Nursing and Midwifery Council's response to NHS Improvement's consultation on 'Developing a patient safety strategy for the NHS – Proposals for consultation'

About us

1 We are the independent regulator for nurses, midwives and nursing associates. We hold a register of the 690,000 nurses and midwives who can practise in the UK, and nursing associates who can practise in England.

2 Better and safer care for people is at the heart of what we do, supporting the healthcare professionals on our register to deliver the highest standards of care.

3 We make sure nurses, midwives and nursing associates have the skills they need to care for people safely, with integrity, expertise, respect and compassion, from the moment they step into their first job.

4 Learning does not stop the day nurses, midwives and nursing associates qualify. To promote safety and public trust, we require professionals to demonstrate throughout their career that they are committed to learning and developing to keep their skills up to date and improve as practitioners.

5 We want to encourage openness and learning among healthcare professionals to improve care and keep the public safe. On the occasions when something goes wrong and people are at risk, we can step in to investigate and take action, giving patients and families a voice as we do so.

Our response

6 We welcome the opportunity to respond to the consultation on a proposal for 'Developing a patient safety strategy for the NHS' (the strategy) and we are supportive of the development of a patient safety strategy which is aligned with the NHS Long Term Plan.

7 We recognise NHS Improvement's (NHSI) remit and that the strategy is designed for the NHS in England, however we would encourage NHSI to consider how it would tie in with the independent and the social care sector as well as similar ongoing work across the other UK countries to enable a joined up approach where possible. Patient safety considerations are not limited to healthcare settings or geographical locations and as the UK professional regulator of nurses, midwives and nursing associates, in whatever setting they may practice, we would support further joined up work to enhance patient safety.

8 Our response is centered on three issues which in our view are key to improving patient safety. These are workforce considerations, information sharing and cooperation, and overhaul of fitness to practise to support a learning culture and enhance patient safety.

9 Our main underlying priority is ensuring high levels of patient safety and we look forward to working closer with NHSI to enable the ambition of making the NHS the safest healthcare system in the world.

Workforce considerations

10 In our view it is paramount that the strategy take into account workforce considerations and how these could impact on patient safety. The NHS Long Term Plan[1] notes that:

"There will always be a background number of vacancies as staff move between employers and advance their careers, but the current number is unsustainable, with the biggest shortfall in nursing" (P.79 of the NHS Long Term Plan).

11 Therefore we believe it would be helpful to consider what impact the current and future workforce constraints may have on implementing the ambitions set out in the consultation document. When demand from the public for health and social care is increasing across the UK, it is vital there are enough professionals to deliver world class care and keep the public safe.

12 As the UK professional regulator of nurses, midwives and nursing associates working with partners across the health and social care sector, we support and develop the workforce, which has a positive impact on the recruitment and retention of nurses, midwives and nursing associates.

Information sharing and cooperation

13 We are supportive of greater information sharing across multiple sources and how existing resources can be better drawn upon to improve patient safety and identify areas for improvement. Additionally, this direction of travel was also reflected in the NHS Long Term Plan with its focus on the new delivery model and to expand Integrated Care Systems (ICS) across all local authorities by 2021.

14 We believe that patient safety could be improved by developing a consistent source for data and learning, and for regulators in particular it essential to effectively share reliable data and intelligence. The need to identify and act on local concerns in the light of recent high-profile incidents, such as Morecambe Bay and the subsequent 'Lessons Learned' Review and report into Gosport War Memorial Hospital, means that health and care regulators need mechanisms for sharing data, engaging locally, working with employers and other regulators and learning from past events. We are undertaking work to ensure that we are improving our data and intelligence collection and increasing our collaborative working with the health and care sector and regulators to work together to improve data sharing and learning.

[1] NHS England (2019) *The NHS Long Term Plan*, https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf

Overhaul of fitness to practise to support a learning culture and enhance patient safety

15 We strongly believe that promoting a just culture that treats the people affected, patients and staff with fairness and respect is paramount in improving patient safety. In our view a focus on blame can result in the wrong causes of unsafe care being identified, placing people using services, patients and staff at future risk. We also agree that a blame culture stifles learning and improvement, and is likely to encourage cover-up, fear and disengagement by the professions. We also believe that a lack of a consistent source for data and learning is a barrier to organisations, including regulators, sharing information which could impact on patient safety.

Proposed aims and principle

Q1 (A): Do you agree with these aims and principles? Would you suggest any others?

16 We are fully supportive of the aim of making the NHS the safest healthcare system in the world and the three principles of a just culture, openness and transparency and continuous improvement. We look forward to working closely with NHSI to making this a reality.

17 In our view, an essential element in embedding these principles is to support the professionalisation of safety investigations and providing healthcare professionals and other staff with the tools to support the patient safety strategy. This would include resources and time for training and to develop the necessary skills to conduct patient safety investigations effectively.

18 As a part of this we would also encourage NHSI to consider how to best involve people who use services and patients in safety investigations. In our view this is essential in understanding why and when things go wrong, and how organisations can learn from failures of care.

Q1 (B): What do you think is inhibiting the development of a just safety culture?

19 We strongly believe that promoting a just culture that treats people who use services, patients and staff with fairness and respect is paramount in improving patient safety.

20 The consultation document highlights that “the culture of fear and blame […] stifles reporting and learning” (P.6 of the consultation document). In our view a focus on blame can result in the wrong causes of unsafe care being identified, placing future patients at risk. We agree that a blame culture stifles learning and improvement, and is likely to encourage cover-up, fear and disengagement by the professions. Furthermore, employers using professional regulators as a threat to intimidate staff is a barrier and causes staff to be fearful of regulation which does not help in moving towards a just culture.

21 We also believe, as highlighted under the first section, that a lack of a consistent source for data and learning is a barrier to organisations, including regulators, sharing information which could impact on patient safety.

Q1 (C): Are you aware of 'A just culture guide'?

22 Yes, we are aware and are supportive of the 'A just culture guide' and additionally we have been pleased to support NHSI in developing and promoting this guide.

23 We also believe that a just culture and patient safety require a significant cultural change, and that leadership on all levels of organisations is essential in achieving these ambitions as well as the overarching aims outlined in the consultation document.

24 Our additional comments relating to a just culture are outlined in response to the questions below.

Q1 (D): What could be done to help further develop a just culture?

25 We welcome the recent developments in this area, such as the establishment of a Just Culture Taskforce for England by the Department of Health in January 2017, the Healthcare Safety Investigation Branch (HSIB) becoming operational as an independent investigation body, the establishment of the Health Service Safety Investigations Body (HSSIB) to build on the work of HSIB, and NHS Improvement adopting a Just Culture tool for the NHS in England at the end of March 2018.

26 As highlighted under Question 1(B) there are a number of things both professional and systems regulators can and are doing to overcame the challenges of a blame culture. In our view, NHSI can play an important role in promoting cross-organisational working and to embed a just culture.

Q1 (E): What more should be done to support openness and transparency?

27 We believe that there are a number of actions both professional and systems regulators can take to combat the underlying issues inhibiting the development of a just safety culture. These actions are:

27.1 **Overhaul of fitness to practise to support a learning culture and enhance patient safety**. Our new Fitness to Practice strategy, 'New Strategic Direction - Ensuring public safety, enabling professionalism'[2] signals our commitment to moving away from a blame culture towards a just culture in health and social care and embed the values of openness and learning that are central to a patient safety culture. We think that changing our approach to fitness to practise gives us the chance to be part of the solution and move towards a patient safe future. We have engaged with the organisations at the forefront of this approach and think that our role can help to underline that a just culture approach is the one most likely to keep people who use services, patients and the public safe;

27.2 **Promote the Duty of Candour**. We strongly believe that healthcare professionals should be open and honest when things go wrong. We remain committed to the ambitions set out in the regulators' joint statement

[2] Nursing and Midwifery Council (2018) *New strategic direction - Ensuring public safety, enabling professionalism*, https://www.nmc.org.uk/globalassets/sitedocuments/consultations/2018/ftp/ensuringpublicsafety_v6.pdf

'Openness and honesty – the professional duty of candour'[3] which was published in 2014, and the importance of the professional duty of candour is reflected in our Code, our proposed new Fitness to Practise strategy and our new education standards for registered nurses, the new standards for midwives which we are currently developing, and the nursing associate standards. The intention is that from the time they enroll as students in education programmes to joining the register and throughout their careers nurses, midwives and nursing associates fully understand the professional duty of candour and what is expected of them and how this relates to patient safety; and

27.3 **Support professionalism**. In 2016 we introduced revalidation, a process that all nurses and midwives in the UK will need to follow to maintain their registration with the NMC. It is designed to be a continuous process that nurses, midwives and nursing associates will engage with throughout their careers and it encourages them to reflect on their practice. Through the revalidation process nurses, midwives and nursing associates will demonstrate their continued ability to practise safely and effectively and it aims to raise awareness of professionals to reflect on the role of the Code in their practice, including their professional duty of candour.

Q1 (F): How can we further support continuous safety improvement?

28 We believe that workforce considerations and supporting the workforce are key to further support continuous safety improvement, and even if the strategy does not directly relate to workforce considerations, we believe it would be helpful to consider what impact the current and future workforce constraints may have on implementing the ambitions set out in the consultation document.

29 Additionally Continuing Professional Development (CPD) plays an important role in supporting the workforce and maintaining public protection. The importance of access to CPD is highlighted in the NHS Long Term Plan which noted:

"CPD − or more specifically workforce development - has the potential to deliver a high return on investment. It offers staff career progression that motivates them to stay within the NHS and, just as importantly, equips them with the skills to operate at advanced levels of professional practice and to meet patients' needs of the future." (P.85 of the NHS Long Term Plan)

30 As a part of this we are looking forward to working more closely with NHSI, including on issues relating to workforce and how we can continue to support the existing workforce and continuous safety improvement.

[3] *Joint statement from the Chief Executives of statutory regulators of healthcare professionals* (2014), http://www.psni.org.uk/wp-content/uploads/2013/02/Joint-statement-on-the-professional-duty-of-candour-FINAL.pdf

Insight

Q2 (A): Do you agree with these proposals? Pease give the reasons for your answer

31 We are supportive of greater information sharing across multiple sources and how existing resources can be better drawn upon to improve patient safety and indemnity areas for improvement. Additionally, this direction of travel was also reflected in the NHS Long Term Plan with its focus on the new deliver model and to expand Integrated Care Systems (ICS) across all local authorities by 2021.[4]

32 The consultation document noted:

"The first of our proposed priority areas, **Insight**, incorporates NHS Improvement's statutory patient safety functions under the Health and Social Care Act 2012 […] we intend to further improve the way that we fulfil these duties to become the best in the world at drawing insight from multiple sources of patient safety information. (P.12 of the consultation document)

33 In our view there are a number of barriers to achieve the ambitions outlined in the consultation document which are relevant to professional regulators. We have also highlighted these in our response to the Patient Safety Learning Green Paper Consultation: questionnaire in 2018.[5]

34 The 2013 Mid Staffordshire NHS Foundation Trust Public Inquiry made a specific recommendation for us to address the 'regulatory gap' between the systems regulators and the professional regulators, and to provide support and guidance for employers. It was in response to these, that we established our Employer Link Service and Regulatory Intelligence Unit. We proactively monitor risks to the public through our intelligence and education quality assurance monitoring activities and now engage continually through our employer link service.

35 We have strong working relationships with other professional and systems regulators and hold a number of memorandums of understanding (MoU) with different organisations across the health and social care spectrum, including the Care Quality Commission. These MoUs set out how we work together and share information to uphold patient safety where there may be concerns about an individual or a healthcare setting. This includes the 'Emerging Concerns Protocol'[6], a joint agreement launched in July 2018. The protocol aims to make it easier for regulators to share information about potential risks to patients, families and professionals, specifically those situations that may indicate future risk and cultural issues that may not be raised through alternative formal systems. However, NHSI and NHS England (NHSE) did not sign the 'Emerging Concerns Protocol' and we would encourage them to consider doing so as it would potentially enable the system to be more joined up.

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[4] NHS England (2019) *The NHS Long Term Plan*,https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf

[5] Nursing and Midwifery Council's response to the Patient Safety Learning *Green Paper Consultation: questionnaire* (2018), https://www.nmc.org.uk/globalassets/sitedocuments/consultations/nmc-responses/2018/nmc-response-to-patient-safety-learning-green-paper-consultation-questionnaire.pdf

[6] *Emerging concerns protocol* (2018), https://www.cqc.org.uk/sites/default/files/20181112_emerging-concerns-protocol.pdf

Q2 (B): Would you suggest anything different or is there anything you would add?

36 We have no further suggestions.

Infrastructure

Q3 (A): Do you agree with these proposals? Please give the reasons for your answer

37 We are supportive of measures to increase awareness around patient safety amongst NHS staff and to continue to develop a patient safety culture. We would also encourage NHSI to consider how the proposed initiatives would fit in with the professional codes of practice registered professionals are required to abide by. This would in our view provide continuity and clarity both for professionals and organisations. We would welcome the opportunity to work with NHSI around what this could look like and how we could work together to improve patient safety.

Q3 (B): Would you suggest anything different or would you add anything?

38 We have outlined below how we embed patient safety in the standards we require of nurses, midwives and nursing associates and how patient safety is the cornerstone around which our education standards are designed.

Patient safety and our Code

39 Patient safety is at the heart of our Code (updated 2018)[7] and all nurses, midwives and nursing associates on our register must abide by the Code. It outlines the professional standards of practice and behaviour and states that nurses, midwives and nursing associates must make care and safety their main concern. Under the Code and the professional duty of candour, people on our register are under an obligation to act without delay if there is a risk to patient safety and public protection. This includes raising and if necessary escalating any concerns about the effectiveness of care people are receiving in any health or social care setting (as set out in our Raising Concerns guidance).[8]

Embedding patient safety in our education standards

40 Patient safety is our key concern and working in partnership with higher education institutions, we set the qualifications students must achieve to step into their first job with the right skills and knowledge to look after the patients, mothers, and the public with kindness, respect and compassion. We work with higher education institutions to design courses that attract around 75,000 students a year from diverse backgrounds and ensure that they are equipped to practise effectively in a range of different environments.

41 Patient safety is embedded in all our education standards, including our new nurse standards, nursing associate standards and the new standards for midwives which

[7] NMC (2018) *The Code - Professional standards of practice and behaviour for nurses, midwives and nursing associates*, https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf
[8] NMC (2018) *Raising concerns - Guidance for nurses, midwives and nursing associates* https://www.nmc.org.uk/globalassets/blocks/media-block/raising-concerns-v2.pdf

we are currently consulting on. An example of how we integrate patient safety is that our new nurse standards are based on seven platforms, one of which being 'Improving safety and quality of care'. These platforms reflect what we expect a newly registered nurse to know and be capable of doing safely and proficiently at the start of their career and are expected to embed these throughout their career. This means that patient safety is an integral part of a nurse's training and ongoing practice, including:

41.1 understanding the relationship between safe staffing levels, appropriate skills mix, safety and quality of care, recognising risks to public protection and quality of care, escalating concerns appropriately;

41.2 complying with local and national frameworks, legislation and regulations for assessing, managing and reporting risks, ensure the appropriate action is taken; and

41.3 demonstrating an understanding of how to identify, report and critically reflect on near misses, critical incidents, major incidents and serious adverse events in order to learn from them and influence their future practice.[9]

42 We are currently consulting on our new standards for midwives, and as with the new nurse standards, patient safety will be at the heart of new standards and ensure that all midwives are equipped to deliver high quality and safe care.

Q3 (C): Which areas do you think a national patient safety curriculum should cover?

43 Please see answer to question 3(B).

Q3 (D): How should training be delivered?

44 Please see answer to question 3(B).

Q3 (E): What skills and knowledge should patient safety specialists have?

45 Please see answer to question 3(A).

Q3 (F) How can patient/family/carer involvement in patient safety be increased and improved?

46 Please see answer to question 3(A).

Q3 (G) Where would patient involvement be most impactful?

47 Please see answer to question 3(A).

Q3 (H) Would a dedicated patient safety support team be helpful in addition to existing support mechanisms? If yes, how?

48 No comments.

[9] NMC (2018) Future nurse: Standards of proficiency for registered nurses

Initiatives

Q4 (A): Do you agree with these proposals? Please give the reasons for your answer

49 We are supportive of the initiatives listed in the consultation document and there are several which directly relate to our role as a professional regulator, including the ambition of reducing the amount of harm caused in key areas of patient safety by 50 percent by 2023/24. We are also supportive of the alignment with the NHS Long Term Plan and the focus on the Patient Safety Collaborative programme which supports the maternity and neonatal health safety collaborative programme and underpin to the ambition to halve the number of stillbirths, neonatal and maternal deaths and brain injuries by 2030.

Q4 (B): Would you suggest anything different or do you have anything to add?

50 No comment.

Q4 (C): What are the most effective improvement approaches and delivery models?

51 No comment.

Q4 (D): Which approaches for adoption and spread are most effective?

52 No comment.

Q4 (E): How should we achieve sustainability and define success?

53 It is difficult to comment on what would constitute success as it is not yet clear what the final strategy would focus on, however we are supportive of prioritising programmes where the most significant harm is seen, litigation costs are highest, unwarranted variation is greatest, and evidence-based interventions are known to mitigate risk.