACKGROUND

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

- In 2007, the government published a White Paper describing their intention to strengthen CHRE's role as an independent voice for patients and the public on healthcare regulation issues.

- The 2008 Health and Social Care Act defined this new objective: CHRE are now required to promote the health, safety and well being of patients and other members of the public.

In March 2009, CHRE will be holding their first national conference since this new objective was established. Prior to the conference, research is required to establish the general public's views about the regulation of health professionals. The research will be used as the basis for a conference presentation and report, as well as associated press materials. In addition, the research will inform policy development work.

2. RESEARCH OBJECTIVES

In order to fulfil its brief as the voice of patients and the public in the regulation of health professionals, CHRE wished to:

- achieve a clear understanding of the general public's perceptions of professional regulation

- seek the general public's views regarding the roles and responsibilities of different organisations in assuring safe and trustworthy health professionals

The specific research objectives were to examine:

- what gives patients and the public trust and confidence that the care they receive from health professionals is safe and of high quality?
- how is trust and confidence challenged or undermined, and what impact does this have on patients and the public?
- where does the responsibility lie for ensuring people feel confident?
- how should this responsibility be fulfilled?
- what is needed to help people feel more confident?

3. METHOD AND SAMPLE

A series of twelve qualitative workshop discussions (2 hours duration) were undertaken. Fieldwork was conducted in Oldham, Swansea, Glasgow, St Albans, Ilkeston and Belfast between the 8th December 2008 and 7th January 2009. The sample is described in detail below.

6 workshops with the 'well' general public, with representation in each workshop of those with experience of non-NHS services:

1. Mixed sex, 18-25 years, Single, no children, BC1C2
2. Mixed sex, 26-39 years, Family stagers, young children, ABC1
3. Mixed sex, 26-39 years, Family stagers, young children, C2DE
4. Mixed sex, 40-59 years, Family stagers, older children, ABC1
5. Mixed sex, 40-59 years, Family stagers, older children C2DE
6. Mixed sex, 60+ years, Empty nesters/retired, BC1C2

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

1. Mixed sex, younger patients, 20-39 years, BC1C2D
2. Mixed sex, older patients, 40+ years, BC1C2D

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

1. Mixed sex, younger patients, 20-39 years, BC1C2D
2. Mixed sex, older patients, 40+ years, BC1C2D

2 workshops with patients who had recently interacted with non-NHS healthcare services:

1. Mixed sex, 25-39 years, Singles/Family stagers, BC1C2D
2. Mixed sex, 40+ years, Empty nesters/retired, BC1C2D

4. MANAGEMENT SUMMARY

Trust and confidence in health professionals is assumed, integral to their status as a health professional. The health professional's manner and the healthcare environment directly influence inherent levels of trust and confidence, which are also indirectly influenced by the media and word-of-mouth reports.

Poor communication, poor levels of knowledge and ethical doubts can undermine trust and confidence in health professionals, ultimately creating frustrated patients. When trust and confidence in health professionals is damaged, frustrated patients can quickly become confrontational and liable to complain in an inappropriate manner.

A hierarchy of the individuals and organisations responsible for ensuring that patients have confidence in health professionals emerged, which included: patient, individual health professional, professional peers, line manager, employer, regulator and government. Although the mix of individuals and organisations involved in taking responsibility for health professionals varied across different healthcare settings, the role of the regulator was consistent: regulators only became implicated in the event of a complaint i.e. something going wrong.

A broad awareness of regulation is exists in the public mind. Levels of knowledge about regulatory mechanisms and activities (and in particular, health professional regulatory mechanisms and activities) are extremely low. The GMC is the only 'household name' amongst healthcare regulators, due to publicity of the Harold Shipman case.

For the general public, the regulation of health professionals is essentially a 'hygiene factor'. It is widely assumed that regulation of health professionals takes place 'behind the scenes' – where it should remain. There was little evidence of the public wanting to hear more about health professional regulation. In reality, there was more interest in experiencing improved services as a result of successful regulation.

In future, there was support for offering the public reassurance that health professionals are regulated and that there is a complaints pathway – should one need it - which will support the interest of patients. Both of these messages will encourage patients to feel more confident in their health professionals.

5. MAIN FINDINGS

5.1 SAMPLE COMMENTS

Socio economic background strongly influenced levels of awareness and understanding of regulation. C2DE respondents typically had little or no understanding of regulation either within or outside of healthcare. By contrast, ABC1 respondents were considerably more knowledgeable about regulation generally, as well as the regulation of health professionals.

In particular, ABC1 individuals working in other regulated industries (for example, construction, teaching, accountancy) had more insight into regulation and based their assumptions about health professional regulation on experiences of regulation in other professional sectors. This often led to incorrect generalisations about how they expected health professional regulation to work.

"With OFSTED the inspectors come round and you get a one, two, three or a four. If you get a four, you're up the creek. If you get a one then they'll leave you alone for a while. There's got to be one like that for. Like, doctors and dentists and chiropractors." (Male patient, 20-39, BC1C2D, Ilkeston)

Level of interaction with healthcare services also influenced levels of awareness, understanding and, critically, *interest* in regulation. Patients with ongoing, chronic conditions had more interest in regulation than those who only interacted with routine 'maintenance' health services. Older patients with ongoing, chronic conditions had the most contact with services - and were therefore the most interested in regulation. This group was in contact with a wide range of health professionals since they were managing a number of conditions, as well as attending routine 'maintenance' appointments.

Age and life stage influenced attitudes towards health professionals. Younger respondents were prepared to be more critical of health professionals. They were less reliant on health professionals and often 'self-diagnosed', using the internet to research symptoms. By contrast, older respondents were more likely to have been *'brought up to respect health professionals'* and were therefore less likely to be critical.

Mothers were amongst the most likely to challenge health professionals if there was an issue with their child's treatment. Some reported highly emotional responses when they suspected that health professionals were not acting effectively:

"They just kept giving me cream and I ended up asking them if the cream was magic, and I was told that my attitude was wrong and they didn't have to take it." (Female, 26-39 years, young children, ABC1, Ilkeston)

Levels of confidence in health professionals varied, influenced by variations in the quality of local NHS services:

- Respondents in Glasgow trusted health professionals implicitly because they felt that services were satisfactory.
- Oldham respondents trusted health professionals fundamentally but reported service problems because of low staffing levels in hospitals.
- In Belfast, there was a noticeable lack of confidence in health professionals, particularly GPs.
- In Ilkeston, respondents were concerned that health professionals might not have the best interests of patients at heart because of time constraints and limited budgets.
- Respondents in Swansea had generally lower confidence in local NHS services and saw private services as far superior.

- Younger respondents in St Albans reported numerous 'horror stories' about local services, but typically blamed 'the system' rather than the individual health professionals involved.

In spite of differences in perceptions of local services, awareness, understanding and expectations of regulation were consistent across all locations.

5.2 CONFIDENCE FACTORS

Confidence in health professionals was high and was seemingly based upon an inherent trust in the status of health professionals:

"You think of a health professional as someone you can trust." (Male, 25-39 years, BC1C2D, Oldham)

"When you see a nurse in uniform in a hospital you expect her to be a nurse!" (Female, 40-59 years, C2DE, Swansea)

It seems that our 'default setting' is to trust our health professionals. Quantitative research has consistently found that health professionals are trusted:

- According to the National Survey of Local Health Services in 2006, 76% of respondents said they definitely had trust and confidence in their GPs *(Picker Institute on behalf of the Healthcare Commission).*
- Another study by the Healthcare Commission of adult inpatients in 2007 found that 92% of patients said their care was "good", "very good" or "excellent".

There was an assumption that being a health professional working in a healthcare environment *guaranteed*:

- training and education, as well as common standards and conduct
- (when prompted) inspection and oversight, as well as registration and fitness to practice

"I've seen some of the things they have to go through to get to where they are, each profession. For doctors they've got six or seven years before being able to work, so you think to yourself 'Well, it's regulated and safe." (Male, 25-39 years, BC1C2D, Oldham)

There was little appetite for questioning this high level of confidence by scrutinising health professionals more closely:

"You really put all your trust in them and don't even think about it." (Female, 26-39 years, C2DE, Belfast)

Levels of confidence remained high, even when faced with serious health problems. Particularly when ill, patients evidently have a vested interest in not questioning their confidence in the health professionals caring for them. Most respondents who had encountered heath emergencies were lavish in their praise for health professionals, and felt able to depend on them fully:

"If me or the kids have ever had an emergency, the NHS have been spot on. You can complain about waiting lists and all the rest of it but if there's an emergency, they're there." (Female patient, 20-39, BC1C2D, St Albans)

Levels of confidence remained high across healthcare settings. Within the NHS, dissatisfaction tended to be associated with 'the system' or blamed on

'management'. For example, lack of time and attention devoted to patients was blamed on time poverty as opposed to neglect on the part of the individual health professional. Often, respondents even sympathised with health professionals' working conditions:

"I think time is an issue. They haven't got the time to spend talking to patients, which makes you feel you're not important. They just do what they've got to do then off to the next patient. It's not their fault, they just don't have the time, they've got so much to do now." (Female 40-59 years, C2DE)

"If the government stopped giving them so much paperwork to do they'd have more time to spend with patients" (Male 25-39 years, BC1C2D, Oldham)

The factors influencing confidence in health professionals were typically drawn from personal experience. Judgements tended to be based on perceptions, rather than knowledge or understanding, for example:

- manner – how the health professional treats the patient
- environment (particularly cleanliness)

If satisfied (or at least not actively *dissatisfied*) with the health professional's manner and the healthcare environment, patients were typically happy to continue to assume confidence in health professionals. If dissatisfied with either of these factors, patients were more likely to question their confidence in health professionals:

"When I dislocated my shoulder everyone was really polite except this one nurse. She was probably the best nurse there but she was just an idiot with me. I thought 'I'd rather have somebody who doesn't know what they're doing than this.'" (Male, 18-25 years, BC1C2, Oldham)

Factors undermining confidence in health professionals tended to cluster around core themes:

- poor communication (for example, leading to misunderstanding)

  "When I got home I took my bandages off, I didn't know I had to keep them on because nobody told me! The nurse just gave me my medicines and sent me on my way." (Female, 25-39 years, BC1C2D, Oldham)

- poor knowledge (for example, leading to misdiagnosis)

  "They more or less told me my illness was in my mind. I went to see a psychiatrist because, if you know about Crohn's disease, it's totally debilitating so I thought I was going mad, it was very scary." (Female patient 40+, BC1C2D, with chronic condition, Swansea)

  "My daughter died of cancer. I knew there was something wrong and they didn't find it." (Female, 26-39 years, Family stagers, young children, ABC1, Ilkeston)

- ethical considerations (for example, potential conflicts of interest in private care situations)

  "The NHS specialist told me I didn't need the operation but the private consultant said I should have it. That just made me think he was in it for the money." (Male, 60+ years, Empty nesters/retired, BC1C2, St Albans)

When undermined, high levels of confidence can quickly turn into a complete loss of confidence: leading to frustrated patients, confrontations – and complaints. This was largely due to a gap in knowledge about how to complain.

Unaware of proper complaints procedures, respondents tended to become aggressive, emotional and difficult:

"There's not a lot you can do… I just refused to move and one of the nurses threatened to kick me out." (Female, 40-59 years, older children, C2DE, Swansea)

Respondents felt that they were not sufficiently informed regarding complaints procedures, particularly when accessing services provided by the NHS or independent health professionals. By contrast, private services were felt to be more customer-focussed and respondents claimed that they had come across more information about how to deal with complaints:

"I'd have thought someone like BUPA or someone like that would have customer services and they seem a lot more friendly as well." (Female patient, 20-39, BC1C2D, Ilkeston)

"I went for a private operation last year and they give you so much information about what the benefits are, what can go wrong and leaflets with information about who to contact if you're not happy." (Female, 26-39 years, ABC1, Ilkeston)

5.2.1 CONFIDENCE FACTORS: THE MEDIA

The media emerged as a factor influencing confidence in health professionals that was outside of personal experience. The media was perceived as an important source of information about health services (particularly local media).

There was, however, an awareness of potential media bias – with respondents conscious that most of their current understanding about regulation has been

generated by negative media coverage (e.g. Harold Shipman). Media engagement with regulation was acknowledged as often superficial and typically based on extreme cases, *"whenever there is bad news and something has gone drastically wrong."* (*Male patient, 40+, BC1C2D, Glasgow)*

"They tend to focus on all the bad things. You only hear bad things, you don't hear about good things." (Male, 18-25 years, Single, no children, BC1C2, Oldham)

5.2.2 CONFIDENCE FACTORS: WORD-OF-MOUTH

Word-of-mouth was another important means of establishing confidence in health professionals, particularly when consulting an independent health professional:

"You'd speak to people and find out what they were like. If everyone said they were good, you'd go to them." (Female patient, 20-39, BC1C2D, Ilkeston)

Word-of-mouth recommendation was particularly influential in smaller communities (e.g. Ilkeston in Derbyshire). If unsure about a health professional, respondents felt that they would (where possible) be happy to rely on peers and word-of-mouth for clarification or reassurance.

5.2.3 CONFIDENCE FACTORS: CONCLUSIONS

Trust and confidence in health professionals is assumed, integral to their status as a health professional. The health professional's manner and the healthcare environment directly influence inherent levels of trust and confidence, which are also indirectly influenced by the media and word-of-mouth reports.

Poor communication, poor levels of knowledge and ethical doubts can undermine trust and confidence, creating frustrated patients. When trust and confidence in health professionals is damaged, frustrated patients can quickly become confrontational and liable to complain in an inappropriate manner. In future, communicating that there are complaints mechanisms supporting patients should encourage patients to complain appropriately and effectively.

5.3 RESPONSIBILITY

Respondents were asked to consider which individuals or organisations had responsibility for ensuring that patients have confidence in health professionals. A hierarchy of responsibility emerged (as described in sections 5.3.1 to 5.3.7) which varied across different healthcare settings (as described in section 5.3.8).

5.3.1 RESPONSIBILITY: PATIENTS

Patients who were engaged with health professionals were perceived to be taking responsibility for themselves:

"It's up to the you to make sure that you take responsibility for your own body and do what they tell you to do to get better." (Male, 26-39, C2DE, Belfast)

"People know what is wrong with them and should make sure they take the right precautions." (Male patient, 40+ years, BC1C2D, Glasgow)

For example, in case study one (see appendix A), the patient was frequently criticised for omitting to tell the GP key information regarding her caffeine consumption.

Two key patient responsibility themes consistently emerged:

- Firstly, patients should communicate openly with health professionals, providing relevant information and asking questions, as well as giving feedback by both complaining and complimenting when appropriate

- Secondly, patients should use services responsibly, respect staff and not waste time or resources

5.3.2 RESPONSIBILITY: HEALTH PROFESSIONALS

The responsibilities of health professionals were clearly defined. Individuals were held responsible for their own manners and conduct, as well as their own professional judgement.

Within the NHS, individuals were not held responsible for restrictions placed upon them by 'the system'. It was recognised that that NHS staff were often overworked and underpaid:

"The ward was filthy and the nurses didn't come anywhere near, they couldn't have because they're already running around like headless chickens because there's not enough of them." (Male patient, 40+, BC1C2D, Swansea)

5.3.3 RESPONSIBILITY: PROFESSIONAL PEERS

Health professionals were also believed to have a responsibility to oversee each other's behaviour. Generally, health professionals were expected to address any perceived failings in their colleagues' performance. More specifically, the input of senior health professionals was expected (for example, differences in opinion such as in case study three, appendix A):

"The doctor should be able to talk to his colleagues or someone higher up who can say if he's right or not." (Female 26-39 years, ABC1, Ilkeston)

Rather than acting as a check on each other's behaviour, there was a concern that doctors in particular might 'close ranks' and that the 'old boys network' might still be influential:

"These surgeons can get away with practically anything. They all look after each other." (Male patient, 40-65 years, BC1C2D Belfast)

"They're all going to look out for each other. You have to sign a disclaimer to say if anything goes wrong they're not held responsible so you don't have a leg to stand on." (Male patient, 20-39, BC1C2D, Ilkeston)

Whilst a clinical chain of command was anticipated, an independent level of oversight was also required.

5.3.4 RESPONSIBILITY: LINE MANAGER

Line managers were perceived as having immediate responsibility for individual health professionals. There was an appetite for more authority and accountability at this level, commonly articulated by the wish for *"a return of matron!"*

The appeal of an increased emphasis at this level of responsibility was two-fold: firstly, a vision of close, ongoing scrutiny on a day-to-day basis; and secondly, patients perceived line managers accessible and approachable. Line managers were often the first person consulted about a potential complaint.

5.3.5 RESPONSIBILITY: EMPLOYER

Employers were perceived as having a role in maintaining established standards and conduct:

"When they employ people they should say 'this is what we do here, we have good manners..', like policies." (Female 18-25 years, BC1C2, Oldham)

"The NHS, they set the policies don't they." (Female 18-25 years, BC1C2, Oldham)

Private sector employers were perceived as having a relatively close and direct relationship with the health professionals they employed. In addition, private employers were perceived to be more business oriented and therefore more interested in customer feedback:

"It's all about money and it's their livelihood so to keep their customer happy they will be the ones to get to the bottom of the issue." (Female patient, 40+ years, BC1C2D, Glasgow)

By contrast, respondents tended to be overwhelmed by the assumed layers of bureaucracy involved in NHS management. Patients felt that they were more likely to engage a solicitor to pursue a complaint within the NHS, due to the assumption that it would be complex to pursue a complaint by themselves.

5.3.6 RESPONSIBILITY: REGULATORS

The need for regulators within the responsibility hierarchy only became apparent when patients envisaged something going wrong. At this point, regulators became relevant to patients. For example, in case study two, appendix A (a

medical accident as a result of a lack of clinical expertise) regulators came into focus:

"Really, no one needs to know about who the regulators are unless they're not regulating procedures properly." (Female, 60+ years, BC1C2, St Albans)

Whilst their role in a complaints situation was clear, health professional regulators are seemingly gaining little recognition from simply maintaining standards ('hygiene factors') on a day-to-day basis.

5.3.7 RESPONSIBILITY: GOVERNMENT

Government responsibilities tended to be focussed on the NHS (i.e. funding, budgets, targets and management structures). When prompted, the government's role in creating legislation was viewed negatively, associated with unhelpfully high levels of bureaucracy assumed to hinder health professionals and negatively impact patients.

It was presumed that government had established regulators and given regulators their powers to regulate:

"The government give them the powers and authority to make sure it's all smooth and everyone's adhering to what they're supposed to do." (Male patient, 20-39, BC1C2D, Ilkeston)

Government's role in the hierarchy was far removed from patients. There was little understanding of how government's role in the hierarchy of responsibility would practically benefit patients on a day-to-day level.

5.3.8 RESPONSIBILITY: VARIATIONS

The emphasis on different individuals/organisations within the hierarchy of responsibility varied across different healthcare situations. The case studies discussed below are described in appendix A.

In case study 1, the role of the patient in providing accurate information was particularly key, as was the role of organisations responsible for education and training. There was not perceived to be a role for the regulator (since the issue was not perceived to be serious enough to warrant a complaint):

"She should just have Googled her anxiety problem instead of even going to the doctors in the first place." (Female patient, 40-65 years, BC1C2D, Belfast)

Case study 2 involved the full hierarchy of responsible individuals and organisations because, as a publicly funded service, NHS Acute Care was associated with (and assumed to require) high levels of regulation. There was a role for the regulator in managing what was clearly perceived to be a justifiable complaint.

In case study 3, there were far fewer individuals and organisations involved in the hierarchy of responsibility because of the private service context: patient, individual health professional, employer and regulator. The government was not perceived as having a role in a private healthcare issue, although it was assumed that the health insurance company would become involved at some point:

"It all comes down to who you are paying – they are the ones responsible." (Male patient, 40-65 years, BC1C2D, Belfast)

There was an extremely short hierarchy of responsibility in case study 4: patient, health professional and regulator. Respondents were shocked to realise that independent health professionals are not working within a hierarchy of oversight and that the regulator is the only check and balance for patients to rely upon in this context.

5.3.9 RESPONSIBILITY: CONCLUSIONS

The full hierarchy of individuals and organisations with responsibility for ensuring that patients feel confident in health professionals is outlined as below:

Patient

⬇

Individual health professional

⬇

Professional peers

⬇

Line manager

⬇

Employer

⬇

"an accountable organisation"

most often called 'governing bodies' (i.e. regulators)

⬇

Government

5.4. REGULATION

Generally, awareness of regulation was low and understanding of the difference between organisations with some level of oversight was extremely muddled.

However, some sense of regulation exists in the public mind. There was awareness of some familiar 'household names', for example, OFSTED, Financial Services Authority, Corgi, OFCOM.

Equally, regulators were easily confused with a wide variety of other types of organisations:

- Professional bodies (e.g. The Law Society, BMA)
- Public bodies (e.g. Health and Safety Executive)
- Local services (e.g. environmental health departments)
- Inspectorates (e.g. HM Inspectorate of Constabulary)
- Ombudsmen

There was a broad understanding that the regulatory role is to protect the public, a role which was therefore seen as important and worthwhile. There was extremely little knowledge, however, about exactly how regulators protect the public:

- Commonly, regulation was equated with 'inspection' (largely thanks to knowledge and experience of OFSTED activities)
- 'Striking off' was another well recognised regulatory activity (particularly in the healthcare arena) due to publicity about GMC activities

Despite vague understanding of the regulatory role, a basic awareness of the presence of regulators was reassuring for the general public.

5.4.1 HEALTH PROFESSIONAL REGULATION

Levels of specific knowledge about health professional regulation were even lower than knowledge of regulation in general:

"Is there someone who monitors dentists, like Ofcom does for telephones?" (Male patient, 40+ years, BC1C2D, Glasgow)

"I don't know what they do, but there must be someone regulating these doctors and dentists." (Female, 25-45, C2DE, Belfast)

The GMC was often mentioned, but so too (often in the same breath) were the BMA and BDA. There was confusion about the roles of these organisations, their relationship with patients, health professionals – and each other! For example, some respondents thought that the GMC was responsible for *all* health professionals, not just doctors. Although regulators and professional bodies with higher profile roles were known by name, their roles were still unclear.

5.4.2 PROFESSIONAL BODIES

Professional bodies were often confused with regulators. When prompted with explanatory information (appendix B), the key differences between professional bodies and regulators were felt to be that the former look after the interests of the profession, as opposed to those of the public:

"You've got the professional bodies making sure they do it right, then if it goes wrong the regulators will put them right, clamp down." (Female patient, 20-39, BC1C2D, Ilkeston)

However, the work of professional bodies was perceived as having an indirect impact on patients, in terms of:

- Professional training and development which is key to guaranteeing high standards of care

- Lobbying as a way of influencing the government to support health professionals to provide high standards of care
- Developing best practice (perceived as fundamental)

5.4.3 REGULATION: CONCLUSIONS

A broad understanding of regulation exists in the public mind, and regulation is typically assumed to exist within the healthcare arena. The GMC is the only 'household name' amongst healthcare regulators; this has some about because of heightened media coverage of the GMC in cases such as Harold Shipman.

Awareness of the presence of regulators (however vague) was reassuring. Greater reassurance regarding the regulation of health professionals would be welcome in future. Clarification about whom professional bodies and regulators represent will be required.

5.5 FULFILLING RESPONSIBILITIES

The tasks which need to be undertaken in order to maintain patient confidence in health professionals were identified as follows:

- Education and training, which was perceived as the responsibility of a mix of organisations: employers, line managers and professional bodies (via universities and colleges)

- HR issues such as staffing levels, disputes and staff motivation, which were perceived as the responsibility of employers

Overall, respondents felt that regulators should have responsibility for:

- Setting standards – and ensuring that standards are met
- Taking action when standards are not met

Despite the perceived importance of the role, respondents failed to find the specific activities of healthcare regulators of any interest. It was assumed that the process of ensuring standards are implemented would be through inspections and 'checks'.

When respondents were prompted with the types of activities undertaken by regulators, these were seen as the types of processes that were *expected* and already assumed to be in place (i.e. setting standards of behaviour and ethics, Registering health professionals, fitness to practice procedures, striking unfit professionals 'off the register', as described in appendix B).There was little interest in knowing more about activities that were expected and therefore 'taken as given':

"I really don't want to know about that sort of thing. I wouldn't read that sort of thing in the papers. It just goes over my head. To be honest with you, I don't even care, we don't even know who these regulators are." (Female patient, 40+, BC1C2D, Swansea)

On a day-to-day level, the role of a health professional regulator was not felt to be relevant to individual patients. Regulators were associated with extreme cases (such as those publicised in the media). The involvement of regulators was assumed to occur late in the process of a complaint, when far removed from the influence of individual patients. As a result, regulators felt very distant to patients, who assumed they would need to progress through a complicated complaints hierarchy before encountering a regulator.

5.5.1 FULFILLING RESPONSIBILITIES: CONCLUSIONS

There was little evidence of the public wanting to hear more about regulation. They were more interested in experiencing improved services as a result of successful regulation.

In reality, there were only perceived to be two reasons for regulators to communicate information about their activities:

1. Firstly, a broad message promoting awareness of the presence of regulation procedures is reassuring:

   "If you walk into hospital and pick up a leaflet and you see 'Governing Body' or something then you're going to be a bit more confident. You're going to think to yourself, at least somebody's looking over me in case something does go wrong, someone's there that's going to back me up." (Male, 26-39 years, ABC1, Ilkeston)

   "You only know them if you're ill… but you should know them. We've not had a problem with the Food Standards Agency but we know they're there. And OFSTED, you know they're out there checking the teachers." (*Female, 26-39 years, ABC1, Ilkeston)*

2. Secondly, informing patients that there are established complaints procedures to follow, if necessary, increases confidence

   "The first thing they need to do is to come out of the closet and say, 'Hey! We are regulators and if you want us, you can get us here." (Male patient, 40+ years, BC1C2D, Glasgow)

6. CONCLUSIONS AND RECOMMENDATIONS

For the general public, the regulation of health professionals is essentially a 'hygiene factor'. It is widely assumed that regulation takes place 'behind the scenes' – where it should remain.

In future, there was support for offering the public reassurance that health professionals are regulated and that there is a complaints pathway – should one need it - which will support the interest of patients.

The general public is typically disinterested in becoming engaged in a discussion about regulation. Currently, awareness and understanding of regulation is low. In order to create a debate how regulation should work, levels of awareness and understanding will need to be increased.

To raise awareness of health professional regulators, consider communicating basic messages such as:

- *Behind the scenes, regulators are constantly working on behalf of patients so that you can be confident in your health professionals*

- *Regulators are independent from health professionals and represent patient interests. Thanks to regulation, health professionals cannot 'close ranks'*

- *Regulators ensure that the same standards are achieved by all health professionals regardless of whether they work for the NHS, private services or independent from an employer*

- *Regulation is not about increasing bureaucracy, it is about health professionals satisfying their regulators that they are achieving consistently high standards*

When raising awareness of health professional regulators, straightforward approaches are likely to be most appropriate. Suggested communication formats were those felt to be appropriate for short, simple messages, for example, signage, posters, appointment cards.

Suggested channels for information were all limited to the immediate healthcare environment (e.g. GP surgeries, hospitals). More detailed information could be made available for the minority who may become more interested (for example, via a website).

In future, patients felt that regulators should consider including patient feedback in regulation processes, suggesting questionnaires, satisfaction surveys, suggestion boxes and even mystery shopping.

APPENDIX A: REAL LIFE CASE STUDIES

Perceptions of NHS acute care tended to dominate views of the hierarchy of responsibility. The case study approach was designed to encourage respondents to think about the hierarchy of responsibility in different healthcare settings.

The following case studies were based on 'real life' respondent experiences:

Case study 1 (NHS GP Practice): Anita's GP failed to inform her that drinking large amounts of caffeine could be contributing to her anxiety problems. Anita feels that the GP should have pointed out this factor.

Case study 2 (NHS acute care): John's knee surgery went wrong, leading to long-term discomfort. His surgeon later admitted that he was not an expert in this type of surgery.

Case study 3 (Private acute care): Bernie is 70 and has private health insurance. The first consultant he saw recommended having an operation; the second felt that an operation was unnecessary. Bernie now feels that the first consultant may not have had his best interest at heart when recommending surgery.

Case study 4 (Independent professional): Anne moved house and registered at a new dental surgery. The dentist took down her personal details, including details of the medication she was taking. He starting discussing her other personal health issues which were unrelated to dentistry, which she felt was inappropriate.

APPENDIX B: STIMULUS MATERIAL

Professional bodies (STIMULUS A)

Professional bodies are membership organisations who are focused on **promoting the interests of the health profession** and its development.

They have a role in:

- **Professional training and development**
- **Lobbying government**
- **Development of best practice**
- **Promoting the role and reputation of the profession**

Regulators (STIMULUS B)

The purpose of regulators is to protect and promote the safety of the public. They do this by:

- setting **standards of behaviour and ethics** that health professionals must meet
- setting **standards for education and training**
- **registering health professionals** who are fit to practise in the UK
- **dealing with concerns about professionals** who are not fit to practise because of poor health, misconduct or poor performance
- **removing professionals from the register and preventing them practising** if this is considered to be in the interests of public safety

Government and MPs (STIMULUS C)

The government determines overarching policy direction and changes in regulation**. Where needed, it** presents legislation to parliament **that provides the legal framework for the operation of the regulatory bodies.**

MPs represent the interests of patients **and** health professionals**; also as part of parliament,** discussing, amending and voting on legislation **that determines regulatory framework.**

Fitness to Practise (STIMULUS D)

Regulators have a **fitness to practise panel** who hear evidence about health professionals and **decide whether the professional is fit to practise**.

Fitness to practise may be judged to be **impaired** for reasons such as **misconduct, lack of competence** and **ill health**.

These hearings would usually be a **final stage of procedures following a complaint**. The purpose is to **protect patients and the public**.

Revalidation (STIMULUS E)

Qualified and practising health professionals will be required to **demonstrate that they remain up to date** and are **fit to practise** on a regular basis. The standard they will be required to meet will be **the same as the standard they had to reach to first qualify** in their role.

The aim of revalidation will be to **support health professionals to raise standards**. It will also aim to **reassure employers, patients and the public**.

Re-licensing is a part of revalidation. **All doctors will receive licenses** in 2009, and these will need to be **renewed every five years**.

The renewal of the license will depend on an **appraisal process**, which will confirm that the doctor has met the standards expected in order to practise.