Attitudes to Regulation of Non-medical Healthcare Professionals

Research among the General Public

Research Study Conducted for
Department of Health

September 2005

Contents

Introduction

This report presents the findings from research on public perceptions and attitudes towards regulation and fitness to practise of non-medical healthcare professionals. The research was conducted by the MORI Social Research Institute on behalf of the Department of Health and was commissioned against the background of the Foster Review of the regulation of the non-medical healthcare workforce. This review has been set up to consider and provide advice about the measures needed to:

- Strengthen procedures for ensuring that the performance or conduct of non-medical healthcare professionals and other health service staff does not pose a threat to patient safety or the effective functioning of services, particularly focusing on the effective and fair operation of fitness to practise procedures;

- Ensure the operation of effective systems of CPD and appraisal for non-medical health-care staff and make progress towards revalidation where appropriate;

- Ensure the effective regulation of health care staff working in new roles within the healthcare sector and of other staff in regular contact with patients.

The research conducted by MORI explores the following areas:

- Public experience of healthcare workers;

- Satisfaction with non-medical healthcare professionals;

- Awareness and understanding of existing regulation, and attitudes towards it, including frequency and types of checks;

- Awareness of the current assessment of non-medical professionals and preferences for future assessment;

- Views on giving patient feedback; and

- Responsibility for performance and quality assurance.

Non-medical health professionals are understood in a broad sense to include all staff other than doctors who treat and advise people in hospitals, GP surgeries, walk-in centres, pharmacies, and in their own homes, or over the phone. This includes a very wide range of health professionals, and as the public would not be familiar with the term "non-medical healthcare professionals", this was defined for them up-front in the discussion groups and at the start of the interviews carried out for the quantitative survey. In both cases, respondents were shown the following list:

- Arts therapists
- Biomedical Scientists
- Chiropodists/Podiatrists
- Chiropractors
- Clinical Scientists
- Dieticians
- Dentists
- Dentists' support staff
- Dieticians
- Midwives
- Nurses
- Occupational Therapists
- Operating department practitioners
- Opticians
- Osteopaths
- Paramedics
- Pharmacists
- Physiotherapists
- Prosthetists and orthoptists
- Radiographers
- Speech & Language Therapists

The findings will contribute towards understanding of public perceptions and attitudes towards regulation and fitness to practise of non-medical healthcare professionals and will inform the Department of Health's review.

Methodology: The research methodology comprised qualitative and quantitative research among the general public, consisting of a series of discussion groups and a large-scale survey of adults carried out across the United Kingdom.

Qualitative Research: Six discussion groups were held among the general public from 10 – 17 August 2005. The locations of the discussion groups were: North of England (2 groups in Stockport); Midlands (2 groups in Birmingham); and South of England (1 group in St Albans and another in Greenwich).

Quotas were set by: age, social class and area, to ensure a broad spread of participants in the discussion groups.

In addition, a quota was set to ensure that each group included at least two or three respondents who had seen one or more non-medical health professionals in the last year, although in practice all had seen one or more.

The following people were recruited for each group:

	Age	Social Class	Gender	Area	Non-medical healthcare professionals seen in last year
Group 1 (Stockport)	55+	C2DE	Good mixture	Urban	All
Group 2 (Stockport)	35-54	ABC1	Good mixture	Urban	All
Group 3 (Birmingham)	55+	ABC1	Good mixture	Rural	All
Group 4 (Birmingham)	35-54	C2DE	Good mixture	Urban	All
Group 5 (Greenwich)	18-34	ABC1	Good mixture	Urban	All
Group 6 (St Albans)	55+	C2DE	Good mixture	Rural	All

The groups lasted around one and a half hours and were digitally recorded with respondents' permission. They were moderated by MORI executives.

The phrase 'non-medical healthcare professional' was introduced at the beginning of the groups and defined as, "People like nurses, pharmacists, dentists, opticians, midwives, physiotherapists, paramedics …basically all the staff who aren't doctors but who treat and advise people in hospitals, GP surgeries, walk-in centres, pharmacies and in their homes or on the phone." Additionally, a list of the professions was on display for participants to refer to.

When asking respondents about their experiences and attitudes towards these professional groups, it was not possible to treat each one in isolation. We were not able to ask questions about each one in turn within the discussion groups owing to the limited time available. We were not able to focus on particular professions within particular groups because of the cost implications of such an approach. The 21 professions covered by the research were treated as one unit.

General Public Quantitative Research: A large-scale quantitative survey was conducted to assess public opinion across the UK on the regulation and revalidation of non-medical healthcare professionals. Questions were placed on the MORI Omnibus, the regular MORI survey among the general public. A nationally representative quota sample of 2,084 adults (aged 15 and over) was interviewed throughout the UK. Of these, 1,973 were interviewed by MORI in Great Britain and 111 were interviewed by MORI Ireland in Northern Ireland.

Interviews were carried out face-to-face, in respondents' homes, with the aid of CAPI terminals (laptops) in Great Britain and on paper in Northern Ireland. Fieldwork was conducted between 3 and 13 September 2005.

Reporting: In the graphs and tables, the figures quoted are percentages. The size of the sample base from which the percentage is derived is indicated. Note that the base may vary – the percentage is not always based on the total sample. Caution is advised when comparing responses between small sample sizes.

As a rough guide, please note that the percentage figures for the various sub-samples or groups generally need to differ by a certain number of percentage points for the difference to be statistically significant. This number will depend on the size of the sub-group sample and the percentage finding itself - as noted in the appendices.

Where an asterisk (*) appears it indicates a percentage of less than half, but greater than zero. Where percentages do not add up to 100% this can be due to a variety of factors – such as the exclusion of 'Don't know' or 'Other' responses, multiple responses or computer rounding.

Publication of Data: Our standard Terms and Conditions apply to this, as to all studies we carry out. Compliance with the MRS Code of Conduct and our clearing is necessary for any copy or data for publication, web-siting or press releases which contain any data derived from MORI research. This is to protect our client's reputation and integrity as much as our own. We recognise that it is in no-one's best interests to have survey findings published which could be misinterpreted, or could appear to be inaccurately, or misleadingly, presented.

Executive Summary

The research findings from the present study bear a striking similarity to those from MORI's earlier research on the regulation and revalidation of doctors. This may reflect one of the findings of the qualitative research: that even though doctors and the other professionals covered by the research are not seen as having the same roles, people seem to find it difficult to talk about non-medical healthcare professionals without also talking about doctors. They therefore fail to treat them as separate groups. This came across strongly in the focus groups, where respondents tended to focus on doctors, even when asked about non-medical healthcare professionals.

There are a number of key findings:

- **There is a high level of satisfaction with non-medical healthcare professionals**, as there is with doctors (MORI/DH 2005);

- **Despite people's broad experience of non-medical healthcare professionals, there is very little understanding of the current system of assessment**. Again, this reflects MORI research on public attitudes towards the assessment of doctors. Whilst most people believe non-medical healthcare professionals are currently assessed, a large minority do not know how often checks are carried out. There is little awareness of which regulatory bodies carry out checks. This is unsurprising given the public's generally low awareness of regulation in general (MORI/OST 2005);

- **There is strong public support for regular checks being carried out on non-medical healthcare professionals**, as there is with doctors (MORI/DH 2005). Most prefer assessments every couple of years and few feel that inspections would be a waste of time and money.

- Responsibility for poor practice is seen to rest with a range of organisations and individuals, although none stand out as significantly more frequently mentioned. This may reflect the low understanding of regulation of non-medical healthcare professionals.

- **There is strong support for the idea of giving patient feedback.** Quality of care, knowledge/technical ability and softer, more interpersonal skills – like communication and giving patients dignity and respect – come out as the most important aspects for feedback. This is in line with MORI's research on public attitudes towards the regulation of doctors, which highlighted both the importance of keeping up-to-date with medical developments and doctors' communication skills (MORI/DH 2005).

The research findings suggest that reassurance on the cost implications and administrative and bureaucratic impacts on healthcare organisations may be important for increasing public support for regular assessments. Whilst a relatively small proportion – around one in ten – agrees that inspections would be a waste of time and money, the views of this group are also much less positive towards regular assessments. This reflects some of the comments in the discussion groups, which highlighted concern about the additional burdens that assessments could make on healthcare providers.

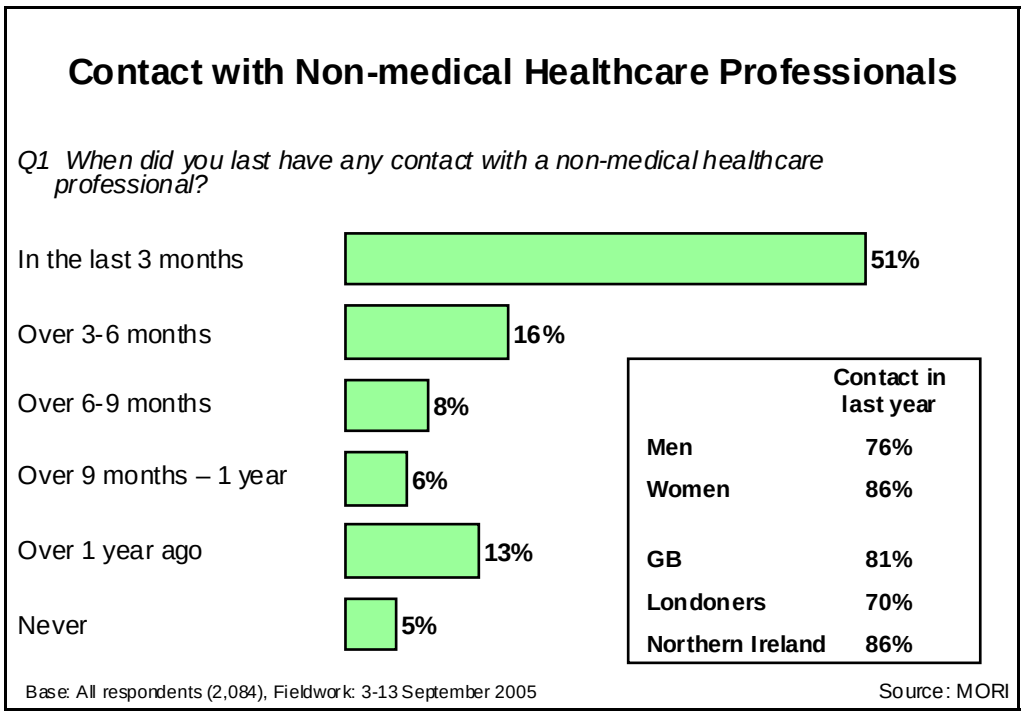
Summary of Findings

Contact with Non-Medical Healthcare Professionals

There is a high level of contact between non-medical healthcare professionals and the general public. This was shown in the discussion groups – where all participants had had exposure to non-medical healthcare professionals at some time in the past – and the quantitative survey, which found four in five had had contact with this group in the last year.

The quantitative survey highlights some marked differences in contact with non-medical healthcare professionals between men and women (45% of men having had contact in the last three months vs 57% for women). Younger men are the least likely to have had contact, compared with older men and women. Seven in ten men aged 15-34 say they have had some contact in the last year, compared with 79% for men aged 35+ and 86% for women.

There are also some large regional and country differences in the levels of contact. People living in London and the West Midlands tend to have much less contact overall, with 70% and 77% respectively having had contact in the last year. By comparison, contact is much higher in the South West and Northern Ireland (86% for each) and Wales (88%).

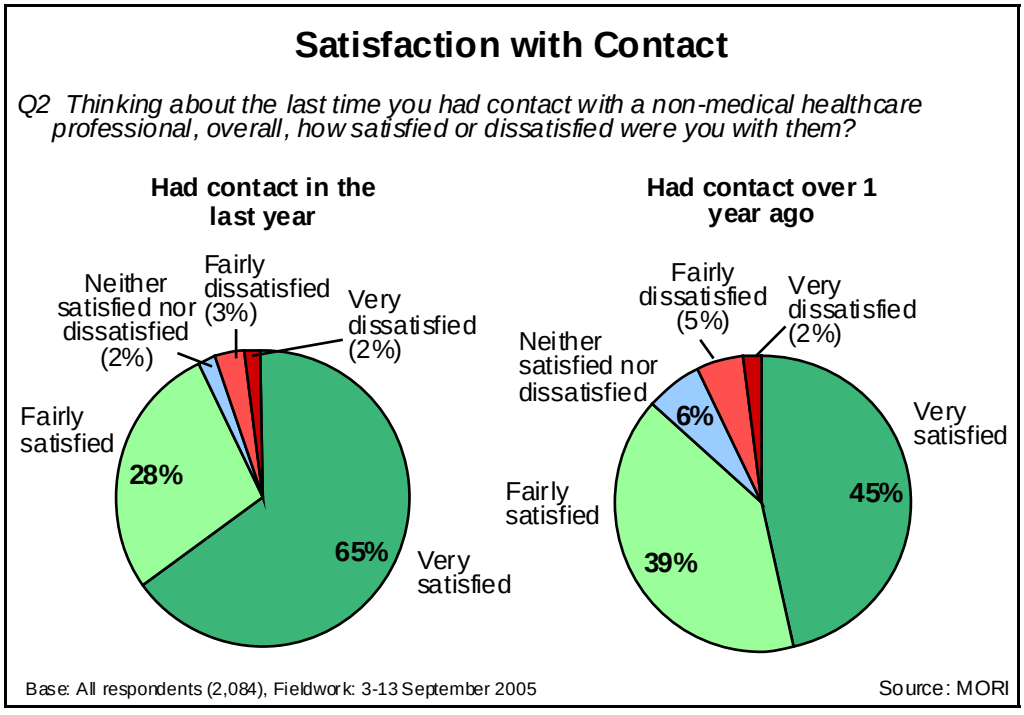


Satisfaction with Non-Medical Healthcare Professionals

The findings from the quantitative research reveal a more positive picture of public satisfaction with non-medical healthcare professionals than was shown in the discussion groups. The quantitative survey shows a high level of satisfaction with non-medical healthcare professionals, with around nine in ten saying they are satisfied with the last contact they had with one (88%). By contrast, the discussion groups revealed a more mixed picture. Whilst praise was given by many people in the discussion groups, experiences of bad practice were also shared, giving the impression that views on the whole are fairly mixed. Although this may reflect the composition of the discussion groups (which may have over-represented those with bad experiences of non-medical healthcare professionals), it may also reflect that during the groups respondents were drawing on their *lifetime's* experience (not just the experience of their last visit), and that one person sharing a bad experience may trigger others to do the same.

The quantitative survey shows that for the UK as a whole there is a high level of satisfaction with non-medical healthcare professionals, particularly among those who have had contact with them in the last year. Nearly nine in ten (88%) are satisfied with their last contact with this group of professionals, and 59% are 'very satisfied' (rising to 65% for those who have had contact in the last year).

Satisfaction levels are fairly consistent between social and demographic subgroups, although Londoners are less likely to be satisfied than those in other regions and countries (77%, compared with 88% for the UK as a whole).



Whilst overall satisfaction levels are similar when we compare those who have had contact with non-medical healthcare professionals in the last year with those whose contact was over one year ago, those with more recent contact are more

likely to be 'very satisfied'. It is difficult to draw any firm conclusions as to why satisfaction is more strongly expressed among those with more recent experience. It may reflect improvements to the quality and range of services available from non-medical healthcare professionals or that recent memories of good quality service are more likely to be fresh (and 'top-of-mind') or even that those with bad experiences may try to avoid using the services.

Awareness and Understanding of Regulation and Assessment

Respondents were mostly unaware of any system regulating non-medical healthcare professionals but there is a widely held assumption that regulation of non-medical healthcare professionals must take place:

> *It's something you never think about, you just presume*
>
> Birmingham, 35-54 yrs, female, C2DE

However, awareness and understanding of what regulation entails or which bodies are involved are low, which reflects MORI's research on awareness of the regulation of science and technology (MORI/OST 2005). [1] Professional bodies were only mentioned in this context by one of the six groups. In some of the others, the BMA was termed the umbrella regulator for all healthcare professions (a theme which has emerged in MORI's previous general public work):

> *If you want to complain about a lawyer you go to the Law Society, medical you go to the BMA. There must be somebody in the BMA who has control of it*
>
> St Albans, 55+, male, C2DE

Low understanding of the regulation of medical professionals reflects people's limited awareness of their backgrounds, training and qualifications. This was shown in one of the discussion groups, where there was disagreement over qualifications:

> *They have all got qualifications. Paramedics, pharmacists, I think physios…*
>
> St Albans, 55+, male, C2DE

[1] See MORI/OST Science in Society research (2005).

Hold on, do paramedics?

St Albans, 55+, male, C2DE

I have been to the optician; in my opinion I don't think there is any qualifications (sic). All the workers in there were 16 or 17. I think it is wrong, that they should be doing that at that age. They need training properly to be an optician

Birmingham, 35-54 yrs, female, C2DE

In most cases it was expected that non-medical healthcare professionals be required to have formal qualifications and training but there was little consensus regarding what these currently comprise.

The discussion groups showed a wide range of views on whether non-medical healthcare professionals are checked, although many assumed they would be:

Before tonight I assumed that all these professionals were regularly checked. It had never crossed my mind to think that they weren't

Stockport, 35-54 yrs, female, ABC1

There is also a wide range of views on the frequency with which checks are felt to carried out (if at all):

Once a year

London, 18-34 yrs, male, ABC1

Probably be every five to ten years

London, 18-34 yrs, male, ABC1

I don't think they do at all

London, 18-34 yrs, female, ABC1

Regardless of their knowledge of the current system, most feel that checks should be in place:

Everybody's competence has to be checked. You can't just take it for granted that everyone is doing it right can you, because they obviously don't all do it right

Birmingham, 55+ yrs, female, ABC1

Only a few were hesitant of carrying out regular checks across the board, and where they were this was mainly due to the scale of what would be required:

> *You have got to go through all the apples to find a bad one haven't you!*
>
> Stockport, 55+ yrs, female, C2DE

In many cases the assumption that both regulation and assessment took place came from respondents' experience of other sectors:

> *Everybody is checked aren't they? I was a civil engineer but I was checked every year*
>
> Stockport, 55+ yrs, male, C2DE

> *Presumably they would get checks, because driving instructors get checked every year, so I would have thought people like that would get monitored at least*
>
> Stockport, 35-54 yrs, male, ABC1

> *I actually sell cars for a living. Everything has to be accounted for and we'll audit against that and we can fail and we'd lose the franchise but we get corrective and then they come back just to double-check. That's for something as simple as selling a car. So for a professional person with a duty of care and an order of care to be done to the public, surely it's more important to apply some of the processes to healthcare and stuff*
>
> Stockport, 35-54 yrs, male,ABC1

Some thought professionals were only checked if complaints had been made against them or if the person was suspected of having made a lot of mistakes. However, there was a great deal of uncertainty, particularly in the case of checking those who are unremarkable:

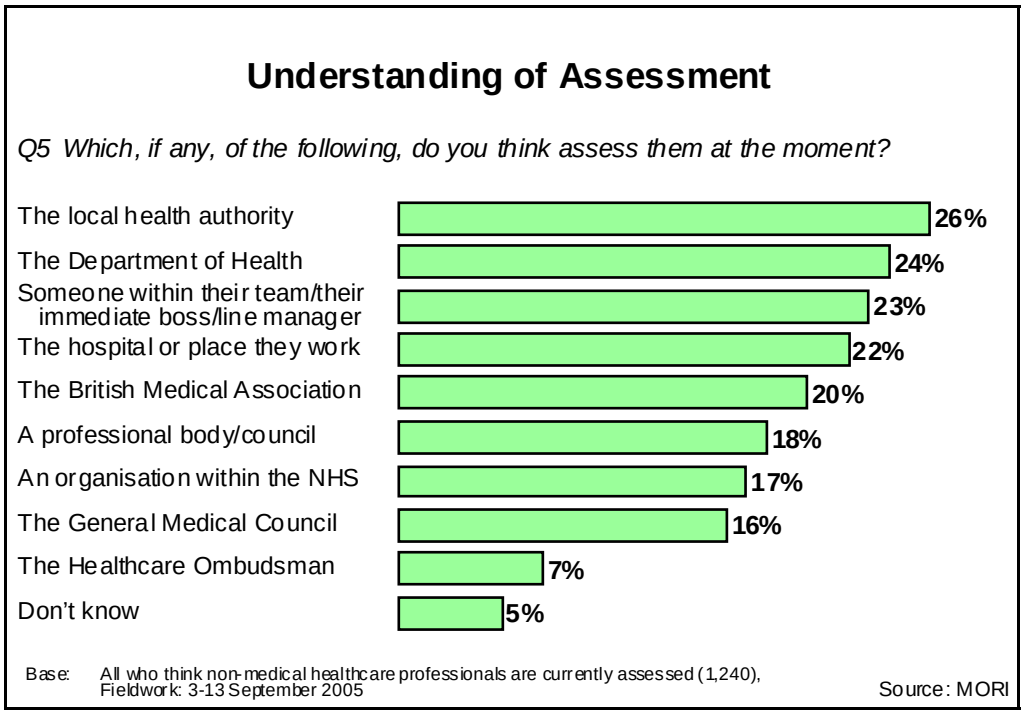
> *What about the guy that just plods along? You have got a guy and he plods along and he is quite happy, who is checking him? Does he get checked?*
>
> Stockport, 55+ yrs, female, C2DE

These feelings are reflected in the quantitative research findings, which show people as being much more likely to think that non-medical healthcare professionals are assessed than think they are not. Only 7% do not feel that non-medical healthcare professionals are assessed, although a large proportion – approaching one in three (29%) – do not know. Around half (49%) feel that there are assessments at regular periods of between every year and every ten years. Around one in ten (9%) think that assessments only take place if concerns are expressed about their ability.

Younger people are more likely to think that regular assessments are made than older people. Nearly three-fifths (58%) of those aged 15-24 years feel there are assessments up to every ten years, compared with 40% of those aged 55+.

Whilst many people feel that assessments are made, knowledge about which organisations carry them out is low. This reflects the findings from the discussion groups, where there was no clear understanding shown. The range of answers given in the quantitative research suggests guesswork on the part of some people taking part in quantitative research. A number of bodies were mentioned as regulators of non-medical healthcare professionals, though none is mentioned by more than around one in four. Local health authority was the highest mention (26%), closely followed by the Department of Health (24%).

Whilst no individual organisation stands out as much more commonly thought of than others in terms of assessing non-medical healthcare professionals, people are more likely to name an external body than the hospital/team and/or health authority. When asked which organisations (from a list) currently assess non-medical healthcare professionals, three-fifths mention the BMA/ GMC/Healthcare Ombudsman and/or a professional body only, compared with around a quarter (24%) who only say hospital/team and/or local health authority only.



More affluent social groups (ABs) are more likely to name a number of internal and external assessors: the team/immediate boss/line manager, the hospital, and a professional body/council. This may reflect a greater confidence in regulation as a whole among professional and managerial groups, compared with unskilled manual workers and those reliant on state benefits. It may also reflect greater involvement with assessment, which was one of the findings from the qualitative research.

There are also some age and gender differences in understanding of who assesses non-medical healthcare professionals:

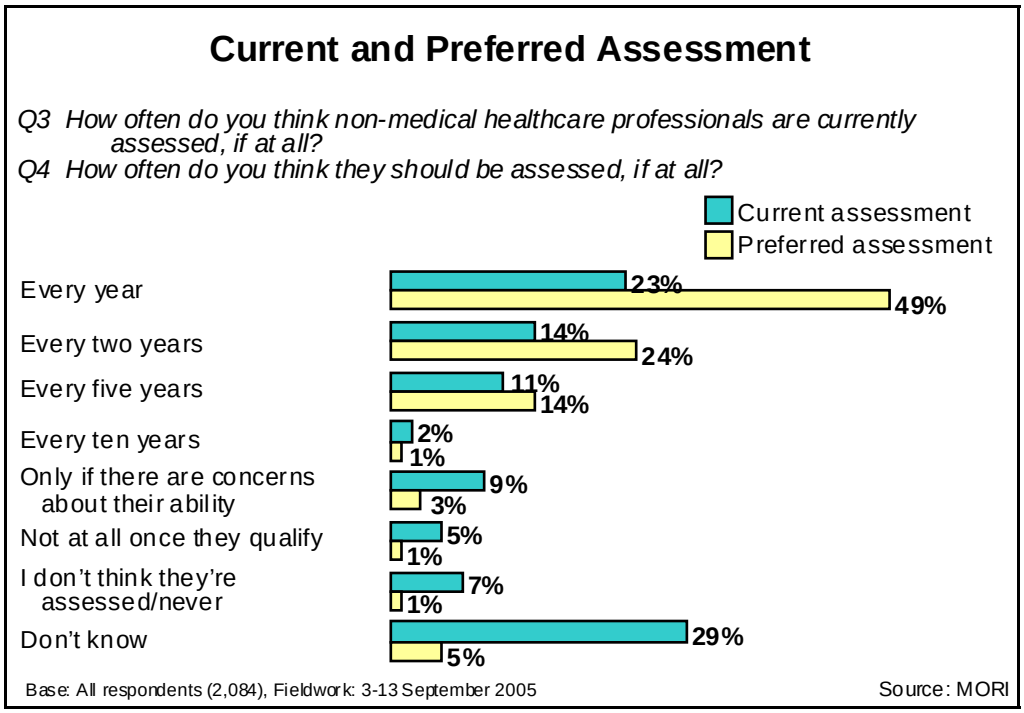
- The Department of Health is much more commonly mentioned by younger men aged 15-34 years (33%, compared with 24% overall);
- The British Medical Association is more likely to be mentioned by men than women (23% vs 18% respectively);
- Immediate team/boss/line manager is more likely to be mentioned by women than men (25%, compared with 20% respectively).

Frequency of Assessment: Current and Preferred

There is much greater demand for regular assessment of non-medical health professionals, than the current perceived levels. Whilst around a quarter (23%) feels that assessment *currently* takes place annually – a similar proportion to those who feel doctors are assessed annually in MORI's recent work on medical

regulation (MORI/DH 2005)[2] - this doubles to around half (49%) who feel non-medical health professionals *should* be assessed every year.

Nearly three-quarters (73%) would like assessment of non-medical healthcare professionals every one or two years, whilst a further 14% feel they should take place at least every five years. This is consistent with the findings from MORI's work on medical regulation, in which seven in ten feel that doctors should be assessed every one or two years.



As already outlined, there is evidence from the discussion groups that there is an *expectation* that checks are made on healthcare professionals. There is also agreement that the competence of healthcare professionals should be checked *every few years*, although there was wide variation in the preferred frequency of such checks:

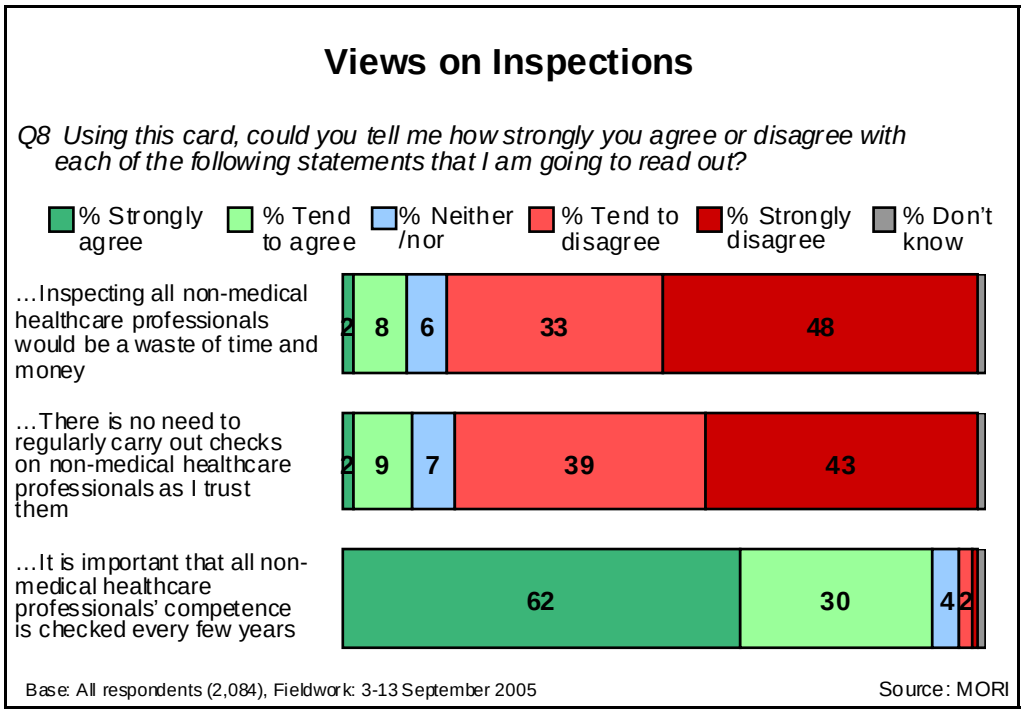
> *I think there has to be regular checks*
>
> Birmingham, 55+ yrs, female, ABC1

> *At least annually and then obviously within three months to check up on any faults that they've given [professionals] a chance to correct*
>
> Stockport, 35-54 yrs, male, ABC1

[2] MORI's previous study on medical regulation for the Department of Health found that 22% of the public think doctors are assessed every year (MORI/DH 2005).

These findings are reinforced by the results from the quantitative survey. Regardless of trust in the professions, regular assessments are seen to be important. Only around one in ten (11%) agrees there is no need to regularly carry out checks on non-medical healthcare professionals because they have trust in them, a finding which is consistent with the earlier study relating to doctors (MORI/DH 2005). This drops to 6% for professionals and senior managerial groups (ABs) and 7% for those with higher educational qualifications.

In line with MORI's work on medical regulation, few think that there is no need to regularly carry out checks or that such inspection would be a waste of time and money (11% and 10% respectively). Those who do are much less likely to favour regular assessments (76% favouring assessment at least every ten years, compared with 92% for those who disagree that such assessments would be a waste of time and money).



Views are fairly consistent between social and demographic subgroups on the need for regular assessments of non-medical healthcare professionals.

The qualitative research showed that people find envisaging the assessment of members of certain professions easier than that of others: for example, they seemed more comfortable with the idea of carrying out spot checks on nursing staff than on checking the work of opticians:

> *On a regular basis, they should hop in like she was saying [about] going in to a restaurant, unannounced, and put a nurse's coat on for a day and walk around and see what is happening*
>
> Stockport, 55+ yrs, female, C2DE

Responsibility for Poor Practice

Responsibility for poor practice is widely seen as resting with a range of organisations, not just individuals. This was highlighted in both stages of the research.

In the case of individuals not performing in a satisfactory manner, the question of who bears responsibility seemed to generate differing views in the discussion groups. Some felt that the healthcare system is a closed shop and that no-one bears responsibility, whilst others felt that supervisors or line managers are responsible. Whilst a distinction was made between an individual mistake and a system error or weakness, there was disagreement about whether responsibility lies with frontline staff. If a mistake was due to an individual not following protocol/procedure, responsibility was seen as lying more heavily with them than if no system was in place. This was shown in discussion about nursing. Some felt that responsibility for poor practice lies with nurses:

> *She is responsible, this is what I am saying about being in charge, and you are responsible for your own patients. The buck stops with you*
>
> Stockport, 55+ yrs, female,C2DE

However, there was also recognition that responsibility rises up the chain (and analogies were drawn with other sectors):

> *You have got to have a structure, like the Army. You have got people, you have got your line management. You have got your nurses, you have got your Sister. From there on you go up and up and up until they go to the last resort, which is the guy at the top*
>
> Stockport, 55+ yrs, female, C2DE

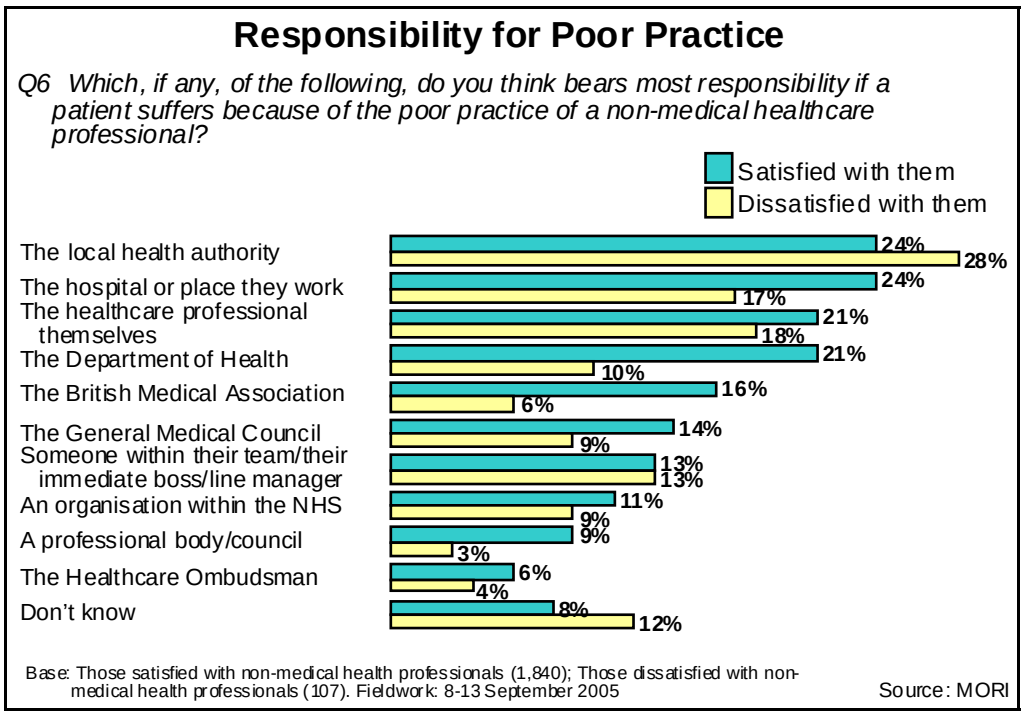
In some cases this passing of responsibility up through the ranks was seen within the context of limited staffing levels. Again, the example of the nurse was used:

> *But she might have been over worked, so whose fault was that, is it they are under staffed*
>
> Birmingham, 35-54 yrs, female, C2DE

The quantitative survey identifies a range of bodies as having some responsibility if a patient suffers because of poor practice. Only 7% feel that the healthcare professional alone is responsible if a patient suffers because of poor practice. But whilst most feel that other individuals or organisations have some responsibility,

none is mentioned by more than around one in four, and no organisation stands out as much more commonly mentioned than any other. The most common mentions are local health authorities (24%), hospitals or work places (23%) and the Department of Health (20%). A similar proportion, around one in five, feels that the healthcare professional themselves bears most responsibility (21%).

When we compare those who are satisfied and those who are dissatisfied with non-medical healthcare professionals, there is little difference in who people think should be responsible for a patient who suffers poor practice. Those who are dissatisfied with non-medical healthcare professionals are *less* likely to see the Department of Health or the BMA as responsible, compared with those who are satisfied. (Please see chart below). However, they are not more likely to feel that any other body or individual is responsible for poor practice.



Making Complaints

There was little consensus in the discussion groups on how a complaint regarding a non-medical healthcare professional might be made. In the case of some professions respondents spoke of not using an individual again:

> *Well I was in pain for four weeks with my dentist, I haven't complained, I just don't go there any more I go privately now and pay for it and I get the best attention possible*
>
> Birmingham, 55+ yrs, male, ABC1

> *With my chiropodist that was rubbish, I just never went back to her, so she lost me*
>
> Birmingham, 35-54 yrs, female, C2DE

This seemed to be the case especially where respondents were paying for services, and therefore were freer to use the open market to take their business elsewhere.

For others, possible avenues for making complaints were given as ringing a professional's office, complaining to the local health authority, hospital authority or hospital department, and contacting the Citizen's Advice Bureau. In a few groups, there was also mention of contacting professional bodies or the ombudsman.

A few respondents seemed to know where to find information on complaints procedures:

> *I am sure I have seen in the doctor's there is a complaints letter, and also for hospitals, I have seen: 'if you want to complain this is the complaints procedure'*
>
> Birmingham, 35-54 yrs, female, C2DE

However in most cases, understanding of complaints processes appears to be low, even if people are aware that such a process exists.

> *If you want a complaint about any one of these health professionals, how would you do it? Is there a sort of Ombudsman?*
>
> Birmingham, 55+ yrs, female, ABC1

> *I know there's an ombudsman and the Patients' Charter and things like that within the National Health Service so you can go back on, you've got some sort of action if things don't work out. I'm not really sure what the due process is*
>
> London, 18-34 yrs, female, ABC1

Regulating Health Professionals

The feeling in most groups was that regulation should be undertaken by an *independent* body, although there was debate about whether this should have public involvement:

They need to have an advisor from the profession, but I think that they need to have an independent body that looks at what is happening (sic)

Stockport, 55+ yrs, female, C2DE

It should be a mix I think by a panel so you get an overview, so you've got somebody that can express the professional view and somebody that just walks in off the streets

London, 18-34 yrs, male, ABC1

The over-riding feeling was that regulation should be at the national level – either that a national body should set the regulatory structure, or that a national body should do this *and* be responsible for its implementation:

Well there have got to be guidelines haven't there, national standards to be met? And then I feel at a local level that they make sure that they are implemented

Birmingham, 55+ yrs, female, ABC1

There was recognition of the potential cost of carrying out regular checks, and some fear over the bureaucratic and administrative burden that might be entailed:

Are we going to pay the people who do the regular checks thousands and thousands of pounds a year, to go around the hospitals?

Birmingham, 55+ yrs, male, ABC1

There were also fears expressed that current staffing levels might not make carrying out regular checks on all healthcare professionals feasible without having a detrimental effect on services:

In an ideal world yes [there would be checks], but in our world there is nobody to do it, is there?

Stockport, 55+ yrs, male, C2DE

The worry over staffing levels also affected what people thought should happen when staff were found not to perform satisfactorily. On the one hand shortages were used to argue that healthcare staff should be retrained rather than stuck off:

Whilst we have got shortages in the National Health scheme (sic), of professional people, we just have to accept the ones that we have got. They might not be perfect, but we just have to make sure that we can retrain them as quick as possible. Because we just can't get rid of them because they do their job wrong, because there would be nobody left

Birmingham, 55+ yrs, male, ABC1

On the other hand, shortages were also used to argue that there may not be scope for retraining:

Is there staff available to enable them to go off and do these refresher courses? We are always being told 'we are short staffed', no matter who it is off that list, there is a shortage. Is there going to be anybody to take over from them whilst they go for that refresher course? I think the crux of the matter is, there is not enough staffing in all areas.

Stockport, 55+ yrs, female, C2DE

The need for accountability in the regulatory system was recognised in the discussion groups:

There's got to be some transparency, if there's self-regulation it seems to be a closed shop, I think there's got to be some sort of public accountability, some sort of possibly civil arm

Stockport, 35-54 yrs, male, ABC1

Self-regulation was not always trusted, owing to fears of cover-up. Self-regulation in the police and the medical profession were criticised:

Most of the [professional] bodies are self regulated, that is one of the problems

St Albans, 55+, male, C2DE

The problem is, when these people are brought before the likes of the General Medical Council and all that, the doctors stick together

Stockport, 55+ yrs, male, C2DE

> *I know with doctors they have like a closed system: doctors reporting on doctors or doctors deciding on who to strike off the register, and there's a lot of problems with that*
>
> London, 18-34 yrs, male, ABC1

There were also disagreements on the extent of medical knowledge needed by the auditor or assessor:

> *I don't think it's absolutely vital that an auditor needs to know about the business. What the auditor needs a clear instruction of what should be going on*
>
> Stockport, 35-54 yrs, male, ABC1

> *You'd need to know the medical nuts and bolts, not necessarily all but some, [but] I don't think it's necessary to say that one dentist or midwife or whatever audits another*
>
> Stockport, 35-54 yrs, male, ABC1

The idea of using a 'knowledgeable Joe public' was aired in one group as a way of combining knowledge of the profession with independence of opinion:

> *You need to have somebody outside of there, who is intelligent - and no disrespect to Joe Public, I am part of Joe Public, Joe Public can't know the ins and outs, but [he] must have a good rudiment of what is going on*
>
> Stockport, 55+ yrs, female, C2DE

Examples of retirees or people who had given up the job through ill-health were given as people who might be able to fill this role. However, not all agreed:

> *A little bit of knowledge is a very dangerous thing so I don't think the public should really do that*
>
> Birmingham, 55+ yrs, female, ABC1

Only one group expressed favourability towards a system of regulation by professional bodies.

The discussion groups provide some evidence that patient ratings and periodically passing written tests of medical knowledge are seen as important, whilst ratings from colleagues are least important. In some cases, it was argued

that colleagues would be reluctant to be critical of one another and the idea of healthcare professionals receiving ratings from colleagues as part of an assessment system was therefore heavily criticised:

> *If you are a friend, you are not going to pick on [them]*
>
> St Albans, 55+, female, C2DE

> *Receiving ratings from colleagues, that is useless because they will probably all pat themselves on the back*
>
> London, 18-34 yrs, male, ABC1

Of the possible components of regulation suggested to respondents in the discussion groups, re-evaluation of qualifications every so many years was felt by the greatest number to be the most important. However, the point was repeatedly made that ability to perform during exams does not necessarily reflect the behaviour of an individual in a professional environment:

> *They could be extremely intelligent and pass any exam; the exam might not be the problem. He could actually know and be fully aware that he has given the wrong treatments*
>
> London, 18-34 yrs, male, ABC1

> *All their exams and everything, it is all right doing it on paper, we can all do everything on paper, it is when you actually go out in to the field and the first contact with a human being*
>
> Stockport, 55+ yrs, female, C2DE

Patient Feedback

In the qualitative research, most respondents felt that patients should be asked to provide feedback:

> *Ultimately they are the people who are receiving the treatment and I think their opinion is quite valid*
>
> London, 18-34 yrs, female, ABC1

This was especially the case in the context of commenting on interpersonal skills.

> *If they are friendly and they see you as a human being, as that lady said, that is all that matters*
>
> Stockport, 55+ yrs, female, C2DE

Some problems with doing this were recognised however, such as those wishing to complain being more likely to complete questionnaires (compared with those who thought they had received a good service), and the difficulty for those who have not had long-running experience of the health service to judge the quality of the treatment they have received.

Emphasis was placed on the need for patient feedback to be confidential and anonymous and action to be taken as a result:

> *[I would want] a questionnaire that you can just write what you like and you don't have to put your name to it or anything like that*
>
> Birmingham, 35-54 yrs, female, C2DE

> *If it was an independent body [then] they could contact you from records from dentists, paramedics, whatever. They could contact you, you would give your responses. As long as your response was in confidence…*
>
> Stockport, 35-54 yrs, female, ABC1

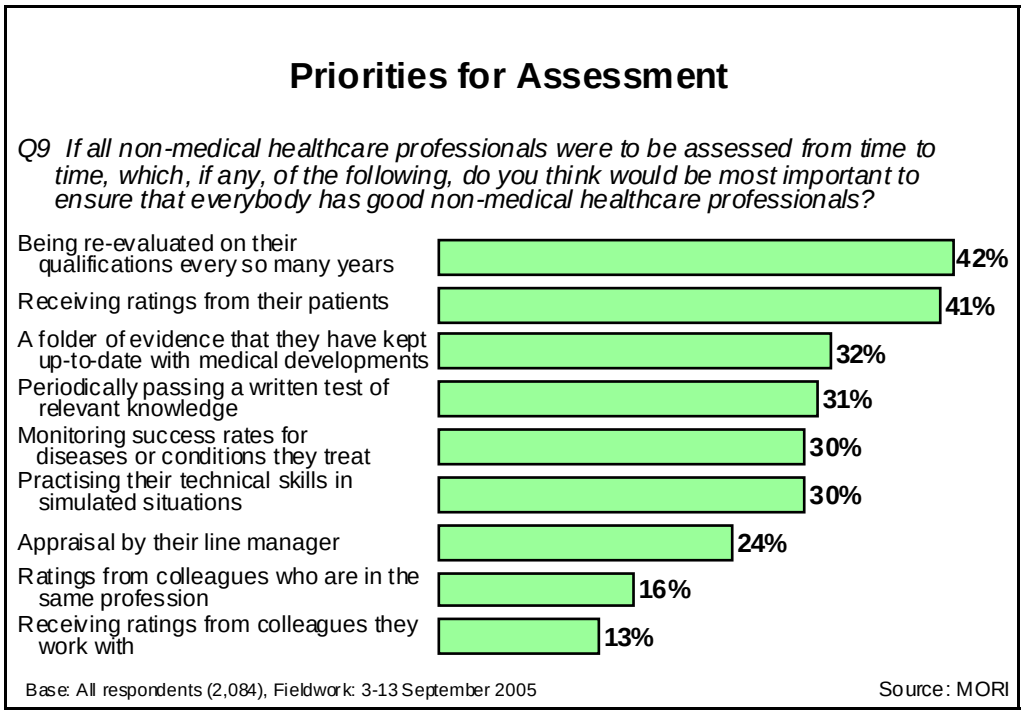
It was stressed in one group that questions need to be straightforward and allow for additional comments should the respondent wish to make any.

Respondents outlined standards of care and punctuality of service as issues that they would want to comment on.

The quantitative survey assesses which aspects of service and care people feel are most important for feedback from patients. A number of other factors stand out as being seen as much more important for feedback. Quality of care – a term which encompasses almost all aspects of the way healthcare services are provided – comes top (56%), followed by communication (45%) and technical ability (41%). By contrast, success rates are much less important when it comes to giving feedback (27%).

These results reflect MORI's *Frontiers of Performance in the NHS*,[3] which highlights the importance of patients being treated with dignity and respect to ratings of overall inpatient care. Other vital factors that came out strongly in the *Frontiers of Performance* research were: cleanliness, effective communication with doctors, successful pain control, a well-organised A&E department and privacy.

[3] See MORI's work on *Frontiers of Performance in the NHS* (June 2004). http://www.mori.com/pubinfo/bp/frontiers2.shtml



These findings reflect the opinions that were expressed in the discussion groups, which emphasised a number of characteristics as important for trust and confidence in non-medical healthcare professionals (and this is consistent with our findings on perceptions of doctors):

- listening;
- giving the impression of caring/ showing concern;
- taking the time to speak to patients;
- giving personal treatment/ treating patients as humans.

Conversely, trust and confidence were felt to be lost by:

- errors being made/ technical skills not being good; and
- lack of care and attention being shown to patients.
- Additionally, lack of staff, cleanliness and hygiene were all seen as reasons for losing confidence in the system as a whole.

Appendices

Technical Details

General Public Omnibus Design

The sample design is a constituency based quota sample. There are 641 parliamentary constituencies covering Great Britain. From these, we select one in three (210) to be used as the main sampling points on the MORI Omnibus. These points are specially selected to be representative of the whole country by region, social grade, working status, MOSAIC rurality, tenure, ethnicity and car ownership. Within each constituency, one local government ward is chosen which is representative of the constituency.

Within each ward or sampling point, we interview ten respondents whose profile matches the quota. The total sample therefore is around 2,100 (10 interviews multiplied by 210 sampling points).

Gender:	Male; Female
Household Tenure:	Owner occupied; Council Tenant/HAT; Other
Age:	15 to 24; 25 to 44; 45+
Working Status	Full-time; part time/not working

These quotas reflect the socio-demographic makeup of that area, and are devised from an analysis of the 2001 Census. Overall, quotas are a cost-effective means of ensuring that the demographic profile of the sample matches the actual profile of GB as a whole, and is representative of all adults in Great Britain aged 15 and over.

Fieldwork

Fieldwork is carried out by MORI using CAPI (Computer Assisted Personal Interviewing). All interviews are conducted face to face, in the home – one interview per household. No incentives are offered to respondents.

Weighting and Data Processing

Data entry and analysis are carried out by an approved and quality-assured data processing company. The data are weighted using 6 sets of simple and interlocking rim weights for social grade, standard region, unemployment within region, cars in household, and age and working status within gender. This is to adjust for any variance in the quotas or coverage of individual sampling points so that the sample is representative of the GB adult population.

Statistical Reliability

Because a sample, rather than the entire population, was interviewed the percentage results are subject to sampling tolerances – which vary with the size of the sample and the percentage figure concerned. For example, for a question where 50% of the people in a (weighted) sample of (2,195) respond with a particular answer, the chances are 95 in 100 that this result would not vary more than (2) percentage points, plus or minus, from the result that would have been obtained from a census of the entire population (using the same procedures). The tolerances that may apply in this report are given in the table below.

Approximate sampling tolerances applicable to percentages at or near these levels (at the 95% confidence level)			
Size of sample or sub-group on which survey result is based	**10% or 90% ±**	**30% or 70% ±**	**50% ±**
2084 UK adults aged 15+	1	2	2
1,973 GB adults	1	2	2
111 adults in Northern Ireland	6	9	9
			Source: MORI

Tolerances are also involved in the comparison of results between different elements of the sample. A difference must be of at least a certain size to be statistically significant. The following table is a guide to the sampling tolerances applicable to comparisons between sub-groups.

Differences required for significance at the 95% confidence level at or near these percentages			
	10% or 90%	**30% or 70%**	**50%**
Size of sample on which survey result is based			
Men (993) vs Women (1,091)	3	4	4
ABs (516) vs DEs (575)	4	6	6
GB (1,973) vs Northern Ireland (111)	6	9	10
			Source: MORI

Definition of Social Grades

The grades detailed below are the social class definitions as used by the Institute of Practitioners in Advertising, and are standard on all surveys carried out by MORI (Market & Opinion Research International Limited).

Social Grades			
	Social Class	**Occupation of Chief Income Earner**	**Percentage of Population**
A	Upper Middle Class	Higher managerial, administrative or professional	2.9
B	Middle Class	Intermediate managerial, administrative or professional	18.9
C1	Lower Middle Class	Supervisor or clerical and junior managerial, administrative or professional	27.0
C2	Skilled Working Class	Skilled manual workers	22.6
D	Working Class	Semi and unskilled manual workers	16.9
E	Those at the lowest levels of subsistence	State pensioners, etc, with no other earnings	11.7

Recruitment Questionnaire

Group: 1	Date:	11 August	Code:
	Time:	4pm	
		General public 55+ C2DE Good mix of gender 2-3 to have seen one or more non-medical health professionals in the last year or so Urban group	1
	Venue Details:	Stockport	

Group 2	Date:	11 August	Code:
	Time:	8pm	
		General public 35-54 ABC1 Good mix of gender 2-3 to have seen one or more non-medical health professionals in the last year or so Rural group	2
	Venue Details:	Stockport	

Group: 3	Date:	17 August	Code:
	Time:	4pm	
		General public 55+ ABC1 Good mix of gender 2-3 to have seen one or more non-medical health professionals in the last year or so Rural group	1
	Venue Details:	Birmingham	

Group 4	Date:	17 August	Code:
	Time:	8pm	
		General public 35-54 C2DE Good mix of gender 2-3 to have seen one or more non-medical health professionals in the last year or so Urban group	2
	Venue Details:	Birmingham	

Group: 5	Date:	10 August	Code:
	Time:	7pm	
		General public 18-34 ABC1 Good mix of gender 2-3 to have seen one or more non-medical health professionals in the last year or so Urban group	1
	Venue Details:	London	

Group 6	Date:	11 August	Code:
	Time:	7 pm	
		General public 55+ C2DE Good mix of gender 2-3 to have seen one or more non-medical health professionals in the last year or so Urban group	2
	Venue Details:	St Albans	

Good morning/afternoon/evening. I'm from MORI, the market & opinion research company. We're currently conducting some research for the Department of Health and would like you to take part in a general public group discussion on a number of health issues. This will take place at ……., will last about one and a half hours and will be audio-recorded for research purposes.

To say thank you for your time and to cover any expenses incurred we would like to offer you £25.

We are looking for a particular group of people; I would therefore like to ask you some questions about yourself. All information collected will be anonymised.

Q1. **Firstly, would you be interested in taking part?**

Yes	1	CONTINUE	
No	2	THANK AND CLOSE	( )

Q2. **Do you or any of your immediate family work, or have you ever worked, in the following jobs or industries?** READ OUT

Market research	1	THANK AND CLOSE
Advertising	2	
Journalism	3	
PR	4	
None of these	5	CONTINUE

Q3. **Have you attended a group discussion for market research purposes in the last six months?**

Yes	1	THANK AND CLOSE
No	2	CONTINUE

Q4. **Are you a health professional (e.g. a doctor, nurse, pharmacist, dentist, physiotherapist etc…) ?**

Yes	1	THANK AND CLOSE
No	2	CONTINUE

Q5. SHOWCARD **Which, if any, of the following have you seen in the last year or so?**

Chiropodist/podiatrist	1	RECRUIT TO QUOTA
Chiropractor	2	
Dentist	3	
Dietician	4	
Nurse/midwife	5	
Occupational therapist	6	
Optician	7	
Osteopath	8	
Paramedic	9	
Pharmacist	10	
Physiotherapist	11	
Radiographer	12	
Speech or language therapist	13	
No	14	

Q6. **GENDER**

Male	1	(CLOSE/RECRUIT MIX)	GOOD
Female	2	(CLOSE/RECRUIT MIX)	GOOD

Q7. **AGE LAST BIRTHDAY**

EXACT AGE ❑❑

Under 18	1	THANK AND CLOSE
18-34	2	RECRUIT TO QUOTA
35-54	3	RECRUIT TO QUOTA
55+	4	RECRUIT TO QUOTA

QA. **Occupation of Chief Income Earner**

Position/Rank/Grade

Industry/Type of company

Quals/Degree/Apprenticeship

Number of staff responsible for

REMEMBER TO PROBE FULLY FOR PENSION AND CODE FROM ABOVE

Class

A	1	RECRUIT TO QUOTA
B	2	RECRUIT TO QUOTA
C1	3	RECRUIT TO QUOTA
C2	4	RECRUIT TO QUOTA
D	5	RECRUIT TO QUOTA
E	6	RECRUIT TO QUOTA

Interviewer number:

Interviewer name (CAPS):.....

I confirm that I have conducted this interview **face to face** with the above person and that I asked all the relevant questions and recorded the answers in conformance with the survey specifications and with the MRS Code of Conduct and the Data Protection Act 1998.

Interviewer Signature:.....

Date: .....

Topic Guide

Core objectives

To explore general public perceptions of how non-medical healthcare professionals are regulated and explore attitudes towards how the general public think they should be regulated.

Outline of the research programme

- 6 X 1 ½ hour focus groups with members of the general public
- Groups to be held 10-17 May
- 10 respondents recruited for 8 to participate
- Quota information

Interview sections	Notes	Approx timing
1. Introductions	Sets the scene	15 mins
2. Fitness to practise and awareness of regulation	Explores ideas of fitness to practise and spontaneous awareness of regulation	15 mins
3. Expectations of regulation	Expectation of regulation and scenario outcome	15 mins
4. Assessment content	Expectation of who should participate in assessment and what they should comprise	20 mins
5. General attitudes	Agree/ disagree statements and NHS priorities	15 mins
6. Conclusion and key message	Summary and key messages	10 mins

Key Questions	Notes/approx timing
1. Introductions	15 minutes
1.1 Scene-setting: • Thank interviewee for taking part • Introduce self, MORI and explain the aim of the discussion • Role of MORI – research organisation, gather all opinions: all opinions valid, disagreements OK • Confidentiality: reassure all responses anonymous and that information about individual cases will not be passed on to any third party (e.g. Department of Health) • Get permission to tape record – transcribe for quotes, no detailed attribution. • First name • Where do you live? Who with? (household details)	**Welcome**: orientates interviewee, gets them prepared to take part in the discussion Outlines the 'rules' of the interview (including those we are required to tell them about under MRS and Data Protection Act guidelines) No detail about specifics (e.g. the regulation or revalidation) at this stage. This ensures that spontaneity is retained for initial discussions and that the interviewee is not overwhelmed with information
1.2 Introduction: We're going to be talking about 'non-medical healthcare professionals' this evening. I know that's a bit of a mouthful, but when I say 'non-medical healthcare professionals', I mean people like nurses, pharmacists, dentists, opticians, midwives, physiotherapists, paramedics… basically all the staff who aren't doctors but who treat and advise people in hospitals, GP surgeries, walk-in centres, pharmacies and in their homes or on the phone. PLACE LIST SOMEWHERE VISIBLE Just to start with, have any of you had any recent experiences with any of these types of people recently? Can you tell us a bit about them? Have they generally been good/bad? Why is that? • What do you think about these people generally? Do you think they're good at their jobs? Bad at their jobs? Why do you say that? • How do you judge? *Explore:* • What gives you the confidence that you have, or the lack of confidence you have in them? How confident are you that you are getting best quality and safest treatment under the current system? • What makes these people a trustworthy nurse/ dentist/ optician/ pharmacist/ midwife/ physiotherapist/ paramedic etc..? • What sort of things affect your trust in them? ALLOW SPONTANEOUS THEN PROBE o Technical ability? Probe: How would you judge this? o Communication skills/ How well they explain things? o Involving you in treatment decisions o Respecting your privacy/ dignity? • What would they have to do to lose your trust?	**Introduction**: provides contextual background information about the interviewee (which can then be used in the analysis)

2. Fitness to practise and awareness of regulation	15 minutes
These people are all professionals, so what are the kinds of things you'd expect them to have to do, in order to become a member of their profession? *If not mentioned, probe:* Do they need to prove professional competence? If so, what does that mean? How would you expect it to be proved? Are there any other things you'd expect them to have to do before becoming members of their profession? *Probe:* Pass CRB checks? Pass health checks? Once they become a member of their professions (so once they become a nurse or an optician or whatever else), what do you think happens? Are they just free to practise as they like from then on? *Probe:* o Do you think further checks are made on them? o IF YES: By who*? Probe: manager, doctor, team they're part of, national organisation, hospital or place they work?* o IF YES: How often do you think the checks are made? o IF YES: What types of checks? Probe: exams? patient feedback? o ASK ALL: Should there be? Do you think your expectations of health professionals have changed at all over the years? IF YES: How/ in what way? What do you think has caused your expectations to change? If you wanted to make a complaint about a paramedic for example, how would you go about it? Who would you complain to? o Would that be the same for a nurse? o Would it depend on what the nurse had done? Have you heard anything about whether non-medical healthcare professionals are regulated – whether anyone monitors them to check that they are doing a good job? If so: Are they regulated? How? *COVER FREQUENCY OF POSSIBLE CHECKS, CONTENT AND EXTENT*	
3. Expectations of regulation	15 minutes
If not aware of how regulated: What do you think happens in cases of poor practice? Who would bear responsibility if something went wrong and a patient was to suffer? Why? I am now going to read out some scenarios and I'll then ask you some questions.	

SENARIO 1: A nurse who is responsible for a group of patients in a hospital ward or a nursing home leaves food near their bedside. Patients who can't feed themselves are not helped, so the food is eventually taken away untouched.

SENARIO 2: A physiotherapist is ill. Colleagues covering his cases discover that no patient records have been kept. Patients are left trying to explain the progression of their complaint and the treatment that they have received up to now.

Ask all:
Ideally, what would you like to see happen?
Would what you'd like to see happen be the same for all these professions, or are there differences? Why?

Explore:

- What processes could there be in place for regulating them?
  COVER FREQUENCY OF POSSIBLE CHECKS AND POSSIBLY EXTENT OF CHECKS.

Who, if anyone, do you think <u>is</u> responsible for undertaking regulation?

Who <u>should be</u> responsible for regulation (if anyone)?

- Should regulation be done at a local or at a national level?
- By who?
  PROBE FOR
  - NHS?
  - Hospital or practice?
  - Medical profession?

If not covered, probe:

- Should it just be other healthcare professionals who decide on regulation? Why do you think that?
- Should the public have a role to play? Why do you think that?
- How do you feel about professionally-led regulation?
  By this I mean that an independent body sets standards for the profession and enforces them. It's led by members of the profession it regulates, but also relies on members of the public (who are appointed by the Government and take part in decisions about standards and also take part in the hearing which decides what to do about a complaint against a member of the profession).
- What are the alternatives in your eyes?

How should regulation be enforced?
Probe

- Should we just rely on complaints being made?
- Should we carry out checks?

If yes to checks:

- Who should we check?
- Everyone? People at random? Just people for whom concern has been raised?

On what level should assessments take place?

o Local level? National level? IF SAY LOCALLY PROBE FOR: should any misconduct be escalated to a national level if they need to be struck off? How often do you think assessments should happen?	
4. Assessment content	20 minutes
What form should assessments take? o Who should feed into the assessment process? *If not covered:* o Do you think patients should give feedback? *If they want to include patients' feedback* o What would you like to give feedback on? (probe: beside manner/ communication skills; how up to date the professionals; their medical knowledge/ technical ability; involving patients in decision making; amount of dignity and respect given to you; success rates of treatments o What kind of information would you like to give? o How would you as patients like to give your feedback? *Questionnaire as they leave the practice that they send to someone else? Postal questionnaire? Telephone interview?* o *Patient feedback publicity* How could patients' be made aware that they can give information? o *What about confidentiality – would you be worried about who contacts you and what information they hold about you?* *Moderator: Hand out list of pre-printed possible options.* "Now on the pieces of paper I've just given you I'd like you to give each bullet point a number from one to eight, with one being the most important and eight being the least important." List of possible components of regulation: – Periodically passing a written test of relevant knowledge – Receiving ratings from colleagues they work with – Receiving ratings from their patients – Practicing their technical skills in simulated situation – Showing success rates for disease or conditions they treat most often – Being re-evaluated on their qualifications every so many years – A folder of evidence that they have kept up-to-date with medical developments Discuss ranking in detail, probe fully. What should happen if someone fails an assessment? o Does it depend on the severity of the failure/risk to patient safety? What do you think that regulating healthcare professionals is saying to those people? *Probe for whether it questions our trust in them* Why do you say that?	

5. General attitudes	15 minutes
Explore: *Moderator: Hand out agree/disagree statements* "Could you write next to each statement whether you agree or disagree with it". Agree/disagree statements: a) Regulation can be unnecessarily expensive and time consuming. b) Inspecting <u>all</u> non-medical healthcare professionals regularly would be a waste of money. c) It is important that <u>all</u> non-medical healthcare professionals' competence is checked every few years d) Regulating healthcare professionals is unfair to them because it questions our trust in them? *Explore:* – *Probe fully* – *Why did they agree/disagree with each?* What do you think are the most important things regulators and health services need to do over the next 5 years? *Moderator: record each item on flipchart paper including "checking non-medical healthcare professionals' ability to practice" or similar, and hand out stickers.* Each of you has three stickers, I want you to come up to the board and stick your stickers next to your top three most important things. Discuss priorities in detail. Probe fully.	.
6. Conclusion and key message	10 minutes
Finally, just to conclude, can you summarise for me what you think about the regulation of non-medical healthcare professionals at the moment? What does a system ensuring that patients are getting the best quality and safest treatment look like? Does the current system look like this or not? Why/ why not? *Prompt where necessary:* • Is there anything else you'd like to say? • What would be the number one thing that you'd like to see? MORI is undertaking this work for the Department of Health who is interested in people's views on regulation of all types of healthcare professional. Is there any key message you would like us to feed back to the Department of Health? Thank respondents, explain the next steps: "The DH will use the findings in a major review it is doing at present, to help decide on recommendations for improving regulation" and close.	Formally ends the discussion and provides reassurance that the findings will be both appreciated by and useful to DH

Toplines

- MORI interviewed a representative quota sample of 2,084 UK adults aged16+. 1,973 of these were in Great Britain and 111 in Northern Ireland.
- Interviews were carried out face-to-face with the aid of CAPI terminals in Great Britain and on paper in Northern Ireland.
- The fieldwork period was 3-8 September 2005 in NI, 8 – 13 September 2005 in GB.
- Data have been weighted to the known population profile.
- Where figures do not sum to 100 per cent, this may be due to computer rounding, multiple codes or the exclusion of 'Don't know'
- * represents a percentage of greater than zero, but less than 0.5%

Q1. **When did you last have any contact with a non-medical healthcare professional?**

	%
In the last 3 months	51
Over 3-6 months	16
Over 6-9 months	8
Over 9 months – 1 year	6
Over 1 year ago	13
Never	5
Don't know / Can't remember	1

Q2. **Thinking about the last time you had contact with a non-medical healthcare professional, overall, how satisfied or dissatisfied were you with them?**

	%
Very satisfied	59
Fairly satisfied	29
Neither satisfied nor dissatisfied	3
Fairly dissatisfied	3
Very dissatisfied	2
Not applicable/ Haven't had contact with one	3
Don't know	1

Q3. **How often do you think non-medical healthcare professionals are currently assessed, if at all? Please read out the letter that applies.**

	%
Every year	23
Every two years	14
Every five years	11
Every ten years	2
Only if there are concerns about their ability	9
Not at all once they qualify	5
I don't think they're assessed/ Never	7
Other	1
Don't know	29

Q4. **How often do you think they <u>should</u> be assessed, if at all? Please read out the letter that applies.**

	%
Every year	49
Every two years	24
Every five years	14
Every ten years	1
Only if there are concerns about their ability	3
Not at all once they qualify	1
Never	1
Other	2
Don't know	5

Q5. **Which, if any, of the following, do you think assess them at the moment? Please read out the letter or letters that apply.**

Base: All who think non-medical healthcare professionals are currently assessed *(1,240)*	%
The local health authority	26
The Department of Health	24
Someone within their team/ their immediate boss/ line manager	23
The hospital or place they work	22
The British Medical Association	20
A professional body/ council	18
An organisation within the NHS	17
The General Medical Council	16
The Healthcare Ombudsman	7
Other	1
I don't think they're assessed	1
Don't know	5

Q6. **Which, if any, of the following, do you think bears most responsibility if a patient suffers because of the poor practice of a non-medical healthcare professional? Please read out the letter or letters that apply.**

	%
The local health authority	24
The hospital or place they work	23
The healthcare professional themselves	21
The Department of Health	20
The British Medical Association	16
The General Medical Council	14
Someone within their team/ their immediate boss/ line manager	13
An organisation within the NHS	11
A professional body/ council	8
The Healthcare Ombudsman	6
Other	2
No-one	2
Don't know	9

Q7. **If you were asked to give feedback on a non-medical healthcare professional, what, if anything, would you want to comment on? Please read out the letter or letters which apply.**

	%
The quality of care that they provide	56
His/her communication skills/ How well he/she explains things	45
His/her knowledge/technical ability	41
The amount of dignity and respect he/she gives to patients	35
How much he/she involves patients in treatment decisions	33
How up-to-date he/she is with new developments in medicine or healthcare	32
Success rates of his/her treatments	27
I would not expect non-medical healthcare professionals to be assessed	*
Other	1
None of these	3
Don't know	4

Q8. **Using this card, could you tell me how strongly you agree or disagree with each of the following statements that I am going to read out.**

	Strongly agree	Tend to agree	Neither agree nor dis-agree	Tend to disagree	Strongly disagree	No opinion
	%	%	%	%	%	%
…Inspecting all non-medical healthcare professionals would be a waste of time and money	2	8	6	33	48	1
…There is no need to regularly carry out checks on non-medical healthcare professionals as I trust them	2	9	7	39	43	1
…It is important that all non-medical healthcare professionals' competence is checked every few years	62	30	4	2	1	1

Q9. **If all non-medical healthcare professionals were to be assessed from time to time, which, if any, of the following, do you think would be most important to ensure that everybody has good non-medical healthcare professionals? Please read out the letter or letters that apply.**

	%
Being re-evaluated on their qualifications every so many years	42
Receiving ratings from their patients	41
A folder of evidence that they have kept up-to-date with medical developments	32
Periodically passing a written test of relevant knowledge	31
Monitoring success rates for diseases or conditions they treat	30
Practising their technical skills in simulated situations	30
Appraisal by their line manager	24
Ratings from colleagues who are in the same profession	16
Receiving ratings from colleagues they work with	13
None of these	2
Don't know	4