Health and Social Care Select Committee Inquiry: NHS leadership, performance and patient safety

With a membership of over half a million registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the United Kingdom and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sectors, including education and research. The RCN promotes priorities for nursing and patient safety, works closely with wider professional bodies and trade unions, and lobbies governments and other bodies across the UK to develop, influence and implement policy that improves the quality of patient care.

The RCN welcomes the opportunity to respond to the inquiry on NHS leadership, performance and patient safety. The answers set out by the inquiry and our corresponding response are set out below.

- **How effectively does NHS leadership encourage a culture in which staff feel confident raising patient safety concerns, and what more could be done to support this?**

A workplace culture is the product of the attitudes and behaviours that exist there. A culture of safety is the product of the attitudes towards safety issues and the way work hazards are managed. A safe organisation is one in which staff are both welcomed and encouraged to report incidents, near misses and concerns. Staff should feel able to be candid about mistakes and to talk openly about error. Staff also need to know that the organisation will focus on system learning, not individual blame and believe they are psychologically safe when raising concerns or putting forward ideas for improvement.

It is vital that all nursing staff feel able and supported to raise concerns relating to staffing levels or patient care being compromised. Staff being supported to raise concerns is about safeguarding and protecting both staff and patients, supporting learning from a situation and making improvements, and reporting into systems to enable assessment and response to issues.

As the RCN's Nursing Workforce Standards state, nursing staff should be encouraged to report any incidents where the safety of patients and the quality of the service provided has been compromised (RCN, 2021). This creates 'psychologically safe'

environments where individuals are enabled to raise concerns without the fear of detriment and enables a learning culture that guarantees the safety of patients and other staff members.

In our 2022 safe and effective staffing survey, fewer than three quarters (73%) of respondents told us that they had been able to do this. One in five (21%) said they felt unable to raise their concerns. Responses were similar for respondents working both in and out of the NHS and across care settings.

Of those who did raise concerns, just over a third (37%) of respondents were able to say that action had been taken to address the issue. A similar number (41%) said no action had been taken. One in five (22%) did not know if any action had been taken. This survey is biennial, and our 2024 findings will be published later this year.
We have also published the RCN Raising Concerns Toolkit, which sets out why and how nursing staff should raise concerns, and what to do if concerns are not acted upon or they are discouraged from raising concerns.

- **What has been the impact of the 2019 Kark Review on leadership in the NHS as it relates to patient safety?**

Kark review of the Fit and Proper Persons test to be implemented by Trust Boards, and the process checked by the CQC, pointed to fundamental issues with insufficient suitably trained and qualified managers to take Director level positions. It is unclear to what extent the recommendations have been implemented, though we know that nursing staff do not have clear career development and progression routes, with protected time or financial reward for achieving higher levels of education and competence.

Nursing needs a clear career framework which supports somebody actively throughout their career. A framework should define how registered and support staff can grow and achieve specific professional milestones and describe the required competencies for each role and how they are interlinked. A new career framework will, however, not in itself create more posts and improved career progression within the NHS will need a package of reform and investment.

We note that the recommendation of the Kark Review (Recommendation 5) to introduce the power to disbar health provider Directors for serious misconduct has not yet been accepted and implemented. This should be taken forward and implemented urgent now to protect the public and keep patients safe.
We recommend regular, public reporting by the NHS against the recommendations made in this and other independent reviews of NHS leadership and patient safety.

- **What progress has been made to date on recommendations from the 2022 Messenger Review?**

The Messenger Review made a range of recommendations, including measures to incentivise the most talented leaders into the most challenging parts of the system. However, for nursing clinical leaders, system-wide policies and practices are having the opposite effect, and we would go as far as to say that nursing clinical leadership is being eroded.

Nursing is the largest safety-critical profession in health care. In many settings, nursing staff work alongside a team of health and social care professionals to ensure the safety and highest level of care for those we care for. However, Registered Nurses are with patients 24/7 and provide and coordinate all care provided as well as managing staff, the environment and flow in and out of hospitals. Therefore, registered nurses must set the standard for nurse staffing and be assured that the nursing workforce is safe for the understanding and dependency of those they care for.
A lack of nursing leadership and relevant support structures within organisations impacts safety, quality of care and patient mortality as well as the mental health and general wellbeing of the nursing workforce. Compassionate, clinical leadership creates a psychologically safe workplace culture. Staff feel safe to raise concerns, and learn from incidents and mistakes, knowing they will be supported as a team or as individuals and be able to pursue high quality standards of care.

However, the experiences of nursing and other NHS staff suggest that toxicity persists. The NHS needs a focus and local support provided regarding culture, such as the no blame culture approaches based on Sidney Dekker's Just Culture model. We also have examples of nurses reporting into non-nurses. This may be due to nursing posts being removed for cost savings, or the requirement for a registered nurse bring removed from person specifications for nursing roles. This does not facilitate confidence or ease in terms of raising concerns.

In addition, access to CPD and clinical supervision is frequently cancelled for nursing staff due to clinical work being prioritised due to staff shortages. Again, this does not facilitate professional development, learning and raising concerns.

The experienced registered nurse has been pulled away from patients, assuming that their expertise in assessing complexity and unpredictability in patient's needs can be broken down into tasks delegated to less experienced support staff. Executive nurses are finding it increasingly difficult to secure support from their Boards for the staff resource (with the right mix of skills) and growing pressure to deliver services with

unsafe staffing levels, including disproportionate temporary (agency) staff.
The RCN has therefore produced Nursing Workforce Standards (2021), which include standards relating to clinical leadership – each of which includes detailed descriptions for implementation by providers and commissioners. We are actively promoting the adoption of our Nursing Workforce Standards, and we recommend that patient safety policy and regulation frameworks embed them as a safety benchmark.
The Messenger Review recommended a standardised appraisal system. The RCN is clear that any appraisal of nursing staff must be carried out by a registered nurse, with facilitated time to do so.

The latest NHS figures still show the lack of diversity in senior leadership roles and more needs to be done to support and offer opportunities for training and development for global majority and ethnic minority staff in the NHS. More needs to be done on racial inequity, as indicated in the Too Hot to Handle report on the survey of 1,300 NHS staff.

- **How effectively have leadership recommendations from previous reviews of patient safety crises been implemented?**

In 2013, Sir Robert Francis made a series of recommendations as part of the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. These included the recommendations that:

- Nurse leadership should be enhanced by ensuring that ward nurse managers work in a supervisory capacity and are not office-bound. They should be involved and aware of the plans and care for their patients.
- The advice of the nursing director should be obtained and recorded in relation to the impact on the quality of care and patient safety of any proposed major change in nurse staffing or facilities.
- There should be at least one nurse on the executive boards of all healthcare organisations, including commissioners.

The recommendations on clinical nurse leadership in patient care are significant for patient safety, yet they remain unresolved in NHS and government policy. In the context of the registered nurse workforce shortage, which has developed over successive governments, there has been a push within the NHS for nursing leaders to take up managerial, rather than clinical, roles. This shortage creates more pressure on nursing and other clinical and support staff, contributing to increased risk to patient safety, and increased pressure on staff to bear responsibility for systemic and government failures.

In some health and care organisations in England, the Director of Nursing can lack full budget-holding power and operational authority, facing pressure within corporate

Board decision-making to act based on finance instead of what is required to ensure patient safety. Despite having accountability for safe and effective nursing care in services, registered nurse leaders often deal with significant system issues, including and budget constraints, without the right tools and resources to address their challenges. There should be greater collective accountability at Board level for responding to the advice of the executive nurse, including in relation to staffing for safe and effective care.

The RCN recommends that there should be a requirement for variance from Executive Nurse advice in Board decision making to be documented and recorded with rationale. There should also be a standardisation of job descriptions and clinical sessions for direct sight from Board to ward, as well as improved culture and patient safety.

Nursing leadership at Integrated Care Board level in England needs protection in the long term. The UK Government rejected calls from the RCN throughout the passage of the Health and Care Bill to include nursing in the minimum requirements for ICB membership. Doing so would have maintained the statutory regulations of the Health and Social Care Act (2012) which had mandated that nurses would be part of the Clinical Commissioning Group (CCG) governing body. The RCN raised concerns that this could result in a lack of nursing representation at board level and in senior commissioning roles, and the overall uneven representation of nursing across senior levels of the Integrated Care Systems (ICSs).

The RCN remains concerned that the position of the Chief Nursing Officer for England does not have parity with the Chief Medical Officer. Since changes to the position and influence of the Chief Nursing Officer (CNO) for England's role and position were introduced in 2011, the RCN has publicly highlighted concerns about the loss of influence for the CNO in England. There continues to be a lack of parity between the role, position, and influence of the CMO and that of the CNO in England, with nursing missing a seat at the most senior levels of decision-making. While it is positive that there are senior nursing roles across public health, the NHS and social care, without an overarching senior nursing role, there is a risk of fragmentation and lack of oversight.

- **How could better regulation of health service managers and application of agreed professional standards support improvements in patient safety?**

Within the NHS, there are significant variabilities in individuals' experience of care and patient safety. Health service managers' decisions on spending priorities affect staffing levels and the culture in which organisations operate. Health service leaders must be held to account for their failings as these can cost lives, as we have observed

from every enquiry. Better regulation and vetting systems will ensure those who have failed their duties cannot get other roles in other health and social care system organisations. This will safeguard the public.

Any change in regulation should be accompanied by improved monitoring and evaluation of both intended and unintended consequences. To ensure patient safety in light of changing population health need, there is a need for regulation models to enable flexibility and timely response to the development of professions and professionals to meet current and future population need. This includes the move from reactive and punitive models to proactive, supportive and preventative models.

Generally, if changes introduce strategies for addressing systemic problems in healthcare rather than focussing exclusively upon the individual, we expect better public protection, learning from mistakes and fewer referrals of nurses to their regulator. Nursing staff are increasingly being held accountable for system failures. The costliest and most distressing cases for our members are those which go to Tribunal. Streamlined processes that can deal with cases at the earliest stage compatible with maintaining public protection and greater use of consensual disposals would reduce the trauma of being involved in a fitness to practise case for our members and contribute to a healthier learning culture in the NHS.

However, properly examining the bigger picture when things go wrong and following up on the learning that arises is not necessarily less expensive but should be seen as a good investment in public safety and reduced harm to patients. This was the airline industry's experience in undertaking such thorough investigations into crashes, with great benefits for safety in the long term, an approach from a different safety critical industry which should be applied to the healthcare sector, and nursing as a safety critical profession.

- How could investigations into whistleblowing complaints be improved?

Employees who raise concerns frequently experience a significant degree of stress and anxiety, as demonstrated by the numerous public examples of whistleblowers being vilified by employers and colleagues. To minimise the effect on their mental health and try to prevent or at least minimise the amount of time lost to stress-related sickness absence, every effort should be made to deal with investigations promptly and provide support to the whistleblower throughout.

Whistleblowers often feel vulnerable to retribution or at least being shunned by colleagues/Line Managers. This can place intolerable pressure on whistleblowers, whose identity is often worked out even when the disclosure is anonymous.

Sometimes, whistleblowers are moved or not required to attend work, and if this is not done with full consultation and agreement, it can feel like a punishment.

This could be improved by ensuring whistleblowers are supported by a manager with sufficient authority to deter retribution/take action. Where the whistleblower is a nurse, a senior nurse should be fully involved. If the manager in the supporting role takes no part in the disclosure investigation, they can focus fully on providing support without having to take a view on the subject matter of the disclosure, which might taint their view and affect their support of the whistleblower.

Some investigations are carried out without keeping the whistle-blower informed which can lead to a perception that they are being ignored, and when conclusions are reached if they are not fully explained can give the impression that they were not listened to or were being ignored. Open and transparent processes that trust the whistleblower to maintain confidentiality of the information would be a more collaborative approach which should help counter the feelings of isolation that the employee might feel when challenging colleagues, and foster trust that they are being listened to.

Whistleblowing policies should be designed to be “user friendly” and consistent with grievance procedures as far as possible. They should also not depend on the employee having to spend time completing extra forms after they have already disclosed in the first place. Managers should be trained to understand when disclosure of information or complaint on the part of an employee should be treated as “whistleblowing” so that the employee can be assured that a procedure is being followed and understand what they can expect.

Some whistleblowers, when they suspect that their complaints will be ignored breach confidentiality by, for example, taking a picture of a patient or medical notes without consent, thereby committing an act of misconduct resulting in a real detriment caused by the disclosure. In cases where whistleblowers breach confidentiality during disclosure, careful and sensitive consideration should be given when considering disciplinary measures, considering the whistleblowers motives and the effect that disciplinary action might have on employee’s willingness to speak out in future.

The time that investigations take can be protracted and add further stress to the employee who raises the issue in the first place. Every effort should be made to shorten the time an investigation takes.

Some Trusts pay external HR consultancies and solicitors to investigate complaints relating to whistleblowing. The role of HR professionals employed by those Trusts is

unclear. Those investigations tend to take long time and their quality can vary greatly. If the public purse is to fund such investigations, there should be a minimum standard set relating to the experience, independence and quality of such investigators.

- **How effectively does the NHS complaints system prevent patient safety incidents from escalating and what would be the impact of proposed measures to improve patient safety, such as Martha's Rule?**

Nursing staff are patients' greatest advocates and stand ready to ensure Martha's Rule has an immediate impact and leaves a lasting legacy. By listening and engaging, nursing staff and other clinicians can help reduce anxiety and take essential steps to improve care and advance learning.
Safe and effective levels of nursing staff will be crucial to implementing Martha's Rule, ensuring enough professionals can provide a second opinion when called upon to do so. We welcome the evaluation that will be undertaken as part of the rollout into the NHS in England.

RCN members brought incident reporting as a Congress item in 2023. They shared that some organisations specifically ask staff not to put in incident forms. No actions or changes to practices occur after raising concerns and in some cases, no feedback or response is provided.
It is important that patient safety incidences and near misses are reported and this is encouraged by all organisations. The incident must be reviewed and investigated to prevent further harm and devastation, through recognised methodology such as rapid clinical judgement reviews, as these ensure a swifter response, owned by clinical staff.

- **What can the NHS learn from the leadership culture in other safety-critical sectors e.g. aviation, nuclear?**

The RCN is clear that skilled nursing labour is not adequately understood in healthcare. That modelling is akin to service industries such as hospitality and retail, despite the professional holding extremely high operational risk. As part of this, the nursing workforce is seen as an expensive commodity rather than the most significant safety critical asset in the healthcare sector. We agree with the assertions of the nursing workforce expert Alison Leary, who articulates this fundamental difference between healthcare and other industries. Leary alerts to the risks of reducing expertise into delivery of tasks, in the assumption that these can be divided and delegated to support staff.

The reality is that such reductionist, efficiency based approaches are likely to underestimate workload in complex, high risk work because the relationships between the workforce and outcomes are complex. This has resulted in a narrow focus on healthcare as a series of tasks to be completed rather than the delivery of person-centred care. This kind of reductionism is also associated with workforce dissatisfaction because it can be dehumanising. The nature of clinical work is people-oriented, both an art and a science. It is not focused on simple deliverable products.

The idea that healthcare work simply comprises a set of 'tasks' perpetuates the idea of task shifting between groups of workers. It reinforces the concept that all is required to meet demand is to "upskill" other workforces to close the gap.

The RCN fully endorses this analysis of the healthcare sector and urges policy makers to test health and social care policy and delivery in how safety critical workforce planning is built into service planning, as it is in other industries which have measures such as safety critical staffing levels (ratios).

We will be focusing on these issues in our response to the government's consultation on the pay structure for nursing staff in the NHS, which closes in April 2024. Experienced registered nurses teach, support, develop and guide in the next generation of nursing staff and other healthcare professionals in the clinical areas. It is therefore essential that all policy frameworks and system structures enable the role of clinical leadership in delivering safe and effective patient care, which currently it does not.