Perceptions of Risk in Health and Care Settings
A Qualitative Study for the Council for Healthcare Regulatory Excellence
April 2012
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1. Executive summary
1. Executive summary

1.1 Background and context

1.1.1 Policy background

The Council for Healthcare Regulatory Excellence (CHRE) promotes the health and well-being of patients and the public through the regulation of health professionals. The CHRE scrutinises and oversees the work of the nine regulatory bodies that set standards for training and conduct for over 30 health and social care professions, ranging from doctors, dentists and nurses to arts therapists, prosthetists and biomedical scientists. With the implementation of the Health and Social Care Act 2010 - 2012, the CHRE will have a new responsibility to accredit voluntary registers of health and care professions.

The expanding remit of the CHRE, coupled with the increasing attention paid by the media to the safety and risks of patients in health and care settings, has prompted questions about the public’s understanding of the types of risks they might face in health and care settings and who should be responsible for mitigating those risks. In this context, the CHRE has commissioned Ipsos MORI to carry out a qualitative research study to explore these questions, and this report details the findings of this study.

1.1.2 Aims and objectives of the research

This research study was commissioned with the aim of exploring the following key research questions:

- What risks do people perceive themselves to face in their interactions with health and care professionals?
- How might these risks be mitigated?

The first question can be broken down further to explore what people believe the risks to themselves as patients or service users in different care settings to be, and whether or not the perceived risks differ with different health and care professions, and/or with regulated and non-regulated professions.

The second question is posed in the context that the CHRE’s approach to regulation states that health and care practitioners, employers, and patients themselves have a role to play in mitigating risks in health and care settings, and it is not just the responsibility of the statutory regulators. In light of this, the CHRE is interested in understanding:

- Which parties or individuals do the public think should be responsible for mitigating risks in health and care settings?
- How do people think responsibility for mitigating risks should be shared between regulators, health and care practitioners, employers, and patients?

1.2 General perceptions

Overall, risks relating to safety and harm did not come to mind spontaneously. There was a general sense that health service users were being protected by regulation and regulatory bodies overseeing health professionals. Regarding responsibility, a key theme emerged here around the extent to which patients should be expected to be responsible for mitigating risks.
Essentially the more that the individual was exercising choice in selecting and using a particular service the more they could be expected to mitigate risk by doing their own research. Key findings in more detail were as follows:

1.2.1 Safety and harm-related risks not ‘front of mind’

The issue of risk in relation to using healthcare professionals was not particularly ‘front of mind’ for most people. When asked for their spontaneous thoughts on risks, issues around safety and harm generally did not emerge. Instead, the risks that spontaneously came to mind tended to be around financial concerns (for example being charged for unnecessary dental treatment), waiting times for appointments, and communication issues (notes and information not being passed on between professionals, or medical staff not speaking good English).

The following chart gives an idea of the relative frequency with which different risks that emerged spontaneously.

1.2.2 Regulation assumed to be happening

Regulation was assumed to be something that was taken care of, meaning that people felt they need not worry about safety and harm.

1.2.3 More responsibility on patient when they are choosing to use a service

Regarding ‘alternative’ services in particular, people took a consumerist approach: where the individual was choosing to use the service (as opposed to situations where they have no choice, such as emergencies), the onus was felt to be on the individual to research the service and professional they chose to use.
1.2.4 Differences in views between younger and older people

Older people tended to be more focused on the role of the regulator, whereas younger people took a more 'consumerist' approach, or focused on the responsibilities of the employer and professional themselves. Older and heavier users of mainstream services had some appetite for taking more responsibility for mitigating risks, but for negative reasons, e.g. some health professions seen as liable to ‘close ranks’ in response to complaints.

1.3 How do people assess risks?

A variety of criteria emerged by which people assessed safety and harm-related risks. Overall, the riskiest professions were seen as those carrying the highest physical risk — in effect, those involving the most physical contact or invasive treatment. Comparing mainstream, social care and alternative professions, the key overarching difference in perception of risk was between risks relating to the nature — i.e. the vulnerability - of the patient or client, and risks relating to the nature of the treatment and potential harm it could cause. The former were associated particularly with social care professions, the latter with mainstream and alternative professions.

When it came to assessing risks, people used a number of criteria, which can be grouped in three categories: factors around the patient, the treatment, and the professional administering the treatment.

Key findings in more detail were as follows:

1.3.1 Riskiest professions seen as those with greatest potential physical risk

Professionals such as doctors, dentists and paramedics are seen as potentially the riskiest and they carry out the most physically risky procedures. In the case of paramedics in particular, the fact that they often need to make quick treatment decisions with patients they are seeing in an emergency situation for the first time, also influences the perception of risk. There were also concerns around the physical risks inherent in the work of some alternative practitioners such as acupuncturists and chiropractors.

1.3.2 Least risky professions seen as those with least physical contact

This included professionals such as psychologists and speech therapists where the treatment was based on talking and developing a relationship over time rather than hands-on physical treatment.

1.3.3 Strategies for assessing risk

The group discussions drew out a number of criteria which people used to assess risk. These fell under three overarching categories:

- **The nature of the patient:** How vulnerable are they (e.g. unconscious, mentally incapacitated, unable to communicate) and do they understand the treatment? The issue of understanding, whilst overlapping with vulnerability, could also apply to perceived ‘esoteric’ alternative treatments where it could be hard for a lay person to link the treatment to the desired outcome.
- **The nature of the treatment:** How invasive — and hence physically risky — is it? Most treatments seen as invasive were mainstream ones. Acupuncture, with its use of
needles, was also seen as invasive. The frequency and timing of contacts with the professional was also important. People differentiated between the nature of contact with a paramedic, for example (little or no prior knowledge of the patient, brief, and pressured, and therefore more risky), and a speech therapist (building a relationship and developing the treatment over time, and therefore less risky). Another consideration was the likelihood of the treatment going wrong — again, acute and emergency services were by their nature viewed as risky in this regard.

- **The nature of the profession:** People looked at the responsibility and powers that professionals had. Those with greater prescribing power, autonomy and responsibility regarding deciding on and directing treatments were seen as posing greater potential risk. However, there was also the perception that these professionals were likely to be the best trained and most motivated, therefore less likely to make mistakes or act negligently. A perceived lack of training, dedication, and appropriate pay fuelled perceptions of risk around some less prestigious social care roles.

Strategies for assessing risk are summarised in the following chart.

**1.3.4 Differences in perceptions between different categories of service**

Risks around mainstream and some alternative services were often about the nature of the treatment — its inherent risks and what could happen if it went wrong or the professional made a mistake. Trust in the professional was also a key influencing factor for both. Regarding social care, the main emphasis was on the nature of the patient: the more vulnerable the patient the less able they were to speak up for themselves and assert their preferences, and the more likely to be exploited. The following chart summarises perceptions of risk in relation to different categories of service:
1.4 Responsibility for mitigating risks

It is very important to bear in mind that the regulator was still seen as a crucial backstop in ensuring standards were adhered to and that service users and patients had a means of recourse when things went wrong. Perception of strong or weak regulation was a key backdrop in people’s deliberations and assessments of risk. In particular, unease and uncertainty around some alternative services was partly driven by a perception of weak regulation.

There was however some appetite for patients to take some responsibility for mitigating risks, but with some important caveats – for example:

- **Is the patient choosing to use the service or not?** If they are they could be expected to take more responsibility – for example doing their own research on practitioners when looking for an alternative treatment. Where the patient is particularly vulnerable (for example unconscious or seriously injured), participants felt they could not be expected to take on responsibility. Some professionals such as GPs a grey area. People felt limited to a choice of GPs within their catchment area and would like to exercise more active choice if they could. The chart below summarises the relationship between choice and responsibility:

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### Differences in perceptions of risk between categories of service

<table>
<thead>
<tr>
<th>Type of service:</th>
<th>Key factors influencing perceptions of risk:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mainstream</td>
<td>Trust, Understanding of the treatment</td>
</tr>
<tr>
<td>Alternative</td>
<td>Nature of the treatment</td>
</tr>
<tr>
<td>Social care</td>
<td>Nature of the patient</td>
</tr>
</tbody>
</table>

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*This work was carried out in accordance with the requirements of the international quality standard for Market Research, ISO 20252:2006.*

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Is the patient well-informed enough about the service? Importantly, although some people discussed doing their own research when looking for alternative services such as BOTOX providers, the methods of research (particularly amongst younger people) were not always necessarily ‘safe’ or rigorous, and depended heavily on word of mouth and recommendations from friends, or a well-presented website. The emphasis therefore needs to be on ensuring patients can make informed, safe decisions.

Overall, then, there is a case to be made for empowering patients to navigate the mass of information on the internet so they can make better decisions.

People also identified ways in which employers and professionals themselves ought to take responsibility for mitigating risks, including:

- **Enabling a ‘whistle blowing’ culture**: Employers had a responsibility to promote a culture of openness and taking concerns seriously, and there was an onus on professionals to be aware of what their peers were doing and reporting concerns where necessary.

- **Training and development**: Employers had a responsibility for providing opportunities and investing in staff; the staff themselves had a responsibility to act professionally and take those opportunities.

- **Quality recruitment and training**: Employers – particularly of low-status and relatively low paid workers such as care workers – had a responsibility to ensure that recruitment and training was rigorous enough to ensure that only suitable people were employed and stayed employed.
1.5 Conclusions and recommendations

The key findings from the research can be summarised as follows:

- **Risk in terms of safety and harm is not on people’s radar**: Communications with them about it should therefore be in such a way that does not cause alarm.
- **Empowering people to make safe decisions**: Without adequate and easily-available information, some people’s methods of assessing risk can be less than safe and thorough. It is therefore important to avoid the impression that the regulator is ‘offloading’ responsibility onto the public; rather that they are empowering people to take some responsibility (as there is some appetite for) by ensuring they can make safe and informed decisions.
- **However, the regulator is still seen as key**: The challenge therefore appears to be how to encourage people to think about their responsibilities for managing risk against a backdrop on ongoing expectation that the regulator is looking after all the safety and harm-related issues so that the patient does not have to worry about them.
2. Background and methodology
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2.1 Policy background

The Council for Healthcare Regulatory Excellence (CHRE) promotes the health and well-being of patients and the public through the regulation of health professionals. The CHRE scrutinises and oversees the work of the nine regulatory bodies that set standards for training and conduct for over 30 health and social care professions, ranging from doctors, dentists and nurses to arts therapists, prosthetists and biomedical scientists. With the implementation of the Health and Social Care Act 2010 - 2012, the CHRE will have a new responsibility to accredit voluntary registers of health and care professions.

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2.2 Aims and objectives of the research

This research study was commissioned with the aim of exploring the following key research questions:

- What risks do people perceive themselves to face in their interactions with health and care professionals?
- How might these risks be mitigated?

The first question can be broken down further to explore what people believe the risks to themselves as patients or service users in different care settings to be, and whether or not the perceived risks differ with different health and care professions, and/or with regulated and non-regulated professions.

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- Which parties or individuals do the public think should be responsible for mitigating risks in health and care settings?
- How do people think responsibility for mitigating risks should be shared between regulators, health and care practitioners, employers, and patients?

2.3 The structure of the report

This structure of this report is centred around the key research questions that the CHRE is interested in exploring. Following the Executive summary and this Background and methodology chapter, the General perceptions chapter provides an overview of the public’s spontaneous views about risks in health and care settings. These views are explored in more depth in the subsequent chapter, entitled The risks of using healthcare services.
Questions around how risks might be mitigated, which parties or individuals the public think should be responsible for mitigating risks, and how people think responsibility for mitigating risks should be shared between regulators, health and care practitioners, employers, and patients is examined in the Responsibility for mitigating risks chapter. The report closes with a chapter summarising the research team’s Conclusions and Recommendations.

2.4 Methodology

2.4.1 Approach

To meet the objectives of this study a qualitative approach was adopted. This is because qualitative research enables in-depth exploration of participants’ perceptions and the factors driving these perceptions, features which are ideal for a study where the primary aim is to gain detailed insight into people’s views and the reasons behind them.

Face-to-face discussion (or focus) groups were chosen as the most appropriate qualitative technique in this context. The dynamics of a discussion group encourages participants to debate, react to what other group members are saying, and generate new ideas, whilst ensuring that each individual is able to speak in detail about their own circumstances and opinions.

Discussion groups were held with members of the public in Belfast, Cardiff, Edinburgh, London and York between 27th March and 13th April 2012. Two groups were held in each location and each group lasted 90 minutes.

2.4.2 Recruitment of participants

In some cases, participants were recruited using a “free-find” technique, which means that they were approached and invited to take part in the discussion groups on the street or in their place of work, as opposed to being selected from a list of people who have registered their interest in taking part in research projects. The former method was chosen over the latter because it enables access to the views of people who are “fresh” to the research process rather than those who frequently participate in such work. This recruitment was handled by Ipsos MORI’s experienced, quality-assured recruitment team. Participation was encouraged by offering participants a cash incentive to thank them for their time and contribution.

The CHRE was interested in hearing the views of users of different types of services, specifically older, heavy users of “mainstream” health and care services; younger light users of “mainstream” health and care services; and young, heavy users of “alternative” health and care services. In this context, older was defined as 45 to 64 years old, and younger was defined as 25 to 44 years old. “Mainstream” health and care services were defined as those that are predominantly state funded involving professions such as doctors, dentists, nurses, pharmacists, dieticians, midwives and social workers and “alternative” services were defined as those not consistently available on the NHS, involving professions such as acupuncturists, homeopaths, osteopaths and play therapists. Other quotas were set for participants regarding their gender, social grade and ethnicity with the aim of recruiting participants who were broadly representative of the UK population. The following table details which groups of people were recruited in which locations.
This work was carried out in accordance with the requirements of the international quality standard for Market Research, ISO 20252:2006.

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<table>
<thead>
<tr>
<th>Location</th>
<th>Group 1</th>
<th>Group 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belfast</td>
<td>Older, heavy users of “mainstream” health and care services</td>
<td>Younger, light users of “mainstream” health and care services</td>
</tr>
<tr>
<td>Cardiff</td>
<td>Older, heavy users of “mainstream” health and care services</td>
<td>Younger, light users of “mainstream” health and care services</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>Older, heavy users of “mainstream” health and care services</td>
<td>Younger, heavy users of “alternative” health and care services</td>
</tr>
<tr>
<td>London</td>
<td>Older, heavy users of “mainstream” health and care services</td>
<td>Younger, heavy users of “alternative” health and care services</td>
</tr>
<tr>
<td>York</td>
<td>Older, heavy users of “mainstream” health and care services</td>
<td>Younger, light users of “mainstream” health and care services</td>
</tr>
</tbody>
</table>

### 2.5 Interpretation of the findings

It is important to note that qualitative research is used to shed light on *why* people hold particular views, rather than *how many* people hold those views. Such research is intended to be illustrative rather than statistically representative of a wider population and, as such, does not permit conclusions to be drawn about the *extent* to which something is happening. With this in mind, when interpreting the findings from this research, it should be remembered that the results are not based on quantitative statistical evidence but, like all qualitative research, on a small number of people who have discussed the relevant issues in depth. It should also be remembered that the views stated here are not facts and not necessarily true, rather they are the participants’ perceptions and the truth as they see it.
3. General perceptions
3. General perceptions

This chapter will examine the public’s spontaneous views about risks in health and care settings and explore some of the differences in views between users of different types of services. The key findings presented in this chapter are:

- The concept of risk in health and care settings was not particularly salient in most people’s minds.
- The types of risks people spontaneously thought of were not ones associated with the physical or mental harm of patients or service users.
- Most participants had not thought much about the regulation of health and care professionals before, though assumed that it took place.
- Younger people had a more ‘consumerist’ approach to health and care services than older people and seemed to feel more desire and ability to change things if they went wrong.
- People thought that patients or service users could be expected to take more responsibility for mitigating risks if they chose to use a service rather than if they had to use a service.

This research study was commissioned to explore what the public think are some of the risks people are exposed to in health and care settings, how they these risks could best be mitigated and who should have responsibility for doing so. In order to explore these ideas, we opened our discussions with the public by asking them what they thought some of the risks in health and care settings were. This gave us a good idea of their spontaneous views of risks and from this it was possible to examine ideas about who should be responsible for mitigating risks. This chapter presents the findings from these opening discussions and presents a picture about participants’ spontaneous perceptions of risks in health and care settings. It also explores some of the differences in views between users of different types of services.

3.1 Spontaneous views relating to risks in health and care settings

The concept of risk in health and care settings is not at the forefront of most people’s minds. In all of the discussion groups we held it took participants some time to engage with the notion of risk. It was not something that people brought up spontaneously or found easy to connect with once the idea was introduced. Furthermore, when participants were asked about risk, the types of risks they spontaneously thought of were not ones associated with the physical or mental harm of patients or service users.

The types of risks participants spontaneously thought of were ones with less serious consequences than ones that could result in the harm of a patient. For example, participants in several groups mentioned the financial risks associated with healthcare, such as money...
spent on ineffective treatments or unexpected costs for treatment. Some participants in London discussed financial risks in relation to dentists.

\textit{I've got pain in this tooth here and I'm frightened to go because I'm frightened how much they may charge me to do whatever it is they've got to do because I don't know.}
Female, heavy user of mainstream services, London

\textit{You go in for a filling and end up in root canal.}
Male, heavy user of mainstream services, London

\textit{Yeah, he can say you need this and this and that, and I can't argue with that?}
Male, heavy user of mainstream services, London

Others focussed on issues related to miscommunication between patients and health and care professionals, or between different types of professionals (for example miscommunication or lack of communication between a GP and a specialist who the GP refers a patient to), or the long waiting times that can exist for appointments with health and care professionals.

\textit{I hear horror stories from other people about them having to wait weeks for what I would call an emergency appointment.}
Female, heavy user of mainstream services, Edinburgh

The relative frequency with which risks were mentioned by participants is shown in the following ‘word cloud’ chart. The larger the font, the more often the risk was mentioned relative to the other risks. As you can see, the most frequently cited risks include things such as too-brief appointments, communication, and cleanliness. None of these risks really involve harm of patients or service users. There are a few risks listed that might involve harm, such as hospital acquired infections and quality.
In a similar way to risks not being at the forefront of people’s minds, most participants had not thought much about the regulation of health and care professionals before. When asked about it, they expressed a general assumption that regulation takes place, but it was not something that they needed to spend much time thinking about, or indeed had done before. As one woman said:

I don’t think any NHS service would be classed as being risky for me personally. I would just have complete faith that they would do the job that they’ve been trained to do. They’re regulated by a national body. I assume that they’ve been trained and educated in the job that they’re doing on behalf of a huge umbrella organisation.
Female, heavy user of alternative services, Edinburgh

Another participant said:

I’ve never been in hospital since I was born so I’ve never had to think about it but I’ve never had any reason to think that they won’t do their job. I’ve got faith in the fact that they’re providing a service and they’ll do their job to the best of their abilities.
Female, heavy user of alternative services, Edinburgh

So risks in health and care settings and the regulation of them were both concepts that people were not engaged with or had thought about much before. In most of the discussion groups, participants only began to discuss, or even considered, risks relating to the harm of an individual once prompted, and they tended to assume that regulation was already taking place. This lack of salience in the public’s mind is important context in which to bear in mind the findings of the rest of the research.
3.2 Key differences in views between the different groups

There were some clear differences in views between the different groups of people we spoke to, for example between older and younger people, or between users of mainstream health and care services and users of alternative health and care services.

When discussing who has a responsibility to mitigate risks in health and care settings, older people tended to focus more on the role of the regulator than younger people, who were more likely to be amenable to the idea of assuming some responsibility themselves. Younger people seemed to feel more desire and ability to change things if they went wrong. They had a more ‘consumerist’ approach to health and care services in general, which may be related to the ‘consumerist’ culture they are used to in other aspects of life. They were more comfortable with the idea of demanding a higher standard of care in situations where it might be lacking. For example, this participant of a group with younger people in York explained how he had queried his GP about his treatment for a thyroid problem:

I’m a thyroid patient so I have to take Thyroxin and when I was first diagnosed I sort of did it myself really and I went to the GP and they did all the tests and they said I was fine. And I said, “Can I have a copy of the blood test results?” And I got them and I looked and I just said to him, “Look this is not right.” And he went, “Oh yeah you’re right.”
Male, light user of mainstream services, York

Of the few older people who were more open to the idea of patients taking some, or more, responsibility for mitigating risks in health and care settings, the reasons for this tended to be fairly negative. They often saw many medical professions as a ‘closed shop’.

Like the BMA isn’t it, they’re made up of people from the profession so they’re not really independent, I think their instincts tend to be with their own professional colleagues rather than, you know, they don’t see us as customers and that’s part of the problem.
Male, heavy user of mainstream services, Cardiff

This meant that if something went wrong then the healthcare professionals themselves would close ranks and protect each other. In such cases, the people we spoke to thought it would be up to the patient or service user to look out for themselves and take some responsibility for mitigating any risks.

Users of alternative health and care services seemed to be more engaged with the idea of taking responsibility for mitigating risks than users of mainstream health and care services. This relates directly to the fact that users of alternative health and care services often choose to do so, whereas users of mainstream services tend not to have much choice about whether or not they do. For example, participants in London pointed out that people who use homeopaths would often choose to do so, but someone who is treated by a paramedic would often have no say in the matter. As such, those who choose to use a service were expected to take more responsibility in terms of checking if the professional was qualified or if they were fit to practise. This is an idea that resonated throughout many of the discussion groups and will be explored further within this report.
4. How do people assess risks?
4. How do people assess risks?

This chapter focuses on understanding how people make judgements about risk. The discussion groups explored the risks around safety and harm that people think they are exposed to in different health and social care settings, and which professions are regarded as most and least risky and why. They then examined the criteria by which people assess risks. The key findings from these parts of the discussion presented in this chapter are:

- The safety and harm-related risks that are most front-of-mind regarding mainstream services, are around high profile issues such as hospital infections and mistakes by surgeons.
- Harm resulting from neglect and lack of care and attention was the chief concern around social care.
- Inappropriate treatment was a key concern in relation to alternative services.
- The riskiest professions were seen as those carrying the highest physical risk. Those with less physical contact were seen as less risky.
- People assessed risk in a variety of ways, most notably by the invasiveness of the treatment, vulnerability of the patient, and power and autonomy (including prescribing power) of the profession.
- Overall, risks associated with mainstream and some alternative professions were about the nature of the treatment, whilst risks associated with social care professions were about the vulnerability of the service user.

4.1 What risks do people think they are exposed to?

As discussed in the previous chapter, risks around safety and potential harm were not at the forefront of people’s minds. Focus was often on risks relating to, for example, financial costs, waiting times or appointments being too short. When probed further, however, participants did start to think about risks around safety and harm, and some differences emerged in perceptions between mainstream, alternative and social care services regarding risks.

The perceived risks around mainstream services in particular were to do with potential physical harm. Hospital-acquired infections, a common theme in media reporting on health services, concerned some people:

*What you’re hearing more and more people talking about now is maybe having to go to some, like a hospital or whatever, doctor whatever for something simple and coming out with something major. And that is actually on the tongues of a lot of people now because of what’s happening in the hospitals with diseases and stuff, infections that are being spread.*
Male, heavy user of mainstream services, Belfast

Hospital-acquired infections may have been at the forefront of the minds of the participants in Northern Ireland due to the recent pseudomonas outbreak in hospitals there. However, infections and hospital cleanliness were also mentioned in the groups held in other parts of the UK:

*There’s a certain hospital near me has got a bad reputation and I wouldn’t like to be sent there. You worry about catching something when you go there.*
Female, heavy user of mainstream services, London

Some were conscious that mistakes could occur in mainstream care settings with serious consequences, for example in surgery.

*I know they knock you out but still it’s quite nerve-wracking going down thinking okay it’s stupid to think they’re going to get it wrong but somebody’s already put the seed in my head that it’s a possibility and they’d witnessed it themselves that it has happened so when I came round I was like okay, yeah they’ve done the right leg.*
Female, heavy user of mainstream services, Cardiff

*You hear the horror stories about surgeons who leave things [in you].*
Female, heavy user of alternative services, Edinburgh

Concerns around potentially inappropriate treatment emerged around some mainstream services such as dentists, and was a particular concern for some in relation to alternative services. Compared to the activities of mainstream practitioners, the methods of alternative practitioners could seem esoteric and difficult for the lay person to understand, leaving more scope for harm to be caused through inappropriate treatment.

*If you went to a doctor and he looks at your throat and you know he’s doing it to have a look, you could be an acupuncturist and say I’d like to see your back. They could stick needles anywhere and you wouldn’t know [why]. It’s like a lack of knowledge.*
Male, heavy user of alternative services, Edinburgh

Not surprisingly, harm and maltreatment relating to lack of care and attention were perceived as particular risks around social care services, rather than harm relating directly from medical treatments.

*If a social worker misses something they get all the bad headlines and the workloads and things are impossible and they’re not being properly supervised. It’s not necessarily totally their fault, but if they miss something and something goes badly wrong, especially with children, then you know that can be quite risky. It can be the same for elderly people, people that have got mental health problems, if it’s not picked up on that somebody’s not taking their medication and is perhaps delusional or goes off and does something crazy as well.*
Female, heavy user of mainstream services, Edinburgh

With some social care workers, the potential harm need not always be physical. The attitude of staff could have an impact.

*The care workers that come into people’s homes are not always the nicest. I mean I’ve had one bully my mother so I know how that can leave her upset and physically drained as well, you know, because they’ve pushed her around, not physically but, you know mentally, in her own home.*
Female, heavy user of mainstream services, York

Perceptions of risks posed by social care staff were partly fuelled by awareness of problems in care homes and other social care settings, and failures in social work child protection, highlighted in the media. A few participants referred directly to the BBC's Panorama television programme, broadcast in May 2011, which showed secret filming of staff abuse of patients at the Winterbourne View private care home near Bristol.

There was that horrible case recently where they filmed them abusing mentally disabled people, so there is a risk there.

Female, heavy user of mainstream services, Edinburgh

4.2 Which professions are seen as most ‘risky’?

In the discussion groups, participants were asked to consider a selection of mainstream, alternative and social care professions and arrange them in order of how risky they perceived them to be in relation to each other. Overall, professions perceived as carrying the greatest potential for physical harm were viewed as the riskiest. This applied mainly but not solely to mainstream healthcare services: there were also some significant concerns about some alternative and social care roles. This is discussed in further detail throughout this subsection.

The following table summarises the three professions identified as the riskiest in each discussion group. Please note that were two sets of professions and different groups were shown different sets. The full sets of professions, along with a table detailing which groups were shown which sets, are listed in the appendices.
<table>
<thead>
<tr>
<th>Group</th>
<th>Top three riskiest professions:</th>
<th>First</th>
<th>Second</th>
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<tbody>
<tr>
<td>London - Older, heavy users of &quot;mainstream&quot; healthcare services</td>
<td>Domiciliary care worker</td>
<td>Doctor</td>
<td>Cosmetic injectable treatment provider</td>
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</tr>
<tr>
<td>London - Younger, heavy users of &quot;alternative&quot; healthcare services</td>
<td>Midwife</td>
<td>Domiciliary care worker</td>
<td>Doctor</td>
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<tr>
<td>York - Older, heavy users of &quot;mainstream&quot; healthcare services</td>
<td>Cosmetic injectable treatment provider</td>
<td>Domiciliary care worker</td>
<td>Chiropractor</td>
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<tr>
<td>York - Younger, light users of &quot;mainstream&quot; healthcare services</td>
<td>Paramedic</td>
<td>Nurse</td>
<td>Domiciliary care worker</td>
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<tr>
<td>Cardiff - Older, heavy users of &quot;mainstream&quot; healthcare services</td>
<td>Paramedic</td>
<td>Nurse</td>
<td>Healthcare assistant</td>
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<tr>
<td>Cardiff - Younger, light users of &quot;mainstream&quot; healthcare services</td>
<td>Dentist</td>
<td>Paramedic</td>
<td>Acupuncturist</td>
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<tr>
<td>Belfast - Older, heavy users of &quot;mainstream&quot; healthcare services</td>
<td>Domiciliary care worker</td>
<td>Social worker</td>
<td>Cosmetic injectable treatment provider</td>
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<tr>
<td>Belfast - Younger, light users of &quot;mainstream&quot; healthcare services</td>
<td>Midwife</td>
<td>Social worker</td>
<td>Cosmetic injectable treatment provider</td>
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<tr>
<td>Edinburgh - Older, heavy users of &quot;mainstream&quot; healthcare services</td>
<td>Paramedic</td>
<td>Dentist</td>
<td>Nurse / Homeopath</td>
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<tr>
<td>Edinburgh - Younger, heavy users of &quot;alternative&quot; healthcare services*</td>
<td>Residential care worker (high risk, high likelihood)</td>
<td>Nurse (high risk, low likelihood)</td>
<td>Paramedic (high risk, low likelihood)</td>
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</tbody>
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*This group spontaneously considered high and low likelihood of things going wrong as well as high and low risk.

When considering which professions were most risky, participants tended to focus on the risk of serious physical harm. Paramedics, doctors, dentists, nurses, and midwives were generally seen as professionals doing things that could potentially cause the greatest physical damage to people.

*The midwife in my eyes is life or death really quickly... or brain damage.*
Female, heavy user of alternative services, London

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This work was carried out in accordance with the requirements of the international quality standard for Market Research, ISO 20252:2006.
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When you say low risk and high risk I take it that's to death is it? 'Cause I mean paramedics I would say is a high risk job.
Male, heavy user of alternative services, Edinburgh

The perception of high risk was as much around what these professionals could miss or omit as much as around the inherent riskiness of the treatments they correctly undertake.

Misdiagnosis… the doctor [GP] has to know everything about all these different things so that's probably the most riskiest, he's not necessarily specialised in one of these fields, so very risky.
Female, light user of mainstream services, Belfast

The risk could be sharpened by factors such as lack of time or not listening properly to the patient.

I've had three quite impacting misdiagnoses in the last decade, all of which I could have done without, one of which gave me considerable pain… and that's just caused by trying to crowd too many patients into too little time and not actually listening to what the patient's saying.
Male, light user of mainstream services, Cardiff

The amount of power and responsibility that a professional had was also a factor for some. That power – and risk - could reside partly in the professional's role as a 'gatekeeper' controlling access to other services.

A doctor [GP] has of all of those probably the most responsibility because it is he or she as a person that you rely upon actually to refer you to many of the others. So the fact that the doctor is the first port of call it is true that the doctor gets the diagnosis right is more important than anything.
Male, heavy user of mainstream services, London

Social workers, she's got to make a judgement call hasn't she as to how she gets you integrated into a health, it is her judgement call, her involvement is quite important really. If she's quite fackksadaisical or doesn't really care that much, you're not going to get the service that you need at the right time, especially for mental health.
Female, heavy user of mainstream services, London

Similarly, some alternative professions were rated as high risk because of the potential for physical harm. Acupuncturists were singled out by some as being particularly risky as the treatment involved use of needles. There was a potential for spread of infection if sterilised needles were not routinely used for each new patient.

I would say that acupuncture there's a high risk 'cause they're dealing with needles…
Female, heavy user of alternative services, Edinburgh

Yeah the needles could be dirty or…
Female, heavy user of alternative services, Edinburgh

There was also a perception that physical harm could result where advice from the alternative practitioner conflicted with mainstream advice and care that a patient may be receiving at the same time. This particularly emerged around homeopathy in one of the groups, where participants discussed the perceived requirement of homeopathy that the patient stops taking their 'conventional' medicines.
Homeopaths, I mean what you’ll often get is you’ll get kind of… I don’t know what they give you, a liquid or a tablet and they ask you to give up certain foods and maybe not take your antibiotics ‘cause that may interfere with whatever you’re taking, and this could do you a world of harm.
Male, heavy user of mainstream services, York

Again, perceptions here may have been partly shaped by media coverage.

I suppose the example of Steve Jobs is quite extreme, but if you had a fairly serious illness would you go to a homeopath generally and take that risk; I don’t know if you would.
Male, heavy user of mainstream services, York

Despite lacking the power and responsibility of more highly trained, well paid professions, and the potential to cause harm via drugs, residential and domiciliary care workers were seen by some as particularly risky roles. As discussed in the previous subsection, this was partly fuelled by media reports and also a perception that many of these workers were very young, low paid, poorly trained and unmotivated.

You could probably just walk into one of those jobs and you know what I mean, I don’t know what kind of training or anything they need to have to get a job in there.
Female, heavy user of alternative services, Edinburgh

I’ve known a lot of people and they’ve actually changed care agencies, real shabby workers, wee young girls maybe only 17 coming in. They don’t know how to use a hoist that moves people or anything.
Female, heavy user of mainstream services, Belfast

As we will see later in this section, the level of training and commitment a professional has could go some way to mitigating the perceived risk, even if the activities of the professional were very risky in themselves.

4.3 Which are seen as least ‘risky’?

Conversely, professions which were perceived as involving less physical contact tended to be seen as less likely to result in physical harm and therefore less risky.

They don’t actually do anything to you, the dental nurse doesn’t do anything she just passes the things to the dentist and the social worker, they don’t actually do anything physical – they don’t take responsibility for your health as such do they.
Female, light user of mainstream services, York

It’s not like they’re [chiropodist/podiatrist] operating or anything. You know they’re not, they’re only looking and touching and you know advising but they’re not actually like performing any sort of surgical procedure.
Female, heavy user of mainstream services, Belfast

The risks of professions dealing with mental health issues – counsellors and psychologists – were harder for participants to assess and pin down. Generally, counsellors in particular were seen as low risk as there was no perceived physical risk from drugs or misdiagnosis.

You’re not taking any risks like with your drugs or … or being misdiagnosed sort of or anything.
Female, heavy user of mainstream services, London

Some were not entirely confident in this assessment regarding psychologists. There was an awareness that mishandling and misdiagnosis of mental health problems could be detrimental to the patient – however for some participants this was hard to assess because they struggled to differentiate the roles of psychologists and psychiatrists.

Oh yeah you’ve got to have at least two doctors to be committed, but even if they made a mistake and said you were suffering from some mental issue that you weren’t and then you had to go and get a second opinion and it could be quite detrimental to you personally.
Female, heavy user of mainstream services, Edinburgh

Some people highlighted the social stigma of mental illness. Mishandling or misdiagnosis could therefore pose a kind of social (rather than physical) risk.

The problem actually is a social problem. If you say to people I have a mental problem, you know, or you say I’m going to see the psychiatrist or psychologist, there’s a bit of a stigma on it isn’t there. If you say I’m going to the GP because I’ve broken my leg or whatever, a physical problem, nobody sort of says anything.
Female, light user of mainstream services, York

Being diagnosed as mentally ill if you’re not, because there’s such a stigma attached to it.
Female, heavy user of mainstream services, Edinburgh

Counsellors were also discussed in one of the Belfast discussion groups. Whilst the consensus was that it was a low risk profession, people were aware that they often dealt with vulnerable or traumatised people.

I’ve had different opinions from people on counsellors… I was working with [relative who had had traumatic experience] for a good while and I actually advised her to try counselling. And she thought it was beneficial but then again there was parts of it just was useless. Some of them do just sit back and relax in the chair and you know you feel when you come away from them you haven’t gained anything.
Female, heavy user of mainstream services, Belfast

4.4 How do people assess risk?

A number of criteria by which people assessed risk emerged from the discussion around which professions were most and least risky. People identified a number of factors which influenced their perceptions of risk. These could be grouped under three overarching themes:

- **Factors relating to the patient**: How vulnerable is the patient? Are they in a position to actively influence their treatment, or not? Are they alone behind closed doors with the professional? How well do they understand the treatment?
- **Factors relating to the profession involved**: Are people in this profession working autonomously or under close supervision? What powers do they have, particularly around administering drugs? Are the well trained and motivated, and is the profession well established and regulated?
- **Factors relating to the treatment being administered**: Is it invasive? What level of physical contact does it involve? How well does the professional know the patient - is
These overarching themes and factors are summarised in the chart below, and discussed in more detail throughout the rest of this subsection.

4.4.1 Factors relating to the patient

How vulnerable is the patient?

Essentially, the more vulnerable the patient was considered to be in a care situation the greater the potential risk people felt there was to them. Two main themes emerged around considerations of the patient’s vulnerability. Firstly, in relation to use of mainstream (and to an extent alternative) services, people considered the level of control and awareness they would have as a patient. Clearly an unconscious person would have no awareness or control and therefore be acutely vulnerable. Scenarios included surgery under general anaesthetic, giving birth, and being attended to by a paramedic whilst seriously injured and unconscious.

You’re not conscious most of the time so you are just putting your life in their hands and you’re just trusting they handled it properly.
Female, heavy user of mainstream services, Cardiff

I think the less control that you have on what’s going on the higher the risk. For example if you’re in an operation and you can’t see anything and you can’t control it.
Female, heavy user of mainstream services, York

These are the extreme examples. However a more general sense of vulnerability in relation to use of mainstream services underlay some of the group discussion, in the sense that

...
people often emphasised the extent to which they put their trust in professionals to get things right.

*When you’re going in with a certain complaint, then… you’re going there really to trust them. They got the experience, they should know.*
Male, heavy user of mainstream services, London

*I suppose you’re putting your trust in people.*
Male, heavy user of mainstream services, Belfast

*You would trust [a paramedic], totally trust but I mean I think it’s just ‘cause of the procedures they have to do makes them high risk because of the things they have to do.*
Female, heavy user of alternative services, Edinburgh

The second main theme around vulnerability related to social care professions. Many of these roles were seen as dealing with people who had a more long-term, inherent vulnerability and reduced capacity, for example children or the elderly, or people with mental health problems. The risk to these types of patients or service users hinged on their perceived lack of a voice, making them less able to challenge poor treatment and more open to exploitation.

*My Gran’s got dementia, if something’s happened to her she wouldn’t even remember so she’ll not be able to tell anybody.*
Male, heavy user of alternative services, Edinburgh

*If someone’s going in there that’s quite vulnerable already and then the psychologist isn’t a well trained or good psychologist, could they make that work? It might not be a physical harm but it could be a mental harm which can be as worse or…I just think that that is quite high risk.*
Female, heavy user of alternative services, Edinburgh

*Patients aren’t in a position to do their own feedback, particularly elderly patients, young patients.*
Male, light user of mainstream services, Cardiff

An additional factor that could sharpen these risks in the minds of participants was the perception that social care interactions in particular often took place behind closed doors, with no oversight of the professional – for example, a care worker visiting an elderly person in their own home.

**How well does the patient understand the treatment they are receiving?**

The discussions identified trust as a major feature in people’s relationships with mainstream health professionals, particularly those whose work carried the greatest potential physical risk (for example doctors, dentists and paramedics). People trusted that they knew what they were doing.

Trust was also an issue in assessing the risks of using alternative services. In addition, however, some participants also felt that alternative treatments were more obscure and esoteric, and difficult for a lay person to understand. The work that mainstream healthcare professionals would do in repairing a broken leg, for example, may be more ‘obvious’ to the patient than the relation between the activities of a chiropractor or acupuncturist and the patient’s condition.
Chiropractor, osteopath and you know as long as they know what they’re doing you’ll be fine but you know if they’re working on your back and stuff you kind of don’t know what they’re doing.
Female, heavy user of mainstream services, Belfast

We don’t know what kind of science it is and so we’re always worried that there’s a risk.
Male, heavy user of mainstream services, York

4.4.2 Factors relating to the profession

What prescribing power do people in the profession have, and what drugs do they have access to?

This links back to the previous consideration about the potential for physical harm associated with particular professions. The consequences of flawed administration of drugs can be catastrophic – hence, in assessing risk, participants often thought about the level of unsupervised prescribing power and access to drugs that types of professionals had:

The dentist can actually use a general anaesthetic if they have an anaesthetist with them, whereas a nurse doesn’t.
Male, heavy user of mainstream services, Edinburgh

The ones that are going to prescribe you something as well ‘cause they could easily prescribe you the wrong thing or not prescribe you something.
Male, heavy user of alternative services, Edinburgh

The level of supervision was important in assessing risks around dispensing medicines. Nurses and pharmacists therefore tended to be seen as less risky in this regard – this is discussed in more detail later in this section.

To what extent do people in the profession act autonomously?

When assessing the risks posed by a profession, participants often asked themselves: would people in the profession follow a care plan or instructions from a senior professional, or would they act more autonomously, perhaps having a role in designing and directing treatment? Professions deemed to belong to the former category were usually considered less risky.

I don’t really think there’s much risk there because the dentist is usually with the nurse telling the nurse what to do or what to give and you know he’s in control then.
Female, heavy user of mainstream services, Belfast

As discussed previously, access to drugs was considered by participants when assessing risk. However, alongside this, they thought about whether the drugs were being administered under supervision or in accordance with a plan drawn up by a more senior clinician, or not.

Pharmacists rely on the GP to do the prescribing. The pharmacist is relying on what the doctor tells him to do – he’s not making his own decisions, he’s got to wait for the GP to tell him.
Male, light user of mainstream services, York

The nurse would normally prescribe what the doctor’s said. They want this and they are going by the doctor.
Male, heavy user of alternative services, Edinburgh
That said, there was also some awareness that nurses’ roles were changing around prescribing powers, and with this greater autonomy and responsibility came greater risk.

You get nurses that can prescribe and things now. I’ve been to the doctors and when I needed antibiotics before and I had to go and it was a nurse led clinic and I got antibiotics prescribed from her, she could have got that wrong so…
Female, heavy user of alternative services, Edinburgh

How well trained and motivated are people in the profession?

Whilst the potential for physical harm was an important factor in assessing how risky a profession was, this was balanced to an extent by considerations of how well trained they were. For some, the more highly trained and dedicated a professional was the less risk they posed – even if the potential consequences of mistakes in their role were severe.

A doctor’s been training for 10 years to do the job that they do so I trust that they’re going to do their job well whereas someone who’s done a night course at college, as good as that course is and as qualified as they are to be an acupuncturist they’re not as well trained as a doctor.
Female, heavy user of alternative services, Edinburgh

This contrasted with attitudes towards some social care workers, as discussed earlier in the chapter. Lack of training and motivation was seen as a risk factor.

They seem to start a lot of them ones with absolutely no training at all. Again I know a few ones that do it and they’ve no training at all.
Male, heavy user of mainstream services, Belfast

The right attitude and motivation was vital for some participants, regardless of the profession. One participant in particular spoke about this at length.

Just recently they said that one of the things that people should have was passion whenever you’re working with people. And it was to do with the recent report about how badly treated a lot of elderly people are, especially ones that are trying to stay in their home and have people going in to see them, and there’s just a sort of general lack of compassion. It’s almost like people are doing these jobs because they have to do them but not because they actually care about other people and I think that goes back to what you were saying about some GPs being better than others, you can do the task, you can do A, B, C but if you don’t actually like other people very much perhaps it’s not the right thing to be… you know you’ve got to have that compassion for other people in a range of circumstances and accept them for what they are and not judge them and not be mean to them. And I think the highest risk is people don’t have that human compassion for others.
Female, heavy user of mainstream services, Edinburgh

Consequently, a certain amount of responsibility was seen to fall on employers to ensure that recruitment processes were high quality. This will be discussed in more detail in the next chapter on mitigating risks.

Is the profession well established?

Mainstream professions such as different types of doctors, paramedics and dentists, were generally viewed as highly trained, heavily regulated and monitored, and thus safer. The
perception of a profession as well established and ‘safe’ was closely bound to perceptions of how well-regulated it was.

Participants were unclear about the regulatory regime for alternative practitioners: there was therefore a perceived risk that unscrupulous or unqualified people could practice more easily.

*The thing is that some professionals could just set-up shop and not have any qualifications at all.*
Female, heavy user of mainstream services, Edinburgh

### 4.4.3 Factors relating to the treatment

**How invasive or otherwise physically risky is the treatment?**

As already established, this was perhaps the key overarching question that people asked themselves when considering the risks posed by various professions. Surgery was seen as inherently risky.

*Anyone that’s going to cut you up so doctors and surgeons.*
Male, heavy user of alternative services, Edinburgh

The risk related to what the surgeon was doing rather than to any concerns about their training or suitability.

*Surgeons but then that’s because you did a risky thing to start with so it’s not particularly their fault.*
Male, heavy user of alternative services, Edinburgh

Related to this was the consideration of how grave the potential consequences could be if things went wrong. Death or serious injury undoubtedly emerged as the most serious consequences in the minds of participants.

*Like should they [midwives] be going on more refresher courses because it is new life, it isn’t just like a chiropodist or like your big toe might have got an in-growing toe nail. Like this is the new life and especially like, imagine if it was like your first baby and that happened to you, you’ve got to live with that forever.*
Female, heavy user of alternative services, London

**How frequent are encounters with professionals and how long do they last?**

The timing and duration of encounters could shape perceptions of risks. Some of the riskiest encounters were seen as those occurring in high-pressure emergency situations where the professional was seeing the individual for the first time - for example with paramedics, where quick ‘life or death’ decisions needed to be made, or with other professionals when the person was being rushed to surgery.

*I had an operation and the anaesthetist rushed in and she took my details because I was going to surgery and she was coming from another hospital so anyway she asked what medication that I was taking and what I was allergic to and I told her... she forgot to put [it] onto her list and it was only when the surgery team came back in and they went through it that it wasn’t on there. That could have been the end of me.*
Male, heavy user of mainstream services, Cardiff
A nurse has got time to, or a dentist has got time to refer it to somebody else if they’re not too sure whereas a paramedic…
Male, heavy user of alternative services, Edinburgh

Therapists of different kinds, psychologists and counsellors tended to be seen as lower risk. As discussed, this was largely due to the non-physical nature of the treatments involved. However another reason was the perception that the relationship with one of these professions would develop over time, over a series of appointments. Unlike, for example, a one-off appointment with a doctor, the potential consequences of something being missed or done wrongly were seen as less severe, as any damage could be reversed in later appointments.

You probably see them for such a long period of time like, so like six months or something like that that probably like the damage that they cause could be solved almost in like the time that you see them. You wouldn’t just see them once I don’t think, a psychologist.
Female, heavy user of alternative services, Edinburgh

It’s more about point in time whereas this is more about a series of things, so the speech and language therapist it wouldn’t be like a 10 minute appointment and that’s it for good, I think generally they give you them for a number of appointments. Occupational therapists are about the same as well.
Male, heavy user of mainstream services, Edinburgh

How likely is it that something will go wrong?

Likelihood was not a major factor in assessing risk in most of the discussion groups. The exception was the Edinburgh group with younger heavy users of alternative services, where likelihood was discussed at length. This group concluded that some of the most potentially risky professions also happened to be the best trained and motivated, and therefore perhaps the least likely in practice to pose a risk to patients.

I think ultimately we were going with what we see as the qualifications and the likelihood so that the more qualified the person you’re saying there’s kind of a low risk, less likelihood that anything will go wrong because they get used so often and individuals are so, more qualified and so well trained.
Male, heavy user of alternative services, Edinburgh

4.5 Differences in perceptions of risk between mainstream, alternative and social care professionals

The purpose of this subsection is to draw out, from the preceding discussion in this chapter, some of the differences in how people assessed and perceived risks between different categories of professional. The key drivers of perceptions of risk in relation to each of the three categories is summarised in the slide below.
Comparing mainstream and alternative professions, trust was an issue in relation to both. Patients were aware that they were often putting their well-being in the hands of professionals who they trusted to know what they were doing. There was an extra dimension to this regarding alternative practitioners, however – as discussed above, some alternative treatments were seen as particularly esoteric and the connections between treatment and symptoms not as obvious as mainstream treatments. For example, it could be difficult for a patient undergoing acupuncture to relate the treatment (insertion of needles) to the condition being treated – and acupuncture can be used to treat a wide range of conditions. The risk of inappropriate or unnecessary treatment was therefore seen as greater.

The key difference in terms of perceptions of risks, however, was between mainstream and alternative services on the one hand, and social care services on the other. The perceived risks around mainstream and some of the alternative services (generally those that involved hands-on treatment or administering medication, for example chiropractors, acupuncturists and homeopaths) tended to be about the nature of the treatment. The focus was on things that could go wrong with the treatment and cause physical harm – for example misdiagnosis, prescribing or administering drugs incorrectly or infection via dirty equipment. The latter applied in particular to dentists; acupuncturists were also mentioned as the treatment involves use of needles.

However, the perceived risks around social care tended to be about the nature of the client rather than the treatment. Clients were often perceived as vulnerable – for example older people, children, or people with mental health problems – and therefore more vulnerable to exploitation or abuse. Their relative lack of a voice and lack of ability to influence their care shape the perception of risk. As explained earlier in this section, the belief that some social care professionals such as residential care workers were low paid and lacked motivation and proper training also fuelled the perception of risk.
5. Responsibility for mitigating risks
5. Responsibility for mitigating risks

This chapter examines where people feel responsibilities lie for mitigating risks. CHRE, under right touch regulation, are keen to consider how responsibility for mitigating risk could be shared and what the public's view is on this. Part of the discussions therefore focused on people's views on where responsibility should lie – whether with service users, professionals, employers, or regulators, and depending on which services and associated risks. The discussion explored how open participants were to the idea of sharing risk with regulators, professionals and others.

The key findings from this part of the discussion presented in this chapter are:

- The most important finding is that whilst there is some appetite for the patient to take more responsibility, this only where they are perceived to be choosing to use the service.
- Where the patient is seen as vulnerable, and where they have little or no choice in using the service – particularly acute or emergency services – people were not keen on sharing responsibility for mitigating risks.
- People recognise there is a lot of information on certain services available online, and that potential users may have a responsibility to do their own research.
- That said, there is an issue about how well-informed some patients are before making decisions, and a need to ensure they can navigate the mass of information online to make informed and safe decisions.
- Employers and professionals themselves are seen as having a responsibility, for example by taking responsibility for training and development and enabling a ‘whistle blowing’ culture.
- Ultimately, the regulator is seen by all as still essential as a means of

5.1 To what extent should patients take responsibility?

During the group discussions, participants ‘unpacked’ many of the differences in terms of perceived risks between different types of services. A similarly complex picture emerged around the question of the extent to which patients should share the risks with professionals, employers and regulators.

Essentially, the more power, control and choice the patient is seen to have in relation to the service they are using, the more people think they could be expected to take more responsibility themselves for mitigating the risks. Broadly, they are more reluctant to share risk for services dealing with particularly sick, vulnerable, or otherwise incapacitated people; and more enthusiastic where the service user is seen as more of a consumer, using a
service because they choose to rather than because they have to. The slide below summarises this.

Choice – the ability to act as a genuine consumer - was therefore the key determining factor when people considered whether or not they would be content to share the responsibility for mitigating risks.

*If you choose it's your own decision and your own risk.*
Female, light user of mainstream services, York

This also applied not just in relation to specific services. Where medical or lifestyle advice was given, for example by a GP or hospital consultant, it was the patient's responsibility to follow it properly.

*You could take the professional’s advice and make it less risky. Say your professional was telling you you have to stop smoking or you have to, you know...then it is up to the patient to take that advice on board and do something with it.*
Female, heavy user of alternative services, Edinburgh

Despite the positive message that there is some appetite for sharing risk in certain circumstances, perhaps the most important message to take from this is that a number of participants who discussed exercising choice did so on the basis of potentially poor or unreliable research (for example asking friends, or being convinced by a professional-looking website rather than knowing how to assess the actual content). If people are to be encouraged to share responsibility, it should be done hand-in-hand with ensuring they are equipped to make safe and well-informed choices and assessments.
5.1.1 People are reluctant to share responsibility around services dealing with vulnerable people

A perceived lack of choice meant that people were less prepared to share risks. Where the patient is particularly vulnerable – for example unconscious or seriously injured and being attended to by a paramedic – it was felt that the onus should not be on the patient to mitigate risks because they have a lack of power or control in the situation. They have little choice but to accept the service provided.

In emergency situations it could be hard for patients, or their shocked and distressed friends or relatives, to communicate clearly. Some felt that it was therefore the responsibility of the professional rather than the patient or anyone with them to ensure the communication was effective and that the professional got the right information about what happened.

I think that’s where the responsibility lies with the professional ‘cause if you’re in a moment of stress, say your partner’s collapsed or you’ve been injured it’s their responsibility to deal with that situation and not yours.

Female, heavy user of alternative services, Edinburgh

This principle also applied to some social care professions looking after vulnerable people. Elderly people with dementia, for example, may be unable to exercise control over the treatment they receive – although some people felt that there was a responsibility on the part of the family to share the responsibility for mitigating risks by researching care homes on behalf of the older person.

5.1.2 More keen to share responsibility where people can act as genuine consumers

Where people were particularly seen to be exercising their own choice, and therefore to be particularly responsible for doing their own research, was around alternative services.

Generally you’ve gone to seek them out, I think I’m going to try homeopathy and it’s a decision for you to try it, it’s not you have to try it.

Female, light user of mainstream services, York

[Re. hypnotherapy and counselling] These two are optional so we don’t have to go to them.

Male, heavy user of alternative services, London

Some participants highlighted how much more independent information there is available now via the internet about certain services, particularly some social care services as mentioned above. Some felt that as this information was there, it was the individual’s responsibility to make use of it.

I think if you were looking for a residential care home for an elderly person you’ve got to try and check-up, I think they’ve just introduced a new type of register where people can actually post things and say what their experience was like so you’ve got a much better idea rather than just being from the home’s point of view how they run it. It’s much more proper feedback of people that use the facility. So I think there is an onus on you to try and do as much research as you can before placing yourself or someone else in one of these places. Some will be better than others.

Female, heavy user of mainstream services, Edinburgh

That said, employers were also seen as having important responsibilities in relation to care home staff, as explored in more detail later in this chapter.
5.1.3 There are some services where the user has only some choice and control

Not all services were seen in such a clear-cut way in terms of whether the user had a choice or not of whether to use them. As the slide above shows, there was an extent to which services were placed on a scale in terms of user choice and control. For example people were seen as having some choice and control in relation to GPs, but this was limited by where the person lives.

You can’t really shop around for your GP, it’s in the catchment area, you go to that one, whereas with an acupuncturist or homeopath, optician, a lot of these things you choose.
Female, light user of mainstream services, York

However this view was not unanimous – even regarding GPs, some felt, however reluctantly, that some responsibility was necessarily on the patient to do their research.

It would be nice if you could trust them but you cannot count on it so you need to take more responsibility yourself.
Female, heavy user of alternative services, London

5.1.4 Need to ensure patients can make safe and informed choices

Whilst people are clearly keen to share some responsibility in areas where they feel they can act as consumers and exercise some genuine choice and control, it is very important to bear in mind is that the methods of ‘research’ that some people may use are not particularly thorough or reliable. Particularly around some alternative services, ‘word of mouth’ was often mentioned – that is, recommendations from friends rather than from trusted professionals or official advice.

It’s the same as the building industry isn’t it?... The risk is on you, you choose your builder because of word of mouth and I’m sure homeopathy/acupuncture is going to be similar. Because it’s an unregulated industry. It’s a free moving industry like the building trade, all the trades.
Male, light user of mainstream services, York

Methods of assessing alternative providers were discussed at some length by younger users of alternative services in London. Users of alternative services, notably cosmetic injectable treatments, relied heavily on recommendations from friends.

I like to be recommended to someone. If it's like reflexology, botox or...
Female, heavy user of alternative services, London

I was quite nervous when I had botox but again it was through a recommended friend and...
Female, heavy user of alternative services, London

Another way some assessed risk, which was equally unreliable, was by looking for certificates or a well designed website. The issue was that it was about assessing appearances – people were less well-equipped to judge the content of websites or certificates.

When I’ve been to see these people I always see that they’ve got certificates on the wall. I don't look for them, if I see them then it gives me a bit of reassurance and I think they’ve studied it. I mean it could just be a print out from the internet I don't know. I still look at it and think oh yeah they’ve passed the test.
Clearly the message for any regulator here is that whilst there is some receptiveness to the idea that patients should take some of the responsibility for mitigating risks, this in itself is not enough. People need to have access to reliable information to be able to make educated and informed judgements. They need to be able to move beyond appearances or word of mouth and have the tools to genuinely assess whether a provider is safe and subject to sufficient scrutiny—because the reassurance that the provider is properly certified and subject to regulation still matters greatly to people.

5.2 To what extent should employers and professionals take responsibility?

Taking responsibility for your own training and development was seen by some as integral to the notion of professionalism, particularly amongst the professions seen as the most prestigious and carrying the greatest responsibility in terms of making potentially physically risky decisions.

\textit{If they’re going to be classed as a professional they need to be professional and seek the relevant help that they need for the job that they’re about to do.}

Female, heavy user of alternative services, Edinburgh

Staff should be encouraged to approach managers if they feel they lack expertise or training. They should not need to be concerned about their careers - if patient safety is what matters, openness should be encouraged.

\textit{If a nurse felt that they couldn’t do their job properly they should have the confidence to be able to go to their manager and say, “I’ve got a problem.” And be able to do that without personal risk to themselves and their careers.}

Male, light user of mainstream services, Cardiff

There need to be management structures in place to ensure that managers are monitoring performance at all levels of the organisation.

\textit{If you go up the levels as well you know you always expect there to be someone above that level checking on what that level does. You know if someone brought an issue in work then it is my responsibility in that role or any managerial responsibility in that role to address that issue and make sure that that’s resolved so that person can move on.}

Male, light user of mainstream services, Cardiff

This culture of openness in the interests of patient safety should also extend to enabing a culture of ‘whistle blowing’. This was discussed in detail in the group of younger heavy users of alternative services in Edinburgh. Peers have a responsibility to be aware of the actions of their fellow professionals and raise concerns where necessary – and managers need to take these concerns on board.
People’s peers, so the paramedics who they work with, if they’re not doing their job right or making mistakes then people should whistle blow and tell managers that they can’t do their job or they’re incompetent.

Female, heavy user of alternative services, Edinburgh

As we have seen in the previous chapter, residential care workers and other similar social care professions were seen by many as particularly risky due to perceptions of poor training, recruitment and motivation. Regarding care homes in particular, the onus was felt to fall therefore very much on employers and owners to ensure that risks to patients were minimised via robust recruitment and training processes.

We’ve gone primarily with the manager but I suppose the manager is effectively just the lackey of the company and it’s, it should be the company that should be able to budget that sort of stuff isn’t it? I think primarily we went with the company and the managers of the company that should look after the staff.

Male, heavy user of alternative services, Edinburgh

The care workers themselves could be seen as the risk:

So who is responsible for minimising risk, I mean is the person themselves, for instance the care home worker, is that person responsible for minimising the risk or is that person in the risk situation needing to be minimised? If you were doing this job, if you were going to be a care worker tomorrow and you just turned up on the doorstep, right, and they just said, “Look after these old people over here.” So you could not be blamed at all really because you just do your best. So it’s totally up to the management, the owner, to say, “This is what we expect of you, this is what you need to do, we’re going to have to train you now for the next few weeks.”

Male, light user of mainstream services, York

The risk of harm in care homes could be mitigated by employers and senior staff ensuring consistent care (i.e. all staff operating to the same standards). Key to this in their minds was ensuring detailed handovers take place between shifts to make sure general care, feeding and medication continue to be administered in a seamless fashion, akin to the perception of what happens in NHS hospitals.

All hospitals have, it’s like 30 or 45 minutes between their shifts like one shift will start and finish at 8.30pm, the following shift actually starts at 7.30pm so they’ve got an hour to tell them about the patient they’ve seen, anything that’s happened, how they’ve treated people and stuff. I can imagine that care homes when a shift finishes at 8pm, the next shift starting at 8pm...’cause it’s all money.

Male, heavy user of alternative services, Edinburgh

To summarise broadly, highly trained professionals with the greatest levels of responsibility are seen as shouldering some responsibility for their training and development as a means of mitigating risks, almost by virtue of their high status. The lower the status of the role, the more that responsibility is seen to rest with the employer to ensure that suitable people are recruited and trained. One participant spoke from personal experience about working as a care assistant and being asked to do things without receiving adequate training or support from the management.

I used to work in a care home myself years ago and it was a nursing home, it was old people. Like they weren’t old as such they were just old but some of them did have a bag and I mean we were only care assistants and we were just expected to know how to do that... You know I mean there are nurses who work there too during the shift but I
mean you’ve got so many residents you know and it’s just like, they say will you do such and such and you’re sort of threw in at the deep end.
Female, heavy user of mainstream services, Belfast

5.3 The role of the regulator

Despite the openness participants showed towards the idea of patients and others taking more responsibility for mitigating risks, it should be borne in mind that regulation and the presence of regulatory and governing bodies were seen as essential and central to people’s approaches to assessing risk. Regulation was felt to provide reassurance.

Being part of that professional body and that badge kind of gives you that reassurance that they’ve served their time.
Male, heavy user of mainstream services, Edinburgh

If you’re going to any of these places you’re hoping that they are qualified, they are registered, they have got the qualifications, they’ve got a Governing body so if you have a problem you can go to them. You know you want to, they’re dealing with your body, your health, maybe your teeth I don’t know, anything, and you want to make sure that they are who they say they are and that they can do a job and they’re not just going to fob you over and just take your money.
Female, heavy user of alternative services, Edinburgh

It was also important to have a means of recourse when things did go wrong. Preventing bad things happening may be down to the professional, but it was inevitable that bad things would happen from time to time, and in those cases a regulator was needed to ensure a just outcome for the patient.

The regulator comes in after the event doesn’t it? The regulator’s after something’s gone pear shaped… The initial responsibility is the professional who’s giving you the service.
Male, heavy user of mainstream services, Cardiff

Someone who’s impartial basically that’s not part of the profession and it’s impartial and can look at any complaint and see if there’s merit to it.
Female, heavy user of mainstream services, Edinburgh

That said, regulation was recognised as not always foolproof.

There are supposed to be bodies that oversee any kind of care situation, the Care Commission are supposed to go and inspect old people’s homes and children’s homes. And you hope that they’re doing their job but then you do find they don’t because there was that horrible case recently where they filmed them abusing mentally disabled people, so there is a risk there. You know things can go wrong because they’re not inspecting them as often as they should do or they announce their inspections so that they’re good when they come for their inspections, but when they’re not there perhaps they’re not doing what they should be doing.
Female, heavy user of mainstream services, Edinburgh

However, overall, a perceived lack of regulation would concern people a great deal. This was demonstrated in discussions about alternative practitioners, where perceived lack of regulation was central to people’s assessment of risk. Alternative services were often seen as less well regulated. Standards could therefore be inconsistent.
Some [osteopaths and chiropractors] are very good and well trained and others you wonder if they're quite that well trained and if they just got into it because they can't actually get the job they really want. You know I've got a friend whose back was broken by an osteopath.

Female, heavy user of mainstream services, York

I think I'd be more concerned about alternative medicines, what kind of regulatory body they have.

Female, heavy user of alternative services, Edinburgh

Also, if the treatment went wrong, lack of proper regulation could mean a lack of recourse for the patient.

[Re. cosmetic injectable providers] If anything goes wrong or somebody doing that isn't qualified you've no come back then. If it was done by a top professional I mean then obviously you have.

Female, heavy user of mainstream services, Belfast

It is fair to say, however, that not all participants agreed that alternative services were somehow less regulated and 'rigorous' than mainstream services.

And I think a lot of those things with that is as well they're ancient, I mean they've been around longer than antibiotics and all sorts so. And I think to open up a place that does reflexology at the moment there are really strict kind of regulations they have to go through. So if they manage to open up I'm sure they've gone through the whole regime.

Male, heavy user of alternative services, London

This uncertainty over regulation – particularly of alternative therapies – coupled with the large amounts of health-related information available on the internet means that there is a case to be made for empowering patients by helping them to navigate this information to make safe judgements, including understanding how to judge whether a service provider is properly regulated.

Usually if you're going to do something new you'll Google it first and they'll have a website. And I mean talk's cheap, they can put anything on the website but at least on the website usually says we're qualified through such and such and we're regulated by such and such. That gives you a little bit of peace of mind but if anything goes wrong, touch wood it doesn't, but you know you think well I can go back to that body and actually do something.

Female, heavy user of alternative services, Edinburgh
6. Conclusions and recommendations
6. Conclusions and recommendations

At the heart of this research is the CHRE’s desire to explore where the public think responsibility for mitigating risks in health and social care settings should lie. Do the public think responsibility in any given situation should lie solely with the regulator, or should it lie with the employer, the health or care professional, or the patient? Or should responsibility be shared between all of these groups and individuals? Are the public willing to accept sharing more of the risks, and in relation to which types of service and circumstance?

The answers to these questions have been discussed in this report. Arising from this are a number of key findings and recommendations especially around how messages about risk and responsibility should be communicated to patients.

- **The concept of risk in health and social care settings was not particularly salient to participants. This needs to be taken into account in communications to avoid causing undue alarm.**
  
  Risk, in terms of safety and harm, was not a subject that people brought up spontaneously during this research, or found easy to engage with once the idea was introduced to them. Furthermore, when the research participants were asked about risk, the types of risks they spontaneously thought about were not ones associated with the physical or mental harm of patients. Rather, they focused on things like waiting times and the cost of certain services. This is important to bear in mind when planning any form of communications about risk in health and social care settings. As the subject is not at the forefront of the public consciousness, any unprompted discussion of it in the media has the potential to cause alarm. Any communications should therefore be carefully set in context and buffered so as not to instigate unnecessary worry amongst the public.

- **Public responsibility should be carefully framed around empowerment.**
  
  It is also important to shape any communications about the public taking more responsibility for risk so they are understood as helping to empower the public, rather than as the CHRE or another regulator passing on their responsibility to others. The latter is potentially something that could happen and it would be likely to cause anxiety amongst the public and a negative sense that the regulator was divesting itself of its responsibilities. It is crucial that communications are carefully planned so that they convey the benefit to the public of being more involved in mitigating risks, and that the responsibility would still be shared and not lie solely with the patient or service user, which could be a daunting prospect.

- **Younger people may be particularly keen to take more responsibility.**
  
  It might be beneficial to target any communications about empowering the public to take more responsibility for risk towards younger people, as there seemed to be more appetite for taking some responsibility for managing risks in health and care settings among the younger participants of our discussion groups than older participants. This could be because younger people are more used to operating in a consumerist society which requires them to make assessments of risks in other settings, for services in the retail and leisure sector for example.

- **‘Empowerment’ should be matched with information to promote safe judgements of risk by the public.**
  
  It is important to ensure that empowerment comes ‘hand in hand’ with information
though, so that members of the public are able to make informed and safe assessments of risk. Some of the users of alternative healthcare services we spoke to were already making assessments of risk when choosing providers, but these assessments were not always based on sound criteria. Judging how risky a provider is based on their website or the recommendation of a colleague or friend is not always infallible – especially if people lack the knowledge to assess whether claims about safety, qualifications and registration are robust. It might be advisable to consider that ways that sufficient information about how to assess, mitigate and manage risks could be provided to the public if they are to be empowered with more responsibility to do so.

To sum up, it seems that, although the issue is not prominent in the minds of the general public at present, some people would be happy to embrace more responsibility for mitigating risks in health and care settings if the message about it was communicated to them in an appropriate way. The messaging should not alarm the public and it ought to be accompanied by information to help people take on this new role and feel empowered rather than put upon. Some groups of people may be more willing to take on this role than others and it is worth considering this when targeting any communications. All of this should help to address the challenge of encouraging the public to think more about their responsibilities for managing risk in health and care settings despite an underlying expectation that a regulator is already doing so.

For which types of service are the public most happy to share risk?

Finally, it is worth drawing out exactly where the public may be most amenable to sharing risk, and where they feel the responsibility should remain largely with the regulator, professionals and employers.

The key issue for people in considering this was whether or not the service was something they would be choosing to use, or using because they had no choice. Alternative services were generally seen as those that a person would choose to use, and therefore they could be expected to be responsible for researching providers and being informed before making a choice – as with any other consumerist-style transaction. Dentists were also perceived to an extent in this way.

Interestingly, this ‘consumerist’ attitude also extended to some social care services such as care homes, where the relative was seen by some as having a responsibility to use the available information online on care homes before deciding where to put their loved one.

GPs – perhaps the most frequently used service amongst participants – were seen partly as a service where the patient exercised a choice: it is up to you to make an appointment with your GP and explain your concerns and symptoms, so to an extent the patient is in control. However, GPs were also seen as a service that people have to use, not least as they were perceived as ‘gatekeepers’ controlling access to other, specialist, services. There was also the perception that choice of GP is limited by where you live: you only have a choice of GPs within your catchment area.

Where people were less keen to share responsibility were those services where the user has no control or choice. This included services dealing with emergency situations where the person was vulnerable, incapacitated, in a great deal of pain, or perhaps unconscious – for example midwives, paramedics, and surgeons. The onus was seen to be on the regulators and employers to ensure standards were adhered to, and on the professionals themselves to behave professionally and take responsibility for their own training, development, and honing of their skills.
As discussed, communications around sharing responsibility need to be carefully shaped with these nuances in mind.
Appendices
Appendices

Appendix 1: Sets of professions shown to participants of groups

Set 1
- Chiropodist/podiatrist.
- Cosmetic injectable treatment provider.
- Counsellor.
- Dental nurse.
- Doctor.
- Domiciliary care worker.
- Hypnotherapist.
- Midwife.
- Osteopath/chiropractor.
- Pharmacist.
- Social worker.

Set 2
- Acupuncturist.
- Dentist.
- Dispensing optician.
- Healthcare assistant.
- Homeopath.
- Nurse.
- Occupational therapist.
- Paramedic.
- Psychologist.
- Residential care worker.
- Speech and language therapist.
### Appendix 2: Table detailing which groups where shown which set of professions

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<th>Location</th>
<th>Group</th>
<th>List of professions used</th>
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<td>1</td>
</tr>
<tr>
<td>Belfast</td>
<td>Younger, light users of “mainstream” health and care services</td>
<td>1</td>
</tr>
<tr>
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<td>2</td>
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<tr>
<td>Cardiff</td>
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<td>2</td>
</tr>
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<td>2</td>
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<tr>
<td>Edinburgh</td>
<td>Younger, heavy users of “alternative” health and care services</td>
<td>2</td>
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<tr>
<td>London</td>
<td>Older, heavy users of “mainstream” health and care services</td>
<td>1</td>
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