Executive summary - Safer care for all – solutions from professional regulation and beyond

There have been many improvements in health and care professional regulation over the last two decades, leading to greater transparency, better governance and a clear focus on public protection. However, the disheartening recurrence of failings indicates that significant challenges remain in the quality and safety of health and social care across the UK.

Our report, *Safer care for all – solutions from professional regulation and beyond,* examines a selection of key issues from the perspective of professional regulation, across four key themes:

- tackling inequalities
- regulating for new risks
- facing up to the workforce crisis
- accountability, fear and public safety.
- These are big problems, and we do not have all of the answers. However, our key recommendations provide possible ways forward, to cut across organisational boundaries in a fragmented health and care landscape.

As well as the recommendations for others, and our own specific commitments, we will use our oversight role to encourage co-operation, collaboration, and coherence across the system. In doing so, we will attempt to overcome some of the challenges inherent in improving such a complex system.

We will also try to influence Governments to take action within their jurisdictions, starting with the current legislative reforms to the regulators we oversee.

The issues we have identified in our report lead to one, overarching conclusion – that the UK needs a more robust approach to ensuring that health and social care are safer for everyone, overseen by people focused on this aim, with the tools to realise it.

Our overall recommendation, therefore, is that:

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.

This summary sets out our main findings, recommendations, and commitments as the Professional Standards Authority, in support of safer care for all.

No more excuses: tackling inequalities in health and care professional regulation

There are major inequalities in healthcare with disparities in how groups of patients and service users gain access to, and experience services. Staff also face inequalities and discrimination in the workplace, and within the regulatory process, which can lead on to patient safety issues.

Regulators and registers are alive to these issues but are still to resolve the disproportionate representation of groups with protected characteristics throughout the regulatory process.

Patients and service users sharing one or more protected characteristics may be more likely to experience poorer outcomes and may be vulnerable to major failures of care. However, there is little understanding of the demographic profile of complainants or the potential barriers to complaining.

Professional regulation and registration alone will not solve the wider societal problem of inequalities. However, regulators and registers are in an influential position with their oversight of a professional or practitioner's journey from training through to registration and practice.

There are further areas where regulators, registers and the Authority itself must do more to bring about change, and we need further debate and discussion around the role of health and social care professionals in tackling discrimination and health inequalities.

Recommendations:

We recommend that:

- 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
- 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
- Regulators and registers review how their fitness to practise processes and guidance address allegations of racist and discriminatory behaviour
- Demographic data on complaints made to the health and care services across the UK is recorded and made available for all bodies to use.

The Commissioner role we discuss in our report could also address the following recommendation:

- Demographic data on complaints should be analysed at a cross-sector level to identify disproportionate impacts and risks to protected groups.

The Authority's commitments to safer care

- We will ensure that the application of our Equality, Diversity, and Inclusion (EDI) standards for regulators is stretching and stimulates continuous improvement.
- We 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.
- We will look at our own processes to ensure that we are not reinforcing or exacerbating inequalities in the regulatory system. Our Equality, Diversity and Inclusion Action Plan: 2022-23 outlines a range of commitments we have made both in relation to our internal processes and our external role.
- We will use our oversight role to encourage co-operation, collaboration, and coherence across the system, noting the inherent challenges in trying to address safety concerns when it is so fragmented.

The future is now: keeping pace with changes in how care is funded and delivered

There are huge changes underway in the provision of health and care with an increase in high street provision and increasing use of technology. These models of care are not all new, and are unevenly spread between UK countries and sectors. The prevalence of commercial providers and the conflicts of interest this can bring, along with online services, and new and innovative models of care, represent a growing trend away from established models of provision. They also open up new risks to patients and service users, and put professionals in difficult positions, where commercially-focused drivers cut across professional judgement, or new technologies blur lines of accountability.

As the delivery of healthcare continues to evolve and change, regulators need to be able to meet the challenges head-on with agility.

By and large, healthcare professional regulators are aware of the issues and are already taking action to manage risks and protect the public. However, they are sometimes reluctant to intervene (for example in matters relating to commercial practices) even where there is a legitimate case for doing so. This is partly due to the risk of challenge if there is no specific duty to act. They are also hampered by outdated and overly prescriptive legislation, and some lack the powers they need to protect the public effectively.

The four UK Governments' current programme of regulatory reform may give regulators more flexibility to respond to emerging risks. It presents an ideal opportunity to take a fresh look at some of these issues and assess whether they need to do more to address them. Governments and regulators should aim to be ahead of the curve in respect of new delivery models, rather than constantly struggling to catch up.

Appropriate scrutiny and action on these issues is made more challenging by the number and range of bodies involved. No one body or organisation is able to take a bird's-eye-view of the emerging risks to patients and service users and identify possible solutions. We need more reliable mechanisms for anticipating changes that open up public protection gaps across the sector, in partnership with patients and service users – it should not be left to individual bodies within their limited remits.

Recommendations:

We recommend that:

- Governments use the current healthcare professional regulation reform programme to:
- **a.** Review the adequacy and effectiveness of the powers of regulators with a role in regulating businesses
  b. Consider whether there is a case for extending business regulation powers to all regulators whose registrants work in 'high street' practices
  c. 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.
- 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.
- Governments, regulators and registers review how they will determine the lines of accountability for new technologies used in health and care.

We have also identified a gap that would ideally be filled by the Health and Social Care Safety Commissioners:

- We recommend the development of reliable mechanisms for anticipating changes in service provision that open up public protection gaps across the sector, and identifying ways to address them.

Facing up to the workforce crisis and regulation's future role

The UK is facing a serious health and social care workforce shortage which it must address if care is not to suffer, and patients and service users come to harm. To address shortages in the statutorily regulated workforce, Governments, regulators, and employers must succeed in retaining existing professionals, and recruiting and training additional ones.

The latter may mean regulators challenging conventions about education and training, and Governments setting up clear pathways. Another option may be to look at those working in unregulated roles who are already helping to address staffing shortages and consider whether they, with appropriate safeguards, might be able to play more of a role. Professionals will also need to have the skills required to prepare them for the needs of different groups of patients and service users and future changes in the delivery of health and care.

Addressing these issues will not be easy. It takes time and money to train more health and care professionals, it may be hard to incentivise existing staff to stay or to recruit quickly enough to relieve pressures. A coordinated, coherent approach is needed to up-skill the workforce to prepare them for new models of care and provide care to diverse groups of patients and service users, and address emerging risks in healthcare provision. These problems need resolving quickly, and safely – with regulatory arrangements playing a key part.

Recommendations

We recommend that:

- 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.
- 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.
- There should also 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.
- 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.
- 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 that could form part of the Health and Social Care Safety Commissioner's role:

- Identifying risks relating to workforce shortages and how practitioners are regulated. This would help to inform the regulatory strategies

The Authority's commitments to safer care

- The Authority will use its oversight role, expertise and convening power to support the development of these regulatory strategies by the UK Governments.

Accountability, fear, and public safety

It is unclear how we can make individual accountability work in a system that is safe for patients and service users, and fair to professionals. The big push towards learning and just workplace cultures is vital in achieving safety aims, and allowing professionals to practise without fear of being unfairly punished if things go wrong. There is, however, a risk of individual accountability being overlooked. The Ockenden report highlighted the simultaneous desire to learn from harm, and impose appropriate accountability for unacceptable failures.

Individual accountability is crucial in keeping people safe in health and care, and professional regulation is integral to this framework. This should be understood when inquiries and reviews investigate major failings.

We have to acknowledge that aspects of professional regulation will always be feared to an extent – and fitness to practise in particular. But there are things regulators can do to alleviate this. Professionals' fear of being unfairly blamed is partly driven by misunderstandings about the role of the regulators, so action taken by regulators needs to be fair and transparent, with clear explanations of how and why decisions are taken. Employers also have a key role in addressing issues locally, communicating the regulator's expectations and referring members of staff where there are concerns.

Just culture approaches to patient safety, such as that promoted by NHS England, rightly include questions about individual responsibility, and where it may be necessary to look more closely at an individual's involvement in an incident. These policies should be clear – as the NHS guidance is – about when it is appropriate or necessary to refer a concern to the regulator – based on the regulator's own criteria.

We have concerns, though, about the safe spaces approach taken by Healthcare Safety Investigations Branch (HSIB) for England, because its high threshold for referral to the regulator does not match the regulators' own. It also seems to run counter to the professional duty of candour that requires professionals to be open and honest when things have gone wrong.

We should acknowledge that well-meaning, new, national approaches to safety and redress can cut across existing patient safety mechanisms. Governments should therefore proceed with caution and review them for unintended consequences.

Although the following recommendations may go some way to alleviating some of the tension between accountability and just learning cultures, we recognise the limits of the work we have been able to do on this. To do justice to the complexity – and urgency – of this issue, we need to have an open, sector-wide conversation, with input from patients and service users, professionals, employers, and many others.

Recommendations

We recommend that:

- 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.
- 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.

Recommendations that could form part of the Health and Social Care Safety Commissioner's role:

- There should be an independent mechanism for centralised coordination and oversight of public inquiries.
- Policy checks should be introduced to ensure that any new national approaches linked to patient and service user safety are coherent with, and do not undermine, existing mechanisms.

The Authority's commitments to safer care

- 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.

Safer care for all: an overarching safety body

Our report illustrates how fragmented the landscape we are operating in is – health, social care, and four countries, each with complex patient and public safety mechanisms spanning numerous different bodies.

For too long, individual organisations with different and specific remits have been expected to work together to address workforce and patient and service user safety issues. This approach is structurally flawed as there is generally no accountability for joint working and collaboration. Bystander apathy and differing organisational priorities also present significant barriers. Everyone understandably looks at the problem through the lens of their own remit, but no one has the overview.

This applies to Inquiries too. While they focus on extreme cases, they are a key driver for change. The Inquiries into failures in children's heart surgery at Bristol Royal Infirmary[9] and the Shipman murders[10] transformed the way professional regulation works. The current system is still imperfect, but it has improved greatly when compared to the previous professional-dominated framework. Inquiries are a mixed bag of statutory and non-statutory, with significant variations in remit that are often unexplained. As far as professional regulation is concerned, some have a strong focus on the actions of regulators (Shipman, Mid-Staffordshire) while others do not (Paterson, Ockenden).

Recommendation

We recommend that:

- Each UK country has 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.
- The commissioners should sit above all other health and care organisations, spanning public as well as private provision. They would also be independent of Governments, and transparent in both their approach and outputs. From this unique oversight position, and working closely with key stakeholders including service users, they would fulfil the following roles:

Risk intelligence

- Review data on risks produced by other organisations to identify national or local trends
- Carry out meta-analyses of inquiry findings to identify trends
- Report specifically on any inequalities concerns arising from the safety data.

Expertise

- Make recommendations for addressing risks identified through the intelligence function
- Identify gaps in the patient and service user safety landscape, and make recommendations for addressing them
- Identify gaps in data collection and make recommendations for addressing them
- Recommend ways in which data collection can be improved and harmonised across the sector
- Signpost people with complaints to the correct organisation (and record concerns as part of its intelligence role)
- Carry out policy checks to ensure that any new national approaches linked to patient and service user safety are coherent with, and do not undermine, existing mechanisms to the ultimate detriment of patient safety.

Inquiries secretariat

- Coordinate inquiries and reviews into health and care failings to bring greater coherence to terms of reference and approaches
- Report on progress against inquiry recommendations so that lessons are learned and mistakes are not repeated.

When it comes to the problems in this report, the Commissioners would help to identify:

- Risks affecting protected groups differentially [Tackling inequalities],
- Emerging risks in how care is funded and delivered that are going unaddressed [Regulating for new risks],
- Risks relating to workforce shortages and how practitioners are regulated [Facing up to the workforce crisis], and
- Unintended risks arising, or likely to arise, from existing, or proposed, national approaches to patient and service user safety [Accountability, fear, and public safety].

Safer care for all – solutions from professional regulation and beyond shows how the key issues of inequalities, new risks, the workforce crisis and accountability all lead us to this inevitable recommendation.

Without a role whose only responsibility is to make the system safer, we will each continue to look at patient and service user safety through our own lens – and potentially compromise public protection.

Work with us towards safer care for all.