

Guest editorial

Joining up the dots of patient safety

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Background

In his *BMJ* editorial after the General Medical Council (GMC) hearing of the Bristol case, Richard Smith quoted Yeats' famous phrase: 'all changed, changed utterly'.¹ His point was that the way medicine is regulated would fundamentally have to alter. No longer would patients blindly trust their doctors because 'doctor knows best'. Smith foresaw a world where the doctor–patient relationship would be one of greater equality. And it is true that things were changing. In the previous December, the Government had launched its white paper *The New NHS: modern and dependable*, in which NICE (The National Institute for Health and Clinical Excellence) and the CHI (The Commission for Health Improvement) were established.² Both these bodies marked a response to increasing concerns about how the quality of patient care could be both standardised and monitored. And in the same month as Smith's editorial, the Secretary of State Frank Dobson established the Bristol Inquiry under the chairmanship of Sir Ian Kennedy, which was to report in 2001.³ Although it is true that the catalyst for these events was primarily individual medical practitioners, it is also true that health care is increasingly about both teams and systems of care delivery. Whatever the case, the landscape for healthcare regulation has fundamentally changed. Ironically, there then followed a series of high-profile medical disasters that engendered inquiries of their own, the most notorious being that into Harold Shipman. How had they been able to practise as poorly, as dishonestly or as murderously as they had? All this forms the backdrop to the white paper *Trust, Assurance and Safety* published last February, nearly 10 years after Smith's challenging editorial.⁴ In it the present Secretary of State looks forward to a 'framework in which patients, the public, the professions and the Government can secure a new settlement' for the delivery of health care.

Modern regulation

One of the major recommendations of The Bristol Inquiry was that patients' needs should have a guaranteed place at the centre of the delivery of care, and that there is a link between individual professionals and the systems they work in. This has permeated down into how regulation is now delivered. Regulators no longer work in isolation from their registrants, the educators, the employers, other regulators of both individuals and systems, and, finally, those who use the services of healthcare professionals. The new legislation that arises out of the recent White Paper places a positive duty on regulators to co-operate.

At the Nursing and Midwifery Council (NMC) we have looked to do this in a number of ways. We have established guidance for employers and professional bodies for when it will be necessary to refer practitioners to the NMC for lack of competence. We have signed memoranda of understanding with bodies like the Health Care Commission and other European regulators. Together with educators we have introduced a new system of quality assurance based on risk. We have worked with the General Teaching Council and the Social Care Council in England to produce a shared set of values and vision for those on our respective registers who work with children. We have collaborated with the four government health departments in different ways, as an acknowledgement that healthcare delivery is increasingly different throughout the UK; as a UK regulator we have to be increasingly aware of that. Finally, we are finding new ways of working with patients and the public to ensure that their voice is heard in the regulation of nurses, midwives and specialist community public health nurses.

Also, as a modern regulator, we are increasingly accountable in the same way as individual healthcare professionals are accountable. Both Sir Ian Kennedy and Dame Janet Smith, who chaired the Shipman Inquiry, were very critical of what they termed 'the

club culture' in some medical institutions. They maintained that these institutions could by some be seen as looking after their own, to the detriment of patients and patient safety. The recent White Paper seeks to avoid any charge of 'perceived partiality', with a heavy focus on the governance and the accountability of regulators. At present over half the council members of the NMC are elected; as such they could be seen to be representing a constituency rather than the public interest. So for all regulators this will mean the end of elections and a move to smaller, more board-like councils. From 2009, all the members of the new style boards will be appointed independently by the Appointments Commission, and there will be parity between registrant and lay members on all the councils. Instead of being accountable to the Privy Council we shall all be directly accountable to Parliament, and in some cases to the devolved administrations as well.

The Council for Healthcare Regulatory Excellence (CHRE), which was set up in the wake of the Bristol Inquiry, has the responsibility of carrying out performance reviews of the nine health regulators, and in addition looks to the promotion of best practice and harmonisation among us. It is important to note that harmonisation does not mean that one size will fit everyone. The regulators range from ourselves at one end, with 682 000 on our register, to the chiropractors with less than 1000 at the other, and we all practise in a wide range of settings. Standardisation would be neither worthwhile nor potentially so. CHRE has therefore developed a set of performance criteria that focus on the core work of regulation, but that are still flexible enough to acknowledge the different regulator profiles. CHRE also has a further, very specific task in monitoring every 'fitness to practise' decision from each regulator, to ensure that the decision has not been unduly lenient from the standpoint of public protection. Initially this was the subject of a certain amount of legal activity in the courts. However, there has been much learning from all parties and this has been fed back into future learning.

The White Paper also recognises the need for regulators to be active in sustaining and improving professional standards. A major piece of this work will consist of a system of revalidation that is cost-effective, that acknowledges the different risks in the delivery of health care, and that does not create unnecessary burdens. This is likely to be one of the greater challenges that arises from the White Paper, and it is likely to take many years to develop and pilot. In the NMC's case it will be important to build on existing quality systems that are already supporting the profession's desire to improve standards. Smith was clear that the fundamental changes he spoke of should not just be about 'removing bad apples', but should serve to improve the whole system as well. Regulation is about joining up the dots, so that a coherent picture of quality and patient safety may be developed and, most important of all, delivered.

REFERENCES

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- 4 HM Government. *Trust, Assurance and Safety. The regulation of health professionals in the 21st century*. Cm 7013. London: HMSO, 2007.

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