Professional Standards Authority for Health and Social Care

Response to Health and Social Care Committee call for evidence on NHS leadership, performance and patient safety

March 2024

1. Introduction

1.1 This is the evidence submission from Professional Standards Authority (PSA) to the Health and Social Care Committee's call for evidence on NHS leadership, performance and patient safety.

1.2 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.

1.3 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. We have commented on those where we think we have a useful contribution to make. We would be happy to provide oral evidence if required.

2. Detailed comments

How effectively does NHS leadership encourage a culture in which staff feel confident raising patient safety concerns, and what more could be done to support this?

2.1 Repeated inquiries and reviews suggest that there are at least pockets of poor culture within the NHS, which create patient safety risks and make it more difficult for staff to raise concerns where they arise.

2.2 This was highlighted by Sir Robert Francis KC's Freedom to Speak Up Review (2015).[1] Action taken in response, to encourage leadership to support a safe learning culture, includes the creation of Freedom to Speak Up Guardians within individual Trusts, as well as the role of National Guardian. While these measures may have led to some improvement, the recurrence of patient safety concerns linked to poor culture, demonstrate that there is still progress to be made.

2.3 The Lucy Letby case is part of a persistent pattern of failings, involving staff not feeling supported to raise concerns when things have gone wrong, and in some cases feel victimised for doing so.

2.4 The theme of how to improve culture within the NHS in order to improve patient safety came out strongly from the PSA's 2022 report *Safer care for all*,[2] in

[1] http://freedomtospeakup.org.uk/the-report/
[2] https://www.professionalstandards.org.uk/safer-care-for-all/safer-care-for-all-recommendations-and-commitments

particular in the chapters on inequalities. In the report we describe a system where both staff and patients are routinely affected by poor behaviours, such as discrimination, which can contribute to the major failures of care that have become all too common.

2.5 To address the question of what more professional regulation can do to support improvements in culture as part of our commitments made in *Safer care for all*, and in the wake of the findings from the Letby case, the PSA has commissioned research with patients and healthcare professionals to explore whether a common code of conduct for all health and care professionals might be beneficial. This code could extend to roles covered by the accredited registers (of non-statutory practitioners), and, in light of recent calls for greater accountability, non-clinical senior managers, too.

2.6 Once this research is finalised, the PSA plans to carry out a scoping review considering such questions as how a common code might help reduce the risk of inconsistency in regulatory decision-making by holding different occupations in health and care to the same standards of behaviour; or foster a shared sense of identity and purpose. This in turn could contribute to improving workplace cultures.

2.7 Given the relevance of this work to the areas of interest for this Inquiry we would be happy to keep the Committee updated on progress.

What has been the impact of the 2019 Kark Review on leadership in the NHS as it relates to patient safety?

2.8 The recommendations from the Kark Review (2019) largely focused on strengthening the pre-existing Fit and Proper Person Test (FPPT).[3] They recommended strengthening the requirements including setting up a barred list, but did not call for statutory regulation for NHS directors. A revised FPPT framework has been in place since September 2023. With this work ongoing, it is difficult to assess its impact on leadership and patient safety at this stage. However, given that the FPPT is aimed only at Board level Directors within the NHS, its impact is necessarily limited in the context of the current wider debate about regulation of NHS managers.

2.9 We understand that NHS England is also considering how to take forward some of the outstanding Kark recommendations, as well as those of the Messenger review of leadership in the NHS.

2.10 In the PSA's own evidence to the Kark review, we highlighted some of the challenges inherent in bringing about improvements in this area and cautioned against pursuing solutions which were not appropriately targeted at areas of outstanding risk. In our thinking linked to the current debates around NHS manager regulation, we have also noted that proposals to improve NHS management and leadership to date have not always been clear about *which groups* within NHS management pose specific patient safety risks, in order to identify what the best mitigation would be. This has potentially reduced their impact.

What progress has been made to date on recommendations from the 2022 Messenger Review?

2.11 We are not close enough to comment on this.

[3] https://www.gov.uk/government/publications/kark-review-of-the-fit-and-proper-persons-test

How effectively have leadership recommendations from previous reviews of patient safety crises been implemented?

2.12 Leadership recommendations from previous reviews and inquiries into patient safety failings have sometimes been implemented in an incomplete or piecemeal fashion. This includes the response to recommendations from the Kennedy Review into children's heart surgery at Bristol Royal Infirmary (2001)[4] and the Francis Inquiry into failings at Mid-Staffordshire (2013).[5]

2.13 Common problems hampering effective implementation include old frameworks not being explicitly revoked when bringing in new measures and a lack of clear definition of the problem, making it harder properly to target any further measures. In particular, it has not always been clear who the target groups are, or whether concerns related to lack of competence and accountability gaps.

2.14 In 2001, 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*.' The Government turned down this recommendation deeming it impractical. [6] It proposed a series of alternative measures, including a code of conduct, which became the Code of Conduct for NHS Managers, to be incorporated into NHS contracts.[7]

2.15 In 2011, the Government once again tried to address 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 to develop *Standards for Members of NHS Boards and Clinical Governing Groups* which were published in 2012. These Standards were accepted by the Secretary of State, and originally intended as the foundation for a review of accountability arrangements for NHS senior leaders, however this was never taken forward.

2.16 In 2013, the Francis Inquiry into failings at Mid Staffordshire NHS Foundation Trust recommended: '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.'

2.17 The Inquiry did not go as far as recommending statutory regulation due to lack of stakeholder appetite. 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 Fit and Proper Person Test (FPPT) was created for NHS Board Directors. However, the FPPT was never formally linked to the PSA's Standards as seemed to be originally intended. As mentioned above, in 2019 the Kark Review recommended

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[4] 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

[5] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

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

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

strengthening the requirements of the FPPT, but did not call for statutory regulation for NHS directors.

2.18 Neither the PSA's Standards, nor the FPPT, whether in its original or updated form, were aimed at managers below Board level – this part of the recommendations does not appear to have been addressed at all. Measures arising 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, or a full regulatory scheme like that for doctors. The PSA's Standards were never put on any formal footing and appear to have fallen out of use.

2.19 For other managers, nothing formal has been put in place. The NHS's own Standards for NHS Managers (2001) have not, to our knowledge, been officially taken out of circulation, and some NHS Trusts still have them on their website. As noted, old frameworks are rarely explicitly revoked, or decisions made or communicated about their status.

2.20 NHS England is considering how to take forward some of the outstanding Kark recommendations, and those of the Messenger review of leadership in the NHS, and also has a range of resources available for Board members and managers.

How could better regulation of health service managers and application of agreed professional standards support improvements in patient safety?

2.21 The recurrence of concerns relating to the regulation of health service managers and the potential impact on patient safety suggests that further action may be needed. However, to ensure that more or different regulation would add value, policy makers should take steps to clearly understand the problem.

2.22 This should involve distinguishing between the constituent groups that make up 'NHS managers' in order to define the target groups, and quantifying and qualifying the public protection risks attached to the different groups, taking into account existing mitigations.

2.23 This is the approach we define in *Right-touch regulation* as a way of understanding the nature and scale of risk to support decisions made within regulatory policy making. Our *Right-touch assurance (RTA)* methodology which uses these principles was developed specifically to advise on questions relating to whether a healthcare profession or occupation should be regulated.[8] The Government consulted in 2022 on criteria for deciding which professional groups should be regulated. This consultation drew on our work on RTA, and was rooted in the principle of regulating only where necessary to protect the public from risk of harm. This remains a useful framework to support further decision-making relating to regulation of managers to ensure that any action pursued is targeted and effective.

2.24 There is a range of different options that could be explored to raise standards, and strengthen accountability for managers, including:

[8] https://www.professionalstandards.org.uk/publications/detail/right-touch-assurance-a-methodology-for-assessing-and-assuring-occupational-risk-of-harm#:~:text=Right%2Dtouch%20assurance%3A%20a%20methodology%20for%20assessing%20and,assuring%20occupational%20risk%20of%20harm&text=We%20have%20developed%20a%20new,occupations%2C%20published%20in%20October%202016.

- Further employer mechanisms to raise standards of competence and/or prevent re-employment
- A PSA accredited register (voluntary)
- A negative register (allowing managers to be added to a list if they have been barred from practice)
- Statutory regulation (only if clearly indicated by the level and type of risk).

2.25 As mentioned above, defining the problem – whether about standards or accountability, will be central to identifying the right solution.

2.26 Statutory regulation, due to the likely cost, complexity and potential unintended consequences should only be used when the case has been clearly made. Other negative effects of the inappropriate use of statutory regulation could include the introduction of barriers to mobility and the import of skills, the issue of defining who is included, and the challenge of dual registration (as some clinical managers will already be registered with an existing professional regulator). It is also worth noting that statutory regulation for the healthcare professions is, with one exception, UK-wide. Regulating healthcare leaders in England only could have unintended consequences relating to mobility of staff around the UK.[9]

2.27 In our view, there is a need to enhance the professional development and accountability of managers.

2.28 Without having carried out a full assessment of risks the PSA cannot state firmly what kind of further regulation would be appropriate or effective in improving patient safety. We would therefore recommend, as first steps, exploration of:

- ways to strengthen employment practices and mechanisms, or
- the use of an external voluntary register, which could become a requirement of employment.

2.29 Neither option would require legislation. They would also allow the gathering of further evidence of risk of harm and help to establish how best to support improvements in patient safety.

2.30 We would also recommend the development of a management career framework, based on competencies, a code and standards, to underpin either more robust employment practices, or a non-statutory register. We wish to highlight to the Committee the importance of these supportive frameworks. Often political attention is focused on accountability mechanisms, but it is usually these positive steps to give everyone the tools they need to do their jobs properly that make the biggest difference.

2.31 Whatever action is pursued it will be important to include a thorough review of existing frameworks, guidance documents, codes and so on, applying to NHS managers, to establish what should be retained, revived or retired, as part of developing an effective solution towards strengthening accountability and upholding standards.

[9] We have considered the question of regulation of a group in fewer than all four UK countries in more depth. See: https://www.professionalstandards.org.uk/publications/detail/regulating-an-occupation-in-fewer-than-all-four-uk-countries

How effectively do NHS leadership structures provide a supportive and fair approach to whistleblowers, and how could this be improved?

2.32 We do not have the expertise to comment, except to say that the continued recurrence of cases involving whistleblowers who do not appear to have been treated fairly, suggest that there is work still to do to improve support for whistleblowers.

How could investigations into whistleblowing complaints be improved?

2.33 We do not have the expertise to comment.

How effectively does the NHS complaints system prevent patient safety incidents from escalating and what would be the impact of proposed measures to improve patient safety, such as Martha's Rule?

2.34 We have recently been carrying out work looking at barriers to complaints arising from observations made in our 2022 report *Safer care for all.*

2.35 Echoing our previous comments, the continued recurrence of significant patient safety failings suggests an ongoing problem with using complaints information to improve safety and prevent escalation of incidents. Indeed, many patients and families involved in recent inquiries and reviews speak of immense challenges in making their voices heard and having to fight to expose sometimes shocking events and failures.

2.36 We have recently run two events looking at barriers to complaints with patient and service user groups and individuals, and wider stakeholders, one of which we ran jointly with the Parliamentary and Health Service Ombudsman (PHSO). Attendees painted a concerning picture of a complex and impenetrable system that is difficult for patients to access and when they do manage to raise concerns, there is little reassurance or evidence that their complaints will be acted upon to improve the system.

2.37 We are also aware of changes to the way in which the NHS in England investigates patient safety incidents. We welcome the shift to PSIRF,[10] which should help to maximise learning from mistakes, and reduce unnecessary bureaucracy. It may have unintended consequences, however, on what information is available to patients and families regarding the circumstances of incident affecting them, which may in turn affect their ability to bring a complaint. We recommend that these potential knock-on effects are monitored.

What can the NHS learn from the leadership culture in other safety-critical sectors e.g. aviation, nuclear?

2.38 We do not have the expertise to comment in detail on what the NHS can learn from other sectors with regard to leadership. However we are generally supportive of widespread learning, where relevant, across safety critical industries. Any learnings should be appropriately sense checked for their relevance and appropriateness to healthcare.

[10] https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/

3. Further information

3.1 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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