Written evidence submitted by the Professional Standards Authority (PSN0021)

This is the evidence submission from Professional Standards Authority (PSA) to the Health and Social Care Committee Independent Expert Panel's Evaluation of the Implementation of Inquiry Recommendations.

The PSA promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and 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.

We have considered the Inquiry questions from the perspective of our sector – the regulation and registration of health and care workers, and regulation in health and care more generally, and in the light of the findings of our 2022 report, *Safer Care for All*.[1]

We have selected below the recommendations against which we hope we can make a useful contribution. However, we wanted to begin with a more general point summarising our thoughts on the limited effectiveness of reviews and inquiries, and a possible way of addressing what we see as an underlying structural issue.

We are not the first to find that successive inquiries tend to identify similar failings, and that their recommendations do not seem to bring about the improvements needed to prevent future harm. Our voice joins others including the Parliamentary and Health Service Ombudsman[2], Dr Bill Kirkup Chair of the Morecambe Bay and East Kent maternity inquiries[3], the House of Lords post-legislative scrutiny of the Inquiry Act 2005,[4] and the charity INQUEST[5].

Our report, *Safer care for all*, published in 2022, is the product of the Authority's research and thinking about the role, potential and limits of professional regulation after two decades of statutory oversight, in furtherance of our statutory objective of public protection.

In the report, we made a recommendation for a Health and Social Care Safety Commissioner[6] – a coordinating function with broad responsibility for identifying, monitoring, reporting, and advising on ways of addressing patient and service user risks. The health and social care safety system, of which inquiries and reviews are an integral part, is made up of a complex jigsaw of institutions. Each has a specific remit, and no single body is tasked with ensuring that together they create an effective safety system that protects patients and service users. Our commissioner proposal is designed to address this structural flaw.

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[1] Professional Standards Authority 2022, *Safer care for all – Solutions from professional regulation and beyond*. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/safer-care-for-all-solutions-from-professional-regulation-and-beyond.pdf?sfvrsn=9364b20_7

[2] https://www.ombudsman.org.uk/publications/broken-trust-making-patient-safety-more-just-promise-0

[3] Dr Bill Kirkup CBE, October 2022. Reading the signals - Maternity and neonatal services in East Kent – the Report of the Independent Investigation. Available at: https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report

[4] https://publications.parliament.uk/pa/ld201314/ldselect/ldinquiries/143/143.pdf

[5] https://www.inquest.org.uk/no-more-deaths-campaign#:~:text=INQUEST%20is%20calling%20for%20urgent,and%20reduce%20the%20prison%20population.

[6] Chapter 5, p82-88

Of particular interest here, we found that the effectiveness of reviews and inquiries, both individually and collectively, was limited – stemming from the lack of a coherent national approach to dealing with major failings in health and social care, including:

- whether to inquire into major failings at all, and whether through a review, non-statutory public inquiry, statutory inquiry, or other
- the scope of inquiries/reviews (e.g. the extent to which the actions of regulators are examined)
- the implementation of recommendations.

We also noted a lack of continuity of service post-publication and the inefficiency inherent in each inquiry secretariat having to be set up from scratch.

In *Safer care for all* we made the case that these problems could be addressed, at least in part, by having a single function responsible for overseeing the safety system. We suggested that one of the roles of this function should be an 'Inquiries Office' which would:

- Coordinate inquiries and reviews into health and care failings to bring greater coherence and objectivity to decisions about how to respond, and how to establish terms of reference
- Follow-up on progress against inquiry recommendations
- Act as a contact point after the publication of the report for further queries
- Carry out meta-analyses of inquiry findings to identify trends (in the absence of a broader risk intelligence function)
- Act as a permanent secretariat so that inquiries can be set up and run quickly and efficiently.

Clearly the way that governments respond to major failings could be more effective, more efficient, and more responsive. For England, one way to achieve this would be to broaden the role of the recently introduced Patient Safety Commissioner role to take on a wider oversight and coordinating function for patient and service user safety along with some or all the functions we have proposed for a Health and Social Care Safety Commissioner, such as a role supporting a coherent and timely response to public inquiries.

An expansion of the Patient Safety Commissioner role should be considered in parallel with expanding or rationalising the roles and remits of different bodies to close the gaps and ensure a safety system that works as a coherent whole.

Should this recommendation for a role expansion not find favour, we think there would still be merit in creating an Inquiries Office in a standalone capacity, to fulfil the functions listed above.

1. Maternity and neonatal care

Recommendation 2. "A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff

to comply with the code and their employers to enforce it." (From the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013)

1.1 It is our understanding that recommendation 215 has not been fully implemented, despite several attempts to address a standards and accountability gap relating to NHS managers.

1.2 To understand why the question of NHS manager regulation persists, it is worth considering its history. Mid-Staffs was not the first inquiry to recommend a more robust system of accountability for this group. In 2001, an inquiry led by Sir Ian Kennedy recommended that:

> *'Managers as healthcare professionals should be subject to the same obligations as other healthcare professionals, including being subject to a regulatory body and professional code of practice.'*[7]

1.3 The Government turned down this recommendation on grounds of impracticality.[8] Instead, it proposed a series of measures, including the creation of a code of conduct, which became the Code of Conduct for NHS Managers, to be incorporated into NHS contracts.[9]

1.4 In 2011, the Government once again tried to grapple with the question of manager accountability, committing to '*commission independently led work to agree consistent standards of competence and behaviour for senior NHS leaders.*' The Secretary of State for Health asked the PSA[10] to develop *Standards for Members of NHS Boards and Clinical Governing Groups* which were published in 2012.[11] These Standards were accepted by the Secretary of State,[12] and originally intended as the foundation for a review of accountability arrangements for NHS senior leaders.

1.5 We now come to 2013, and recommendation 215 of the Mid-Staffs Inquiry under consideration by this Expert Panel. The Inquiry stopped short of recommending statutory regulation explicitly because there was little enthusiasm for this among most stakeholders at that time.[13] The Government of the day argued that the Standards developed by the PSA fulfilled the first part of Recommendation 215 relating to a code. For the compliance part of the recommendation, the Government proposed a new test of fitness for Board Directors, which became the Fit and Proper Person Test (FPPT).[14] However, the FPPT was never formally linked to our Standards as seemed to be originally intended. In 2019 Tom Kark KC reviewed the FPPT and recommended strengthening the requirements including setting up a barred list, but

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[7] July 2001. *The Report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995: learning from Bristol*. Available at: https://webarchive.nationalarchives.gov.uk/ukgwa/20100407202128/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005620

[8] https://webarchive.nationalarchives.gov.uk/ukgwa/20100407202124/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002859

[9] https://www.porthosp.nhs.uk/about-us/policies-and-guidelines/policies/HR/Code%20of%20Conduct%20for%20NHS%20Managers.pdf

[10] Then the Council for Healthcare Regulatory Excellence.

[11] https://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/standards-for-members-of-nhs-boards-ccg-bodies-advice.pdf?sfvrsn=1bf07420_4

[12] https://www.gov.uk/government/news/respect-and-compassion-at-centre-of-new-standards-for-nhs-leaders

[13] Sir Robert Francis has since made clear that his personal view is that full statutory regulation is needed for NHS managers. https://www.bmj.com/content/357/bmj.j2101.full

[14] https://assets.publishing.service.gov.uk/media/5a7c8c4e40f0b62aff6c270f/35810_Cm_8777_Vol_2_accessible_v0.2.pdf

did not call for statutory regulation for NHS directors.[15] A revised FPPT framework has been in place since September 2023.[16]

1.6 It is of note that neither our Standards, nor the FPPT, whether in its original or updated incarnation, were aimed at managers below board level – this part of the recommendation seems to have been widely overlooked. Mechanisms resulting from this recommendation have focused on Board-level directors, and always stopped short of any kind of statutory scheme – whether a public 'negative register' of individuals who have been barred,[17] or a full regulatory scheme like that for doctors. Our Standards were never put on any formal footing and appear to have fallen out of use.

1.7 For more junior managers, nothing formal has been put in place. The NHS's own *Standards for NHS Managers* have not, as far as we are aware, been officially taken out of circulation (some NHS Trusts still have them on their website). NHS England has a range of resources for Board members and managers. It is also considering how to take forward some of the outstanding Kark recommendations, and those of the Messenger review of leadership in the NHS,[18] in the light of the related debates by the Lucy Letby case.[19] This most recent development may suggest that the gap in standards and/or accountability for NHS managers persists, despite previous attempts to address it – although we may have to wait for the statutory Thirlwall Inquiry to report to draw any firm conclusions from this case.

1.8 What is clear however is that there is still a great deal of concern about the arrangements for NHS managers. We conclude from the above that policy development and resulting implementation in this area have been plagued by flaws. Any new attempts to review and strengthen standards and accountability arrangements for this group would be well advised to avoid some of the mistakes of the past by: [20]

- Distinguishing between the constituent groups that make up 'NHS managers' (e.g. NHS provider executive and non-executive Board Members, junior NHS managers who do not sit on the Board, non-clinical managers, Integrated Care Board members, etc.)
- Including a comprehensive review of existing mechanisms and if appropriate revoking and replacing them, to create a simple, coherent transparent framework
- Identifying the public protection risks attached to the different groups
- Being clear about the problems to address, because, for example, mechanisms for addressing a standards gap are not necessarily the same as those required to address an accountability one

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[15] https://www.gov.uk/government/publications/kark-review-of-the-fit-and-proper-persons-test
[16] https://www.england.nhs.uk/wp-content/uploads/2023/08/PRN00238-i-Kark-implementation-fit-and-proper-person-test-framework-2.pdf
[17] https://www.professionalstandards.org.uk/docs/default-source/publications/feasibility-of-prohibition-order-schemes---initial-evaluation.pdf?sfvrsn=c797120_0
[18] https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future
[19] https://www.bbc.co.uk/news/uk-66578698
[20] These proposals stem mainly from work we have previously published to guide decisions about regulatory policy: *Right-touch regulation* https://www.professionalstandards.org.uk/what-we-do/improving-regulation/right-touch-regulation , and *Right-touch assurance* https://www.professionalstandards.org.uk/docs/default-source/publications/right-touch-assurance---a-methodology-for-assessing-and-assuring-occupational-risk-of-harm-(october-2016).pdf?sfvrsn=f21a7020_0

- Considering the full range of options for assurance (including an assured voluntary register,[21] negative register, employer-led mechanisms, and so on), and using statutory regulation only if clearly indicated by the level and type of risk
- Considering strengthening or rationalising existing arrangements where possible, rather than overlaying new ones.

1.9 We are in contact with NHSE about the work they are undertaking to address concerns about NHS managers, and possible options for assurance for this group, including the option of accrediting a register under our Accredited Registers programme for non-statutorily regulated groups in healthcare.[22]

1.10 In addition, we have long supported the idea of a common code of conduct for all health and care professionals. Currently each statutory professional regulator publishes standards for its registrants, and while they generally cover similar areas, there are differences between them. In the light of recent discussions about what more can be done to tackle problems of poor culture within the NHS arising from a series of high-profile failures of care, we are re-visiting the case for such a code. As well as increasing accountability, a common code that applies to senior managers could also promote cohesion across the wider team responsible for the safe and effective delivery of health and care services.

1.11 We are commissioning a piece of research with members of the public, patients, and professionals to explore:

- the potential value, benefits, and risks of a common code of conduct for health and care professionals on statutory registers
- the merits, or otherwise, of extending it to health and care professionals on accredited registers and senior management in health and care
- key areas that it should cover.

1.12 Following the outcome of this research we intend to take forward a wider scoping review on the benefits of developing a common code of conduct. We would be happy to keep the Panel updated on this work.

2. Training of staff in health and social care

Recommendation 1. "Targeted interventions on collaborative leadership and organisational values, including a new, national entry-level induction for all who join health and social care." (From the *Health and social care review: leadership for a collaborative and inclusive future report*, 2022)

2.1 Our only comment on this recommendation is that any such initiatives should be considered as part of a more rounded review of standards and accountability arrangements, as described in our previous answer.

[21] https://www.professionalstandards.org.uk/what-we-do/accredited-registers
[22] https://www.professionalstandards.org.uk/what-we-do/accredited-registers

3. Culture of Safety/whistleblowing

Recommendation 1. "Culture of safety: Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns.

Action 1.1: Boards should ensure that progress in creating and maintaining a safe learning culture is measured, monitored and published on a regular basis.

Action 1.2: System regulators should regard departure from good practice, as identified in this report, as relevant to whether an organisation is safe and well-led."

(From the Freedom to Speak Up Review, 2015)

3.1 Cultural issues are repeatedly identified by inquiries and reviews as a factor in major failings, but so far, no recommendations have succeeded in addressing them.

3.2 The Government accepted all the recommendations from the 2015 Freedom to Speak Up Review in full and took steps soon afterwards to establish freedom to speak up guardians in individual Trusts as well as the role of National Guardian hosted by the Care Quality Commission. This was a positive development, but the regular emergence of patient safety issues connected to poor culture shows that challenges remain. Debates around the Lucy Letby case have shed further light on the fact that staff in many Trusts still do not feel supported to raise concerns when things have gone wrong, or in some cases feel victimised for doing so.

3.3 It is worth acknowledging that this is a hugely complex policy area, in which it can be hard to identify individual underlying causes, and effective ways of bringing about tangible improvements. We nonetheless offer in the following paragraphs some suggestions that we believe could help.

Tackling toxic cultures

3.4 A significant number of NHS staff report experiencing harassment, bullying, or abuse from colleagues.[23] Alongside this, discrimination remains a major issue: in 2022, NHS staff from ethnic minority groups were over twice as likely to experience discrimination than white staff.[24] The BMA 'Sexism in Medicine' report 2021 found that 91% of female doctors experienced sexism at work, with 56% experiencing unwanted verbal conduct, and 31% experiencing unwanted physical conduct. A 2023 study found that almost 1/3 of female surgeons have been sexually assaulted.[25]

3.5 Against this backdrop, and with mixed messages from leaders about tackling these sorts of issues,[26] it is unsurprising that efforts to foster a culture of safety and learning have floundered.

3.6 In our view, a concerted effort is needed across the NHS, independent sector and social care, in partnership with wider stakeholders and with support from government, to tackle bullying,

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[23] According to the 2022 survey, around 1 in 10 experienced this from managers, and nearly 1 in 5 from other colleagues: https://public.tableau.com/app/profile/piescc/viz/ST22_national_full_data_2023_03_09_FINAL/Aboutthissurvey .

[24] https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/nhs-staff-experience/nhs-staff-experiences/latest/

[25] https://academic.oup.com/bjs/article/110/11/1518/7264733?login=false

[26] https://www.bmj.com/content/383/bmj.p2450.full

harassment and discrimination. This should include an evaluation of the effectiveness of previous/current initiatives intended to address these challenges.

Resolving the tension between safety cultures and individual accountability

3.7 We are fully supportive of moves to improve workplace cultures within the NHS, and to create spaces in which people feel able to speak up and raise concerns. In addition to local initiatives, such as the pioneering work by NHS Mersey Care,[27] we are aware of two significant national initiatives that fall under this bracket: the Health Services Safety Investigations Body (HSSIB) safe spaces approach to safety investigations,[28] and the new Patient Safety Incident Reporting Framework (PSIRF).[29]

3.8 We do however have some concerns about how these approaches are meant to intersect with arrangements for individual accountability, and particularly professional regulation, which relies on information being available and shared about the actions of individuals. Investigations into major failings in care often identify information not being shared with the right people at the right time as a contributing factor – and there is a risk that in an effort to promote learning, avoid 'blame' and to protect disclosures, barriers to the free-flow of safety-critical information are being erected.

3.9 We are in the process of arranging discussions with relevant stakeholders to try to iron out these tensions, so that fair individual accountability can become an integral part of safety cultures.

Greater accountability at management level within the NHS

3.10 As noted in our comments above, previous attempts to strengthen accountability arrangements for managers within the NHS appear to have failed. Given managers' key role in shaping culture and promoting safety, any improvements in this area should help create a better culture and safer care.

Greater cohesion between teams and professions

3.11 As mentioned above, having different codes for different professional groups may be counter-productive when trying to foster cohesion, teamwork, and a shared understanding of acceptable behaviours. For example, while all regulators address discrimination in their codes, the strength of the wording they use varies. Some require registrants actively to challenge discriminatory behaviour, other wording focuses on respecting and providing for diversity and difference.[30]

3.12 Our suggestion of a common code of conduct across health and care professions could help embed a consistent set of behaviours and a more positive workplace culture. This could be extended to managers within the NHS.

Further embedding the duty of candour

3.13 Openness and honesty when things have gone wrong are key to fostering a culture of learning and safety, and so we welcome the recently announced DHSC review of the statutory duty of candour.[31]

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[27] https://www.merseycare.nhs.uk/working-us/our-just-and-learning-culture
[28] https://www.hssib.org.uk/news-events-blog/reviewing-our-new-powers-and-how-they-will-impact-you/
[29] https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/
[30] https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/safer-care-for-all-solutions-from-professional-regulation-and-beyond.pdf?sfvrsn=9364b20_7

3.14 The review should, in our view, consider how this duty links with the professional duty of candour, as there are differences and health and care professionals must comply with both – and the implementation of the professional duty is not without its issues.[32] It will also be important to consider *why* the duties of candour may not be embedding as expected or hoped, as the barriers to openness are multiple and complex.[33]

Need for leadership to bring about action on cultural issues

3.15 Our proposal for a Health and Care Safety Commissioner is relevant here. The cultural issues affecting patient safety are precisely the sort of cross-cutting problem we would expect a Commissioner to be able to take on. They would be in a prime position to identify the influences on culture and bring together the different parties to effect change.

3.16 We support the decision of the Patient Safety Commissioner (PSC) for England to take a broad interpretation her role, including a focus on NHS culture.[34] However, as we noted in our framing remarks, there are legislative constraints on the remit of the PSC, and we would urge the Government to broaden it out to patient safety more generally.

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[31] https://www.gov.uk/government/publications/duty-of-candour-review-terms-of-reference#:~:text=It%20means%20that%20when%20something,possible%20and%20a%20meaningful%20apology.
[32] https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/telling-patients-the-truth-when-something-goes-wrong---how-have-professional-regulators-encouraged-professionals-to-be-candid-to-patients.pdf?sfvrsn=100f7520_6
[33] https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/candour-research-paper-2013.pdf?sfvrsn=5b957120_8
[34] https://www.patientsafetycommissioner.org.uk/our-work/priorities/