# **Patient Safety Principle - Analysis of Public Consultation**

1. The purpose of this analysis is to provide an overview of the responses received from respondents and how these informed changes to the final principles. It is not intended to be a complete analysis of all questions in the survey.
2. The public consultation ran from 24 July 2024 to 6 September 2024 via an online consultation platform. It was promoted on the PSC website, our socials and via trusted partners and stakeholders. We thank all the respondents for sharing their thoughts and experiences.

## **Online responses**

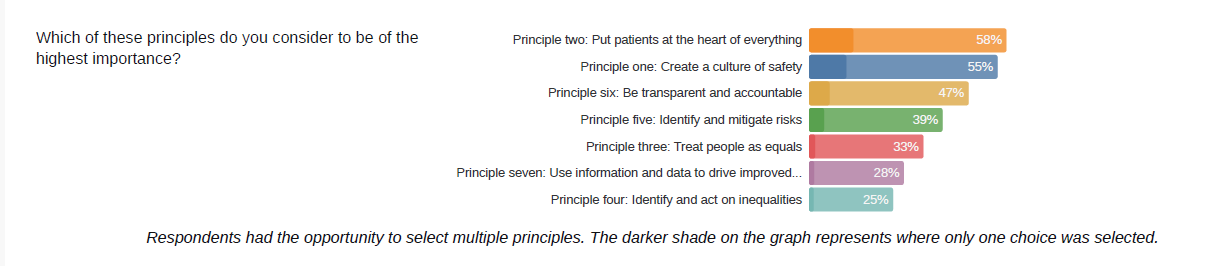
1. Of the 785 responses received via the online consultation within scope[[1]](#footnote-2) -
   1. 58% of responses came from members of the public; 31% from an individual working in health and/or social care and 11% from organisations.
   2. 78% of respondents identified as female.
   3. 86% of respondents identified as being from the White ethnic group; 4% from the Asian ethnic group; 2% from the Black ethnic group.
   4. 35% considered themselves to have a disability.

### Agreement with the principles

1. There was strong ‘positive sentiment’ from respondents (people responding ‘strongly agree’ or ‘agree’) to all seven of the draft principles. All seven principles scored a positive sentiment of 77% or above with principle 4 (identify and act on inequalities)) receiving the lowest percentage (77%). No principle received more than 10% in terms of a ‘strongly disagree’ response.
2. Several free text responses suggested that some respondents may have misunderstood the wording of the agree/disagree questions. Some responses indicated that people thought they were answering to what extent they agreed/disagreed that the draft principle was currently a reality in the health service for them, rather than expressing their view on the principle in the abstract.
3. As a result, responses, when analysed by different demographics, may partially reflect those groups’ current experiences with healthcare. For example:
   1. On age – positive sentiment in terms of agreement with the draft principles fell amongst the youngest age group that submitted responses (aged 25-29) in relation to principle 2 (50% vs 79% overall) and principle 3 (25% vs 78% overall). These two principles were headed ‘patients at heart of everything’ (principle 2) and ‘treat people as equals’ (principle 3). Conversely, support amongst those aged 80 or above was above the overall figure for both these principles.
   2. On ethnicity - positive sentiment in terms of agreement with the draft principles was lower across the board amongst those who identified as members of the Black ethnic group. For example, only 54% of those who identified as members of the Black ethnic group expressed a positive sentiment in relation to agreement with principle 3 (treat people as equals) - versus 78% overall - and principle 4 (identify and act on inequalities) - versus 77% overall. Analysis of the free text responses for this group also, however, revealed concerns about some of the wording of the draft principles, which we have taken onboard and made changes:
4. Organisations, and those who work in health and social care, were overall more positive in their agreement with the principles than members of the public across each of the principles.

### Importance

1. Respondents ranked principle 2 (patients at the heart of everything) as the most important (58%), followed by principle 1 (create a culture of safety), with the full results shown in the graphic below:



1. The order of the principles is not reflective of their relative importance. However, this data was useful when considering questions around implementation, which is why we asked the question.

### Usefulness

1. All principles scored 69% or more in terms of positive sentiment when respondents were rating usefulness. This figure is lower than the agreement questions (76% or more). People expressed the least positive sentiment about usefulness in terms of staff development (69%) and the most positive sentiment in relation to designing services (74%).
2. The free text responses suggests that this lower score was driven by concerns around implementation. Respondents expressed doubts that these principles would be useful in changing anything without further action to make them a reality, for example around workforce. They also asked for further guidance on how they could be used. These views were particularly strong amongst those from a health and care background and from organisations in healthcare.
3. As a result, we have published a guide alongside the final principles to help leaders think about how they can use these principles in their day-to-day work.

## **Consultation responses – not submitted via the online platform.**

1. In addition, responses via email and post were received. We received 16 responses via email, which were analysed and fed into the process separately from those submitted via the online platform.

## **Comments on individual principles**

### Introductory paragraphs

1. The NMC, GMC and NGO all commented that they felt that leadership was a skill that everyone has the potential to demonstrate, and that the language of ‘senior’ leaders was too narrow. NIHR SafetyNet asked whether ‘leader’ include leaders outside the healthcare system such as politicians. As a result of this feedback, we modified the wording in the intro to refer to ‘leaders at all levels.’

### Principle 1 (create a culture of safety)

1. Most of the feedback from organisations on this principle suggested small changes to the wording to align with existing work and strategies. Where possible, we included these changes, whilst keeping the wording succinct.
2. NHS Providers also rightly flagged the importance of a proactive and integrated approach to managing safety - that requires the culture of safety that this principle is all about. This is now captured by reference to a safety management system.

### Principle 2 (put patients at the heart of everything)

1. The use of the term ‘informed consent’ attracted interest and support from patients who expressed the view of the importance of this concept and how they felt it was not currently honoured by the healthcare system.
2. We received a number of responses in respect of the language of ‘patients.’ Patients, for example, flagged questions about what happens in terms of patient engagement when the patient lacks capacity. The NMC also mentioned the important role of families. Finally, organisations noted that often it is patient representative organisations – rather than individual patients - who have the most capacity to engage with them and suggested including a reference to them in the wording.
3. In response we have now adopted the term ‘patients and communities’ and, where appropriate, ‘patients, workers and communities.’ This makes it clear that patient engagement may require work with a wide range of people and organisations, including family, friends, and carers.
4. Other changes reflect feedback received from patients as well as the Parliamentary and Health Service Ombudsman (PHSO) and the Medicines and Healthcare products Regulatory Agency (MHRA) that proactive/continuous engagement is what is often required, and from NHS Providers that the principle would be strengthened by a reference to the design of healthcare.

### Principle 3 (treat people equitably)

1. The main feedback that we received in relation to principle 3 was around the language of equality vs equity. This issue was raised by the British Medical Association (BMA) and the National Institute for Health and Care Research (NIHR) Patient Safety Research Collaborations (PRSC) SafetyNet, as well as many individuals including many from an ethnic minority background.
2. The feedback is best summarised by a member of the public who identified as being part of the Black ethnic group, who said:

This aspirational statement is not in line with what is needed and/or the Equality Act 2010. We cannot treat people equally, because we need to design services according to local need and historical and continuing inequality. Treating people the same (i.e. equally) is why we have in some localities Black women dying in pregnancy at much higher rates than White women.

1. As a result, we have modified the language of principle 3 from that of equality to that of equity.
2. The PHSO and the CNO’s office also suggested some groups will not routinely engage with healthcare and leaders will need to be proactive in reaching out to them. The MHRA also noted this as a challenge. We have added some additional wording to capture this point.

### Principle 4 (identify and act on inequalities)

1. The PSHO suggested linking the action with an outcome, which we have adopted.

### Principle 5 (identify and mitigate risks)

1. Action against Medical Accidents (AvMA), the General Pharmaceutical Council (GPhC) and the PHSO said the principles need to address that staff often feel vulnerable to speak up or are penalised for doing so. This was also reflected in feedback to principles 1 and 6. We modified the wording of this principle to make clear that workers should be encouraged and empowered to speak up – and reordered the wording to ensure this point comes first.
2. Valproate Victims and the General Medical Council (GMC) suggested adding a word about timely escalation of risks, which we included.
3. NMC and others felt that employers/internal structures are often better placed to deal with concerns than regulators. As a result, we removed reference to any particular body and included the wording of the ‘most appropriate person or body’.

### Principle 6 (be transparent and accountable)

1. Whilst we received comments from organisations and individuals that this wording did not reference or align with the legal Duty of Candour, we decided to keep the current wording in the interests of clarity. None of these principles is designed to supersede or undercut the existing legal and regulatory provisions.
2. Instead, we strengthened the wording by setting out that transparency is what a culture of safety requires.

### Principle 7 (use information and data to drive improved care and outcomes for patients)

1. The BMA, the Royal College of Physicians (RCP), the Care Quality Commission (CQC) and the GMC all said the wording needed to make clear that it did not supersede existing legal and regulatory frameworks.
2. To ensure the principle remained concise, we included a reference to compliance with the Caldicott Principles, developed by the National Data Guardian. These principles include ‘principle 6: comply with the law.’
3. Those working in health and social care noted that importance of patient involvement and education around data usage to build trust and encourage participation. They, and many individual respondents, also said patient access to their data to help them manage their care was missing. This has now been included at the start of principle 7.
4. A number of organisations said that this principle needed to be better tied to patient safety and improved outcomes. Several individuals wanted this principle on data to highlight the fact that patient safety should not be assumed but actively measured and monitored. We have added wording around strengthening patient safety to address this.
5. The DHSC/NHSE policy team flagged the importance of data transparency and the sharing of data in a free and timely manner, which we have reflected by reference to improved data flows. They also wanted a reference to having robust arrangements in place if things go wrong in terms of data and data sharing, which is captured by the new reference to the Caldicott Principles.

## Additional comments

1. We received many additional comments about areas people believed should be reflected in the principles or areas of work that the PSC should be involved with. We have captured this broader feedback.

1. For the purposes of the quantitative analysis in this document, we chose to exclude those members of the public who did not respond as being based in ‘England’ (58) – in line with the remit of the Patient Safety Commissioner. [↑](#footnote-ref-2)