Patient Safety Commissioner – Principles of Better Patient Safety Consultation

Principle 1- Create a culture of safety

Leaders have a responsibility to lead by example to inspire a just and learning culture of patient safety and quality improvement. They set out to keep people safe, supporting continuity of care, and foster a culture of compassion, listening and restorative practice.

To what extent do you agree or disagree with the principle?

Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree

You can provide a brief explanation (250 words):

While we agree with principal, leaders often work in under-resourced environments where time for learning and training might be limited which can be a barrier to improvements in culture. In such an environment avoiding blame is even more important and NHS leaders have to lead by example and move from a blame-based approach, which can lead to a culture of fear for NHS staff. The current focus on assigning blame stifles learning, causes poor levels of recruitment and retention, and stops organisations from looking at systematic failures such as underfunding of services. This culture of fear can disproportionately be felt by certain groups, based on evidence they are more likely to face harsher consequences for potential errors in patient care, for example doctors who earned their primary medical qualification outside the UK.

In addition, a BMA survey found that confidence in raising concerns differs by ethnicity. Ethnic minority doctors were almost twice as likely as white doctors to say that they would not feel confident in raising concerns about patient care for various reasons, including distrust in a system that does not address incidents of discrimination. This fear of speaking up impacts on patient safety.

A just and learning culture addresses system failings and pressures, rather than putting individuals through unnecessary procedures. We want to see a culture which is driven by learning, care and collaboration; we believe this is best for patients and best for the workforce. These asks are set out in the BMA's Caring, Supportive, Collaborative report.

Principle 2 – Put patients at the heart of everything

Leaders put the patient at the heart of all the work that they do, with patient partnerships the default position at all levels of the organisation. They consider the needs of patients, working collaboratively with them to identify risks, and deliver person centred care. Leaders ensure that the patient voice is central to fully informed consent and shared decision making.

To what extent do you agree or disagree with the principle?

Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree

You can provide a brief explanation (250 words):

Patients from all backgrounds should be actively, equitably involved in decisions about all aspects of their healthcare and must be given resourced, inclusive time to be heard. Both the GMC and BMA have long-standing guidance on the process of seeking consent and the steps that should be followed in order to obtain valid and informed consent from patients. Both sets

of guidance emphasise the importance of listening to patients and a shared decision-making process. The BMA's toolkit on consent states that the information patients share is as important as the information given to them. Patients also have the right to know who is treating them and with what level of qualification. Patients are not always aware where they are seeing a Medical Associate Professional (MAPs) and the limits of this role. Transparency around this is important in informed consent.

Coproduction with patients from all backgrounds across decision-making groups is important to ensure patients are at the heart of all decisions, across all healthcare settings. Settings that include but are not restricted to primary and secondary care, care homes, immigration and detention centres and prisons. Patient representatives must be supported cand well-informed to ensure their voice is loud. It is also important that patients are involved when errors happen to inform learning.

We suggest removing the word 'fully' as the duty is to comply with law and guidance on informed consent. Giving patients all conceivable information can be harmful without context and interpretation.

Principle 3 – Treat people as equals

Patients are treated with fairness, respect, equality, and dignity. Leaders incorporate the views of all, and proactively seek and capture meaningful feedback from patients, families, and staff. Feedback is acted on, to embed equality of voice.

To what extent do you agree or disagree with the principle?

Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree

You can provide a brief explanation (250 words):

We agree that treating patients, families and staff from all backgrounds as equals (with attention to equity) is essential for better patient safety.

BMA's research into racism and sexism have found that not all doctors' opinions are valued the same, this has detrimental effects on patient safety. A doctor's grade can also impact how they are treated; SAS doctors have shared with the BMA that their expertise is not always valued or represented. Leaders must ensure they listen to doctors irrespective of their background when it comes to patient safety and service design.

It is also the case that characteristics of a patient contribute significantly to health inequalities and preventable deaths, partly due to a difference in treatment. For example, Black women are almost four times more likely to die from childbirth than White women, and women in the most deprived areas are 2.5 times more likely to die than those in the least deprived areas. We need to ensure that leaders are pro-active in addressing the root causes of these inequalities, including addressing discriminatory attitudes in the NHS workforce, fair allocation of resources and taking down the barriers to accessing healthcare for certain communities.

The BMA has long-raised concerns that patients in Immigration Removal Centres are not treated equally compared to the rest of the population. Limited staffing and variability in the quality of

care impacts their health and wellbeing. Doctors must be resourced and supported to deliver quality healthcare and granted autonomy to raise safeguarding concerns.

Principle 4 – Identify and act on inequalities

Health inequalities, and the drivers of health inequalities, are identified and acted upon at every stage of healthcare design and delivery.

To what extent do you agree or disagree with the principle?

Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree

You can provide a brief explanation (250 words):

Health inequalities are prevalent in society but are largely avoidable. Tackling the worsening poverty gap; injustice, and discrimination are urgent matters if we want to address health inequity. Health services play a leadership role in addressing these issues, particularly in removing barriers to healthcare.

One significant driver of health inequality is the extent to which someone feels able to use health services. Marginalised groups have historically received, and too often continue to receive, poorer NHS care. Marginalised groups are also often excluded from research, and indeed there is a history of exploitation in research. All of which can lead to unsafe care. It also leads to a justifiable mistrust of health services, which can manifest in poorer access to healthcare. The unequal uptake of the Covid-19 vaccine amongst certain ethnic minority groups is a clear example of what can happen where trust is not rebuilt. Health services must be equitably resourced and focus their efforts on addressing the historic mistrust of health services amongst marginalised groups, including ethnic minority groups let down by institutional racism, and reduce barriers to healthcare.

The use of artificial intelligence (AI) in healthcare is of increasing interest. If used ethically, and equitably, AI could bring positive change. However, we would encourage the commission to consider the risk that AI, particularly bias, might exacerbate health inequalities.

There must be clarity on who is responsible for action here. Systemic pressures can prevent action in some cases; however much leaders or doctors might want to act.

Principle 5 – Identify and mitigate risks

Targeted and coordinated action is directed to mitigate patient safety risks. Leaders escalate new and existing risks to healthcare commissioners and regulators. Staff are supported and empowered to proactively identify risks, hazards, and improvements.

To what extent do you agree or disagree with the principle?

Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree

You can provide a brief explanation (250 words):

A BMA survey of over 7,800 doctors found only 48% would always feel confident in raising concerns, 38% would only sometimes feel confident, and 10% would not feel confident at all. To address this, we the following recommendation: ‘all systems regulators should ensure employing organisations put in place measures that support culture change necessary to

encourage staff wellbeing and demonstrate that doctors are aware of, and feel comfortable using, mechanisms for raising concerns.'

As highlighted in our 2022 report, *Brick by Brick*, the condition of NHS estates is undermining the quality and safety of patient care. 43% of doctors surveyed said that conditions in their workplace have a negative impact on patient care. Given the subsequent growth in the total NHS maintenance backlog – a record £11.6bn in England (2022/23) – this issue appears likely to have worsened. Patients, staff, and leaders must be able to report estates concerns and know that funding will be provided to address them.

The BMA has raised concerns around the risk to patient safety associated with the rapid expansion of MAPs roles. MAPs must never be used to plug medical staffing shortages, this risks MAPs working outside their competencies and with inadequate supervision. Patients and staff must be supported to raise concerns where they identify risks associated with the use of MAPs in in all healthcare settings. Until there is agreement on scope of practice, regulation, supervision, to ensure safe care, MAP expansion should be halted.

Principle 6 – Be transparent and accountable

Leaders create a culture where there is honest, respectful, and open dialogue and where candour is the default position. This work enables a continuous improvement cycle and ensures that patients and staff do not face avoidable harm due to a cover up culture.

To what extent do you agree or disagree with the principle?

Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree

You can provide a brief explanation (250 words):

The BMA's 2018 research (*Caring, supportive, collaborative: Doctors' vision for change in the NHS*) found that doctors did not feel supported by leadership to raise concerns. We agree with this principle and have, as a result of our research, called for a full reform of the CQC's approach to regulation and inspection in England to address cultures of fear and address cover-up cultures. It is vital that medical error is not criminalised – to do so risks strongly discouraging doctors, teams and the organisations they work in from identifying and learning from mistakes to continuously improve patient safety.

With the increasing use of MAPs to deliver healthcare, there must be transparency for patients around which member of a healthcare team is treating a patient. Patients are often not aware who they are seeing, the limits of MAPs, or their right to see a doctor, this lack of awareness is confusing and often misleading. The lack of transparency can lead to false reassurances for patients which has been tragically evidenced as a direct patient safety issue.

Principle 7 – Use information and data to drive improved care and outcomes for patients and help others do the same

Leaders use and provide information and data of all types to drive their work, from all sources available to them. They should ensure that good quality data captures and meets the needs of all patients, including those from underrepresented groups. All staff are supported to pass on information relevant to the improvement of patient care. Best practice should be shared widely.

To what extent do you agree or disagree with the principle?

Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree

You can provide a brief explanation (250 words):

We strongly agree with the intention behind this principle but have some concerns about the wording which must be amended. Sharing patient data must be compliant with the long established legal, ethical and professional standards for protecting patient confidentiality (as set out in GMC and BMA guidance). The term 'pass on information relevant to the improvement of patient care' is ambiguous as it is unclear to whom the data will be passed on and whether this refers to the direct care of individual patients or 'secondary purposes' (eg, medical research or health service planning). Such distinctions are crucial because data collected in different contexts is subject to different legal and ethical frameworks, which require different procedures and safeguards (as per the referenced guidance).

At the heart of our position on the use of data is the fundamental principle that public and patient trust in the NHS's ability to handle data must be maintained. Patients must feel able to discuss sensitive matters with healthcare professionals without fear that the information may be improperly disclosed. Therefore, we strongly support data use to support and improve healthcare delivery when it is managed transparently and securely within robust governance processes which respect patient confidentiality.

Coproduction with patients and the public should be embedded into governance & oversight mechanisms, & across all stages of data sharing, to ensure decision-making is informed by public values, views, and expectations. Patients need to know what data is being referred to and how their data is used and safeguarded.

Which of these principles (1-7) do you consider to be of the highest importance?

Additional areas

Do you wish to highlight any other areas not covered by the draft principles that you think should be included in our final version? (250 words)

Overall, we believe that health equity could be better embedded across the principles. There must be a commitment to equity in every principle. We would also like to see a stronger mention of the importance of taking an anti-racism, anti-sexism, anti-discrimination stance when providing safe care for people from all backgrounds.

We also believe that greater clarity is needed about where responsibility for delivering the principles lies, and in particular (as an organisation representing doctors) how the responsibilities of individual doctors might appropriately be circumscribed, given the responsibilities of others (politicians, regulators, and commissioning and providing organisations in the NHS) for promoting and delivering systemic change.

Further areas of concern related to patient safety include:

- Robust ways to record patient safety concerns when raised – this is essential to help identify where procedures and systems needed to be changed
- How information is shared between healthcare workers (including between paramedics and hospital staff; healthcare staff and care home staff)

- The need for coordination between patients who pay for their own care in the private sector as a short-term measure because of NHS waits or lack of NHS care. They need a seamless way of transferring their care into the NHS.

Usefulness

Overall, how useful do you think these Principles will be as a guide for senior leaders?

Please indicate to what extent you agree or disagree with the following statements:

- The principles will be useful when taking strategic decisions.

Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree

- The principles will be useful when designing services.

Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree

- The principles will be useful when making individual decisions about patient care.

Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree

- The principles will be useful when responding to a concern from a patient.

Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree

- The principles will be useful after an adverse event.

Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree

- The principles will be useful in supporting staff development.

Strongly disagree, Disagree, Neither agree nor disagree, Agree, Strongly agree

If you wish to explain any of your answers above, please do so here (up to 400 words)

Although we agree that these principles are useful, unless senior leaders are given the resources to adequately staff and resource healthcare systems these principles will be of limited value. There must also be greater clarity on who the 'senior leaders' are.

If you wish to include any final comments, please do so here (up to 250 words)

We would like to emphasise the importance of investment and resourcing in and across the NHS to achieve safe, high-quality care for patients. It is important throughout to draw a distinction between the ideal and aspirational, and what is actually feasible in the realities of an under-resourced, understaffed NHS.

Fundamentally, a significant proportion of patient safety risks in the NHS come from lack of resource, whether personnel, medicines and devices, or estates and facilities. The voices of those who have identified a resourcing issue must be heard ultimately by the people who make the funding decisions, which is the Government of the day, so that they understand that safety is at risk. Shuffling of resources by relatively unempowered managers within a fixed funding

envelope to address the most pressing safety concern is a short-term fix and hides other harms in the process.