NMC response to the 'Patient Safety Learning Green Paper Consultation: questionnaire'

Introduction

1. We are the independent regulator of the UK's 690,000 registered nurses, midwives and nursing associates. Better and safer care for people is at the heart of what we do, supporting all the professionals on our register to strive for the highest standards.

2. We set the qualifications students must achieve to step into their first job with the right skills and knowledge to look after patients, mothers, and the public with kindness, skill, respect and compassion. Learning does not stop the day nurses, midwives and nursing associates qualify. To promote public trust and safety, we require professionals to demonstrate throughout their career that they are committed to learning and developing to improve as practitioners.

3. We want to encourage openness and learning among the professions to improve care and keep the public safe. If things go wrong, we can step in to help keep patients and families safe.

4. We welcome the establishment of Patient Safety Learning (PSL) and strongly support the aims behind the Green Paper.[1] We are grateful for the opportunity to respond to this consultation. We are supportive of working with other regulators in promoting a 'just culture', and we strongly believe that healthcare professionals should be open and honest when things go wrong.

Our view on the recommendations for regulators

5. We welcome the specific recommendations for professional regulators highlighted in the Green Paper and the additional focus on implementing these important recommendations that the final White Paper will provide.

6. There is clearly still a way to go in realising a patient safe future. We believe that we are currently meeting or are undertaking programmes of work to meet the majority of recommendations that have been identified in the paper. We have referenced this work throughout our response and have linked back to these recommendations where appropriate.

Our response

Question 1. Thinking about the challenges of addressing patient safety improvement that we set out above…Are we on the right track?

[1] https://s3-eu-west-1.amazonaws.com/ddme-psl/content/Patient-Safety-Learning-Green-Paper-PDF-Online-170918.pdf?mtime=20180917191215

Are the issues we identify above correct? If not, what do we need to change and why? What have we missed or need to add?

7. We recognise the many challenges around patient safety that have been identified in the Green Paper, particularly that the reasons for failures of care and reaction to those failures are influenced by a complex series of factors. We support its overarching goal to improve patient safety and the measures and recommendations contained within it.

8. We are not in a position to comment on all of the patient safety issues identified, as some of these fall outside of our regulatory function, but we have provided further comments on the issues that fall within our remit.

Organisations are not learning from when things go wrong

9. An inability to learn, to recognise when things are going wrong, and to take action to mitigate or prevent harm has been an all too common feature of failures of care in recent history, at local, employer and regulatory levels. It is vital that organisations learn when things go wrong, are open and immediately apologise, and take firm action to ensure that the same mistakes do not happen again.

10. That applies to us as much as to all organisations in the health and social care sector. Where we have got things wrong in the past, we have apologised and are making significant changes and improvements to the way we work. Following the publication of the Professional Standards Authority (PSA) 'Lessons Learned' review into our handling of concerns about midwives' fitness to practise at the Furness General Hospital[2], we have taken steps to better support and engage with patients and families and to be more transparent.

There is no consistent source for learning and data

11. Being able to effectively share reliable data and intelligence is a vital requirement for regulators. The need to identify and act on local concerns in the light of recent high-profile incidents, such as Morecambe Bay and Gosport Memorial Hospital, means that health 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.

12. 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 service.

[2] https://www.professionalstandards.org.uk/docs/default-source/publications/nmc-lessons-learned-review-may-2018a0851bf761926971a151ff000072e7a6.pdf?sfvrsn=6177220_0

13. We are supportive of engaging in more collaborative ways of working with other regulators, patient organisations and the wider health and social care sector (professional regulator recommendations 8 and 9). We have strong working relationships with other professional regulators and hold a number of memorandums of understanding (MOU) with different organisations across the health and social care spectrum. 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.[3]

14. This includes the 'Emerging Concerns Protocol'[4], 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.

Healthcare roles don't feature patient safety routinely in training, objectives and CPD, and patient safety skills are missing or inconsistent

15. We support the vision outlined in the Green Paper (and in professional regulator recommendation 3) for patient safety to be a professional discipline, and strongly agree that all healthcare staff whose activities could affect patient safety should be able to demonstrate that they are suitably qualified and experienced to carry out their roles.

16. Our nursing and midwifery education standards set out general requirements for safe and effective practice. These standards are required to be met by all nursing, midwifery and nursing associate students on NMC approved programmes prior to entry onto the register, ensuring they are fit to practise at the point of registration.

17. In 2016, we embarked on a major programme of change for education to review and update all of our education standards. Our vision in developing new standards and requirements is that they will be outcomes based and enable innovation, agile and future focused, measurable and assessable, and will prepare nurses and midwives to deliver safe, compassionate and effective care. These changes show our commitment to supporting the professionalisation of patient safety (professional regulator recommendation 3) for future nurses and midwives and ensuring that patient safety is embedded throughout their education and training (professional regulator recommendation 5).

18. Our new Standards of Proficiency for Nurses[5] will be used from 28 January 2019 and all pre-registration nursing programmes will need to be approved against the new standards by the end of August 2020. Enhanced patient safety was one of the core design principles for drafting these standards. We have sought to emphasise the link between patient safety and effective learning by focussing on governance, quality and the learning culture in which students learn. This also includes positive

[3] https://www.nmc.org.uk/about-us/who-we-work-with/organisations-we-engage-with/mous/
[4] https://www.cqc.org.uk/sites/default/files/20181112_emerging-concerns-protocol.pdf
[5] https://www.nmc.org.uk/globalassets/sitedocuments/education-standards/future-nurse-proficiencies.pdf

learning role models for students and being empowered and supported to raise concerns on patient safety.

19. In 2017, we began a review of our midwifery education standards to ensure that they are fit for purpose and that newly qualified midwives are equipped with the knowledge, skills and attributes they need to deliver safe, effective, respectful and compassionate care to all women, newborn infants, partners and families at the point of entry onto the register. Patient safety is one of themes that will be threaded throughout the standards in recognition of its importance. We will shortly consult on our new midwifery standards and aim to publish the final set in January 2020.

20. All nurses, midwives and nursing associates on our register must abide by the Code (updated 2018).[6] The Code outlines the professional standards of practice and behaviour. It states that nurses, midwives and nursing associates must make care and safety their main concern. Under the Code and the professional duty of candour[7], 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] We take action against those of our register who do not meet the requirements of our Code and standards, and whose fitness to remain on the register is called into question as a result, through effective yet proportionate fitness to practise proceedings.

21. All nurses, midwives and nursing associates on our register must complete the revalidation process every three years in order to retain their registration. Revalidation embeds the Code in nurses and midwives practise and promotes reflection on their practise and learning from mistakes (professional regulator recommendation 5). We believe that revalidation provides an opportunity for nurses and midwives to share best practice with, and use, the PSL's Learning Platform to encourage and promote a patient safety culture across the professions.

Question 2. With regard to the patient-safe future we describe above, have we identified the right things? Have we missed out anything important? What do we need to change and why?

22. We support the principles of a patient-safe future that have been outlined in the Green Paper. We believe that this is a sensible approach to improving patient safety and do not have any additions.

23. As highlighted throughout our response, we are currently undertaking a number of workstreams that we believe will assist in promoting patient safety and realising the aims of a patient safe future and implementing the recommendations for professional regulators. We look forward to building a close working relationship with PSL and assisting in their aims of reducing avoidable patient harm and moving toward a patient-safe future.

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[6] https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf
[7] https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/openness-and-honesty-professional-duty-of-candour.pdf
[8] https://www.nmc.org.uk/standards/guidance/raising-concerns-guidance-for-nurses-and-midwives/

Question 3. When thinking about creating a patient-safe future, which aspects of a patient-safe future should be PSL's priority?

24. In our view, it is difficult to prioritise one proposal over another, as it is important that each proposed activity is addressed in conjunction with the others for each to be the most effective and impactful in addressing the wider issues of patient safety. We have outlined in more detail the priorities that fall within our regulatory function and what we are doing as an organisation in these areas.

Support the professionalism of patient safety

25. We are committed to supporting the professionalism of patient safety (professional regulator recommendation 3). As we have highlighted, we are currently reforming our fitness to practise function with a new strategy that puts patient safety first. We consider that effective and proportionate fitness to practise processes actually means putting patient safety first, and that an open, transparent and learning culture will best achieve this. In turn we will enable professionalism by supporting nursing and midwifery professionals to address concerns about their practice, so that members of the public can continue to have confidence in the professions and confidence in us to promote and defend high standards.

Promoting a just culture

26. We strongly agree that promoting a just culture that treats patients and staff with fairness and respect is an important priority for improving patient safety and the PSL (professional regulator recommendations 1, 2 and 7). A focus on blame can result in the wrong causes of unsafe care being identified, placing future patients at 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.

27. We've welcomed 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.

28. Our new strategic direction in fitness to practise 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 patients and the public safe.

Listen and respond empathetically to the voice of patients and families

29. We understand the value of listening to families, patients and the individual. Our new fitness to practise strategy recognises this and is part of the significant changes we have made to the way we work (professional regulator recommendation 8). We

now have a person-centred approach to fitness to practise, which helps us put patients, families and the public at the heart of what we do. Helping us to properly understand what went wrong, and make sure concerns raised by patients and families are properly addressed and that they understand our processes.

30. We have established a dedicated Public Support Service which has already made some positive changes to improve the way we engage patients, families, and members of the public and understand the regulatory concerns about our registrants. We now have specialist teams to provide extra help and support in some of our most complex and sensitive cases and offer dedicated support and assistance for witnesses in our proceedings. We have developed a tailored needs assessment for individual members of the public who make referrals to us, to ensure that we are listening to and addressing each individual person's needs and concerns. Going forward we will explore how the Public Support Service could have a broader focus across the entire organisation in conjunction to our fitness to practise proceedings.

Question 4. Which should be our lowest priority?

31. As we have noted in our response to Question 3, we think it is difficult to prioritise one aspect of the PSL's priorities over another. As such, we do not believe that there is a lowest priority and that by tackling all of the identified priorities, we can move towards a patient safe future.

Question 5. Progress to improve patient safety needs the whole system to pull in the same direction. Many organisations and roles will contribute to a patient-safe future. We would like your thoughts about the kinds of actions needed by organisations to ensure a patient-safe future.

32. We agree that their needs to be a whole system approach to improving patient safety and that professional regulators cannot work in isolation, and support the PSL's aims to pull the system in the right direction. Such an approach does not just include working with others, but also ensuring that organisations themselves ensure that patient safety is embedded in everything that they do.

Organisational change at the NMC

33. We are putting patient safety at the centre of our organisational purpose and culture (professional regulator recommendation 4). We are currently undertaking work to update our organisational values and behaviours to ensure these reflect our primary purpose of ensuring patient safety. These values and behaviours will underpin our organisational policies, symbolising who we are as an organisation, alongside what it looks and feels like to be an NMC employee.

Effective collaborative working

34. We hold strong working relationships with regulators, employers, patient groups, professional organisations and other health and care organisations, but we can

always do more to work more effectively with others. We are undertaking a number of projects to improve our collaborative working (professional regulator recommendation 9).

35. As outlined under Question 2 we hold a number of MOUs with organisations throughout the health and care sector. This ensures that we share and receive data and concerns around professionals and settings from other organisations, ensuring that we work together to improve patient safety. We are aware that we can always improve collaborative working and our data collection and sharing, and are committed to doing this through our new Employer Link Service and Regulatory Intelligence Unit.

36. We work closely with other regulators, on research projects and joint guidance. For example we have developed joint guidance with the General Medical Council on the professional duty of candour[7] which compliments the requirements set out in the Code. However, collaboration does not stop there and it is important that professional requirements for candour are complemented by employers fostering a culture of openness and candour locally.

37. In December 2018, the NMC will be working with the General Dental Council on a cross-regulatory research project looking at the concept of seriousness in fitness to practise cases. The learning from the research project will be used to underpin a proportionate regulatory model in which enforcement powers are used appropriately, developing improved upstream regulation and considering opportunities for a common approach across healthcare regulation. It should be possible to develop insight into the factors that influence decision making throughout the fitness to practise process and to identify and explore the perceived need for regulatory intervention in areas not directly connected to the professional's practice or public role.

Question 6. What do you think are the three things you or your organisation could do to make the biggest contribution to a patient-safe future?

Regulatory reform

38. Our legislative framework is very prescriptive and contains a significant amount of unnecessary procedural detail. It does not allow us to adapt and modernise and prevents us from adopting more cost-effective and proportionate approaches to regulation. It makes us very process driven as a regulator and inflexible when it comes to needing to change or flex to respond to changing circumstances. It drives an adversarial approach in our fitness to practise function, and a complex and bureaucratic registration process.

39. Amending our legislation is a time-consuming process which takes approximately 18 months to two years and involves a lengthy period of collaboration between us and the Department of Health and Social Care (DHSC) and securing parliamentary and Privy Council time. The length of time that the process takes prevents us from responding in a timely fashion to the constantly evolving health and social care environment in which we operate.

40. We now need more flexible legislation that allows us to change quickly and keep pace with the realities of modern healthcare. If we're to continue to meet the changing needs of patients and the public, government needs to replace decades-old laws with a more flexible and autonomous model. Our primary aspiration is to see the NMC's complex and fragmented legislation completely replaced with a single, overarching statute that is proportionate, high level and enabling. It would replace the current resource intensive NMC and Government commitment to manage continual small scale legislative change, and would allow us to become the flexible and modern regulator that we want to be.

41. A new modern piece of legislation would set out the key objectives and functions of the NMC and the overarching requirements to hold registration, ensuring that all nurses, midwives and nursing associates were required to meet the same standard before entering the register. It would also ensure that our key regulatory processes were fair and transparent. However, we strongly believe that only the fundamental and high level requirements should be placed in the legislation itself, requirements that would not need to be amended on a regular basis. This would mean that Government and NMC resources would not need to be expended on regular and time consuming technical amendments.

42. The detailed requirements for our regulatory functions, including registration, education and fitness to practise would be set down in standards, policies and guidance that could be easily amended if we needed to change or vary our regulatory approach. These non-legislative requirements would be approved by the Council following consultation and stakeholder engagement and would allow us to be far more responsive as a regulator.

43. The approach we would like to see aligns with the Professional Standards Authority's (PSA) principles of right touch regulation and is something that we have long called for.

A system view of patient safety and collaborative working to achieve this

44. We know that from listening to our stakeholders, from the Lessons Learned review and our own internal quality assurance processes that we can continue to improve how we operate. Working effectively and sharing information with regulators and other key stakeholders within clearly defined boundaries is an important part of this.

45. We are now regulating in an era where our approach to the gathering, analysis and use of intelligence is vital for ensuring that risks to patient safety can be effectively prevented and monitored. We are working with other regulators to regulatory bodies to improve the collation, sharing and acting on intelligence collected across the healthcare system. By focusing on intelligence, we hope to gain new insights into what we do, helping us to be more effective, transparent and proportionate.

46. We are exploring joined up working with other regulators and developing written agreements. We're setting out the information we'll share with other organisations in the interests of public protection. We are also strengthening our links with local providers and working closely with employers to make sure that we achieve the aims of our new fitness to practise strategy.

47. By establishing the Regulatory Intelligence Unit (RIU) and continuing to develop the Employer Link Service (ELS), we are seeking to strengthen our relationships with employers and other regulators. Developing more effective relationships with stakeholders, especially employers, is a good way of positively influencing the number and quality of appropriate referrals. It is also a means of encouraging feedback from employers to inform service improvement initiatives internally.

48. We are working with the system regulators to improve patient safety in the independent sector by training care home managers about fitness to practise. In 2017-2018, we worked with the systems regulator in Northern Ireland to devise and deliver learning events for new care home managers. We are looking to run similar events with the system regulators in Scotland and Wales.

Patient safety as a central theme in our education standards

49. We recognise patient safety and quality of care is important to health and care delivery and these are central themes which are at the heart of our new standards of proficiency for registered nurses and the standards of proficiency for midwives that are currently being developed (professional regulator recommendations 3 and 5).

50. Our new Standards of Proficiency for Nurses[5] have a specific focus on the knowledge and skills required for nurses' role in contributing to risk monitoring and quality of care improvement agendas. Education providers are encouraged to enhance student learning by building upon the NMC proficiencies and linking up to other best practice guidelines and case studies. Similarly patient safety will be a key theme threaded throughout our new midwifery standards.

51. We believe that our new nursing and midwifery proficiencies will be ensuring that the nurses and midwives of tomorrow will have a greater understanding of patient safety and their roles in contributing to risk monitoring, assisting in moving towards the professionalisation of patient safety.

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