The Nursing and Midwifery Council's response to NHS Improvement's consultation on the draft 'Framework for involving patients in patient safety'

About us

1 Our vision is safe, effective and kind nursing and midwifery that improves everyone's health and wellbeing. As the professional regulator of more than 700,000 nursing and midwifery professionals, we have an important role to play in making this a reality.

2 Our core role is to **regulate**. First, we promote high professional standards for nurses and midwives across the UK, and nursing associates in England. Second, we maintain the register of professionals eligible to practise. Third, we investigate concerns about nurses, midwives and nursing associates – something that affects less than one percent of professionals each year.

3 To regulate well, we **support** our professions and the public. We create resources and guidance that are useful throughout people's careers, helping them to deliver our standards in practice and address new challenges. We also support people involved in our investigations, and we're increasing our visibility so people feel engaged and empowered to shape our work.

4 Regulating and supporting our professions allows us to **influence** health and social care. We share intelligence from our regulatory activities and work with our partners to support workforce planning and sector-wide decision making. We use our voice to speak up for a healthy and inclusive working environment for our professions.

Our response

5 We welcome the opportunity to respond to this proposed 'Framework for involving patients in patient safety' ('the framework'), as highlighted in the NHS Patient Safety Strategy.

6 We continue to be fully supportive of the ambition to enable people who use services to be more involved in their care, including in patient safety. We also welcome the opportunity to continue to collaborate with NHS Improvement (NHSI) on the development of a new Patient Safety Incident Response Framework following the testing phase (p.18 of the framework).

7 Ensuring the safety of people who use services is a responsibility which rests across all sector organisations, including our own. The numerous inquiries and reports on failures of care in the health and care sector remind us that involving those receiving care in decision making and in the planning and delivery of services is too often overlooked. The recent Independent Medicines and Medical Devices Safety (IMMD) Review has shown that neglecting this responsibility can

lead to avoidable harm with life-long consequences. Many of the failures which the review investigated were the result of the system not listening to the very real concerns of people who use services, and of failures in informed consent. This again underscores the importance of involvement and collaborative work across the whole sector in order to share information and improve care.

8 One of the recommendations of the IMMD review was that a new Patient Safety Commissioner be established. We encourage NHSI to consider what further opportunities there are to support people using services to navigate a complex regulatory landscape.

9 We note also that there are many similarities in the underlying themes between the IMMD review and the recent Paterson Inquiry including: a call for greater transparency, dismissive and blame cultures acting as barriers to speaking up, truly informed consent and the need for multidisciplinary teams to be effective for safety in patient care. We would urge NHSI to ensure that it clearly connects this framework with those findings. We would also recommend that the framework consider and, where appropriate, connect with any similar initiatives being undertaken in the other UK countries.

10 We understand that the framework is developed primarily for NHS trusts and commissioners in England. The framework also notes that it could be useful in other NHS settings, including primary care and community services (p.5 of the framework). We would encourage NHSI to consider how this may be a valuable resource for the independent and social care sector. As a four country regulator we would also emphasise the importance of working with the other UK governments to share best practice in this area and ensure cooperation.

Consultation questions

11 In line with our regulatory remit and expertise, we have responded to questions five, six, fifteen and seventeen.

Question 5. Does the draft Patient Safety Partner Framework provide sufficient guidance about supporting patients to be involved in their own safety?

12 We strongly support the ambition set out in the framework, and the NHS Patient Safety Strategy from 2019, to improve patient safety and to involve people who use services in their own care.

13 The framework notes that *"Patient concerns and complaints are a valuable resource for monitoring and improving patient safety. Local organisations should ensure all concerns and complaints are properly reviewed"* (p.14 of the framework). We fully support this and continue to encourage the professionals on our register to speak up and raise concerns any initiatives that encourage people to raise concerns about anything that gets in the way of providing good care. An open learning culture that encourages professionals to speak up and which provides avenues for patient feedback and complaints, is paramount for improving patient safety in a complex regulatory health and social care landscape.

14 Information sharing between organisations is also integral to supporting this ambition, and we would recommend that NHSI make this a more prominent part of

the framework. We believe that strengthening systems of information sharing between service providers, systems regulators and professional regulators is essential. For example, a person who use services or their family, carer or Patient Safety Partner might not be aware of the various regulatory obligations and responsibilities of the organisations providing their care. As a result, they often find it difficult to know where and how to raise concerns.

15 We fully support the inclusion and emphasis on the duty of candour (p.16-17 of the framework). It is particularly important as it has been raised as an area of concern in the IMMD review. We know that the professional duty of candour is essential in supporting healthcare professionals and people who use services. As a result, it is embedded in our Code, our strategic direction to fitness to practise and our new education standards. We have also developed guidance jointly with the General Medical Council on the professional duty of candour. It is also valuable to consider how this links in with the wider organisational duty of candour.

Question 6. Are there any challenges to involving patients more in their own safety that we have not recognised?

16 We agree with the ambition in the framework that people who use services should be supported and encouraged to proactively raise any concerns or questions they have with healthcare professionals. We also agree that organisations should move away from a culture where people who use service have to wait to be invited to raise concerns. However, as the framework notes, there are factors that impact on the opportunity to do so. For the professionals on our register, one of the most significant of these is 'staff workloads and priorities' (p.9 of the framework).

17 As initially highlighted in our response last year to the consultation on developing the NHS Patient Safety Strategy, we believe it would be beneficial to consider what impact current and future workforce constraints may have on patient safety. This include supporting people using services to become full participants in their care and safety.

18 While the framework is not primarily focussed on workforce considerations, we believe it is nonetheless a vital factor. Workforce constraints impact everything, from how much time a healthcare professional can spend with people who use services, to the workload and wellbeing of healthcare staff. Successful workforce planning is therefore a key component in improving the safety of both staff and those accessing services.

19 We know from our data that too much pressure is a main reason for nurses, midwives and nursing associates leaving the profession. Respondents to our annual survey of professionals who left our register said that highly demanding work environments arising from a combination of high expectations, pressure of responsibility and volume of work, contributed to high stress levels.

Question 15. Are you aware of/is your organisation taking any additional approaches to involving patients and the public in patient safety work?

20 The safety and protection of people who use services and the public is at the heart of our new Strategy for 2020 - 2025, which sets out our purpose and vision for the next five years. Our plans for achieving these include more meaningful

engagement and collaborative working to enhance our insights and influence (including with NHSI), creating ambitious professional and educational standards to enable us to proactively support our professionals, and improving our knowledge and data systems to allow us to become a more visible and informed regulator. We are working to make co-production our habitual means of developing standards and policy, to be clear about what a person-centred approach means in the context of regulation, and to build public awareness and understanding of what we and the professionals on our register do.

21 The three pillars of our Strategy are:

21.1 **Regulating**: Promoting and upholding high standards and stepping in to investigate on the rare occasions when care goes wrong;

21.2 **Supporting**: Proactively supporting members of the public and the professionals on our register by striking the right balance between investigating poor practice and promoting excellent practice; and

21.3 **Influencing**: Collaborating with our partners as a key part of addressing common concerns and driving improvement across the sector.

22 Central to the development of our new strategy were the views of people using health and care services across the UK. Over the course of 2019 we heard from over 10,000 people, spanning regional engagement, online surveys regarding what we should focus on in our strategy and as part of independent research.

Question 17. Please use the box below if you have any other comments on our draft Framework for involving patients in patient safety

23 The importance of supporting a learning and just culture in improving patient safety is highlighted in both the NHS Patient Safety Strategy from 2019 and the NHSI's 'A Just Culture Guide'. A focus on blame can result in the wrong causes of unsafe care being identified, placing people who use services and staff at future risk. Although not directly impacting on how organisations can include people who use services in patient safety, we believe that promoting a just culture that treats the people affected, people using services and staff with fairness and respect is paramount in improving patient safety.

24 Relating to a just and learning culture, we also encourage NHSI to look in greater detail of how the framework can further take into account equality and diversity considerations as a key component of person-centred care. Person-centred care includes taking into account people's personal context and individual needs, including their protected characteristics under the Equality Act 2010. We believe these considerations are essential in supporting individuals to be involved in their own care and patient safety.

25 To be able to recognise and support people using services' different needs and individual situations is essential in enabling them to contribute to their own care, and to improve patient safety and realise the ambitions outlined in the framework.