Response to the NHS Improvement's consultation on developing a patient safety strategy for the NHS

February 2019

1. Introduction

1.1 The Professional Standards Authority for Health and Social Care promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament. More information about our work and the approach we take is available at www.professionalstandards.org.uk

1.2 As part of our work we:

- Oversee the nine health and care professional regulators and report annually to Parliament on their performance
- Conduct research and advise the four UK governments on improvements in regulation
- Promote right-touch regulation and publish papers on regulatory policy and practice.

1.3 We welcome the opportunity to respond to NHS Improvement's consultation on developing a patient safety strategy for the NHS. We take a particular interest in this consultation as an organisation whose purpose it is to protect the public. Our work on increasing openness amongst professionals and research into how risks to patients can be better managed may be of use to NHS Improvement. We welcome the impetus by NHS Improvement to improve patient safety. Below, we have made a number of comments about the strategy which are divided into the different areas of the consultation.

Comments on the consultation

2. Principles

2.1 The principles of a just culture, openness and transparency, and continuous improvement are helpful to underpin NHS Improvement's patient safety strategy. We suggest that 'patient-focused' may be a useful addition to the principles. Given that the objective of a patient safety strategy is to further protect patients, the starting point for creating any patient safety initiative should be to ask how it affects patients.[1]

[1] We point out that the Authority has carried out research understanding the public's attitudes to safety and risk, for example Policis' research of public attitudes to dishonest behaviour by health professionals, and we have recently commissioned work to explore the role that patients may play in their own safety, which will be published later in the year.

Culture and candour

2.2 In relation to a just culture, we highlight the need to correct a common misperception that professional regulation is punitive. This misperception can inhibit the development of a just culture. The purpose of regulators' fitness to practise processes is to protect the public, not to punish health professionals. It identifies misconduct and impairment and acts proportionately to protect the public and uphold standards. We suggest that professional regulation has a role to develop a just culture as regulators act proportionately in fitness to practise investigations in order to ensure public safety and better practice.[2]

2.3 Since 2013, we have developed an evidence base on candour issues, such as in our advice to the Secretary of State on barriers to candour, which may be of use to NHS Improvement.[3] We recently published a report, *Telling patients the Truth when something goes wrong*[4], where we suggested that greater openness and transparency by professionals can be developed by professional regulators through education and training, case studies and a common standard of candour amongst professional regulators. We make clear though that openness and transparency is a cross-system endeavour, professional bodies, regulators, universities and other organisations all need to work together to develop an open and transparent culture across the NHS in England.

2.4 Regarding continuous safety improvement, we point out that regulators help improve patient safety continuously via continuing fitness to practise (CPD) requirements. There has been further emphasis on this as there is a trend in regulation towards 'preventative regulation' – rather than focusing on reacting to harm, concentrating on preventing it from occurring. Regulators are all taking forward, through their continuing fitness to practise programmes, ways to prevent harm to patients by supporting and encouraging registrants to remain compliant with regulatory standards throughout their careers.

3. Insight

3.1 We agree with NHS Improvement's aim to better collect, amalgamate and use data in order to improve patient safety. The insights garnered from data can help build a picture of the status of health provision in England and can enable NHS Improvement to understand what works and does not work to improve patient safety.

3.2 However, when obtaining data for insights we suggest NHS improvement cast its net more widely than suggested in the consultation document. The data of professional regulators may be useful to provide insights on patient safety. For

[2] Regulators also have other tools such as CPD and revalidation in order to ensure registrants keep learning and attain proper standards. There is also a professional duty of candour, signed up to by eight of the regulators that we oversee, which requires every healthcare professional must be open and honest with patients when something that goes wrong.

[3] *Candour, disclosure and openness Learning from academic research to support advice to the Secretary of State*, 2013, Professional Standards Authority.

[4] *Telling patients the truth when something has gone wrong*, 2019, Professional Standards Authority

example, fitness to practise (the process by which regulators determine whether an individual work as a health professional) data may be able to yield insights to help NHS Improvement take preventative action. [5] Analysis of regulatory data can assist in the identification of situational factors most prone to be associated with lapses in conduct or competence. It provides a starting point for further analysis and research into why such patterns exist and how they might be best addressed.

4. Infrastructure

4.1 We welcome NHS Improvement's review of infrastructure to improve patient safety. Our only comment is that NHS Improvement may want to consider how to ensure the establishment of infrastructure such as a dedicated patient safety team does not duplicate the role of existing infrastructure and how new infrastructure is encouraged to collaborate with other existing parts of the health system in England which already aid patient safety.

5. Initiatives

5.1 When understanding risks, professional regulators could have a significant contribution to make. We mentioned earlier that professional regulators are working to identify potential harm earlier in order to better protect patients. To do this harm needs to be understood comprehensively. Regulators are working in the area of data analysis and insight, to assist early identification and action in problematic situations, and to recognise patterns in the circumstances where things go wrong. Regulators also work collaboratively as shown in the Emerging concerns protocol.[6] Therefore, regulators are building up great expertise on risk that could be useful for NHS Improvement when choosing and prioritising initiatives.

5.2 One of the emphases of the professional regulation agenda has been for greater focus on education and training of future and current professionals to better protect patients. We suggest that NHS Improvement may want to look towards education and training, whether it be by university education or continuing fitness to practise, as a means to improve patient safety.

5.3 When deciding how to make an effective approach to patient safety initiatives, NHS Improvement may find our recent report useful, *Telling patients the truth when something has gone wrong*, particularly regarding the use of case studies. We found that when dealing with difficult subjects such as candour where there are 'shades of grey' it may be useful to use case studies. Case studies can help professionals better understand guidance as they are 'relatable and interesting' for professionals and situate a theoretical standard of candour in the reality of everyday life. Our report also found that it would be useful for organisations to reframe candour from viewing it from a negative

[5] For example, the General Medical Council's Data Explorer shows the wealth of data garnered by regulators.
[6] *Emerging Concerns Protocol*, Care Quality Commission.

vantage point where the focus of guidance is on a lack of candour to a more positive one. Having a positive discussion about professionals who are candid may better influence professionals to be candid as they see it as a professional strength.[7] The use of both case studies and positive reframing may help NHS Improvement in making its initiatives more effective in adoption.

5.4 Finally, at the centre of defining success of patient safety initiatives should be safety outcomes for patients.

6. Consultation details

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3. Are you responding as an individual or on behalf of an organisation? An organisation

4. If responding on behalf of an organisation, which organisation do you represent? Professional Standards Authority for Health and Social Care

7. Further information

7.1 Please get in touch if you would like to discuss any aspect of this response in further detail. You can contact us at:

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[7] *Telling patients the truth when something has gone wrong*, 2019, Professional Standards Authority