Health Professions Council
6 December 2005
SURVEY OF ATTITUDES TO THE HEALTH PROFESSIONS COUNCIL

Executive Summary and Recommendations

Introduction

Mori were commissioned to conduct focus groups with registered health professionals. Five focus groups were held across the UK, each with eight health professionals taking part from all 13 professions. The sessions lasted 1½ hours. The report will contribute towards the basis of the communications strategy for the next five years.

Decision

This paper is for information only. No decision is required.

Background information

Registrants were asked how they felt about a number of issues such as protection of title, the role of HPC, the role of their professional body etc. They were also asked about CPD and what their attitudes towards the changes are. This information will be used to influence HPC's future communications with registrants and employers.

Resource implications

None

Financial implications

None

Appendices

See attached Mori report

Date of paper

25th November 2005

Health Professionals Council – Public & Stakeholder Views

Research Among Health Professionals & the General Public

Research Study Conducted for the Health Professions Council

(a) Draft report of findings

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August- September 2005

Contents

2. Introduction

This report presents the findings from research among the general public and Health Professionals' (HPs). The research was conducted by the MORI Social Research Institute on behalf of the Health Professions Council.

The general public quantitative research conducted by MORI explores the following areas:

- Public experience of health professionals;
- Public awareness and understanding of existing regulation, and attitudes towards it, including whether checks are made, what types of checks are made and complaints handling;
- What factors inspire confidence in HPs among the general public;
- Awareness of HPC;
- How the public feel that the HPC should best communicate its services; and

The qualitative research among HPC-registered HPs explores the following areas:

- Attitudes towards regulation of HPs and the HPC in general;
- Interactions with the HPC including registration and complaints handling; and
- Views on the HPC's communications strategy.

The phrase 'health professional' was introduced at the beginning of the general public interviews and a list of the professions regulated by the HPC was on display for participants to refer to. Respondents were shown the following list:

- Arts therapists
- Biomedical Scientists
- Chiropodists/Podiatrists
- Clinical Scientists
- Dieticians
- Occupational Therapists
- Operating department practitioners
- Paramedics
- Physiotherapists
- Prosthetists and Orthoptists
- Radiographers
- Speech & Language Therapists

The findings will contribute towards understanding of public perceptions and attitudes towards regulation of health professionals and will inform the HPC's review of their communications strategy.

Methodology: The research methodology comprised qualitative and quantitative research among both the general public and HPs (only those registered with the HPC were invited to participate). These stages are described further below.

Qualitative Research with Health Professionals: For research among registrants of the HPC, 5 discussion groups were conducted. The locations for the focus groups were: South of England (Richmond); Midlands (Birmingham): Wales (Cardiff); Scotland (Edinburgh) and Northern Ireland (Belfast).

Quotas were set by: gender, profession (aiming to recruit a good mix of all 13 health professions) and NHS/Private affiliation (aiming to ensure each group had participants representing the private sector).

The groups lasted around 1½ hours and were digitally recorded with respondents' permission. They were moderated by MORI executives. By its very nature, qualitative work provides insight into issues and a feel for the range of opinions held. However, the numbers of participants are small and results cannot be regarded as being representative of Health Professionals as a whole.

The following people were recruited for each group:

	Location	Date	Gender	NHS/ Private	Professions represented
Group 1	Edgbaston (Birmingham)	16/08/2005	Mainly female	8/2	Podiatrist; Speech & Language Therapist; Occupational Therapist; Physiotherapist; Radiographer; Dietician; Biomedical Scientist; Clinical Scientist.
Group 2	Thames Ditton (Kent)	18/08/2005	Good mixture	8/2	Podiatrist; Speech & Language Therapist; Orthoptist; Occupational Therapist; Physiotherapist; Radiographer; Dietician; Paramedic.
Group 3	Cardiff	23/08/2005	Good mixture	8/2	Podiatrist; Speech & Language Therapist; Orthoptist; Occupational Therapist; Physiotherapist; Radiographer; Dietician; Arts Therapist; Paramedic; Prosthetist.
Group 4	Belfast	23/08/2005	Good mixture	8/2	Speech & Language Therapist; Occupational Therapist; Physiotherapist; Radiographer; Paramedic; Prosthetist; Biomedical Scientist; Clinical Scientist
Group 5	Edinburgh	24/08/2005	Mainly female	8/2	Podiatrist; Speech & Language Therapist; Orthoptist; Occupational Therapist; Physiotherapist;

					Radiographer; Dietician; Paramedic; Prosthetist.

General Public Quantitative Research: A large-scale quantitative survey was conducted to assess public opinion across the UK on the regulation of HPs and awareness of the HPC itself. Questions were placed on the MORI Omnibus, the regular MORI survey among the general public. A nationally representative quota sample of 2,127 adults (aged 15 and over) was interviewed throughout the UK. Of these, 1,979 were interviewed by MORI in Great Britain and 148 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 22 and 26 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.

3. Executive Summary

- TO BE INCLUDED ONCE REPORT CONTENT IS FINALISED

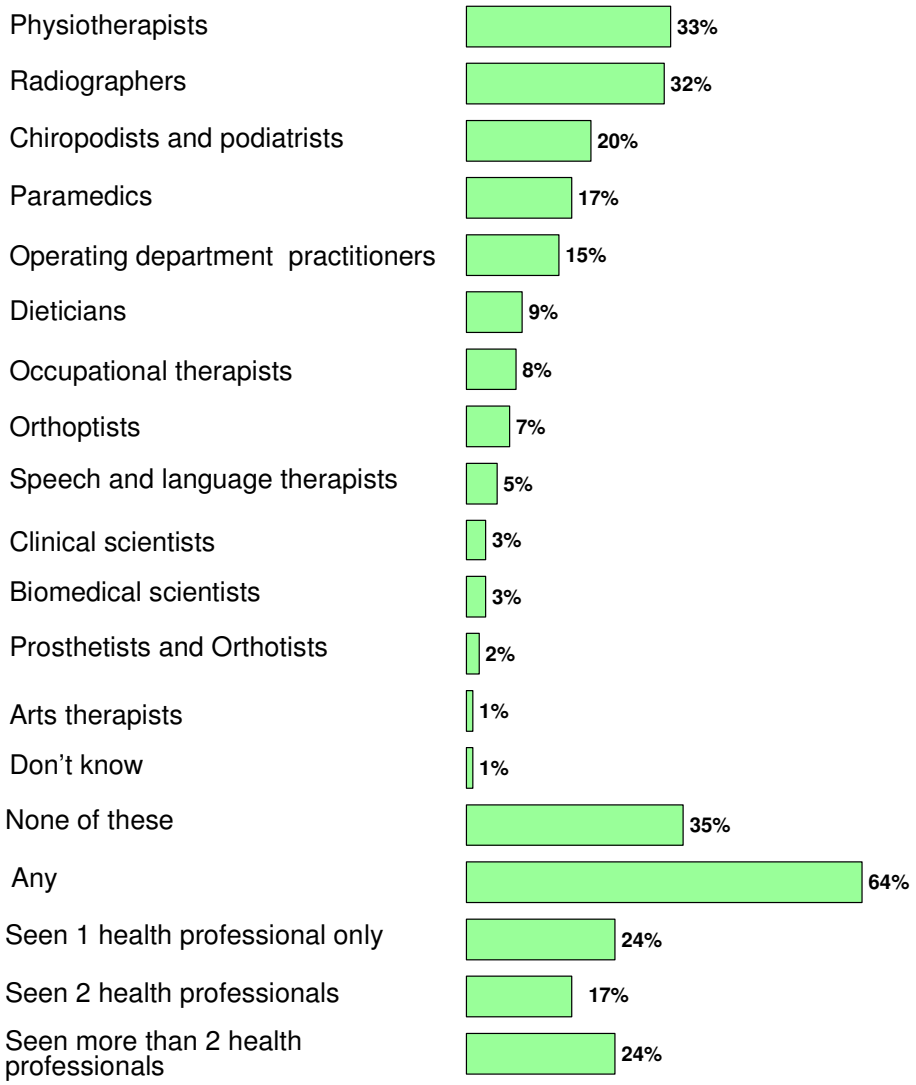
- General Public Survey

(a) Contact with Health Professionals

There is s high level of contact between Health Professionals working under the 13 HPC-regulated titles and the general public. Around two-thirds of the general public say they have used the services of at least one of the 13 HPs regulated by the HPC. The most frequently seen HPs are Physiotherapists and Radiographers, where a third report having used their services. Usage is not necessarily confined to one HP only. In fact, over two in five report having used the services of two or more HPs whilst only a quarter report using one HP only.

Contact with Health Professionals

Q1. Which, if any, of the following health professionals' services have you ever used?



Base: 2,217 UK residents aged 15+. Field work dates: 22-26 September 2005 Source: MORI

Gender, age and traits relating to social class (i.e. housing tenure, household income and social grade) all seem to have an impact on

usage of HPs. Women (68%) are more likely than men (61%) to have used the services of an HP. Usage increases sharply as people get older. Just under half of younger people (aged 15-24) report having used HPs whilst this figure increases to over seven in ten among those aged 45+. People in social class group AB and C1 are more likely to say they have used a HP (73% and 65% respectively). A finding related to this, is that those who own their own home (68%) and those with higher annual income (70%) are more likely to have used the services of a HP.

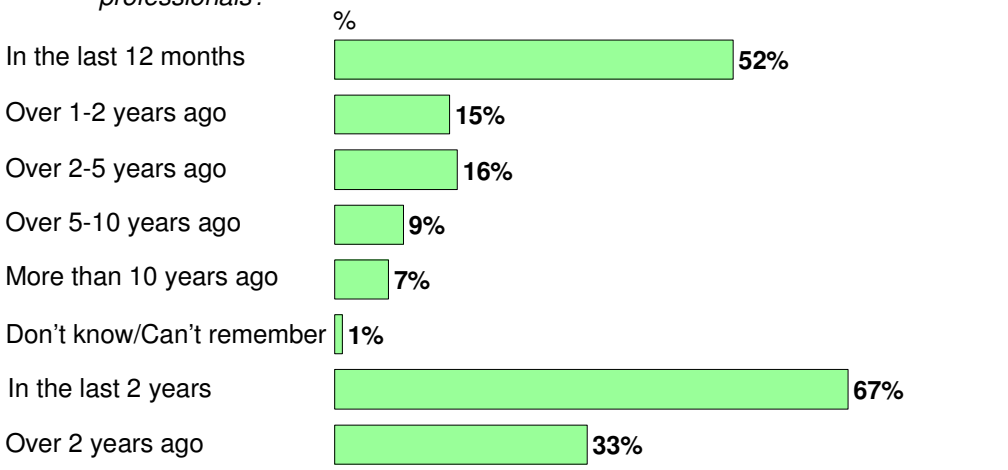
There are also some large regional and country differences in the levels of contact. People living in the North East (78%) and the North West (74%) of England report the most contact with HPs whilst usage is lowest in London (46%) and Northern Ireland (57%).

(i) How recent was this Contact?

Among those who report having contact with a HP, over half (52%) say it was within the last year, which increases to two thirds (67%) within the last 2 years.

Last Contact with a Health Professional

Q2. When did you personally last have any contact with any of these health professionals?



Base: All who have seen a health professional (1,364). Fieldwork dates: 22-26 September 2005 Source: MORI

Consistent with their being most likely to have had contact with HPs, women (70%) and older people (72%) are most likely to have had contact with a HP within the last two years. A possible indication that HPs are becoming more established in NI and Wales is that people living in these areas are most likely to have seen a HPC within the last two years and are least likely to have seen one over two years ago.

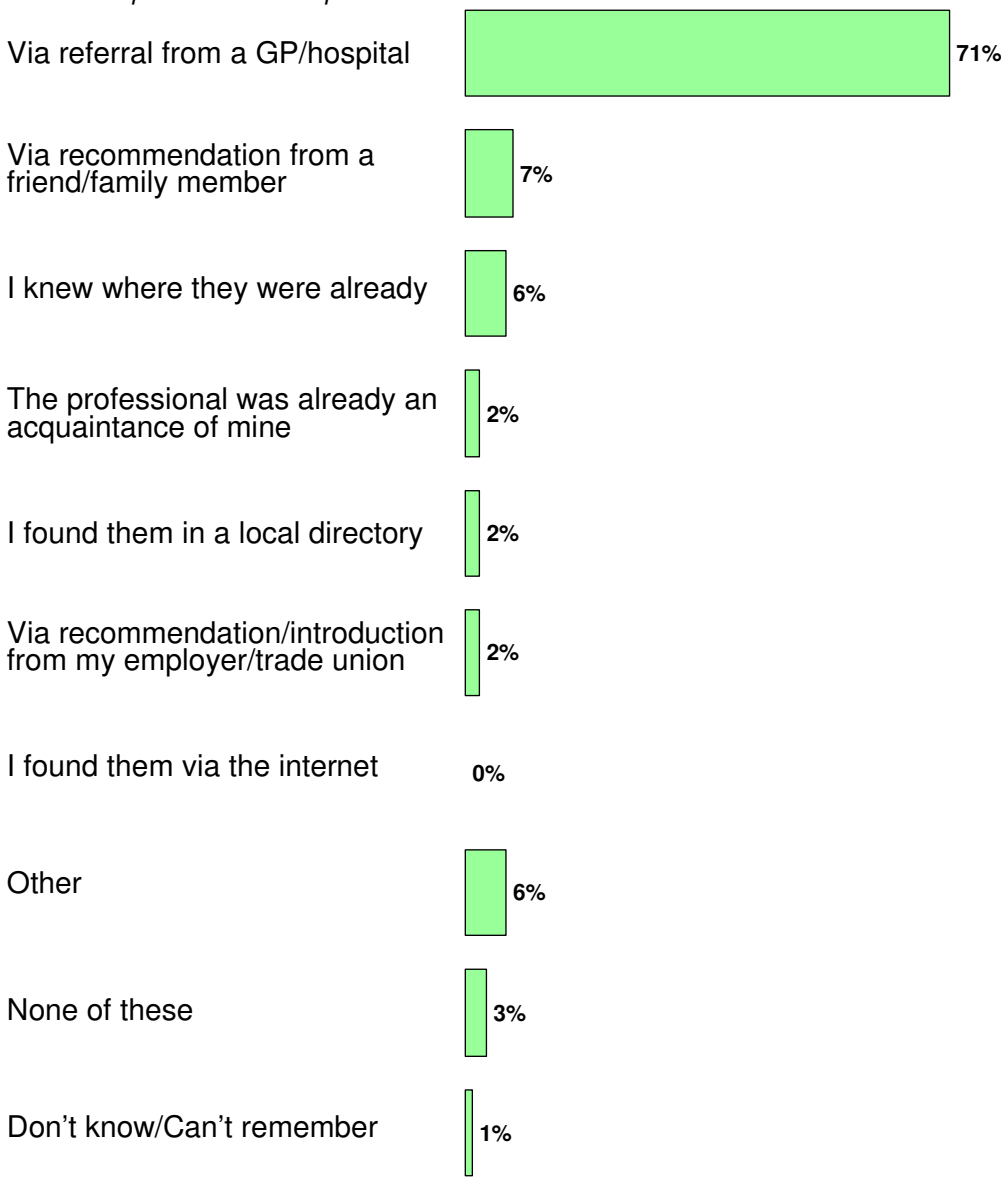
(b) Regulation of Health Professionals

(i) Awareness and Experience of Regulation

When asked about the most recent occasion on which they came into contact with a HP, the majority of those who report using a HP's services state that they saw the HP **via a referral from a GP or hospital**. Of those who approached their HP direct, the largest proportion of just under one in ten (7%) say they acted on a recommendation from a friend or family member.

Choosing a Health Professional

Q4. Thinking about the last occasion that you had contact with one of these health professionals on the previous card, through which, if any of these ways did you come to see that particular health professional?



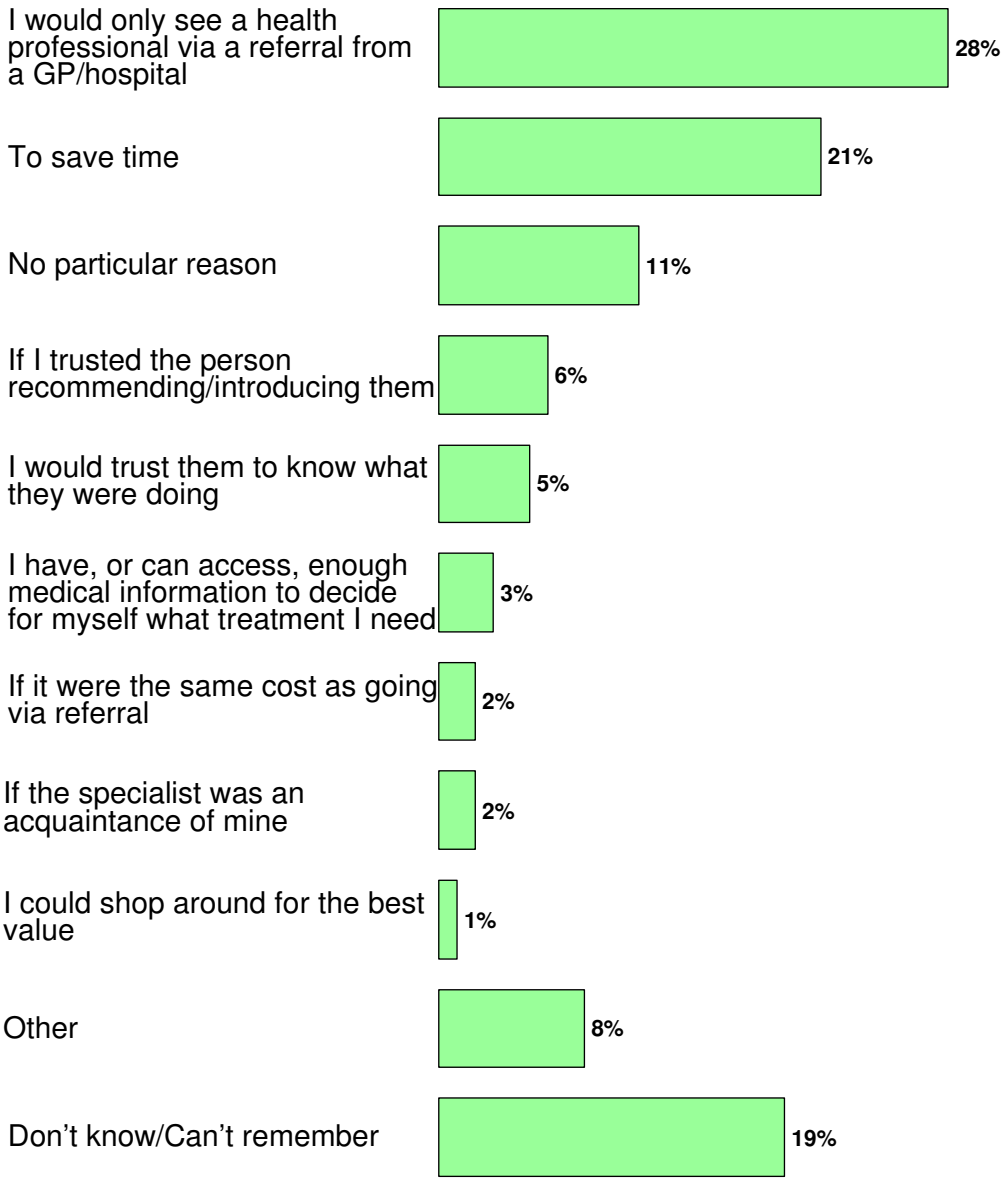
Base: All who have seen a health professional (1,364).
Field work dates: 22-26 September 2005

Source: MORI

To further investigate the motivations behind people going direct to a HP without a GP or hospital referral, all respondents were asked under what circumstances they would make this decision. Almost three in ten (28%) state that they would *only* see a HP having obtained a referral from their GP or hospital beforehand. However, among those who would go direct to a HP, the most common reason cited is to *save time*. Trust is also a factor with 11% choosing to go direct if they either trusted the person who recommended the HP, or they trusted the HP to be competent and able.

Contacting a Health Professional Directly

Q5. For what reasons, if any, might you choose to go direct to one of these health professionals, rather than via referral?



Base: 2,217 UK residents aged 15+. Field work dates: 22-26 September 2005

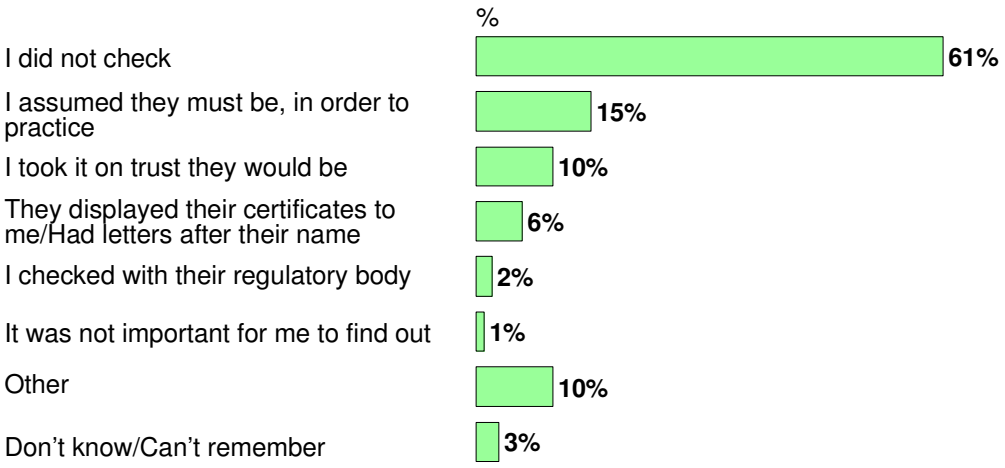
Source: MORI

Interestingly, those educated to A-level or higher (22%) and those in social class AB (26%) are less likely to say that they would *only* see a HP via a GP or hospital referral i.e. they are the groups most likely to base their decision on other factors, such as access to information or recommendations from friends or family.

When asked whether or not they checked in advance if the last HP they saw was qualified to treat them, three in five (61%) did not check at all. A further 15% *assumed* that the HP was qualified due to the fact that they were permitted to practise and 10% *trusted* the HP to be qualified. Thus in sum, over eight in ten (85%) made no recognized attempt to verify their HPs qualification to treat them. Of those who did make checks, 6% were satisfied by certificates shown and/or letters after the HP's name. However, only 2% say they checked with that HP's regulatory body in advance of being treated by them.

Checking a Health Professional's Qualifications

Q3. Thinking about the first occasion that you saw one of these health professionals, how, if at all, did you check in advance whether or not they were qualified to treat you?



Base: All who have seen a health professional (1,364). Fieldwork dates: 22-26 September 2005 Source: MORI

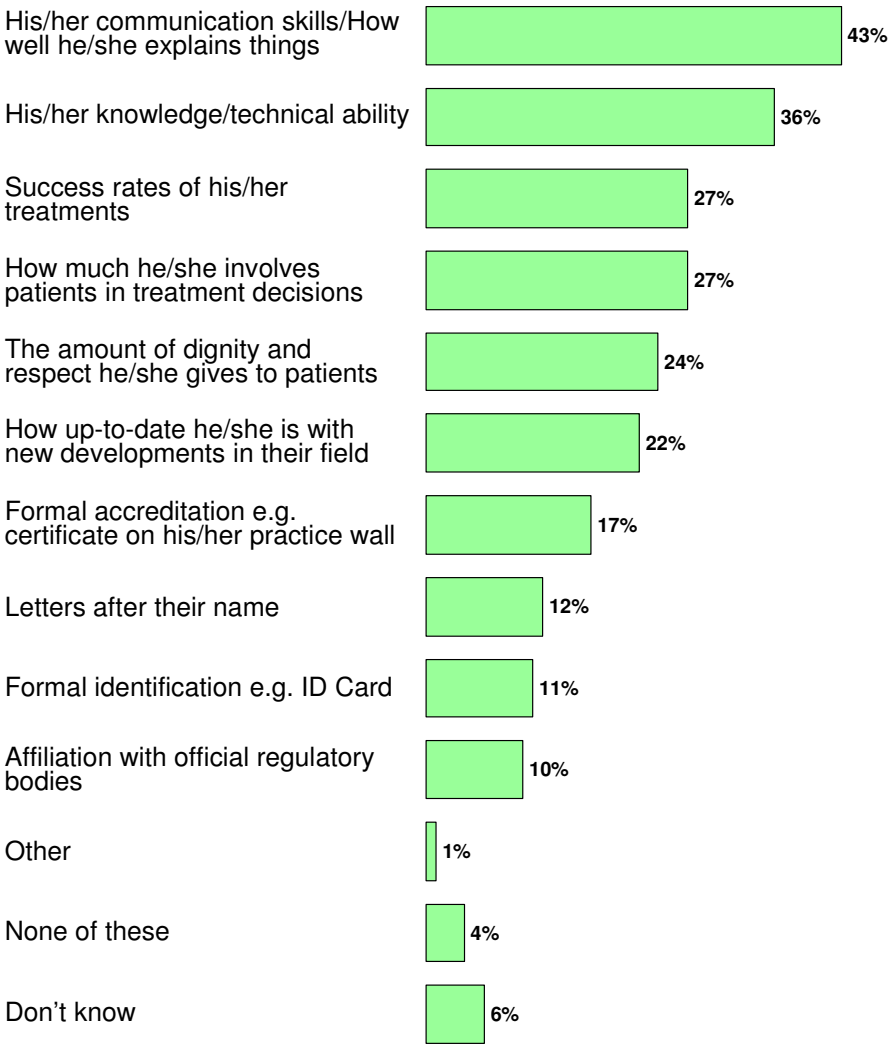
Older people (aged over 55), those in social class AB and people educated to degree level or higher are least likely to say they did not check their HPs qualifications at all (56%, 55% and 53% respectively). Groups most likely to be treated by a HP without first checking their credentials are younger people (69%) and social class DE (66%). Encouragingly, however, those whose last contact with a HP was less than two years ago (59%) are less likely to say that they did not make any checks than those who last saw a HP over two years ago (65%).

(ii) What Inspires Public Confidence in Health Professionals?

There are key factors that between a quarter and two-fifths of the general public say most affect the confidence that they have in a HP. The most important is the *communication skills* of a HP, which is cited by 43% of respondents. This is followed by factors relating to the HP's *competence* – i.e. knowledge and technical ability (36%) and success rates of their treatments (27%). Softer, interpersonal skills such as how much they involve patients in their decisions (27%) and the amount of dignity and respect they give to their patients (24%) are also perceived to be key. More official indicators of a HPs competence are less popular, with only one in ten citing that letters after their name, formal ID cards or affiliation with official regulatory bodies are the factors that most affect the confidence people have in a HP.

Confidence in Health Professionals

Q6. Which two or three of the following factors, if any, would you say most affect the confidence you personally have in a health professional?



Base: 2,217 UK residents aged 15+. Field work dates: 22-26 September 2005

Source: MORI

Groups most likely to feel that affiliation with official regulatory bodies is a key factor in increasing their confidence in HPs are those from higher social class groups (ABC1) and those educated to A-level or higher.

When the UK general public are asked who they would contact if they had a complaint about a HP the most commonly cited organisation is their Local Authority (35%). Just under a quarter say they would contact the HP's immediate boss or line manager directly and 15% say they would contact the office or department in which that HP works. Interestingly, although only 11% say they would not know who to contact to make a complaint against a HP, the HPC is cited by only 5% of respondents indicating that public awareness of the organisation is very low. Awareness of the HPC as a contact point for complaints about HPs does not differ significantly across subgroups. However, London residents are a notable exception – 12% of whom report that they would complain to the HPC compared to 5% of the sample overall.

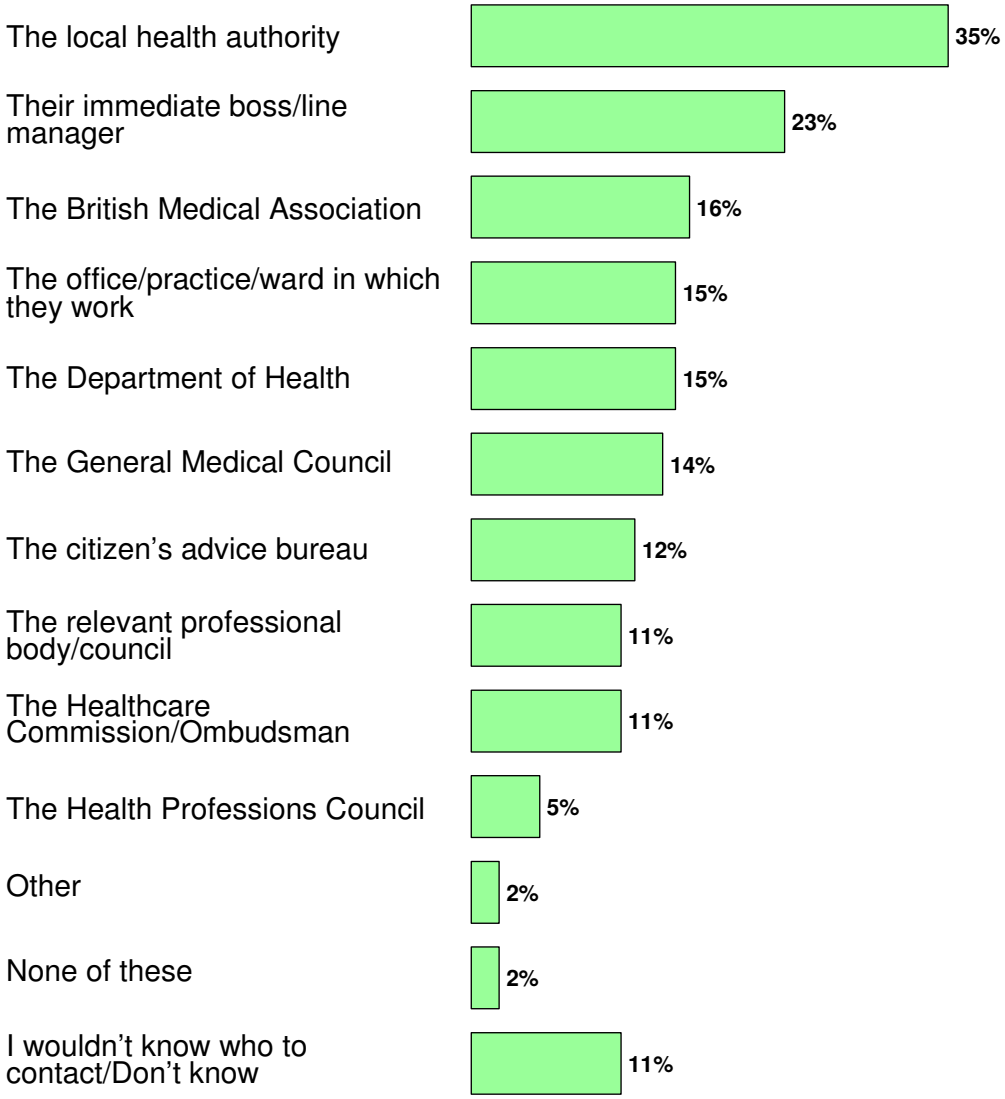
Awareness of which bodies are involved in regulating HPs is low, which reflects MORI's research on awareness of the regulation of science and technology (MORI/OST 2005) [1] and also research into regulation of doctors[2]. Professional bodies were mentioned in this context by one in ten of the general public. A sixth cited the BMA as the organisation they would complain to in the first instance. This is a theme that emerges often in MORI's general public work, whereby the BMA is perceived as the umbrella regulator for all healthcare professions.

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

[2] See MORI/GMC Research on Attitudes towards Doctors (2005)

Complaints about Health Professionals

Q7. Which, if any, of the following, would you personally contact if you had a complaint to make about a health professional?



Base: 2,217 UK residents aged 15+. Field work dates: 22-26 September 2005

Source: MORI

(c)

Communications Strategy

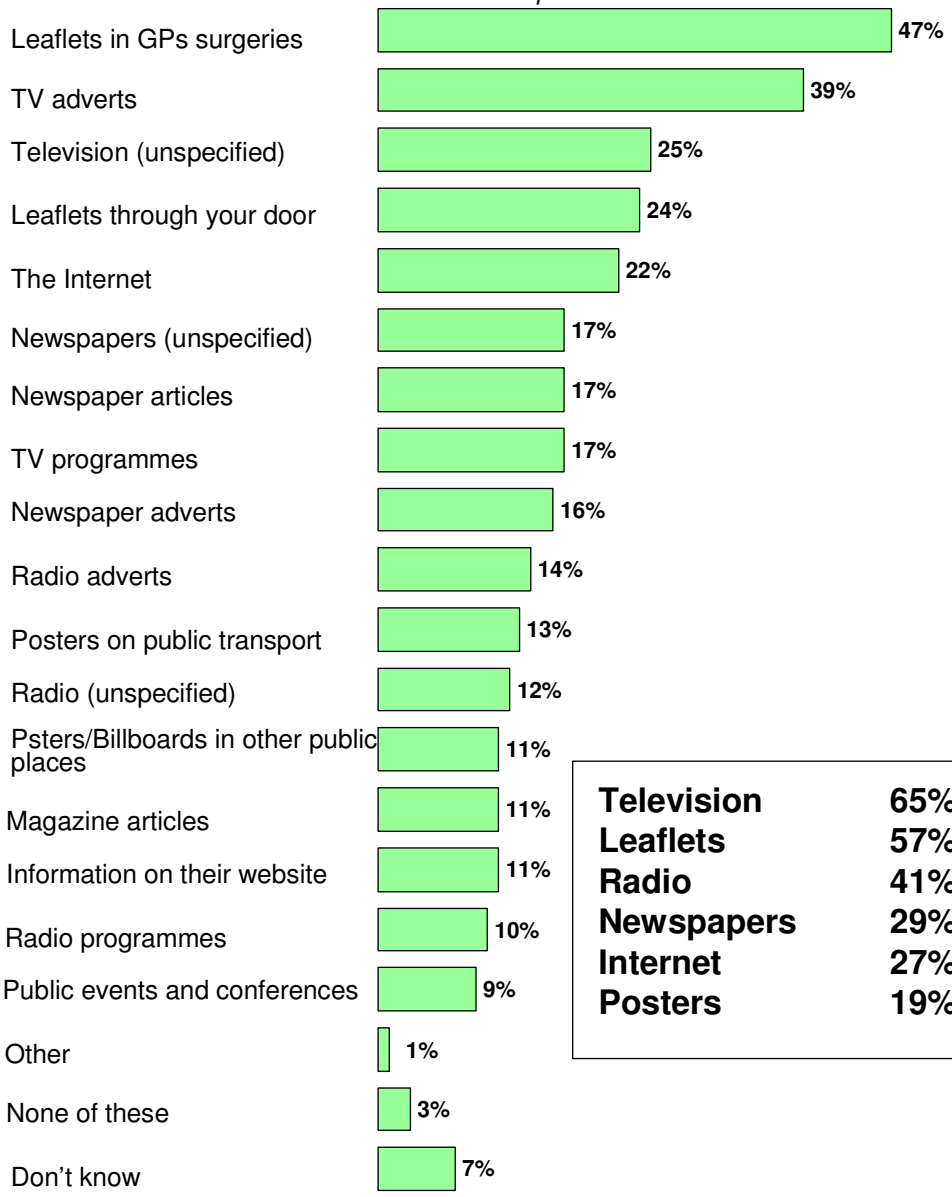
The finding above indicating low public awareness is supported by the fact that only 12% of the UK general public report having heard of the HPC. Awareness is highest among social class AB (16%), those with A-level qualifications or higher (16%) and residents of Northern Ireland (19%). Awareness is lowest among young people (8%), those with no formal qualifications (9%) and residents of London (9%).

(i) Public Priorities for the HPC's Communications

Given the low public awareness of the HPC, it is important to gauge which methods they feel would best communicate the HPC, its role and the services which it provides. The key single method of communication preferred by the public is information provided in leaflets in GPs surgeries, which is stated by just under half of respondents (47%). As for various types of media, Television is the most popular with around two-thirds (65%) mentioning it, the majority of whom support the promotion of the HPC using TV adverts. Newspapers are cited by two in five (41%) as a good communications channel and both Radio and Internet being mentioned by just under three in ten respondents (29% and 27%) respectively.

Communication of the HPC's Services

Q9. Through which, if any, of these ways do you personally think the HPC should best communicate its services and role to the public?



Base: 2,217 UK residents aged 15+. Field work dates: 22-26 September 2005 Source: MORI

Preferences for the various communications channels do not differ significantly between demographic groups, with the exception of the Internet where, as would be expected, people most likely to prefer this method of communication are those most likely to use it – i.e. younger people, those of higher social grade and those earning higher household income.

4. Health Professionals

(a) Health Professionals' Views on Regulation

There is a general feeling among the groups of HPs that regulation for their professions is becoming much more effective since CSPM became HPC. A key part of this change is the increased focus on Continuing Professional Development.

> *I think there is greater emphasis now on regulation so I think people are more aware in all the professions about regulation than what the requirement is to practice within that. I think there is a greater awareness amongst all the professions about the regulation.*
>
> Female Health Professional, Cardiff

> *Within the Trust system it is highly regulated. Everybody has to be, you won't get past first base for a job if you are not HPC regulated.*
>
> Male Health Professional, Belfast

The key priority for a regulator to emerge from the groups was that HPs feel a regulator should protect patients by ensuring that only competent and qualified professionals can work under the various HP titles.

A key issue for participants, particularly among paramedics, physiotherapists and chiropodists, was with people operating using similar professional titles to themselves, who do not hold the same level of qualifications but who the public believe to be similarly qualified. For example, there appeared to be a range of titles around the area of sports therapy, which could lead the public to believe that the person had the same qualifications as a physiotherapist.

For paramedics in Belfast, the issue was with private companies providing ambulance type services and in Cardiff it was with their staff wearing similar types of uniforms but not being trained paramedics. These participants believed that the public could not differentiate between them.

Therefore, one of the roles considered to be integral to the job of health care regulation is making the public aware of the difference between different types of titles. Participants also thought that regulators have a role to inspect everybody in practise using the titles to ensure that they are registered and qualified.

Most participants recognised that Health Professions are well regulated and that people could not get jobs in the professions without the relevant qualifications and registrations. However, there was a consensus that the private sector gave more cause for concern. The concern was on two levels: firstly, in relation to people being able to set up and practise using similar titles to the registered professions and secondly, in relation to the extent to which some in the private sector keep up-to-date in terms of their CPD.

> *People can go off in independent practice and pretty much do their own thing, and because many are working in*

> *isolation they're not regulated by their colleagues or managers as such. So I guess what we would be looking for is some kind of system where there would be a guarantee that they are regulated in a consistent way that might be similar to their NHS colleagues.*
>
> Male Health Professional, Birmingham

(b) Health Professionals' Views of the HPC

(i) General attitudes

The general feeling is that the HPC is relatively new and still needs to build up confidence among its registrants who say it is too early to judge whether or not the HPC is effective. Participants found it difficult to express whether or not they had confidence in the HPC because of their low level of awareness and contact. The few who had had contact with them considered them to be professional and efficient.

> *I think things aren't really up and running as they should be, so seeing the portfolios, the CPD development and evidence-based practice and everything is all, they're all buzzwords, but they're not actually being looked into in any sort of detail at the moment. So it's almost as if the HPC is there, but it's not really up and running fully to actually regulate effectively.*
>
> Male Health Professional, Kent

> *I think Trusts are becoming more aware of the powers of the HPC, although I didn't fully understand that until tonight. Our files are being audited much more regularly now. And we have much more clear written guidelines.*
>
> Female Health Professional, Belfast

Knowledge of the HPC's specific functions is low with most stating that they are just aware that the HPC keeps a register and investigates complaints.

> *I see the HPC as more of a disciplinary body. If a disciplinary action needs to be taken, like a court or something like that.*
>
> Male Health Professional, Belfast

Many participants expressed the view that they see the HPC as 'just somewhere to be registered'.

Some felt that they are largely self-regulated or that they prefer to go to their professional bodies before the HPC if they have a complaint or issue. Others said that they were adequately regulated in the past and the HPC's arrival has made little difference.

> *I think we were fairly well regulated, even before the HPC took over. We have all got professional bodies of our own, who do a fairly good job of regulating us anyway. All the*

bodies that were registered previously anyhow, we all have our own professional organisations.

Male Health Professional, Cardiff

Confusion was expressed in all groups around the role of professional bodies and the HPC and the perceived overlap between the two.

I think that could be the problem, that it might be all things to all people? They have to be accountable to government, accountable to professionals, public. That is an awful lot, in my opinion, for an organisation to take on

Female Health Professional, Cardiff

I think really, for a lot of people, there is your professional body and then the regulator, and I think it is sometimes the professional body that keeps a closer eye. I did two registrations quite quickly and the one for my professional body was much more detailed. The HPC one was just clarifying the bank details so they could have my money.

Female Health Professional, Belfast

And you are wondering what role HPC actually play in the thing. I know they have rules and regulations about who is fit to be health professionals.. But the Trust know those anyway, so it sometimes seems to me like another layer of bureaucracy in the whole system.

Male Health Professional, Belfast

A common concern about the HPC is that as it is an organisation covering various health professions it may not give adequate consideration to the intricacies involved with each specific profession.

I don't think the HPC has, I don't think it has enough professionals with certain knowledge. It is difficult for a body of that size to know in detail what we all do. But in so doing they should recognise that they don't know that and they should liaise with our own professional bodies.

Male Health Professional, Cardiff

> *We opted out of the CPSM, and we were self-regulated. My profession feel very disappointed that we are not going to be very well represented. We are just worried that that is going to be lost; there is a lot of history and life experience there.*
>
> Female Health Professional, Cardiff

However, not all respondents were negative. Some, especially in the Edinburgh group, felt that regulation for their professions is becoming much more effective. This improvement has come about since CPSM became HPC. A key part of this change is the increased focus on Continuing Professional Development (CPD) and HPC encouraging and making CPD obligatory for all professions.

All groups also perceived that there is a problem in that the *public* aren't aware of the HPC. Some group participants have still been saying/advertising that they are 'state registered' until recently, because that's a term that the public understands (rather than HPC registered).

> *I think it's a shame, it's a pity they have to change the name from being state registered to HPC because the state registration idea was gradually getting understood by the wider public. And now we're right back to square one with years and years of education ahead of us to try and get them to understand what it means. I can't understand why they felt it necessary to change the name really because ostensibly it's exactly the same organisation with perhaps a slightly wider remit.*
>
> Female Health Professional, Birmingham

> *I took a very bold step in my yellow pages advertising this year, instead of putting state registered, it is what the public know I put HPC registered instead, but monitoring my new patient contacts. It has actually gone down this year. I have had people say to me "What is HPC registered". Everybody else has still kept it as state registered.*
>
> Male Health Professional, Cardiff

> *We spent years and years trying to persuade our patients that you must go for someone state registered, all of a sudden the HPC has come along, state registration doesn't exist any more, so we can't use state registered any more, we are going to be HPC registered now, but no publicity has gone into telling anybody what the HPC is.*
>
> Male Health Professional, Cardiff

> *I do wonder whether a member of the public would know where to go to. Say they had a problem with myself or any therapist, especially a private sector one, for whatever reason would you probably go to the police or? I don't think they'd know about the body.*
>
> Male Health Professional, Kent

> *The lack of awareness amongst the public is a big issue. And I know from the website that the HPC has undertaken some major adverts to raise awareness. But I am not so sure the general public are aware of the regulatory bodies.*
>
> Female Health Professional, Cardiff

(ii) Service Priorities

As for where the HPC's priorities should lie, the consensus was that **communications** should be the key focus for the HPC. Specifically, better communication with the general public about the importance of going to a registered health professional is needed.

HPC registrants consistently stated that the HPC needs to communicate more and do more for its members i.e. they feel they don't get enough from the HPC for their money, and see it as a regulator with the power to strike them off, rather than as an organisation which supports them/gives them information.

IT was seen as less important as this is an area where the HPC is perceived to be strong enough already (however, the IT improvements listed would be very welcome - e.g. online registration and payment).

Another low priority was **customer service**: most didn't anticipate that they'd need very much customer service from the HPC because they haven't so far.

Although most see the way it keeps its register as a key strength of the HPC, **registration** was high on people's priority list because of its high importance. More proactive policing of registrants and those advertising healthcare services was a popular suggestion (focusing efforts on the private sector in particular).

Training/CPD was a very big issue for some. There was a lot of interest in it, and lots of uncertainty about it. There was support for the HPC's role in CPD – especially a feeling among a few (mainly those from smaller professions, with smaller/less powerful professional bodies of their own) that it will ensure that all professions are up to the same standard.

> *We need a flow chart to guide people through the CPD, the pathways, and how it all fits. Maybe it just needs that flow chart to give people confidence, that if you are not very experienced, this is how you can pull it all together. One of the key issues is obviously about resources to do CPD because everyone works within constrained budgets. It is*

> *not only financial it is obviously time, time to go and do all this studying and meet requirements*
>
> Female Health Professional, Cardiff.

However, there is a lot of uncertainty: about what counts towards CPD, and about whether the HPC is qualified to approve training courses (do they have the expertise/knowledge that each profession's own body has?). There also seems to be a lot of uncertainty about how HPC defines **fitness to practise**.

(c) Interaction with the HPC

Other than for registration, few participants had had any other contact with the HPC. These were to discuss fitness to practise investigations and actions needed and the HPC's work was seen by these participants as thorough and efficient in these matters, if a little too prolonged.

Impressions formed during contact while registering were often negative:

- administrative errors and the related delays in being able to practise were a common grievance and

- complaints about inflexibility and too much bureaucracy in the registration process were also common

> *I think anything that will make it leaner and meaner and easier for staff will be beneficial. So if you can make that whole process less bureaucratic, you will receive huge positive feedback if you can get that whole process right. It is about the registration. And if people can check on the press of a button "Am I registered or have I paid?" it will be so much easier*
>
> Female Health Professional, Cardiff

Most didn't feel they could rate the customer service they had received because they didn't feel they had received very much – this lack of service/communication itself, though, was a cause of dissatisfaction.

A couple of participants had had bad experiences with the HPC's handling of their call - one respondent had rung the HPC to talk about registration and the call was not handled well. She was passed from department to department; no-one knew who could deal with her query. However, she acknowledged that this was a long time ago. Another was annoyed at simply being referred back to the HPC website.

(i) Registration

Most had looked at the online register before coming to their group. However, they usually would only look every 2 years after renewing registration to check their renewal has been processed. The level of information on the register is seen to be adequate - they would not want too much detail (e.g. wouldn't want personal address) on the web.

Some suggested it should have an improved search facility to make it more user-friendly as at present it is possible to sort it by surname only and this is too labour-intensive.

> *When you use it, it only lets you search on someone's surname. I am trying to search for a colleague of mine whose surname is Thomas and it took ages. I think it would help if they expanded that a little bit so you could give a bit more detail. Imagine what it would have been like if I had put in Smith. It took a long time to bring up*
>
> Male Health Professional, Cardiff

Participants saw the register as necessary and getting better, however some say it would be better to renew it annually to reduce errors and make it easier to police.

(ii) The HPC Website

Most had looked at the website before the group, but wouldn't otherwise use it except to check that they are registered or to look for something specific that HPC might be able to help them with. Those who have used it say that it provides useful information. Some participants felt that this is geared more towards the public than health professionals.

> *I have to admit I actually found it very good. I thought it was a very detailed website and there's a lot of information there. I think, and it is accessible to the general public as well as professionals so that they made a comment in a couple of places about using clear simple language so that everybody was able to access it. I didn't look at every page because there was just so much there.*
>
> Female Health Professional, Birmingham

Many participants thought that the public should be made more aware of the register and encouraged to use it to check that professionals are registered. They thought that it should not be there to identify all registered professionals for those seeking someone for treatment – that is the role of GPs or yellow pages. The register was seen as a check for people *after* they had found a professional that they wished to see.

Some respondents mentioned that there is too much information on the website about complaints that are currently in progress. In particular, there are details on the internet – for anyone to see – about people who have had complaints lodged against them including details of the specific complaints. The respondents were not comfortable that their colleagues and the public can see this level of information before someone has been judged to be in the wrong.

> *It's awful because if something happened, and you're completely innocent and it's the patient's word against yours and they're investigating it and that's traumatic enough to be suspended from work, but to have your name on the website.*
>
> Female Health Professional, Cardiff

Possible improvements are being able to register/pay fees online – as long as the site is secure. Participants would also like updates on the HPC activities on the website. Some suggested the website could have a separate section that was accessible only to registered members, via a username and password.

Other suggestions included providing links to specific websites for the 13 professions covered by the HPC – for those who wish to learn more about them and what they do. Another frequent suggestion was to provide key learning points on the website from fitness to practise cases investigated by the HPC.

> *If I wanted information on my profession then I would find it somewhere else. I wouldn't instantly think that the HPC should give that.*
>
> Male Health Professional, Cardiff

> *One of the things we did want to recommend was about the key learning points coming out of complaints. You can click on what the allegations are, and then you can download the full documentation. But we were trying to save resources, do we really want to download a document that is huge, just to have some of the key learning points.*
>
> Female Health Professional, Cardiff

(iii) Complaints Handling

There was limited awareness of the complaints process. Most considered that if they had a complaint they would first go to their line manager or their profession-specific body. The HPC is seen as the 'formal' avenue for very serious cases and would only be approached after all other avenues had been explored.

> *For me personally it's like the end of the road … go to a professional first and. I know I'd want to be judged by my peers first and then maybe HPC's the end of the line as far as, you've done something so bad that it's either stay or go and they have the final say.*
>
> Female Health Professional, Birmingham

> *We went to our professional body. My line manager dealt with it from them. I didn't want to go to the HPC because that scares people, if you like, you think about getting struck off, don't you. And do you want to inflict that on someone, having an HPC investigation. But then you think of the patient at the end of it, that is what spurred us on to contact them.*
>
> Male Health Professional, Cardiff

> *We do deal with our own complaints and we've got our own system where you have to within 20 days answer the complainant's letter and then a full investigation will follow. It's our internal complaints system and an investigation officer will be appointed for a particular case. At the end of it they will submit a report which will then be either accepted higher up or not, and if it does get accepted then it results in disciplinary, which we do in-house as well.*
>
> Male Health Professional, Birmingham

Personal experiences were limited to those in management roles, who saw it as a long but thorough and robust process. The general consensus among others was that they have confidence that the HPC is professional and would deliver a fair, correct result for a fitness to practise complaint.

Several mentioned they would like the HPC to send out a spec of what 'fitness to practise' actually constitutes, and what represents failure against these standards. Others also requested the HPC to issue clearer guidelines as to when they should be involved in a complaints case.

Several respondents also felt that even the public, if dissatisfied with a health professional, are unlikely to use the HPC. They would more likely ask to speak to someone's manager, or might report to a professional body. One respondent working in private practise felt that patients simply wouldn't return to a particular professional working privately if they weren't happy with their services, or – in the case of serious misconduct – would report to the police.

This supports the findings of the quantitative research whereby when the UK general public are asked who they would contact if they had a complaint about a HP – see page 12 of this report.

(d) Registrants' Views on the HPC's Communications

Perhaps unsurprisingly, given the low public awareness shown in the quantitative research, all groups felt that the HPC needs to work on its public image. All felt there needs to be much more advertising – e.g. in hospitals, in doctors surgeries and that the campaign must be very high profile.

According to HPs, there is a strong need to raise awareness of the HPC's purpose. The public message should focus on the HPC's role in checking that your HP is registered. The term 'HPC registered' needs to have some tangible credibility/meaning for the general public. Many suggested that the term 'state registered' is still strongly ingrained in public consciousness.

> *Having taken away the state registered title, which is one that Joe Public loved and took to their hearts, they almost need another title, if you like, to say this is a professional and they are a registered professional. I don't think HPC registered runs off the tongue and makes Joe Public feel they will go and see him rather than anyone else.*
>
> Female Health Professional, Cardiff

There was very low awareness of HPC media advertising among all groups of HPs. Participants felt there need to be much more promotions, however, those who had seen the media adverts, were largely positive.

> *They quite impressed me. I got to know them before you lot, so maybe the public doesn't. I wonder if these are all different channels. They were really on the mark; I thought they were really good.*
>
> Female Health Professional, Belfast

Other than notification in relation to registration, participants reported limited direct communication from the HPC. Letters etc. are seldom read in detail and some argue that these use too high quality printing and the HPC's money would be better spent elsewhere.

> *If people aren't going to read the literature there is no point sending it. If you were going somewhere to hear someone that you wanted to hear talk, that would be great. But we are absolutely bombarded with information in our jobs, and we have to prioritise what we read.*
>
> Female Health Professional, Belfast.

Respondents were equivocal about receiving more communications from the HPC. Those against it cited the fact that they are already bombarded with literature from other sources. They suggested that the HPC could issue them with diaries, pens etc. which they would keep on

their desk and which would help maintain awareness should they need them.

In support of the popularity of newsletters among the general public, those in favour of receiving more HPC communications mentioned a newsletter would be useful. This should contain updates of work HPC has done recently (e.g. details of media campaigns to raise their public profile), reminders that registration renewal is pending etc. The newsletter should show what the HPC is spending its money on.

One participant even suggested that the HPs themselves could have a role in promoting the HPC.

> *Those of us who have contact with the public should give them an HPC leaflet in whatever literature we are giving them.*
>
> Male Health Professional, Belfast

Some respondents suggested that they would like to see the HPC in person, perhaps attending conferences for the professions and getting a slot to talk about their role. However, the HPC needs to make sure that venues are big enough to accommodate everyone who will want to attend.

Checked &Approved:

Anna Carluccio

Checked &Approved:

Adam Palenicek

Appendices

5. 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.

6. 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 (2,127) 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% ±**
2127 UK adults aged 15+	1	2	2
1,979 GB adults	1	2	2
148 adults in Northern Ireland	5	7	8
			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 (998) vs Women (1,139)	3	4	4
ABs (484) vs DEs (622)	4	5	6
GB (1,979) vs Northern Ireland (148)	5	7	8
			Source: MORI

7. 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).

(a) 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

8. Recruitment Questionnaire

MORI/25539

Recruitment Questionnaire

August 2005

HPC Focus Groups

Good morning/afternoon/evening, my name is . . . . . from MORI, the opinion poll company. We are inviting Health Care Professionals to take part in an interview on their opinions on a number of issues relating to Health Professionals; I wonder if you could help me? The group will last around 1 hour and 30 minutes.

To say thank you for your time and cover any expenses incurred we would like to offer £120.

1 We are looking for particular types of people; therefore I would like to ask you some questions about yourself. All information collected will be anonymised.
2

Q1. **Are you registered with the Healthcare Professions Council?**

Yes	1	CONTINUE
No	2	THANK AND CLOSE

3

Q2. **Would you be interested in taking part?**

Yes	1	CONTINUE
No	2	THANK AND CLOSE

Q3 **Do you or any members of your immediate family work in any of the following areas, either in a paid or unpaid capacity? READ OUT**

Journalism/the media	1	
Advertising	2	
Public relations (PR)	3	
Market Research	4	THANK AND CLOSE
No, none of these	7	CONTINUE
Don't know	8	THANK AND CLOSE

Q4 **Have you participated in a focus group discussion for a market research company in the last 6 months?**

Yes	1	THANK AND CLOSE
No	2	CONTINUE

Q5. **GENDER**

Male	1	RECRUIT TO QUOTA
Female	2	

Q6. **AGE LAST BIRTHDAY**

EXACT AGE ❑❑

34 or under	1
35-54	2
55 and over	3

Q7. **PROFESSION**

Arts therapists	1	
Biomedical scientists	2	
Chiropodists and podiatrists	3	
Clinical scientists	4	
Dieticians	5	
Occupational therapists	6	
Operating department practitioners	7	
Orthoptists	8	
Paramedics	9	
Physiotherapists	10	
Prosthetists and orthotists	11	
Radiographers	12	
Speech and language therapists	13	
		RECRUIT TO QUOTA
Other	7	THANK AND CLOSE
Don't know	8	THANK AND CLOSE

Q8. **Are you an NHS or Private Health Professional?**

NHS	1	
Private	2	
		RECRUIT TO QUOTA
Other	7	THANK AND CLOSE
Don't know	8	THANK AND CLOSE

Interviewer number:

Interviewer name (CAPS):.....

I confirm that I have conducted this interview **by telephone** 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.

Interviewer Signature:.....

Date:.....

9. Topline Results

Health Professions Council
General Public Survey Topline – 04/10/2005

- MORI interviewed a representative quota sample of 2,127 UK adults aged 16+. 1,979 of these were in Great Britain and 148 in Northern Ireland.
- Interviews were carried out face-to-face with the aid of CAPI (Computer Assisted Personal Interviewing) terminals in Great Britain and on paper in Northern Ireland.
- The fieldwork period was 22-26 September 2005.
- 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%

Q3. **Which, if any, of the following health professionals' services have you ever used? I'd like you to think of all the ways in which you may have used these services e.g. hospitals, GP surgeries, walk-in centres, pharmacies and in their homes or on the phone. Please take into account both treatment and advice from these particular health professionals.**

	%
Physiotherapists	33
Radiographers	32
Chiropodists and podiatrists	20
Paramedics	17
Operating department practitioners	15
Dieticians	9
Occupational therapists	8
Orthoptists	7
Speech and language therapists	5
Clinical scientists	3
Biomedical scientists	3
Prosthetists and Orthotists	2
Arts therapists	1
None of these	35
Don't know	1
Any	**64**
Seen 1 health professional only	**24**
Seen 2 health professionals	**17**
Seen more than 2 health professionals	**24**

Q4. **When did you personally last have any contact with any of these health professionals?**
Base: All who have seen a health professional (1364)

	%
In the last 12 months	52
Over 1-2 years ago	15
Over 2-5 years ago	16
Over 5-10 years ago	9
More than 10 years ago	7
Don't know/Can't remember	1
In the last 2 years	**67**
Over 2 years ago	**33**

Q5. **Thinking about the first occasion that you saw one of these health professionals, how, if at all, did you check in advance whether or not they were qualified to treat you?**
Base: All who have seen a health professional (1364)

	%
I did not check	61
I assumed they must be, in order to practice	15
I took it on trust they would be	10
They displayed their certificates to me/ Had letters after their name	6
I checked with their regulatory body	2
It was not important for me to find out	1
Other	10
Don't know/Cant remember	3

Q6. **Thinking about the last occasion that you had contact with one of these health professionals on the previous card, through which, if any of these ways did you come to see that particular health professional?**
Base: All who have seen a health professional (1364)

	%
Via referral from a GP/ hospital	71
Via recommendation from a friend/family member	7
I knew where they were already	6
The professional was already an acquaintance of mine	2
I found them in a local directory (e.g. Yellow Pages)	2
Via recommendation/introduction from my employer/trade union	2
I found them via the internet	*
Other	6
None of these	3
Don't know/Can't remember	1

Q7. **For what reasons, if any, might you choose to go direct to one of these health professionals, rather than via referral?**

	%
I would only see a health professional via a referral from a GP/hospital	28
To save time	21
No particular reason	11
If I trusted the person recommending/introducing them	6
I would trust them to know what they were doing	5
I have, or can access, enough medical information to decide for myself what treatment I need	3
If it were the same cost as going via referral	2
If the specialist was an acquaintance of mine	2
I could shop around for the best value	1
Other	8
Don't know/Can't remember	19

Q8. **Which two or three of the following factors, if any, would you say most affect the confidence you personally have in a health professional?**

	%
His/her communication skills/ How well he/she explains things	43
His/her knowledge/technical ability	36
Success rates of his/her treatments	27
How much he/she involves patients in treatment decisions	27
The amount of dignity and respect he/she gives to patients	24
How up-to-date he/she is with new developments in their field	22
Formal accreditation e.g. certificate on his/her practice wall	17
Letters after their name	12
Formal identification e.g. ID Card	11
Affiliation with official regulatory bodies	10
Other	1
None of these	4
Don't know	6

Q9. **Which, if any, of the following, would you personally contact if you had a complaint to make about a health professional?**

	%
The local health authority	35
Their immediate boss/ line manager	23
The British Medical Association	16
The office/ practice/ ward in which they work	15
The Department of Health	15
The General Medical Council	14
The citizen's advice bureau	12
The relevant professional body/ council	11
The Healthcare Ombudsman	9
The Health Professions Council	5
The Healthcare Ombudsman	2
Other	2
None of these	2
I wouldn't know who to contact/Don't know	11

Q8. **Before today's interview, had you heard of the HPC, or not?**

	%
Yes	12
No	86
Don't know	2

Q9. **Through which, if any, of these ways do you personally think the HPC should best communicate its services and role to the public?**

	%
Leaflets in GPs' surgeries	47
TV adverts	39
Television (unspecified)	25
Leaflets through your door	24
The Internet	22
Newspapers (unspecified)	17
Newspaper articles	17
TV programmes	17
Newspaper adverts	16
Radio adverts	14
Posters on public transport	13
Radio (unspecified)	12
Posters/Billboards in other public places	11
Magazine articles	11
Information on their website	11
Radio programmes	10
Public events and conferences	9
Other	1
None of these	3
Don't know	7

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