Consultation response from Patient Safety Learning

Public consultation on the Professional Standards Authority's draft strategic plan for 2023-26 (23 February 2023)

This is a submission by Patient Safety Learning to the consultation on the Professional Standards Authority draft strategic plan 2023-26. The response was submitted as part of an online survey, with the questions and answers which formed this detailed below.

Are there any factors we should consider in addition to those we have identified in the strategic plan that will affect the regulatory landscape in the next three years? You can read these in our draft Strategic plan.

We welcome the Professional Standards Authority's (PSA) stated commitment in this draft Strategic Plan to safety, identifying one of its key strategic aims as being to 'promote and support safer call for all'. We believe that this an integral to the PSA's effectively carrying out its role in overseeing and driving improvements among the 10 statutory bodies that regulate health and social care in the UK.

Patient Safety Learning believes that the persistence of avoidable harm in health and social care is one of the greatest challenges that we face. According to NHS pre-Covid estimates, there are 11,000 avoidable deaths annually due to safety concerns, with thousands more patients each year seriously harmed.[1]

Avoidable harm has an untold physical and emotional impact on those affected, resulting in a loss of trust in the health system by patients, and frustration and a loss of morale among healthcare professionals at not being able to provide the best possible care. This also comes at a huge financial cost, with the Organisation for Economic Co-operation and Development (OECD) estimating that the direct cost of treating patients who have been harmed during their care in high-income countries approaches 13% of health spending.[2]

The continuation of significant levels of avoidable harm in health and social care not only has a major impact on patients, but also on the professionals working in the sector and regulated by bodies that the PSA oversees. In our view the persistence of this harm, with its ongoing impact on patients and health and social care professionals, is a key issue in the regulatory landscape which will remain in place throughout the next three years of the PSA's new strategic plan.

Patient Safety Learning believes that the persistence of avoidable harm is the result of our collective failure to address the complex systemic causes that underpin it. We argue that there needs to be a transformation in our approach to this problem. Key to this is ensuring patient safety is treated as core to the purpose of health and social care, not simply as one of several competing strategic priorities to be traded off against each other. In our report, 'A Blueprint for Action', underpinned by systemic analysis and evidence, we detail six foundations of safe care for patients and these practical actions to address them.[3]

To achieve this transformation will require everyone - politicians, policymakers, patients, families and communities, clinicians, managers, system and professional regulators, researchers and academics, and health and social care system leaders – involved in this effort. We see the PSA as having an important leadership and policy role in this, ensuring that safety is placed at the heart of our health and social care system.

References

1. NHS England and NHS Improvement, The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients, July 2019. https://www.pslhub.org/learn/organisations-linked-to-patient-safety-uk-and-beyond/government-and-alb-direction-and-guidance/nhs-improvement/nhs-patient-safety-strategy-safer-culture-safer-systems-safer-patients-2-july-2019-r59/
2. OECD, Patient Safety, Last Accessed 20 October 2021. https://www.oecd.org/health/patient-safety.htm
3. Patient Safety Learning, The Patient-Safe Future: A Blueprint For Action, 2019. https://s3-eu-west-1.amazonaws.com/ddme-psl/content/A-Blueprint-for-Action-240619.pdf?mtime=20190701143409.

Which of the four themes in *Safer care for all* do you think are most important for us to focus on? Please rank in order of priority with '1' as the most important (we realise that all these themes are important so it may be difficult to prioritise).

Tackling inequalities – Ranking 3
Regulation for new risks – Ranking 4
Facing up to the workforce crisis – Ranking 2
Accountability, fear and public safety – Ranking 1

Can you tell us more about how you answered question 5. This will give us more details and help us identify any themes and priorities.

As an independent voice for patient safety, we have ranked our number one priority as the theme of 'Accountability, fear and public safety'. We believe this theme's emphasis on striking a balance between making individual accountability work in a system that is safe for patients and fair to healthcare professionals is crucial to ensuring patient safety.

This section of the 'Safer care for all' report places an emphasis on the importance of ensuring that workplace cultures do not unfairly punish healthcare professionals for mistakes when things go wrong whilst also retaining the importance of individual accountability. Patient Safety Learning also believes it is vital that we create an environment in health and social care organisations which fosters an open and fair culture, enabling patient safety issues to be raised, discussed and resolved, ensuring incidents of avoidable harm are responded to with empathy, respect, rigour and action for improvement. To achieve this, patient safety incidents must be reported consistently, and staff and patients feel safe and supported in doing so.

We ranked the theme of 'Facing up to the workforce crisis' as the second most important in this list due to the clear link between this issue and patient safety.

There is a wide body of research highlighting the negative impacts on patient outcomes as a result of insufficient staffing levels.[1] [2] In addition to this, reports into major patient safety scandals, such as the Francis report on the Mid-Staffordshire NHS Foundation Trust, have made clear the link between patient safety incidents and safe staffing levels.[3] It is about having the right numbers of staff, with the right skills, in the right place at the right time.[4]

In this context, we believe that the Professional Standards Authority (PSA) in our view rightly identifies the serious workforce shortages we face in both health and social care as a key challenge to the quality and safety of care. We also welcome the report's specific recommendation that the four UK governments should work together to develop a coherent strategy for the regulation of professionals, to support delivery of the national workforce strategies.

We ranked tackling inequalities third on this list in recognition of the serious threat to patient safety that these pose, with poorer outcomes for specific patient groups presenting themselves in a variety of different ways.[5] The PSA make a number of helpful recommendations in this area, emphasising the importance of collecting appropriate health and social care data relating to people with protected characteristics, reducing barriers to raising complaints and identifying issues that disproportionately impact particular groups. We welcome these proposals.

References

1. Anne Marie Rafferty, Research proves we need safe staffing, RCN Bulletin, 23 July 2019. https://www.rcn.org.uk/magazines/bulletin/2019/august/qa-research-behind-safe-staffing-aug-2019
2. National Institute for Health and Care Excellence, Safe staffing for nursing in inpatient mental health settings, Last Accessed 22 August 2020. https://www.nice.org.uk/guidance/gid-sgwave0701/documents/safe-staffing-for-nursing-in-inpatient-mental-health-settings-final-scope2
3. The Mid Staffordshire NHS Foundation Trust Public Inquiry, Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 6 February 2013. https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry Royal College of Nursing, Safe and Effective Staffing: Nursing Against the Odds, 2017. https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2017/september/pdf-006415.pdf
4. Patient Safety Learning, 2021: Health inequalities and patient safety, 15 December 2021. https://www.patientsafetylearning.org/blog/2021-health-inequalities-and-patient-safety

Are there any recommendations and commitments in *Safer care for all* that you think we should prioritise for action? Please indicate which you think are the top three priorities for us and others to work on in the immediate term. You can find these here or indicate from the menu below. Please tick only three, but you have the opportunity to explain more about your choices in the comment box.

☑ **Recommendation 1:** Each UK country should have a Health and Social Care Safety Commissioner, or equivalent function, with broad responsibility for identifying, monitoring, reporting, and advising on ways of addressing patient and service user risks. (See text for details of actions we recommend are taken forward by the commissioners.)

☐ **Recommendation 2:** Regulators and registers work collaboratively to improve the diversity of fitness to practise panels, other decision-makers and senior leadership to ensure they reflect the diversity of the community more closely.

☐ **Recommendation 3:** Regulators and registers work with other health and care bodies to gain a better understanding of the demographic profile of complainants and reduce barriers to raising complaints for particular groups.

☐ **Recommendation 4:** Regulators and registers review how their fitness to practise processes and guidance address allegations of racist and discriminatory behaviour.

☐ **Recommendation 5:** Demographic data on complaints made to the health and care services across the UK is recorded and made available for all bodies to use.

☑ **Recommendation 6:** Governments use the current healthcare professional regulation reform programme to: Review the adequacy and effectiveness of the powers of regulators with a role in regulating businesses.
• Consider whether there is a case for extending business regulation powers to all regulators

whose registrants work in ‘high street’ practices
• Ensure regulators have the agility to address the challenges brought about by new approaches to funding and delivering care, including the introduction of new technologies.

☐ **Recommendation 7:** Regulators tackle business practices that fail to put patients first, risk undermining confidence in the professions, or fail to allow registrants to exercise their professional judgement. A cross-sector review should be conducted of the effectiveness of arrangements to address financial conflicts of interest among healthcare professionals.

☐ **Recommendation 8:** Governments, regulators and registers review how they will determine the lines of accountability for new technologies used in health and care.

☐ **Recommendation 9:** Regulators and registers work collaboratively to identify opportunities to speed up workforce supply, equip practitioners to deal with future challenges in how care is delivered, close safety gaps and protect patients and service users.

☐ **Recommendation 10:** There is a clear process to guide the development of new health and care roles including the scope and purpose of the role, and the process for deciding on the level of assurance required.

☐ **Recommendation 11:** There should be an agreed way of deciding when to deviate from taking a UK-wide approach based on a review of risks and benefits alongside consideration of the national context.

☐ **Recommendation 12:** Those involved in health and care workforce planning and delivery across the UK actively support additional and alternative means of assurance as a means of managing risks to patients and service users.

☐ **Recommendation 13**: The four UK Governments work together to develop a coherent strategy for the regulation of people, to support delivery of their national health and social care workforce strategies.

☑ **Recommendation 14:** Regulators should do more, both individually and collectively, to clarify and explain their approach to cases where a professional has been involved in a patient or service user safety incident.

☐ **Recommendation 15:** The UK Government should ensure that the 'safe spaces' investigation approach being implemented in England does not cut across the duty of candour or otherwise negatively impact on transparency or accountability.

☐ **Recommendation 16 (PSA commitment):** The Authority will ensure that the application of our EDI standards for regulators is stretching and stimulates continuous improvement.

☐ **Recommendation 17 (PSA commitment):** The Authority will work to ensure a consistent approach across both regulated and unregulated practitioners through our Accredited Registers programme and will be introducing clearer requirements for registers on EDI later this year.

☐ **Recommendation 18 (PSA commitment)**: The Authority will look at its own processes to ensure that we are not reinforcing or exacerbating inequalities in the regulatory system.

☐ **Recommendation 19 (PSA commitment):** The Authority will use its oversight role to encourage co-operation, collaboration, and coherence on EDI issues across the system, noting the inherent challenges in trying to address safety concerns when it is so fragmented.

☐ **Recommendation 20 (PSA commitment):** The Authority will use its oversight role, expertise and convening power to support the development of regulatory strategies by the UK Governments.

☐ **Recommendation 21 (PSA commitment):** The Authority will bring people together to find ways for the HSIB England’s ‘safe spaces’ approach, and other initiatives for improving safety culture, to support candour and accountability. This will include patients, service users and families, professionals, regulators, and many others.

Please explain more about why you have chosen these three recommendations/commitments?

We have suggested prioritising the following three recommendations:

RECOMMENDATION 1 - Each UK country should have a Health and Social Care Safety Commissioner, or equivalent function, with broad responsibility for identifying, monitoring, reporting, and advising on ways of addressing patient and service user risks.

In the 'Safer care for all' report, the Professional Standards Authority (PSA) highlights that the current approach to safety across health and social care is too complex and fragmented. It points out that while many individual organisations take a view on safety, they all do so only through the lens of their own remit, with no one taking an overarching overview.
We agree with the PSA's diagnosis of this issue. In our recent report, 'Mind the implementation gap', we also have highlighted similar concerns.[1] In this we detail how a key difficulty in implementing improvements in patient safety in the UK is a result of the absence of a systematic and joined-up approach to these issues, compounded by unclear leadership at a system level.

Given the barriers that this lack of system leadership for safety presents to tackling avoidable harm, we consider this to be an area the PSA should prioritise in its work. The recommendation of exploring the potential role for independent commissioners, or an equivalent function, is a helpful means of approaching this. We would concur with the PSA that there are significant benefits to be gained for both patients and healthcare professionals from improving the coordination and oversight at a system level for patient safety.

However, we would emphasise that any such change must also be part of a wider transformation in our approach to patient safety, placing this at the heart of our healthcare system. This cannot just be limited to the most senior levels of health and social care, we need everyone – politicians, policymakers, patients, families and communities, clinicians, managers, system and professional regulators, researchers and academics, and health and social care system leaders – involved in this effort.

RECOMMENDATION 6 - Governments use the current healthcare professional regulation reform programme to: Review the adequacy and effectiveness of the powers of regulators with a role in regulating businesses.

- Consider whether there is a case for extending business regulation powers to all regulators whose registrants work in 'high street' practices
- Ensure regulators have the agility to address the challenges brought about by new approaches to funding and delivering care, including the introduction of new technologies.

Patient Safety Learning believes it is vital for patient safety that regulators scope effectively captures the full picture of health and social care and stays ahead of the curve in regard to potentially emerging patient safety risks. We believe the intention of Recommendation 6 is consistent with this and therefore consider it an area the PSA should prioritise in its future work.

We concur about the need to look at the case for extending regulation so-called 'high street' practices. We believe that it is vital that we ensure that patient safety considerations are at the heart of new healthcare innovations and technologies, from the point of development through to their deployment. We also need to ensure there is a direct role for patients in the

development and implementation of new innovations, and consistent use of Patient Reported Outcome Measures (PROMS) and Patient Reported Experience Measures (PREMS) to monitor their safety in use.

We believe that patient safety should be a core purpose of all service planning and delivery in health and social care. We are therefore supportive of the PSA prioritising work around ensuring regulators have the agility to adapt to new challenges brought about by different approaches to funding and delivering care, including the introduction of new technologies. It is important that to ensure safety there are appropriate systems and professional regulation across the whole of the patient journey in health and social care; all organisations (primary, secondary, tertiary, home and social care), all locations (primary care premises, mobile service facilities, patients' homes, high street premises, care homes, online service provision, hospices, hospitals etc), whether NHS or independent care. In our view this should be a key consideration for the PSA in approaching its role.

RECOMMENDATION 14 - Regulators should do more, both individually and collectively, to clarify and explain their approach to cases where a professional has been involved in a patient or service user safety incident.

One serious area of concern that has emerged time and again in inquiries and investigations into serious patient safety issues, avoidable harm and patient deaths relates to the response of regulators when concerns have been raised, both in terms their speed and the actions that they take. For this reason we believe this is an area that the PSA should prioritise in their future work and believe that this recommendation around the importance of clarity in these processes is a positive one.

Clarity in how regulator approaches cases involving a patient safety incident is firstly important for patients themselves. They need to have confidence that serious concerns are being responded to and acted upon in an appropriate manner, providing assurance that patient safety is being prioritised.

Secondly it is also important to the staff involved in an incident. We see this as a key part of creating an environment with an open and fair culture, that enables patient safety issues to be raised, discussed and resolved and which ensures incidents of avoidable harm are responded to with empathy, respect, rigour and action for improvement. Staff need to understand these processes and have confidence that they are focused on improving safety. This is a key requirement to ensure that patient safety incidents are reported consistently, staff must feel safe and supported in doing this.

In considering how it implements this recommendation, we believe that as well as clarity and transparency being important elements in ensuring staff have confidence in these processes, and therefore feel able to speak up about patient safety issues, the PSA also needs to consider the importance of ensuring referrals to professional regulators by employers and others are not vexatious. In our view this issue, which we have seen raised by many patient safety whistleblowers in the past, needs to be addressed. Such concerns undermine trust and confidence in professional regulation and can be very damaging for registrants.

References

1. Patient Safety Learning, Mind the implementation gap: the persistence of avoidable harm in the NHS, 7 April 2022. https://www.patientsafetylearning.org/blog/mind-the-implementation-gap-the-persistence-of-avoidable-harm-in-the-nhs

Are there other activities not included in the draft Strategic Plan that you think the Authority should prioritise in the period 2023-26?

No.

Do you agree that our vision (safer care for all through high standards of competence and conduct in health and social care professionals) is appropriate for the work of the Authority?

Yes.

Please explain your response.

Patient Safety Learning believes that patient safety needs to be placed at the heart of health and social care and believe that the Professional Standards Authority working towards this vision should help to support this.

Do you agree that our mission (to protect patients, service users and the public by improving the regulation and registration of health and social care professionals) is appropriate for the work of the Authority?

Yes.

Please explain your response.

We concur that this mission fits the organisational remit of the Professional Standards Authority as we understand it.

Do you agree with our proposed Strategic Aim 1: To protect the public by delivering highly effective oversight of regulation and registration; and how we plan to deliver this aim and monitor progress?

Yes.

Do you agree with our proposed Strategic Aim 2: To make regulation and registration better and fairer; and how we plan to deliver this aim and monitor progress?

Yes.

Do you agree with our proposed Strategic Aim 3: To promote and support safer care for all; and how we plan to deliver this aim and monitor progress?

Yes.

Further comments on response

While we support this aim broadly we do have some feedback concerning the proposals to deliver this detailed in the draft Strategic Plan.

Under Strategic Aim 3 the Professional Standards Authority (PSA) states that in 2023/24 it will review the remit of the Patient Safety Commissioner for England and the introduction of

a similar role in Scotland, and make recommendations in relation to the scope and delivery of these roles.

We would note that as the Patient Safety Commissioner for England only formally started in her role in September 2022, any review would need to take place in the latter half of 2023/24 if this is to be fair and effective. We believe that the Patient Safety Commissioner would need to be in post for at least a year before the PSA could assess how this role operates in practice. Given that the Commissioner has to initially set up this post as the inaugural role holder, it may be that a longer period is needed before this review takes place, for example 18 months (halfway through her first term in office).

With a similar rationale we have concerns about a proposed review in 2023/24 of the Patient Safety Commissioner for Scotland as indicated in the draft Strategic Plan. This role has yet to be formally established and is currently being reviewed and debated through the Scottish legislative process. Given this, we believe it is unlikely that the initial postholder will have not had sufficient time in office for any review of their role within the year 2023/24 to be fair and effective. Furthermore, we would also emphasise that it is important that this role has a review process that is separate to that of the Patient Safety Commissioner for England. We think this is important as this role may operate in a significant different manner in practice, given the English Commissioner has a remit that is restricted to medicines and medical devices while their Scottish counterpart will have a broader role to support the system-wide improvement of safety in healthcare in Scotland. These differences in remit may have significant consequences for how these two Commissioner's approach their roles.

Under Strategic Aim 3 the Professional Standards Authority also states that in 2024/25 it will support the development of Patient Safety Commissioner roles in England and Scotland; and the implementation of similar functions in Wales and Northern Ireland".

Patient Safety Learning is not aware of any plans, by either the Welsh Government or Northern Ireland Executive, to either create Patient Safety Commissioner's within their respective parts of the United Kingdom, or to come forward with different proposals for the implementation of similar functions. We would suggest that the phrasing of this is revised in the draft Strategic Plan to reflect that this should only be considered as a possible future task the PSA can undertake, reflecting that there are currently no plans in place in Wales or Northern Ireland to act on.

How do you think the role of the Authority should evolve in the future, particularly in the context of the reform of professional regulation in health and social care?

We are aware that there have been discussions in some quarters about whether there may be an argument for simplifying the current approach to professional regulation. In particular this issue has received more attention since the passing of the Health and Social Care Act, with Part 3 Section 103 including powers for the Secretary of State to modify the functions regulators, abolish bodies and transfer their functions to other bodies.

Patient Safety Learning recognises the potential advantages of aligning the regulation of healthcare professionals from a patient safety perspective. We see the benefits of developing a common statement of professional practice across a range of different roles, to make clearer what the public can expect from health and care workers and when to report a concern to the regulator.

We also note that to meet this aim of aligning regulation, the creation of a single regulator is not the sole approach to this. As the PSA itself has indicated in a previous report, 'Reshaping regulation for public protection', a simple reduction of the existing number of regulators

would have potential benefits in this regard, as well as providing a simpler structure for patients and the public to navigate.[1]

Whether or not such changes may be considered in future by the Secretary of State for Health and Social Care, we do believe that it remains important for patient safety that there is an organisation such as the PSA with oversight over the regulation and registration of healthcare professionals.

References

1. Professional Standards Authority for Health and Social Care, Reshaping regulation for public protection: Our view on the implications of the Health and Care Bill for professional regulation, 28 October 2021. https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/reshaping-regulation-for-public-protection.pdf?sfvrsn=94d74820_7

Are there any aspects of these proposals that you feel could result in differential treatment of, or impact on, groups or individuals based on the following characteristics as defined under the Equality Act 2010:

- [ ] Age
- [ ] Disability
- [ ] Gender reassignment
- [ ] Marriage and civil partnership
- [ ] Pregnancy and maternity
- [x] Race
- [ ] Religion or belief
- [ ] Sex
- [ ] Sexual orientation
- [ ] Other, please specify

If you have responded 'yes' to any of the above, please explain why and what could be done to change this.

One of the recommendations we prioritised, recommendation 14, concerned ensuring regulators should do more, both individually and collectively, to clarify and explain their approach to cases where a professional has been involved in a patient or service user safety incident. An element of this we think may need to be considered further, with reference to the Equality Act, is race. We are aware that a high number of professional regulation referrals relate to healthcare professionals from ethnic groups outside the White British group. We believe that the Professional Standards Authority needs to consider issues such as this in is approach to this issue and the actions it may need to take to ensure that regulators in dealing with these issues treat all groups regardless of their background fairly in investigations.