professional standards authority

Right-touch reform

A new framework for assurance of professions

A summary: Harm prevention

Can we reduce the amount of harm?

Read our full report ↘

WHO WE ARE

We are an independent body, accountable to the UK Parliament. We exist to protect the public by improving regulation and registration of health and care professionals.

At the heart of everything we do is a simple purpose:

To protect patients, service users and the public by improving the regulation and registration of health and care professionals and practitioners

HOW WE WORK

We ensure that our values are at the core of our work: they are at the heart of who we are and how we would like to be seen by our partners. We are committed to being:

- focused on public interest
- independent
- fair
- transparent
- proportionate.

There are three main areas to our work:

- Reviewing the work of the regulators of health and care professionals
- Accrediting organisations that register health and care practitioners in unregulated occupations
- Giving policy advice to Ministers and others and encouraging research to improve regulation.

HARM PREVENTION: CAN WE REDUCE THE AMOUNT OF HARM?

In *Right-touch reform* we set out to develop thinking about where regulation sits in relation to reducing harm. Looking at 'moving upstream' is a new focus for regulation.

How and to what extent can regulators reduce the amount of harm caused to patients and others, both through their own interventions and those which are achieved through collaboration?

How we define harm

We define harm as '**physical injury or psychological distress experienced by people through interaction with health or social care practitioners'**. We use the term **risk** to mean 'the likelihood of harm occurring' or the probability of a particular situation or set of circumstances resulting in harm.

Many of the fitness to practise cases that we review include situations where health and care professionals through misconduct, or by their unprofessional behaviour, have exposed a patient, colleague or other to increased risk of harm where they would be expected to have acted otherwise, even where the potential harm has not materialised.

The specific types of misconduct or failures of competence which can result in harm are also wide-ranging, and include:

- dishonesty re qualifications/convictions/registration
- dishonesty/fraud/theft
- failure to follow health and safety/infection control
- failure to have appropriate indemnity insurance
- failure to refer
- failure to visit/examine/assess/diagnose/follow up
- inappropriate delegation of care
- inappropriate/failure in prescribing/administration of medication
- inappropriate/inaccurate dispensing of medication.

This list illustrates some of the different kinds of event and behaviour which could put patients/service-users (and colleagues) at risk of harm and are just some of the terms used to categorise misconduct on our fitness to practise database. For the full list see Appendix 1 of *Right-touch reform*.

Protecting patients and reducing harms should be one part of the shared purpose of the regulatory system.

These types of unprofessional behaviours or misconduct (listed opposite) can result in many different kinds of harm including, but not limited to:

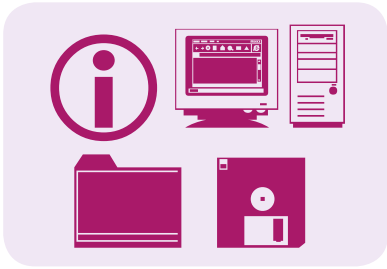
- Harm to the **physical and/or mental health of patients** and those close to them, their career, financial status and family life, sometimes irrevocable
- Harm to the **physical and/or mental health of the registrant**, their career, financial status and family life, sometimes irrevocable
- Harm to the **reputation of an organisation delivering care** – thus damaging the trust of future patients in the safety of care
- **Disruption to the ongoing work of teams**, and thus potentially to the quality of patient care in the future
- **Loss of trust**.

This is just a summary of the *Harm prevention* section in our special report ***Right-touch reform***. Read the ***full chapter*** to get more detailed background and context.

PREVENTING HARM: WHAT CAN WE DO BETTER?

Learning from past events: retrospective analysis of fitness to practise data

Currently the regulators' fitness to practise and complaint processes occur after the fact – after the alleged harm has occurred. Policy has recently focused on the potential of regulators to contribute to harm prevention. One way to do this is by looking at what has gone wrong in the past and learning from it.



Read our latest research:

- ***Categorisation of fitness to practise data***
- ***Bad apples? Bad barrels? Or bad cellars? Antecedents and processes of professional misconduct in UK Health and Social Care: Insights into sexual misconduct and dishonesty***

The regulators and the Professional Standards Authority have at their fingertips a huge source of data with the potential to generate insights, improve knowledge and understanding, and help identify patterns of behaviour.

Some of this data has already been put to use in the recent research funded by us. The study identified three different types of perpetrator of professional misconduct by analysing final fitness to practise determinations.

However, this data is currently collected for a legal process and has not been designed for retrospective analysis. Differences in how allegations are categorised, terminology and the level of detail can make it difficult to compare regulators' fitness to practise data. It is also very much focused on the registrant and not those harmed, so there is little opportunity to examine it from the complainant's perspective.

Recommendation: improve fitness to practise data

We need to re-look at policy around fitness to practise data to ensure consistency about what is collected and how it is categorised which could enable regulators to use this data and share their knowledge with other agencies optimally placed to intervene.

Read the full report to find out more

Delving into the data: case study

We funded research by Professfor Rosalind Searle and published the results of the study in November 2017. Professor Searle and her team examined 6,714 final fitness to practise determinations from the Authority's database. Amongst other research methodologies, the team applied cluster analysis to identify how different kinds of misconduct group together for the different professions. They identified three different types of perpetrator:

- the self-serving 'bad apple'
- the individual who is corrupted by the falling standards of their workplace, and
- the depleted perpetrator struggling to cope with the pressures of life.

This research has been the most ambitious project to date to use the Authority's data on final fitness to practise determinations. It highlights how this data can be used more widely – beyond the regulatory process – potentially to support preventative interventions in future by regulators, employers, and others.

PREVENTING HARM: WHAT CAN WE DO BETTER?

The role of patients in safe care; achieving a balance between too much trust and too little trust

ENCOURAGING PATIENTS TO GO WITH THEIR INSTINCTS

Patients are well placed to be agents of their own safety. However, excessive or blind trust in professionals can leave service-users vulnerable. It is important to encourage patients to listen to their instincts when they feel something is not right, and empower them to express qualms constructively, ask questions when they feel uncertain, and take action, including reporting or escalating any concerns.

We intend to undertake further research so we can better understand how patients currently contribute to the safety and effectiveness of the care they receive, and to develop our understanding of their role in this respect. We would then look at developing ideas and proposals around the mutual roles of the patient and of the regulator, encouraging a conversation which extends beyond the professional regulators and which encompasses a wider range of issues to develop innovative ways to support public engagement with regulators.

(RE)BUILDING TRUST

Trust is an area of growing interest in research in healthcare and in regulatory policy. Recent work has discussed the importance of trust for patients, not least because patients 'have limited information (about their illness or treatments); they delegate responsibility for making decisions about their care to professionals; they rely in turn on professionals' professionalism to ensure the care they receive is appropriate; and in this way their trust addresses the inherent uncertainty underlying medical care'. A loss of trust in either a specific individual, in an organisation or in the arrangements for the delivery of care at a higher level has consequences beyond the individual, such as deterring patients from seeking needed care. Trust in an individual can invoke trust in a wider organisation or system, and vice versa; distrust or loss of trust can also transfer between patients and those close to them.

Read the full report to find out more

Enabling the public in particular to ask questions or raise concerns when they think that something just isn't right.

FITNESS TO PRACTISE DATA: LISTEN TO BOTH SIDES OF THE STORY

We have discussed issues around using fitness to practise data for retrospective analysis and future risk management. As this process places the registrant at the centre of the story, the patient's voice can be lost and they may not get the same opportunity to tell their side of the story. This of course is at the heart of the frustration experienced by many members of the public who refer problems to regulators. We have recommended looking at how fitness to practise data is used and one aspect of this would be a greater focus on the patient's perspective on what has happened to cause them harm and what impact this has had on them, and the circumstances in whcih harm occurred.

Recommendations: what role can patients play

- **Explore further the role of the patient in the safety of care, and the role of the regulator in supporting patients in this respect**
- **Further work should be done to model ways in which patients can be supported and encouraged to be constructively distrustful.**

HAZARDS AND HARMS: THINKING ON PREVENTION

The work of Professor Malcolm Sparrow has been influential in developing thinking in the sector around how regulators might use their knowledge and insights towards preventing harm. Regulators should place greater focus on actual and specific serious harms and how to 'sabotage' them. They can do this by analysing and identifying 'hazards' – factors that can cumulate, contribute and result in harm occurring. In the context of health and care professional regulation these hazards could include those relating to:

- the competence, health, or wellbeing of individuals involved when such harms occur
- the vulnerability of a patient or patient group
- the state of professional relationships within a team, or
- the features of the working environment or employing organisation.

There are different kinds of hazard:

▶**Intervention**: hazards which arise from the complexity and inherent dangers of the activity (for example undergoing surgery will likely be riskier than having an injection)

▶**Context**: hazards which arise from the environment in which care takes place (if there is a lack of communication/handover/training then giving the injection could increase in risk because the patient notes may not be up-to-date and person giving the injection may not be aware the patient is allergic)

▶**Agency/vulnerability**: hazards which arises from service user vulnerability (if the patient receiving the injection is vulnerable, for example suffering from dementia, they may not be able to inform the person injecting them that they are allergic).

PREVENTING HARM – WHOSE RESPONSIBILITY IS IT?

Preventing harm cannot just sit with regulators. It requires collaboration, coordination and communication between professional and system regulators as well as employers and others (managers, teams, professionals themselves as well as patients) who are better placed to react more quickly when harm is likely to occur.

See ***Right-touch assurance*** – the tool we developed to assess risk of harm presented by different health and care occupations.

HARM 'SABOTAGE'

Identifying the hazards which combine to result in harm is the first step, the next step is to try to halt their progress. Sparrow refers to this as 'sabotaging' harms and to apply the concept of 'sabotaging' harms successfully, we need to answer a series of questions relating to the circumstances in which harm occurs:

WHAT	Are the factors which could negatively influence behaviour, including but not limited to health and wellbeing, or environmental or other factors bearing on individuals' behaviour?
WHAT	Are the traits of relationships between professionals which might result in harmful outcomes for patients?
WHAT	Are the team dynamics which might result in elevated risk of harm?
WHAT	Are the organisational features or factors which might result in elevated risk of harm?
WHAT	Are the factors at play when registrants, patients and the public decide whether or not to raise concerns about elevated risk of harm?

We (the Authority and the regulators) have started to answer some of these questions, through our research and policy work. Find out more on our website.

HOW REGULATORS CURRENTLY CONTRIBUTE TO REDUCING HARM

Most regulatory activity contributes to reducing harm. Regulators do this by:

- applying controls to who they allow on to their registers
- quality-assuring higher education courses/training to ensure that registered professionals hold the correct, and appropriate qualifications and are fit to practise
- regulators' standards/codes set out the professional behaviour expected of their registrants through continuing fitness to practise processes, they ensure that their registrants keep up-to-date with the latest developments in their profession and remain fit to practise
- regulators can investigate cases/complaints about professionals and their fitness to practise panels can remove registrants from practice (or impose lesser sanctions) if they find there is a case to answer and registrants are not fit to continue to practise/fail to maintain or uphold the standards of their profession.

However, regulators can seem far-removed from registrants practising a profession on the frontline, often under stressful conditions and in pressurised environments.

We have commissioned research into what impact regulators have on those they register, but it is not an easy question to answer.

An area where regulators have made considerable progress though is in developing the ways in which they require their registrants to demonstrate their ongoing fitness to practise.

READ OUR RESEARCH

We started looking at whether professional identity has any benefit on patient safety as part of our work researching what impact regulators have on those they regulate.

- **Professional identity and the regulator's role - an overview**
- **Research into professional identity and regulation**
- **Professional identities and regulation - a literature review**

How registrants can continue to ensure they are fit to practise – the right-touch way

We have previously published our thoughts on how regulators can assure their registrants comply with their standards and remain competent. We believe that there should be less of a narrower focus, for example on measurement of inputs such as hours. It should be the quality of the CPD activity which counts.

There are a number of common themes across the different arrangements. **Peer review** and **feedback** come through as key areas, with almost all regulators including this as a continuing fitness to practise requirement. Similarly, the importance of **individual reflection on practice** comes through in most systems, with requirements for registrants to participate in reflective discussions or complete reflective writing, examining how the standards of conduct and competence have been relevant to specific areas of their practice. The use of **patient and peer feedback** is also a common feature, as is a move to base requirements closely around the **standards set by the regulator,** although some of the regulators including the General Osteopathic Council (GOsC) and the HCPC have specific standards which registrants must meet to demonstrate continuing fitness to practise.

RECOGNISING THE PERSONAL IN THE PROFESSIONAL
by encouraging reflective engagement with regulatory standards

1. FORMATIVE SPACES

Seeking to encourage registrants to discuss problematic situations openly and at an early stage

Nipping a potential problem in the bud by talking issues through with colleagues could help to reduce harm, enabling registrants to explore and resolve problems before risks are elevated. However, this is likely to be more effective if discussions are informal and confidential. There could be some anxiety on the part of the regulators around transparency if these discussions are outside their direct control. Confidential and informal discussions could offset some of the innate tensions between regulators and their registrants and counteract defensive practice which can pose a risk to patients.

Recommendation:

Further work is needed to explore how to apply the idea of formative spaces to different professional groups and how to make sure regulators are on-board. We need to balance the potential benefits of the formative space with the need by regulators to be alerted to serious concerns.

2. RELATIONAL REGULATION

Seeking to bridge the gap between professional standards and the daily practice of a profession

Put simply, registrants may view their regulator (and the standards set by them) as out of touch with the daily demands and pressures of practising the profession. This means that regulators are unlikely to be the first port of call for professionals when they are uncertain of how to act in a particular situation. They are more likely to turn to colleagues first and foremost and then perhaps supervisors/managers and helplines. Relational regulation looks at bridging this gap between regulatory standards, which are relatively fixed in time, with the working world as professionals experience it.

Recommendation:

We need to continue to consider and discuss relational regulation, its potential for engaging registrants with professional standards and its relationship to right-touch regulation.

This is just a summary taken from the full chapter on Harm prevention. For more details of the background, context and the academic sources quoted, check the ***full chapter***.

3. INTERPETIVE VIGILENCE

Identify the minor mishaps that could point to a bigger problem

Research has shown that enforced transparency can result in defensive and secretive practice and registrants who see a colleague, for example subject to fitness to practise procedures, may also disengage from their regulator, though their association with bad publicity or how they perceive their colleague to have been badly treated by the regulator.

Through straightforward and practical measures ‘emerging risk can and should be identified by piecing together cues in apparently inconsequential, minor, ‘small events’, to protect against ‘small mishaps that can combine to create a major catastrophe.’

Recommendation:

Emerging from these different domains of research – harm sabotage, relational regulation, formative spaces, and interpretive vigilance – are a set of ideas which we recommend are further developed to encourage registrant engagement with regulatory standards in the workplace. We propose further work to explore how, through different ways and through different models, local action at the level of the employer or workplace can assist in clarifying the purposes and meaning of regulatory requirements, and can promote constructive and mature engagement with registrants.

HARM PREVENTION: CONCLUDING THOUGHTS

Our aim in publishing ***Right-touch reform*** and its chapter on ***harm prevention*** is to stimulate debate and discussion and to clarify thinking in the sector about where regulation sits in relation to reducing harm.

OUR RECOMMENDATIONS INCLUDE:

Continue to **develop approaches focused on the avoidance of harms** within the sector.

Continue to seek **new ways to use data to support insights into trends and patterns** in the circumstances in which misconduct occurs.

Identify the **range of potential targeted regulatory action** subsequent to identification of 'high-risk' groups, and identify ways in which these could be made non-discriminatory.

Work to develop a methodology to engage retrospectively with those involved in fitness to practise cases, to discuss the hazards that were present when things went wrong in an open and exploratory way.

Review the way in which regulators collect data about fitness to practise, and how within available resources a common data set might be developed.

Explore **how 'formative spaces' could add further value** for different professional groups.

Carry out further work **to understand the nature of the relationship between regulators and their registrants** and how it is constructed, and to identify strategies by which misperceptions might effectively be addressed.

Explore how, through different ways and through different models (formative spaces, relational regulation, interpretive vigilance, or others) l**ocal action at the level of the employer or workplace can assist in clarifying the purposes and meaning of regulatory requirements**, and can promote constructive and mature engagement with registrants.

Explore further the role of the patient in the safety of care, and the role of the regulator in supporting patients in this respect.

We hope that the chapter on harm prevention in ***Right-touch reform*** can be used as the basis for meaningful discussions about the future of professional health and care. We timed its publication to assist people interested in responding to the Department of Health's consultation on ***Promoting professionalism, reforming regulation***. Find out what **we said in our response**.