

NMC response to the Francis report

**The response of the Nursing and Midwifery
Council to the Mid Staffordshire NHS
Foundation Trust Public Inquiry report**

18 July 2013

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Foreword from Mark Addison and Jackie Smith

As the professional regulator for nurses and midwives in all four countries of the United Kingdom, we exist to protect the public. The vast majority of healthcare professionals, including the vast majority of the 674,000 nurses and midwives on our register, work hard to provide good quality care for the millions of patients they look after.

Sadly, some do not. The events at Stafford Hospital exposed in the two Francis Inquiry reports, and those at other settings which have been the subject of similar reports, show us what happens when things go wrong, when the interests of patients are not put first and when their concerns are not listened to. This can never be excusable.

Since the publication of the first Francis Independent Inquiry report in 2010, we have recognised that we need to play our part in raising standards and bringing about the changes in culture which are so critical to improving patient safety and making healthcare patient focused. As a regulator, we can do this in three ways.

First, by setting standards for the education of those wanting to become nurses and midwives. These standards need to highlight the importance of the values of compassion and care alongside the essential clinical skills needed in the twenty first century. This work has already been done. The first cohort of nurses to be educated under our new education standards will start professional practice next year. We will now evaluate the new standards to see if any further improvements need to be made.

Second, we need to ensure that the nurses and midwives who join our register continue to demonstrate those key values and remain capable of safe and effective practice throughout their careers. Those values and the duty to put patients first are clear in our Code and the standards we set. This is what we mean by revalidation or continued fitness to practise. We are planning to introduce a fair and proportionate system of revalidation for all nurses and midwives by the end of 2015.

Third, we need to have effective systems in place to deal promptly and fairly with those nurses and midwives who do not continue to demonstrate those values of compassion and care and who act in a way which presents a serious risk to patients or the wider public. This is the role of our fitness to practise directorate. We have made significant improvements in how we deal with such cases over recent years. We know that more progress is still needed.

We can only take effective action if we know about the concerns in the first place. In the past professional regulators only acted on individual referrals. This meant, as happened in Mid-Staffordshire, that inadequate regulatory action was taken. This situation has already changed at the NMC. We now proactively open cases in the light of information we receive from other sources. We recognise that there is more to do.

We need to raise our profile so that the public and employers understand our role and how to bring serious concerns to our attention. We also need to work more closely with other regulators across all four countries of the United Kingdom to share data and intelligence so that the right action can be taken promptly by the right body to safeguard the public.

The primary responsibility for providing a good standard of care and treatment rests with the individual nurse or midwife. They need to be supported in providing that care by their employer or the setting in which they work. The vast majority of concerns raised by patients should be resolved at that local level. We strongly support the need for more effective local complaints arrangements and the need to encourage an open, learning and patient focused culture across all healthcare settings. We are planning to introduce new regional representatives to support local arrangements for resolving complaints, and putting things right, where possible.

In this response, we set out what we have already done and what further action we are planning to take to fulfil our key role of protecting the public across all four countries of the United Kingdom. We also hope this will help to restore the faith of the public in the professions we regulate and the many healthcare settings in which they work.



Mark Addison

NMC Chair



Jackie Smith

NMC Chief Executive

Our role and purpose

- 1 We are the nursing and midwifery regulator for England, Wales, Scotland, and Northern Ireland. Everything we do as a regulator supports our primary purpose of protecting the public:
 - We set standards of education, training, conduct and performance for nurses and midwives across the UK.
 - We hold the register of those who have qualified and meet those standards.
 - We have fair and effective fitness to practise processes to investigate and deal with nurses and midwives who fall short of our standards.

Introduction

- 2 In February 2013, the Mid Staffordshire NHS Foundation Trust Public Inquiry reported to the Secretary of State for Health (the Francis report).
- 3 In March 2013 the government published its initial response to the Francis report. In that document the NMC signed up to the Statement of Common Purpose in which we pledged to learn the lessons from Mid-Staffordshire. This document sets out how we are fulfilling that pledge.
- 4 The Francis report was primarily concerned with failures in an acute hospital setting and made many recommendations which were specifically addressed to the healthcare system in England. Our registrants work in a wide variety of healthcare settings including primary care, care homes and the private sector as well as acute settings in all four countries of the UK. In responding to a national report of this nature we need to ensure that any recommendations we accept and any changes we make to our Code, standards or procedures can be applied in all settings across the UK.

What we have done since the first Francis Independent Inquiry report in 2010

- 5 We made a number of significant changes after the publication of the first Francis Independent Inquiry report in 2010¹ which started to address some of the key concerns raised:
 - We published new standards for pre-registration nursing education in 2010 which place significant emphasis on care and compassion for patients.
 - We launched new guidance for nurses and midwives on raising and escalating concerns and on the care of older people.
 - We introduced a helpline for directors of nursing as the first point of contact to discuss fitness to practise issues.

¹ Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009

- We held employer roadshows and events to raise our profile and ensure employers were clear about when to refer concerns to the NMC.
- We developed a new process to encourage early resolution of fitness to practise cases and a new voluntary removal process.
- We developed greater transparency by ensuring details of nurses and midwives who have been struck off or suspended in the last five years are visible to the public via our online search facility.
- We began work on an appropriate model of revalidation to ensure continuing fitness to practise of all nurses and midwives.

What we have done since the Francis report was published on 6 February 2013

- 6 Since the Francis report was published in February 2013, it has been discussed at each Council meeting and copies of all the related Council papers are [available on our website](#). A newly constituted Council was appointed in May 2013 and decided to publish this full response document setting out our decisions and actions in July 2013.
- 7 We intend to continue to report our progress at each Council meeting and to keep the [Francis page](#) of our website updated with any significant developments. We will also include details of our progress against our planned actions in our reports to the Parliamentary Health Committee.
- 8 We have also been engaging with the various reviews being led by other organisations to address some of the key issues raised in the report including:
 - 8.1 The Cavendish Review into healthcare assistants and support workers.
 - 8.2 The Ann Clwyd/Tricia Hart Complaints Review.
 - 8.3 The NHS Bureaucracy review.
 - 8.4 The steering group for pilots led by Health Education England (HEE).
 - 8.5 The Professional Standards Authority (PSA) review relating to procedures for multi-regulator cases.
 - 8.6 A new PSA review looking at how professional regulation can encourage registrants to be candid.
 - 8.7 The Don Berwick safety review.
- 9 We have already embarked on a programme of further work to respond to a number of key recommendations in the Francis report.

Summary of planned actions

Planned Action	Current timetable
<p>1. Raising our public profile and encouraging appropriate referrals to improve our ability to act promptly to protect the public</p>	<p>Website re-launch – by April 2014 New public and employer guidance documents – by April 2014 Public and patient facing information about the new Code – by Dec 2014 This work is also supported by our plans for strategic engagement and our ongoing work with patient and public groups</p>
<p>2. Developing more risk-based and proportionate fitness to practise processes to ensure that our resources are effectively targeted on public protection and introducing regional advisers to provide employer liaison and advice</p>	<p>Paper to Council on options for more risk-based and proportionate fitness to practise processes – Sept 2013 Designing an operating model for regional advisers – July–Dec 2013 Pilot of model for regional advisers – Jan–June 2014 Evaluation of pilot and further development work – July–Dec 2014 Implementation of regional adviser model – Jan 2015</p>
<p>3. Improving our joint working and intelligence sharing arrangements with other professional and systems regulators</p>	<p>Finalise new operational protocol and data sharing agreement with the Care Quality Commission (CQC) – by Dec 2013 Explore data sharing agreement with the General Medical Council (GMC) – by April 2014 Review and update all existing Memorandum of understanding (MOUs) and agree a new MOU with the Disclosure and Barring Service (DBS) – by April 2014 Develop operational protocols and data sharing agreements with systems regulators in other UK countries and other UK professional regulators – during 2014–15</p>
<p>4. Improving the NMC witness experience for those involved in fitness to practise proceedings</p>	<p>Analysis of witness feedback and interviews, scoping of plans and introduction of any quick changes – by Dec 2013 All new witness support arrangements in place – by April 2014</p>

<p>5. Reviewing the Code² and other practice standards</p>	<p>Gather initial evidence for the Code and standards review, aligned with revalidation consultation – Sept–Dec 2013 Development of new code and standards for practice supported by relevant guidance to deliver revalidation and respond to Francis – Nov 2013 – March 2014 Code and standards formal consultation on the basis of substantive draft – April –July 2014 Further development of code post consultation – July – Nov 2014 Council approval of new code and standards – Nov 2014 Publication of new code and standards – Dec 2014</p>
<p>6. Evaluating our pre-registration education standards</p>	<p>Establishment of Education Advisory Group – Nov 2013 Methodology scoped and agreed with Education Advisory Group – March 2014 First phase of evaluation based on agreed methodology – June 2014 Report to Council on first phase – Sept 2014 Development of further evaluation work will be informed by results of first phase.</p>
<p>7. Making changes to our legislation so that our processes are more efficient and allow us to more effectively protect the public</p>	<p>Section 60 timetable fixed by the Department of Health (DH) DH Resources Board – July 2013 Drafting and consultation – 2013/14 Legislative changes in force – by July 2014</p>
<p>8. Developing a proportionate revalidation model</p>	<p>Options paper to Council – Sept 2013 Development of new code – by Dec 2014 (see detailed timetable above) Implementation of agreed model – by Dec 2015</p>

Our responses to the recommendations

- 10 The Francis report contains 290 recommendations. Some of these are addressed singly or jointly to the NMC but there are a significant number of other recommendations which may directly or indirectly affect the work of the NMC. In the body of this response, we have outlined our approach to the key themes and recommendations that are directly or indirectly relevant to us. We have broadly followed the order of the report but have grouped together some of the related recommendations. We have detailed the actions we have taken or will take in response and the timescales for those

² The code: Standards of conduct, performance and ethics for nurse and midwives

actions. For ease of reference, a table summarising our responses to each recommendation in numerical order appears at the end of this response.

Putting the patient first and fundamental standards of behaviour (5–12)

- 11 We support all the recommendations relating to the need for healthcare professionals and organisations to ensure that the interests of patients are always put first. These recommendations also highlight the need to raise awareness of, and ensure compliance with, professional codes across the NHS. This need to raise awareness can also be applied to the wider healthcare environment and to all four countries of the UK.
- 12 All nurses and midwives are bound to comply with “The code: Standards of conduct, performance and ethics for nurse and midwives” (the Code). The Code requires all registered nurses and midwives to meet very similar standards to those set out in the Francis report and we will ensure that in any future revised Code, the principle of always putting patients first is reiterated.

The people in your care must be able to trust you with their health and wellbeing.

To justify that trust, you must:

- **make the care of people your first concern, treating them as individuals and respecting their dignity.**
- **work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community.**
- **provide a high standard of practice and care at all times.**
- **be open and honest, act with integrity and uphold the reputation of your profession.**

The code: Standards of conduct, performance and ethics for nurses and midwives

- 13 We have also issued guidance on *Raising and escalating concerns*³ to highlight the professional duty on all nurses and midwives to report patient safety incidents and highlight concerns about safeguarding and the care environment. Further details of this guidance are set out in paragraph 28.
- 14 We support the introduction of fundamental standards by the CQC and will be responding to the CQC consultation. As part of our planned review of the Code (outlined in paragraph 71), we will ensure that a duty to comply with any relevant national fundamental standards that are introduced is included in the revised Code. This will mean that responsibility for a breach of any fundamental standard by a nurse or midwife responsible could result in regulatory action, including a striking off order. We will engage with

³ *Raising and escalating concerns -Guidance for nurses and midwives* (NMC 2010)

Northern Ireland, Wales and Scotland to consider whether similar proposals might be developed.

Effective complaints handling (109–122)

- 15 We support the need for improvements in complaints handling arrangements across the NHS and the wider healthcare environment. We are not a complaints body and we recognise that many patients' concerns are resolved most quickly and effectively locally. Action by a professional regulator should only be taken if there is a serious fitness to practise issue which requires regulatory action to protect the public.
- 16 The Code places specific duties on nurses and midwives in dealing with concerns or complaints raised by patients.

- **You must give a constructive and honest response to anyone who complains about the care they have received.**
- **You must not allow someone's complaint to prejudice the care you provide for them.**
- **You must act immediately to put matters right if someone in your care has suffered harm for any reason.**
- **You must explain fully and promptly to the person affected what has happened and the likely effects.**
- **You must cooperate with internal and external investigations.**

The code: Standards of conduct, performance and ethics for nurses and midwives

- 17 Our new *Standards for pre-registration nursing education* (the education standards) were set in 2010. The previous 2004 standards were updated and strengthened as a result of the findings of the first Francis Independent Inquiry report and emerging evidence at that time. The first nurses to have followed programmes approved against these new standards will commence practice in 2014.
- 18 The education standards lay down key competencies which are relevant to communicating with patients and complaints handling, including the following requirements:
 - All nurses must act first and foremost to care for and safeguard the public. They must practise autonomously and be responsible and accountable for safe, compassionate, person centred, evidence-based nursing that respects and maintains dignity and human rights.
 - They must show professionalism and integrity and work within recognised professional, ethical and legal frameworks. They must work in partnership with other health and social care professionals and agencies, service

users, their carers and families in all settings, including the community, ensuring that decisions about care are shared.

- All nurses must recognise when people are anxious or in distress and respond effectively, using therapeutic principles, to promote their wellbeing, manage personal safety and resolve conflict.
 - They must use effective communication strategies and negotiation techniques to achieve best outcomes, respecting the dignity and human rights of all concerned.
- 19 There are also a number of key skills that should be reflected throughout the pre-registration education programme, some of which directly address complaints handling.

Care, compassion and communication outcomes –

People can trust the nurse to engage therapeutically and actively listen to their needs and concerns, responding using skills that are helpful, providing information that is clear, accurate, meaningful and free from jargon and using appropriate and relevant communication skills to deal with difficult and challenging circumstances.

Organisational aspects of care outcomes –

People can trust a nurse to respond to their feedback and a wide range of other sources to learn, develop and improve services by sharing complaints, compliments and comments with the team in order to improve care, actively responding to feedback, supporting people who wish to complain.

Key skills clusters from NMC Standards for pre-registration nursing education 2010

Improving the NMC witness experience

- 20 We recognise that improving the experience of patients, complainants, registrants and other witnesses involved in our fitness to practise proceedings is essential to public protection and public confidence. As part of a recent internal review of our adjudication procedures we identified a number of areas where our engagement and interaction with witnesses could be improved and we set up a working group to look at this issue.
- 21 The working group analysed feedback from witnesses and identified many opportunities for improvement. We are now conducting face to face interviews of witnesses at all our hearing venues in London and Edinburgh. We are also carrying out an internal survey about how our staff currently engage with witnesses.

- 22 Once we have collated all the feedback we will make some final decisions about what steps to take but the ideas being considered include the following:
- More information on the NMC website about hearings including an interactive video or map of the hearing room which explains the layout, parties and process in order to demystify the experience for witnesses.
 - New points of contact for witnesses at all stages of the process and provision for meeting specific needs of individual witnesses and customers, particularly vulnerable witnesses.
 - The development of an end to end system for witness support that continues after the hearing is complete to ensure the witness has an understanding of what has happened and that deals with issues that may arise from their experience. This will also feed information and learning back into the organisation.
 - Extending our existing practice of allowing witnesses to visit a venue before a hearing, to more witnesses. These visits may include a tour and a meeting with witness liaison teams. We will also increase availability of site visits and presentations.
- 23 We will improve the information on our website about the availability of witness support and visits by September 2013. We will complete our analysis of the feedback, make any further quick improvements and scope any longer term plans by December 2013. We will have all the new arrangements in place, including the website changes, by April 2014.

Clwyd/Hart Complaints Review

- 24 We have been contributing to the Ann Clwyd and Tricia Hart Complaints Review and have agreed to make the following pledges:
- Our Code and education standards include clear duties on nurses and midwives in relation to complaints handling, communication with patients and raising concerns. We will be undertaking a planned review of the Code and other practice standards in the next year as part of the preparation work for revalidation. We will ensure that these duties are highlighted in the revised Code which will form the benchmark for appraisals and revalidation. We will also take more immediate steps to raise awareness of these duties and our guidance on raising concerns amongst nurses, midwives and the public.
 - We will improve the experience of patients and other complainants who become involved in our fitness to practise proceedings by providing more information and support throughout the process.
 - We will work more closely with other regulators and healthcare organisations to share data and intelligence including, where appropriate, complaints information and patient feedback, in order to enable us to better protect the public.

Openness, transparency and candour (173–183)

- 25 We support the recommendation that every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and that organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.
- 26 The Code requires all registered nurses and midwives to be open and honest and act with integrity, to give a constructive and honest response to anyone who complains about the care they have received, and to explain fully and promptly what has happened and the likely effects if someone in their care has suffered harm for any reason. Our education standards also address these areas. Taken together, these duties are akin to a professional duty of candour.
- 27 We also support the recommendation that any statement made to a regulator or a commissioner in the course of its statutory duties must be completely truthful and not misleading by omission. As stated above, the Code requires all registered nurses and midwives to be open and honest and act with integrity and it also requires them to co-operate with internal and external investigations.
- 28 The Code also places a clear obligation on nurses and midwives to act without delay if they believe that they, a colleague or anyone else may be putting someone at risk. They are also under a duty to raise concerns if they experience problems that prevent them from working within the Code or if problems in the care environment are putting patients at risk. These standards are explained further in *Raising and escalating concerns guidance - Guidance for nurses and midwives* (NMC 2010), which highlights the professional duty on all nurses and midwives to raise concerns on safeguarding and the care environment.

As a nurse or midwife you have a professional duty to report any concerns from your workplace which put the safety of the people in your care or the public at risk.

Speaking up on behalf of the people in your care and clients is an everyday part of your role and just as raising concerns represents good practice, 'doing nothing' and failing to report concerns is unacceptable. Failure to report concerns may bring your fitness to practise into question and endanger your registration.

Raising and escalating concerns - Guidance for nurses and midwives (NMC 2010)

- 29 A breach of any of the duties set out in the Code by a registered nurse or midwife can lead to regulatory action including a striking off order. We are committed to ensuring that in any future revised Code the importance of

these duties are highlighted. Further details of our planned review of the Code are set out in paragraph 71 below.

- 30 We recognise that we need to do more work to ensure that these duties are understood by nurses, midwives, employers and the public. We also agree that a lot of work still needs to be done across the NHS and the wider healthcare environment to ensure that any cultural, systemic and other barriers to compliance with these duties by front line staff are removed or reduced.
- 31 We understand that the recommendations relating to a new statutory duty of candour and related criminal liability for individuals are being considered by the Don Berwick safety review and we await the conclusions of that review with interest. We have also been invited to contribute to a new review by the PSA looking at how professional regulation can encourage registrants to be candid.
- 32 Whilst the need for candour is clear, any such legislative steps will have profound implications and the benefits and impact need to be fully explored. In particular, it is important to ensure that patient safety will be enhanced and that the other key recommendations about the need for a new culture of openness and organisational learning across the NHS and beyond are not undermined.
- 33 Recently, we held a listening event for a large group of our stakeholders in relation to this issue. There was broad agreement on the need for more openness and candour but diverse views on how this is best achieved. There was some support for a statutory duty of candour but considerable concern about the consequences of introducing criminal sanctions. We will be feeding back on the full range of views expressed to the PSA and exploring ways to raise public awareness of the existing professional duty in the Code.

Nursing education (185,189,190)

- 34 We are responsible for setting the UK-wide standards for all pre-registration nursing and midwifery education. We fully support the recommendation that there should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. We have already taken steps to meet this recommendation in relation to the education standards for which we are responsible.
- 35 As explained in paragraph 17 above, our new education standards were set in 2010. They have been gradually introduced by universities since September 2011 and all of them must be compliant by September 2013. The first intake of student nurses to have completed these new programmes is expected to register with the NMC in September 2014.
- 36 These new education standards directly address all the matters raised in this recommendation as well as the 6Cs (*Compassion in Practice*

*initiative*⁴). For example, the standards focus on patients' needs for 'communication, compassion and dignity' and the key skills guidance contains specific provisions on 'care, compassion and communication'.

- 37 The education standards on selection and admission are values based, specifically focusing on good character. This priority continues throughout their studies, as students cannot pass each of the three progression points during the course unless they can demonstrate safety, safeguarding and protection, professional values, expected attitudes and the behaviours that must be shown towards people, their carers, families and others.
- 38 We recognise the importance of ensuring the high quality of practice placements for nursing and midwifery students. From September 2013, our standards will be quality assured through a new framework, featuring proactive management of emerging risk by ensuring that universities.
- 39 We also recognise the new role played by Health Education England (HEE) in providing national leadership and strategic direction for education, training and workforce development for the whole NHS workforce in England. We look forward to working with HEE on areas of work relevant to nurses and midwives.

Evaluation of education standards

- 40 We are now planning a robust evaluation process for our new education standards. We understand that the public will want to be reassured that, once they have been fully rolled out, the new standards will address some of the most serious concerns raised in the Francis report. In particular, the concerns about the time spent by nurses and midwives in practice during their training and the content of their courses with regard to communication and the values of dignity, compassion and care. This evaluation will give us a proper evidence base for further revisions to these new standards.
- 41 We will be establishing an Education Advisory Group in November 2013 to advise on the methodology and scope of our evaluation, with particular regard to the new issues raised in the Francis report and any further developments. The methodology will be scoped and agreed with the Education Advisory Group by March 2014 and the first phase of the evaluation based on the agreed methodology will be completed by June 2014. This is likely to be focused on the areas of admission and aptitude as the first students will not yet have completed their courses. We will report to Council on the first phase in September 2014. Thereafter, further evaluation work will be undertaken.

Practical hands on training and experience (186–7)

- 42 We understand the concerns which led to the recommendations relating to the importance of practical experience but we believe that those concerns have already been addressed as a result of the steps we have taken to

⁴ Compassion in Practice: *Nursing, Midwifery and Care Staff - Our Vision and Strategy* (Department of Health and NHS Commissioning Board, December 2012)

introduce new education standards for nurses and midwives since the time of the events in Mid-Staffordshire.

- 43 All of our full time nursing education programmes last at least three years and require 50 percent of time to be spent in hands-on training in a practice setting and 50 percent in academic study. The courses are divided into stages and students cannot progress to the next stage of the course unless they have undertaken a period of practice learning and assessment. We feel satisfactory completion of such a period of hands-on training at an early stage of the course, as a requirement for continuation in nurse training, meets the spirit as well as the letter of recommendation 187. Progression is staged to enable students to demonstrate their increasing competence and ability to operate independently and make safe and effective use of practice learning.
- 44 Currently formal learning and supervised work as a healthcare support worker can be counted through accredited prior learning routes. Conversely, requiring candidates for nursing education programmes to undertake a minimum period in a healthcare support worker post may not advance patient safety as supervision and mentorship cannot be guaranteed.
- 45 We note that in the government's initial response to the Francis report, it made a new proposal in relation to pre-training work experience for prospective nursing students in England which went further than recommendation 187. This proposal is now going to be explored further by means of a series of pilots and we are represented on the steering group led by HEE for those pilots.
- 46 It will be important that the pilots establish whether there is a clear evidence base for introducing a mandatory requirement of this nature, over and above the existing practice elements for student nurses outlined above, or whether the spirit of the government's proposal can be best addressed in other ways.
- 47 We note the issues raised in the Council of Deans *Working paper on Healthcare assistant experience for pre-registration nursing students in England* and look forward to seeing how these concerns are addressed in the evidence from the pilots.
- 48 We are also interested to see how the government's proposal links in with recommendations in the recently published Cavendish Review into healthcare assistants and support workers, and in particular, whether the prospective nursing students would have to undergo the minimum training to be introduced for healthcare assistants before being allowed to undertake their practice placements. If this is the case, it will be important to understand how the costs and resources implications of such a requirement would be addressed and what arrangements would be made for students under the age of 18.
- 49 Finally, we note this proposal only concerns prospective nursing students in England and the final decision on its implementation will rest with the

government. If any wider proposal was being considered to make such work experience a pre-admission requirement in the national pre-registration education standards which apply across all four countries of the UK, there will be a need for us to consult with governments and stakeholders in Northern Ireland, Scotland and Wales.

Aptitude tests (188)

- 50 The education standards require students to be tested for aptitude in literary, numeracy and communication skills and assessed as to health and good character on admission to programmes. In terms of aptitude it should be noted that all students must be assessed as to their fitness for practice in addition to fitness for award before completion of their programme. All students must meet all the theory and practice requirements to complete a programme, and there is no facility to 'compensate' for weak performance on one side with strong performance on the other. Service users and carers also contribute to the nursing programmes through recruitment and assessment in practice.
- 51 Our standards for competence reinforce this by identifying the knowledge, skills and attitudes students must acquire by the end of the programme. For example students must practise in a 'holistic, non-judgmental, caring and sensitive manner that avoids assumptions, supports social inclusion, recognises and respects individual choice, and acknowledges diversity'.
- 52 We are committed to undertaking an evaluation of our new education standards as outlined in paragraph 40 above and we will have particular regard to issues of caring and compassion. This will give us a proper evidence base for any further revisions to these new standards including the need for an aptitude test. As a four country regulator, we will also need to consider the UK-wide implications of the introduction of any such aptitude test.

Nurse leadership (196–7)

- 53 We recognise the importance of good quality nurse leadership to enhance patient care and support the wider nursing workforce. We are not responsible for setting standards for post-graduate leadership training but our education standards require nurses to demonstrate their potential to develop management and leadership skills during their period of preceptorship and beyond. We define preceptorship as a period of structured transition from the student nurse to a more fully rounded professional, aiming at providing a foundation of professional development and improvement.
- 54 Our education standards also require that people can trust the newly registered graduate nurse to be an autonomous and confident member of the multi-disciplinary or multi-agency team and to inspire confidence in others. Nurses are then equipped to become more involved and responsible for the planning and delivery of care and improving future services. The duties in our Code and other standards apply to nurses and

midwives acting in a management or leadership capacity as well as in their clinical roles.

Older person's nurse (200)

- 55 Age UK noted in its response to the Francis report, that: 'At any one time about 65 percent of patients in hospital will be over the age of 65. Many of them will be frail, suffering from dementia and have complicated conditions. We need to ensure our hospitals are equipped to care for older people with skill and compassion'. It went on to say that when Age UK says 'our hospitals', it means equally the staff who work in them. 'We need to ensure all staff are well trained in caring for frail older people and empowered to deliver excellent care supported by senior managers. It also means listening to and working with patients and their families to make sure care is right.'
- 56 The same picture of increasing numbers of older patients exists in other healthcare settings. Against this background, we understand the serious concerns that led to the recommendation for a new status of registered older person's nurse. We believe that we have already started to address those concerns in a number of different ways which will better achieve the same goal.
- 57 We have already moved to recognise societal changes that mean people live longer, have more diverse needs, and make up an increasing proportion of our patient population. We share the view expressed by Age UK above that **all** nurses (and other healthcare professionals) need to be better trained and prepared to deal with the particular needs of older and more vulnerable patients, not just a group of nurses with specialist registration status. We note that this view was shared by the government in its initial response.
- 58 Our education standards for competence specifically require nurses to be attentive to the needs of older people and the key skills make clear the importance of meeting the needs of older adults. We have also recognised the need for more detailed support, developing *Guidance for the care of older people* (NMC 2009) which supports key standards within the Code.



The essence of nursing care for older people is about getting to know and value people as individuals through effective assessment, finding out how they want to be cared for from their perspective and providing care which ensures that respect, dignity and fairness are maintained.

Most of the principles of care identified in this guidance are not specific to older people but are what anyone receiving care would desire irrespective of age. Older people do not have a particular need for the care outlined here compared with any other age group but it would appear that they are less likely to receive this care because of the inherent ageism in our society.

Guidance for the care of older people (NMC 2009)

- 59 During the approval of pre-registration nursing programmes we look for a clear indication of how students will learn to care for older people and we will monitor the outcomes of this through our quality assurance activity. We will also pay particular regard to this issue during our planned evaluation of the new education standards outlined above. This will give us a proper evidence base for any further revisions to these new standards or any further steps we need to take to address this important issue.
- 60 It should also be noted that universities already offer postgraduate qualifications enabling nurses to specialise in the care of older people should they wish to do so.

Healthcare support workers (207 – 213)

- 61 We understand the concerns that have led to the many recommendations in the Francis report relating to healthcare support workers. We support the recommendations for a code of conduct and the setting of minimum standards for the education and training of healthcare support workers in England and for the introduction of uniform descriptions and means of identification. We are aware that there are a number useful precedents in other parts of the UK from which England could learn in ascertaining what makes a difference to the performance of healthcare support workers.
- 62 We have also addressed the issue of the relationship of registered nurses to healthcare support workers to the extent our remit allows. The Code makes nurses and midwives accountable for decisions to delegate care to a support worker. A nurse or midwife must only delegate to a support worker who has had appropriate training and whom they deem competent to perform the task. The nurse or midwife must then confirm that the outcome of the delegated task meets required standards. Nurses and midwives are under a duty to raise a concern if they do not feel able to meet the duties in the Code by delegating a particular task to a healthcare support worker.

Work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community

Delegate effectively

- You must establish that anyone you delegate to is able to carry out your instructions.
- You must confirm that the outcome of any delegated task meets required standards.
- You must make sure that everyone you are responsible for is supervised and supported.

The code: Standards of conduct, performance and ethics for nurses and midwives

- 63 We note the very recent publication of the Cavendish Review report into healthcare assistants and support workers. We welcome the report for its emphasis on the valuable work that these individuals do for patients and on their importance to the multi-disciplinary team. We will now look at the recommendations in detail and respond in due course. We have already addressed some of the issues raised in relation to practical hands on training and experience for nursing students in paragraphs 42-49 above.
- 64 As part of our planned review of the Code (outlined in paragraph 71) we will review the core content in relation to delegation by nurses and midwives to healthcare assistants and support workers, and consider whether it can be strengthened.
- 65 The issue of registration or some other form of regulation of healthcare support workers is a matter for the government. Any decision should be taken on the basis of a proper evaluation of the evidence, a full assessment of the benefits for public protection and a detailed understanding of the likely level of resource involved.
- 66 Any future decision as to which organisation should be responsible for any such regulation will also be a matter for the government at the relevant time. We note that in its initial response document the government did not consider that the case for a registration system had been made. We would expect to be consulted further if that position changed.

Appraisals and revalidation (192–194, 229)

- 67 We support the need for strong appraisal arrangements across the NHS and the wider healthcare environment. Such arrangements will help to improve standards locally and will encourage and support a culture of individual professional responsibility and ongoing learning and reflection.
- 68 We are currently developing proposals for a proportionate revalidation process for all the nurses and midwives on our register in all four UK countries. As part of this work we are seeking input across the sector and we will also be determining what guidance on appraisals it is appropriate for us to set. We are pleased to note the firm endorsement in the government's response of the need for strong appraisal procedures, including annual appraisals. We hope to see strong support for such arrangements from both the CQC and NHS Employers and look forward to working with them. We will also be looking for similar commitments from the other healthcare sectors and from the other three UK countries.
- 69 We note the recommendations in relation to the development of a system of revalidation similar to that of the GMC involving responsible officers appointed under new legislative provisions. We are committed to developing a revalidation system which is appropriate for nurses and midwives. Given the differences of scale and resources, it is likely to be different from the model introduced by the GMC.
- 70 We will be considering a number of options for revalidation at our Council meeting in September 2013 and all the relevant papers will be on our

website. The first phase of our revalidation programme is planned to be in place by the end of 2015. This will include the launch of a revised Code and proficiency standards to support revalidation, extensive stakeholder engagement work to ensure appropriate appraisal systems are in place across all healthcare sectors, and communications with nurses and midwives to ensure understanding and compliance with the new arrangements. We will also be exploring how our proposed new regional representatives can also support our revalidation plans.

Review of the Code

- 71 As a responsible regulator we are planning to undertake a comprehensive review of the current Code in the light of the recommendations in the Francis report. Although we are satisfied that the key duties on nurses and midwives highlighted in the report are already set out plainly in the current Code, we want to explore how the key messages can be strengthened and developed. This will include a particular focus on the issues of fundamental standards, complaints, candour, communication, older people and delegation raised in the report.
- 72 We also recognise that there is a need to raise awareness of, and ensure compliance with, the Code across the NHS and the wider healthcare environment in all four countries of the UK. We will be taking immediate steps to highlight the key duties raised in the Francis report amongst nurses and midwives, but we recognise that the launch of a revised Code will enable us to raise its profile more effectively amongst the wider public.
- 73 The planned review will also allow us to ensure that the new Code and proficiency standards are appropriate to support revalidation. We will be undertaking pre-consultation work gathering initial evidence for the Code and standards review, aligned with our revalidation consultation between September and December 2013. We will then develop a new Code and standards for practice supported by relevant guidance to deliver revalidation and respond to Francis by March 2014 and will then consult on the substantive draft. Following further development work after the consultation, we will seek the Council's approval of the new Code and standards in November 2014 with a view to publication in December 2014. We will publish public facing materials about the new Code at the same time.

NMC's administration and profile (228, 230–233)

- 74 We understand the concerns behind recommendation 228 relating to administrative reform of the NMC following on from the Strategic Review by the PSA (then CHRE) in 2012. We are making good progress against the recommendations in that review. There is much work still to be done and our Corporate Plan for 2013–2016 sets out our objectives and planned work to address the key issues. Work is also already underway, as outlined below, to narrow the regulatory gap between us and the CQC.
- 75 Further progress towards improving our efficiency and effectiveness will also be supported by the legislative changes which have now been agreed by the government. These changes will allow us to make some significant

improvements to our fitness to practise function including the appointment of case examiners to make decisions at the end of our investigations. We hope that these changes will be in place by mid 2014.

- 76 We fully support recommendations 230 and 233 that we need to raise our public profile. We are already working on plans to ensure that our role as a professional regulator is properly recognised and understood by patients and the public.
- 77 We also need to have the systems in place to ensure that we continue to focus our resources effectively and proportionately in order to protect the public. We have been undertaking research into our current fitness to practise caseload and outcomes and are using this to evaluate the effectiveness of our current approach. This work will inform the development of a more risk-based and proportionate fitness to practise model to ensure that our resources are effectively targeted on public protection. The Council will consider an options paper at its meeting in September 2013.
- 78 We note recommendation 231 about the coordination of NMC procedures with internal disciplinary action. We do not believe that our fitness to practise procedures currently obstruct the progress of internal disciplinary action by providers. In fact, in most cases we would expect the provider or employer to complete its own internal investigation before making any necessary referral to the NMC. An earlier referral is only needed where there is an immediate and significant risk to patient safety which would warrant interim action to restrict the nurse or midwife's practice during the investigation of the issues. Even in these instances, we would not expect the making of an interim order by the NMC to prevent the completion of the internal disciplinary action.
- 79 As part of our review of our current fitness to practise processes we will be reviewing the guidance we provide to employers and the public and we will ensure that this issue is addressed directly as part of that work. We envisage that work being completed by April 2014.
- 80 We support recommendation 232 about the introduction of something akin to the GMC's employer liaison advisers. We have already started scoping the introduction of new regional advisors. They will perform a function similar to the GMC's employer liaison advisers of providing support and guidance locally for employers and others with concerns about nurses and midwives. We will also be exploring how these roles can support our other regulatory functions, including revalidation. We are currently planning for these posts to be rolled out by 2015, with a pilot being undertaken in 2014.

Working with others (35, 226, 234)

- 81 We are committed to improving our joint working arrangements with other regulators and to improved data gathering and intelligence sharing.
- 82 We support recommendation 226 that we should work more closely with the systems regulators and to share their information and analyses on the

working of systems in organisations in which nurses and midwives are active. We agree that this will enable us to act as a more effective professional regulator of those nurses and midwives in management and leadership positions. We also agree that we should not have to wait until a disaster has occurred to take appropriate regulatory action.

- 83 We also agree with recommendation 35 that sharing of intelligence between regulators needs to go further than sharing of existing concerns identified as risks. It should extend to all intelligence which when pieced together with that possessed by partner organisations may raise the level of concern. We recognise that we all need to develop better ways of turning data into intelligence to help identify settings or situations where patient safety may be at risk. We can then work with other regulators to ensure that timely and proportionate action is taken.
- 84 To this end we have started work with the CQC on developing a new operational and data sharing agreement to build on our existing Memorandum of Understanding. This will allow for quicker and more consistent sharing of data and intelligence and making of cross-referrals to improve the ability of both organisations to act promptly to protect the public. We aim to have completed this initial work by the end of 2013.
- 85 In order to support this work, we have also embarked on the development of new corporate ICT and data governance strategies. This work is underway and we have agreed with the CQC that our respective ICT teams should start discussing how our data sets can be further aligned to facilitate the exchange of more data and support the analysis of more intelligence in the future.
- 86 We will also be working with the CQC to review our respective criteria for cross-referrals and exchange of information relating to education practice settings. We have agreed to contribute to the consultation on the CQC's new fundamental standards and we have also agreed that profile raising work is needed in both organisations to underpin the new working arrangements amongst frontline staff.
- 87 We then hope to develop similar operational agreements with the systems regulators in Scotland, Wales and Northern Ireland in 2014–2015. We will also be exploring closer joint working arrangements and improved data and intelligence sharing with the GMC and other professional regulators in 2013–2014. We are also aware that the GMC is undertaking further work in this field of intelligence sharing and we are in contact with them to see how we can all move forwards together in this area.
- 88 Alongside these new developments, our existing contact points with the CQC and the other systems regulators across the UK remain in place, and we continue to make and receive referrals about fitness to practise cases and patient safety issues. In England, we are represented on the National Quality Board and are starting to engage with the new Quality Surveillance Groups on patient safety issues. We have also been receiving and sharing intelligence with other regulators at risk summits about practice settings for our students.

- 89 We continue to engage regularly with many other healthcare and public and patient organisations as well as other regulators and organisations representing nurse and midwives, to listen to their views and exchange ideas about how to improve our processes and how to support and promote good practice.

Investigation of systemic concerns (227)

- 90 We do not support the recommendation that the NMC should be tasked directly with investigating systems issues. It is important that the distinct roles and responsibilities of professional and systems regulators are understood by all. We consider that any blurring of these boundaries in the way suggested is unlikely to lead to better public protection. We do recognise the concerns that led to this suggestion but we believe that the steps being taken by ourselves, the CQC and other regulators to work more closely together to address the most serious patient safety issues will provide a better solution.
- 91 Recently, we held a listening event for a large group of our stakeholders in relation to this issue. There was broad agreement that the NMC should not become directly involved in investigating systemic concerns as this might lead to a lack of clear accountability. There was widespread support for our plans for much closer working between the NMC and other regulators and for the sharing of data and information. We will be reviewing all the suggestions that were made in taking this work forwards.

Joint proceedings (235)

- 92 We are interested in exploring the recommendation relating to joint proceedings further with the PSA and the other healthcare regulators. We welcome the Law Commission's long term plans for greater harmonisation combined with more legislative flexibility amongst the healthcare regulators. In the meantime, we would support any steps which improve the public's understanding of our role as professional regulators and result in improved consistency where this is possible within our existing legislative frameworks.
- 93 The key objective in making any such change must be that it will improve public protection or strengthen the patient voice. With this in mind, we would be interested in any steps which improve the timeliness and effectiveness of our investigation and adjudication processes in multi-regulator cases or improve the experience of those engaged with them.
- 94 At our recent listening event for stakeholders in relation to these issues, there was a wide-ranging discussion but no consensus as to the best way forward. There was a clear view that more evidence would be needed before any significant changes to the current arrangements could be justified. We will be feeding back the range of views expressed to the PSA and we will be reviewing all the suggestions that were made in taking forward our own strategic thinking in these areas.

Learning wider lessons

- 95 In addition to all our actions and plans in response to the other recommendations outline above, we have also taken time to see what wider lessons we can learn from the Francis report as an organisation.
- 96 We have reviewed the report and identified a number of key areas where we can learn corporate lessons, including staff issues, dealing with corporate complaints, quality assurance, governance and the role of corporate boards. We will now be taking those matters forwards and incorporating the learning into our governance arrangements and our new human resources strategy.

Conclusion

- 97 The recommendations in the Francis report which impact on the NMC are wide-ranging and challenging. We have already made a significant amount of progress towards addressing them but much work is still to be done. We look forward to engaging with all those who care about the future of healthcare across the UK as we our take our plans forward over the next few years.

July 2013

Summary table of NMC responses to the Francis report

A summary of our response to the themes and recommendations from the Francis report which directly or indirectly affect the work of the NMC

No.	Chapter	Abbreviated recommendation (For the full table of recommendations see page 85 of the executive summary of the Francis Report http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf)	Summary of NMC response
<p>Accountability for implementation of the recommendations These recommendations require every single person serving patients to contribute to a safer, committed and compassionate and caring service.</p>			
1	Intro	<p>It is recommended that:</p> <ul style="list-style-type: none"> • All commissioning, service provision, regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work; • Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions; • In addition to taking such steps for itself, the Department of Health should collate information about the decisions and actions generally ... • The House of Commons Select Committee on Health should be invited to consider incorporating into its reviews of the performance of organisations accountable to Parliament a review of the decisions and actions they have taken with regard to the recommendations in this report. 	<p>Since February 2013 the Francis report has been discussed at each Council meeting and copies of all the reports to Council are available on our website.</p> <p>A new Council was appointed in May 2013 and this full response document sets out the Council's decisions and actions in response to the response.</p> <p>We intend to continue to report our progress to the Council at each meeting and to keep the Francis page of our website updated with any significant developments.</p> <p>We will include details of our progress against our planned actions in our reports to the Health Select Committee.</p>

<p>Putting the patient first The patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.</p>			
5	21	<p>In reaching out to patients, consideration should be given to including expectations in the NHS Constitution that:</p> <ul style="list-style-type: none"> • Staff put patients before themselves; • They will do everything in their power to protect patients from avoidable harm; • They will be honest and open with patients regardless of the consequences for themselves; • Where they are unable to provide the assistance a patient needs, they will direct them where possible to those who can do so; • They will apply the NHS values in all their work. 	<p>We support this recommendation.</p> <p>All nurses and midwives are bound to comply with “The code: Standards of conduct, performance and ethics for nurse and midwives” (the Code).</p> <p>The Code already requires all registered nurses and midwives to meet very similar standards and we will ensure that in any future review of The Code, the principle of always putting patients first is reiterated.</p>
<p>Fundamental standards of behaviour Enshrined in the NHS Constitution should be the commitment to fundamental standards which need to be applied by all those who work and serve in the healthcare system. Behaviour at all levels needs to be in accordance with at least these fundamental standards.</p>			
9 – 12	21 20 2	<p>9. The NHS Constitution should include reference to all the relevant professional and managerial codes by which NHS staff are bound, including the Code of Conduct for NHS Managers.</p> <p>10. The NHS Constitution should incorporate an expectation that staff will follow guidance and comply with standards relevant to their work....</p> <p>11. Healthcare professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work. Their managers need to ensure that their employees comply with these requirements</p> <p>12. Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon...</p>	<p>We support this recommendation which highlights the need to raise awareness of, and ensure compliance with, professional codes across the NHS.</p> <p>All nurses and midwives are bound to comply with “The code: Standards of conduct, performance and ethics for nurse and midwives”.</p> <p>We have also issued guidance on “Raising and escalating concerns” to help nurse and midwives to feel confident about reporting patient safety incidents.</p>

<p>A common culture made real throughout the system – an integrated hierarchy of standards of service No provider should provide, and there must be zero tolerance of, any service that does not comply with fundamental standards of service. Standards need to be formulated to promote the likelihood of the service being delivered safely and effectively, to be clear about what has to be done to comply, to be informed by an evidence base and to be effectively measurable.</p>			
13–18	21, 9,11	<p>Standards should be divided into:</p> <ul style="list-style-type: none"> • Fundamental standards of minimum safety and quality – in respect of which non-compliance should not be tolerated. Failures leading to death or serious harm should remain offences for which prosecutions can be brought against organisations. There should be a defined set of duties to maintain and operate an effective system to ensure compliance; • ... <p>NB Recommendations 14–18 are related to this.</p>	<p>We support the introduction of fundamental standards and will be responding to the Care Quality Commission (CQC) consultation. We will ensure that the need for compliance with any relevant fundamental standards that are introduced are addressed in any revision of the Code.</p>
<p>Responsibility for, and effectiveness of, healthcare standards</p>			
28	21	<p>Zero tolerance: A service incapable of meeting fundamental standards should not be permitted to continue. Breach should result in regulatory consequences attributable to an organisation in the case of a system failure and to individual accountability where individual professionals are responsible. Where serious harm or death has resulted to a patient as a result of a breach of the fundamental standards, criminal liability should follow and failure to disclose breaches of these standards to the affected patient (or concerned relative) and a regulator should also attract regulatory consequences. Breaches not resulting in actual harm but which have exposed patients to a continuing risk of harm to which they would not otherwise have been exposed should also be regarded as unacceptable. (our emphasis)</p>	<p>As stated above, we support the introduction of fundamental standards and will be responding to the CQC consultation.</p> <p>As a responsible regulator, we are planning to undertake a comprehensive review of the current Code in the light of the recommendations in the Francis report. Although we are satisfied that the key duties on nurses and midwives highlighted in the report are already set out plainly in the current Code, we want to explore how the key messages can be strengthened and developed. This will include a particular focus on the issues of fundamental standards, complaints, candour, communication, older people and delegation raised in the report.</p> <p>When we review the Code, we will ensure that a duty to comply with any relevant national fundamental standards that are introduced are addressed in the revised Code. This will mean that responsibility for a breach of any fundamental standard by a nurse or midwife</p>

			<p>responsible could result in regulatory action.</p> <p>See Summary of Planned Actions on page 7.</p> <p>See our comments in response to recommendation 183 below in relation to the introduction of criminal liability on individuals.</p>
35 & 36	9	<p>35. Sharing of intelligence between regulators needs to go further than sharing of existing concerns identified as risks. It should extend to all intelligence which when pieced together with that possessed by partner organisations may raise the level of concern. Work should be done on a template of the sort of information each organisation would find helpful.</p> <p>36. A coordinated collection of accurate information about the performance of organisations must be available to providers, commissioners, regulators and the public, in as near real time as possible, and should be capable of use by regulators in assessing the risk of non-compliance. It must...</p>	<p>We support this recommendation and have already started work on closer joint working arrangements with the CQC including improved data and intelligence sharing. We aim to have completed this work by the end of 2013.</p> <p>We then plan to develop similar operational agreements with the systems regulators in Scotland, Wales and Northern Ireland in 2014.</p> <p>We will also be exploring closer joint working arrangements and improved data and intelligence sharing with the GMC and other professional regulators in 2013–2014.</p> <p>See Summary of Planned Actions on page 7.</p>
43	6	<p>Media Those charged with oversight and regulatory roles in healthcare should monitor media reports about the organisations for which they have responsibility.</p>	<p>We have long established systems for monitoring media coverage of potential fitness to practise issues relating to registered nurses and midwives and we proactively open investigations when serious concerns appear to have been raised.</p>
<p>Effective complaints handling Patients raising concerns about their care are entitled to: have the matter dealt with as a complaint unless they do not wish it; identification of their expectations; prompt and thorough processing; sensitive, responsive and accurate communication; effective and implemented learning; and proper and effective communication of the complaint to those responsible for providing the care.</p>			
109 – 122	3	<p>109. Methods of registering a comment or complaint must be readily accessible and easily understood. Multiple gateways need to be provided to patients, both during their treatment and after its</p>	<p>We support the need for improvements in complaints handling arrangements across the NHS and the wider healthcare environment. We are not a complaints body and many patients' concerns are most</p>

		<p>conclusion, although all such methods should trigger a uniform process, generally led by the provider trust.</p> <p>110. Actual or intended litigation should not be a barrier to the processing or investigation of a complaint at any level. It may be prudent for parties in actual or potential litigation to agree to a stay of proceedings pending the outcome of the complaint, but the duties of the system to respond to complaints should be regarded as entirely separate from the considerations of litigation.</p> <p>111. Provider organisations must constantly promote to the public their desire to receive and learn from comments and complaints; constant encouragement should be given to patients and other service users, individually and collectively, to share their comments and criticisms with the organisation.</p> <p>112. Patient feedback which is not in the form of a complaint but which suggests cause for concern should be the subject of investigation and response of the same quality as a formal complaint, whether or not the informant has indicated a desire to have the matter dealt with as such.</p>	<p>quickly and effectively resolved locally.</p> <p>The Code requires all registered nurses and midwives to give a constructive and honest response to anyone who complains about the care they have received, not to allow someone's complaint to prejudice the care provided to them, to act immediately if someone suffers harm and to explain fully and promptly what has happened and the likely effects. Our education standards also address key skills in communicating with patients and complaints handling. When we review the Code, we will ensure that these principles remain clear.</p> <p>Action by a professional regulator should only be taken if there is a serious fitness to practise issue which requires regulatory action to protect the public.</p> <p>We have been contributing to the Ann Clwyd and Tricia Hart complaints review. Complaints handling is already a key skill in our new pre-registration nursing education standards and we would support its inclusion in the appraisals of all healthcare professionals.</p> <p>We are also taking steps to improve the experience of patients and other complainants who become involved as witnesses in our fitness to practice proceedings.</p> <p>See Summary of Planned Actions on page 7.</p>
<p>Openness, transparency and candour Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered. Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators. Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.</p>			
173-174	22	173. Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open	<p>We support this recommendation. The Code already requires all registered nurses and midwives to be open and honest and act with integrity, to give a constructive and honest response to anyone who complains about the care they have received, not to allow someone's</p>

		<p>and truthful.</p> <p>174. Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.</p>	<p>complaint to prejudice the care provided to them, to act immediately if someone suffers harm and to explain fully and promptly what has happened and the likely effects. Our education standards also address these areas.</p> <p>A breach of these standards by a nurse or midwife responsible can lead to regulatory action. When we review the Code, we will ensure that these principles remain clear.</p> <p>See Summary of Planned Actions on page 7.</p>
176 – 7	22	<p>176. Any statement made to a regulator or a commissioner in the course of its statutory duties must be completely truthful and not misleading by omission.</p> <p>177. Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.</p>	<p>We support this recommendation. As stated above, the Code already requires all registered nurses and midwives to be open and honest and act with integrity. It also requires them to cooperate with internal and external investigations. When we review the Code, we will ensure that these recommendations are closely followed.</p> <p>See Summary of Planned Actions on page 7.</p>
181 – 3	22	<p>181. A statutory obligation should be imposed to observe a duty of candour:</p> <ul style="list-style-type: none"> • On healthcare providers who believe or suspect • On registered medical practitioners and registered nurses and other registered professionals who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient to report their belief or suspicion to their employer as soon as is reasonably practicable. <p>The provision of information in compliance with this requirement should not of itself be evidence or an admission of any civil or criminal liability, but non-compliance with the statutory duty should entitle the patient to a remedy.</p>	<p>As stated above, the Code already requires all registered nurses and midwives to be open and honest and act with integrity, to give a constructive and honest response to anyone who complains about the care they have received, not to allow someone’s complaint to prejudice the care provided to them, to act immediately if someone suffers harm and to explain fully and promptly what has happened and the likely effects.</p> <p>The Code also places a clear obligation on nurses and midwives to act without delay if they believe that they, a colleague or anyone else may be putting someone at risk and to raise concerns if they experience problems that prevent them from working within the Code or are putting patients at risk.</p> <p>A breach of these standards by a nurse or midwife responsible can</p>

		<p>183. It should be made a criminal offence for any registered medical practitioner, or nurse, or allied health professional or director of an authorised or registered healthcare organisation:</p> <ul style="list-style-type: none"> • Knowingly to obstruct another in the performance of these statutory duties; • To provide information to a patient or nearest relative intending to mislead them about such an incident; • Dishonestly to make an untruthful statement to a commissioner or regulator knowing or believing that they are likely to rely on the statement in the performance of their duties. 	<p>lead to regulatory action including a striking off order.</p> <p>We understand that these recommendations of a new statutory duty of candour and criminal liability for individuals are being considered by the Don Berwick safety review and we await the conclusions of that review with interest.</p> <p>Whilst the need for candour is clear, any such legislative steps will have profound implications and the benefits and impact need to be fully explored to ensure that patient safety will be enhanced and that the other key recommendations about the need for a new culture of openness and organisational learning across the NHS and beyond are not undermined.</p>
Nursing			
185	23	<p>Focus on culture of caring</p> <p>There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires:</p> <ul style="list-style-type: none"> • Selection of recruits to the profession who evidence the: <ul style="list-style-type: none"> – Possession of the appropriate values, attitudes and behaviours; – Ability and motivation to enable them to put the welfare of others above their own interests; – Drive to maintain, develop and improve their own standards and abilities; – Intellectual achievements to enable them to acquire through training the necessary technical skills; • Training and experience in delivery of compassionate care; 	<p>We are responsible for setting the UK-wide standards for all pre-registration nursing and midwifery education. We fully support this recommendation and we have already taken steps to meet it.</p> <p>Our new <i>Standards for pre-registration nursing education (the education standards)</i> were set in 2010. The previous 2004 standards were updated and strengthened as a result of the findings of the first Francis Report and emerging evidence at that time. The first nurses to have followed programmes approved against these new standards will commence practice in 2014.</p> <p>These new education standards directly address all the matters raised in this recommendation as well as the 6Cs (<i>Compassion in practice initiative</i>). For example, the standards focus on patients' needs for 'communication, compassion and dignity' and the key skills guidance contains specific provisions on 'care, compassion and communication'.</p> <p>The education standards on selection and admission are values</p>

		<ul style="list-style-type: none"> • Leadership which constantly reinforces values and standards of compassionate care; • Involvement in, and responsibility for, the planning and delivery of compassionate care; • Constant support and incentivisation which values nurses and the work they do through: <ul style="list-style-type: none"> – Recognition of achievement; – Regular, comprehensive feedback on performance and concerns; – Encouraging them to report concerns and to give priority to patient wellbeing. 	<p>based, specifically focusing on good character. This priority continues throughout their studies, as students cannot pass each of the three progression points during the course unless they can demonstrate safety, safeguarding and protection, professional values, expected attitudes and the behaviours that must be shown towards people, their carers, families and others.</p> <p>Our guidance on <i>Raising and escalating concerns</i> (NMC 2011) further highlights nurses and midwives' professional duty to raise concerns on safeguarding and the care environment.</p> <p>We are committed to undertaking a full evaluation of our new standards, commencing in 2014, and we will have particular regard to these issues. This will give us a proper evidence base for any further revisions to these new standards.</p> <p>See Summary of Planned Actions on page 7.</p>
186-7	23	<p>Practical hands-on training and experience</p> <p>186. Nursing training should be reviewed so that sufficient practical elements are incorporated to ensure that a consistent standard is achieved by all trainees throughout the country. This requires national standards.</p> <p>187. There should be a national entry-level requirement that student nurses spend a minimum period of time, at least three months, working on the direct care of patients under the supervision of a registered nurse. Such experience should include direct care of patients, ideally including the elderly, and involve hands-on physical care. Satisfactory completion of this direct care experience should be a pre-condition to continuation in nurse training. Supervised work of this type as a healthcare support worker should be allowed to count as an equivalent. An alternative would be to require candidates for qualification for registration to undertake a minimum period of work in an approved healthcare support worker post involving the delivery of such care.</p>	<p>We understand the concerns which led to these recommendations but we believe that those concerns have been addressed as a result of the steps we have taken to introduce new UK-wide pre-registration education standards for nurse and midwives since the time of the events in Mid-Staffordshire.</p> <p>All our programmes last at least three years and require 50 percent of time to be spent in practice learning and 50 percent in academic study. The first progression point cannot be passed unless the student undertakes a period of practice learning and assessment. We feel satisfactory completion of such a period at an early stage of the course, as a requirement for <i>continuation</i> in nurse training, meets the spirit and the letter of recommendation 187.</p> <p>Currently formal learning and supervised work as a healthcare support worker can be counted through accredited prior learning routes.</p>

			<p>Conversely, requiring candidates for nursing education programmes to undertake a minimum period in a healthcare support worker post may not advance patient safety as supervision and mentorship cannot be guaranteed.</p>
188	23	<p>Aptitude test for compassion and caring The NMC, working with universities, should consider the introduction of an aptitude test to be undertaken by aspirant registered nurses at entry into the profession, exploring, in particular, candidates' attitudes towards caring, compassion and other necessary professional values.</p>	<p>The new education standards require students to be tested for aptitude in literary, numeracy and communication skills and assessed as to health and good character on admission to programmes. Students must also be assessed before programme completion as to their fitness for practice in addition to their fitness for award. Our programmes are half theory, half practice and education and training takes place as a partnership between a university and a practice environment. Students must meet all theory and all practice requirements to complete a programme, and there is no facility to 'compensate' for weak performance on one side with strong performance on the other.</p> <p>Our standards for competence reinforce this, identifying the knowledge, skills and attitudes students must acquire by the end of the programme. For example, students must 'practise in a holistic, non-judgmental, caring and sensitive manner that avoids assumptions, supports social inclusion, recognises and respects individual choice and acknowledges diversity'.</p> <p>We are committed to undertaking a full evaluation of our new education standards, commencing in 2014, and we will have particular regard to these issues of caring and compassion. This will give us a proper evidence base for any further revisions to these new standards including the need for an aptitude test. As a four country regulator, we will also need to consider the UK-wide implications of the introduction of such a test.</p> <p>See Summary of Planned Actions on page 7.</p>

189	23	<p>Consistent training The NMC and other professional and academic bodies should work towards a common qualification assessment/examination.</p>	<p>We are responsible for setting the UK-wide standards for all pre-registration nursing and midwifery education. Our new <i>Standards for pre-registration nursing education</i> (the education standards) were set in 2010. The previous 2004 standards were updated and strengthened as a result of the findings of the first Francis Report and emerging evidence at that time. The first nurses to have followed programmes approved against these new standards will commence practice in 2014.</p> <p>See our further comments in response to recommendation 185 above.</p>
190	23	<p>National standards There should be national training standards for qualification as a registered nurse to ensure that newly qualified nurses are competent to deliver a consistent standard of the fundamental aspects of compassionate care.</p>	<p>National pre-registration education standards are already in place. See our comments in response to recommendations 185– 189 above</p>
192	23	<p>Strong nursing voice The Department of Health and NMC should introduce the concept of a Responsible Officer for nursing, appointed by and accountable to, the NMC.</p>	<p>See our comments in response to recommendation 229 below.</p>
193-4	23	<p>Standards for appraisal and support 193. Without introducing a revalidation scheme immediately, the NMC should introduce common minimum standards for appraisal and support with which responsible officers would be obliged to comply. They could be required to report to the NMC on their performance on a regular basis. 194. As part of a mandatory annual performance appraisal, each nurse, regardless of workplace setting, should be required to demonstrate in their annual learning portfolio an up-to-date knowledge of nursing practice and its implementation. Alongside developmental requirements, this should contain documented evidence of recognised training undertaken, including wider relevant learning. It should also demonstrate commitment, compassion and caring for patients, evidenced by feedback from</p>	<p>We support the need for strong appraisal arrangements for all staff across the NHS and the wider healthcare environment. Such arrangements will help to improve standards locally and will encourage and support a culture of individual professional responsibility and ongoing learning and reflection.</p> <p>We are currently developing proposals for a proportionate revalidation process. As part of this work we are seeking input across the sector and we will also be determining what guidance on appraisals it is appropriate for us to set. We are pleased to note the firm endorsement in the government’s response of the need for strong appraisal procedures, including annual appraisals. We hope to see strong support for such arrangements from both the CQC and</p>

		<p>patients and families on the care provided by the nurse. This portfolio and each annual appraisal should be made available to the NMC, if requested, as part of a nurse's revalidation process. At the end of each annual assessment, the appraisal and portfolio should be signed by the nurse as being an accurate and true reflection and be countersigned by their appraising manager as being such.</p>	<p>NHS Employers and look forward to working with them. We will also be looking for similar commitments from the other healthcare sectors.</p> <p>See our further comments in response to recommendation 229 below.</p> <p>See Summary of Planned Actions on page 7.</p>
196-7	23	<p>Nurse Leadership</p> <p>196. The Knowledge and Skills Framework should be reviewed with a view to giving explicit recognition to nurses' demonstrations of commitment to patient care and, in particular, to the priority to be accorded to dignity and respect, and their acquisition of leadership skills.</p> <p>197. Training and continuing professional development for nurses should include leadership training at every level from student to director. A resource for nurse leadership training should be made available for all NHS healthcare provider organisations that should be required under commissioning arrangements by those buying healthcare services to arrange such training for appropriate staff.</p>	<p>Our education standards for competence require nurses to demonstrate their potential to develop management and leadership skills during their period of preceptorship after registration and beyond.</p> <p>The specific essential skill targeting this area indicates that people can trust the newly registered graduate nurse to be an autonomous and confident member of the multi-disciplinary or multi-agency team and to inspire confidence in others. Nurses can then become more involved and responsible for the planning and delivery of care and improving future services.</p>
200	23	<p>Key nurses</p> <p>Consideration should be given to the creation of a status of Registered Older Person's Nurse.</p>	<p>We understand the serious concerns that led to this recommendation but we believe that we have already started to address those concerns in a number of different ways which will better achieve the same goal. We have already moved to recognise societal changes that mean people live longer and have more diverse needs. Our new education standards for competence specifically require nurses to be attentive to the needs of older people and the key skills spell out the importance of meeting the needs of older adults.</p> <p>We have also recognised the need for more detailed support, developing <i>Guidance for the care of older people</i> (NMC 2010) which</p>

			<p>supports key standards within the Code. During the approval of pre-registration nursing programmes we have seen a clear indication of how students will learn to care for older people and we will monitor the outcomes of this through our quality assurance activity.</p> <p>We are also aware of the work in the field of post-registration training being started by Health Education England (HEE). Many universities already offer postgraduate qualifications enabling nurses to specialise in the care of older people should they wish to do so.</p>
207 – 213	23	<p>Strengthening identification of healthcare support workers and nurses 207. Uniform description of healthcare support workers 208. Identity labels and uniforms for healthcare support workers</p> <p>Registration of healthcare support workers 209. Registration system for healthcare support workers providing direct physical care to patients ..</p> <p>Code of conduct for healthcare support workers 210. A national code of conduct for healthcare support workers.</p> <p>Training standards for healthcare support workers 211. A common set of national standards for the education and training of healthcare support workers. 212. Code of conduct, education and training standards and requirements for registration for healthcare support workers should be prepared and maintained by the NMC after due consultation with all relevant stakeholders, including the Department of Health, other regulators, professional representative organisations and the public. 213. A nationwide system to protect patients and care receivers from harm.</p>	<p>We understand the concerns that have led to the many recommendations in the report relating to healthcare support workers.</p> <p>We support the recommendations for a code of conduct and the setting of minimum standards for the education and training of healthcare support workers and for the introduction of a uniform description and means of identification where possible.</p> <p>We have also addressed the issues of the relationship of registered nurses to healthcare support workers to the extent our remit allows. The Code makes nurses and midwives accountable for decisions to delegate care to a support worker. A nurse or midwife must only delegate to a support worker who has had appropriate training and whom they deem competent to perform the task. The nurse or midwife must also confirm that the outcome of the delegated task meets required standards and that the support worker is supervised and supported.</p> <p>We note the very recent publication of the Cavendish Review into healthcare assistants and support workers. We welcome the report for its emphasis on the valuable work that these individuals do for patients and on their importance to the multi-disciplinary team. We will now look at the recommendations in detail and respond in due course. We have already addressed some of the issues raised in our responses to recommendations 186 and 187 in relation to practical</p>

			<p>hands on training and experience for nursing students.</p> <p>As part of our planned review of the Code we will review the core content in relation to delegation by nurses and midwives to healthcare assistants and support workers, and consider whether it can be strengthened.</p> <p>See Summary of Planned Actions on page 7.</p> <p>The issue of registration or some other form of regulation of healthcare support workers is a matter for the government and any decision should be taken on the basis of a proper evaluation of the evidence.</p> <p>Any decision as to who should be responsible for any such registration or regulation is also a matter for government in the light of the likely impact of such a decision at the relevant time. At present our priority remains the effective regulation of nurse and midwives for the protection of the public.</p>
Professional regulation of fitness to practise			
226 – 7	12	<p>NMC – investigation of systemic concerns</p> <p>226. To act as an effective regulator of nurse managers and leaders, as well as more front-line nurses, the NMC needs to be equipped to look at systemic concerns as well as individual ones. It must be enabled to work closely with the systems regulators and to share their information and analyses on the working of systems in organisations in which nurses are active. It should not have to wait until a disaster has occurred to intervene with its fitness to practise procedures. Full access to the Care Quality Commission information in particular is vital.</p>	<p>We support the recommendation that we should work more closely with the systems regulators. We agree that this would enable us to share their information and analyses on the working of systems in organisations in which nurses and midwives are active in order to act as a more effective professional regulator of those nurses and midwives in management and leadership positions. We also agree that we should not have to wait until a disaster has occurred to intervene with our fitness to practise procedures.</p> <p>To this end we have already started work with the CQC on developing a new operational and data sharing agreement to build on our existing Memorandum of Understanding (MoU) and allow for quicker and more consistent sharing of data and intelligence and making of cross-</p>

		<p>227. The NMC needs to have its own internal capacity to assess systems and launch its own proactive investigations where it becomes aware of concerns which may give rise to nursing fitness to practise issues. It may decide to seek the cooperation of the Care Quality Commission, but as an independent regulator it must be empowered to act on its own if it considers it necessary in the public interest. This will require resources in terms of appropriately expert staff, data systems and finance. Given the power of the registrar to refer cases without a formal third party complaint, it would not appear that a change of regulation is necessary, but this should be reviewed.</p>	<p>referrals. We then plan to explore reaching similar agreements with systems regulators in each of the other three UK countries. See our further comments in response to the related recommendation 234 below.</p> <p>See Summary of Planned Actions on page 7.</p> <p>We do not support the recommendation that the NMC should be tasked directly with investigating systems issues. It is important that the distinct roles of professional and systems regulators are understood by all. We do not consider that blurring of the boundaries in the way suggested is likely to lead to better public protection. We do recognise the concerns that led to this suggestion but we believe that the steps being taken by ourselves, the CQC and other regulators to work more closely together to address the most serious issues will provide a better long term solution.</p>
228	12	<p>NMC – Administrative reform It is of concern that the administration of the NMC, which has not been examined by this Inquiry, is still found by other reviews to be wanting. It is imperative in the public interest that this is remedied urgently. Without doing so, there is a danger that the regulatory gap between the NMC and the Care Quality Commission will widen rather than narrow.</p>	<p>We understand the concerns behind this recommendation following on from the Strategic review by the PSA (then CHRE) in 2012. We are making good progress against the recommendations in that review. There is much work still to be done but our 2013– 2016 Corporate Plan addresses all the key issues and work is already underway, as outlined above, to narrow the regulatory gap between us and the CQC.</p> <p>Further progress towards improving our efficiency and effectiveness will also be supported by the legislative change which has now been agreed by the government. This will allow us to make some significant improvements to our fitness to practise function.</p> <p>See Summary of Planned Actions on page 7.</p>

229	12	<p>NMC – Revalidation It is highly desirable that the NMC introduces a system of revalidation similar to that of the GMC, as a means of reinforcing the status and competence of registered nurses, as well as providing additional protection to the public. It is essential that the NMC has the resources and the administrative and leadership skills to ensure that this does not detract from its existing core function of regulating fitness to practise of registered nurses.</p>	<p>We are currently developing proposals for a proportionate revalidation process which is appropriate for nurses and midwives. Given the differences of scale and resources, it is likely to be different from the model introduced by the GMC.</p> <p>We are pleased to note the firm endorsement in the government’s response of the need for strong appraisal procedures, including annual appraisals. We hope to see strong support for such arrangements from both the CQC and NHS Employers and look forward to working with them. We will also be looking for similar commitments from the other healthcare sectors.</p> <p>Such arrangements will help to improve standards locally and will encourage and support a culture of individual professional responsibility and ongoing learning and reflection.</p> <p>The Council will be considering a number of options for revalidation in September 2013. The first phase of our revalidation programme is currently being planned to be in place by the end of 2015.</p>
230	12	<p>NMC – Profile The profile of the NMC needs to be raised with the public, who are the prime and most valuable source of information about the conduct of nurses. All patients should be informed, by those providing treatment or care, of the existence and role of the NMC, together with contact details.</p> <p>The NMC itself needs to undertake more by way of public promotion of its functions.</p>	<p>We support this recommendation and are already working on plans to ensure that our public profile is raised appropriately. Our role as a professional regulator needs to be recognised and understood by patients and the wider public. We also need to have appropriate systems in place to ensure that we continue to focus our resources effectively and proportionately in order to protect the public.</p> <p>See Summary of Planned Actions on page 7.</p>
231	12	<p>NMC – Coordination with internal procedures It is essential that, so far as practicable, NMC procedures do not obstruct the progress of internal disciplinary action in providers</p>	<p>We do not believe that our fitness to practise procedures currently obstruct the progress of internal disciplinary action by providers. In fact, in most cases we would expect the provider or employer to complete its own internal investigation before then making any</p>

			<p>necessary referral to the NMC. An earlier referral is only needed where there is an immediate and significant risk to patient safety which would warrant interim action to restrict the nurse or midwife's practice during the investigation of the issues. Even in these instances, we would not expect the making of an interim order by the NMC to prevent the completion of the internal disciplinary action.</p> <p>As part of our review of our current fitness to practise processes we will be reviewing the guidance we provide to employers and the public and we will ensure that this issue is addressed directly as part of that work. We envisage that work being completed by April 2014.</p> <p>See Summary of Planned Actions on page 7.</p>
232	<p>1</p> <p>2</p>	<p>NMC - Employment liaison officers</p> <p>The NMC could consider a concept of employment liaison officers, similar to that of the GMC, to provide support to directors of nursing. If this is impractical, a support network of senior nurse leaders will have to be engaged in filling this gap.</p>	<p>We support this recommendation. We have already started scoping the introduction of new regional advisors. They will perform a function similar to the GMC's employer liaison advisers of providing support and guidance locally for employers and others with concerns about nurses and midwives. We will also be exploring how these roles can support our other regulatory functions, including revalidation. We are currently planning for these posts to be rolled out by 2015, with a pilot being undertaken in 2014.</p> <p>See Summary of Planned Actions on page 7.</p>
233 – 235	<p>1</p> <p>2</p>	<p>NMC and GMC – For joint action Profile</p> <p>233. While both the GMC and the NMC have highly informative internet sites, both need to ensure that patients and other service users are made aware at the point of service provision of their existence, their role and their contact details.</p> <p>Cooperation with the Care Quality Commission</p> <p>234. Both the GMC and the NMC must develop closer working relationships with the Care Quality Commission – in many cases</p>	<p>See our response to recommendation 230 above.</p> <p>See Summary of Planned Actions on page 7.</p> <p>We accept this recommendation and have already started work with the CQC on developing a new operational and data sharing agreement</p>

		<p>there should be joint working to minimise the time taken to resolve issues and maximise the protection afforded to the public.</p> <p>Joint proceedings 235. The Professional Standards Authority for Health and Social Care (PSA) together with the regulators under its supervision, should seek to devise procedures for dealing consistently and in the public interest with cases arising out of the same event or series of events but involving professionals regulated by more than one body. While it would require new regulations, consideration should be given to the possibility of moving towards a common independent tribunal to determine fitness to practise issues and sanctions across the healthcare professional field.</p>	<p>to build on our existing MoU and allow for quicker and more consistent sharing of data and intelligence and making of cross-referrals. We are planning to finalise our agreement with the CQC by the end of 2013 and then explore reaching similar agreements with other systems and professional regulators by the end of 2014.</p> <p>See Summary of Planned Actions on page 7.</p> <p>We are interested in exploring this recommendation further with the PSA and the other healthcare regulators. We welcome the Law Commission’s long term plans for greater harmonisation combined with more legislative flexibility amongst the healthcare regulators. In the meantime, we would support any steps which increase public understanding of our role and improved consistency amongst regulators where this is possible within our existing legislative frameworks. In particular we would be interested in any steps which improve the timeliness and effectiveness of our investigation and adjudication processes in multi-registrant cases or improve the experience of those engaged with them.</p>
Information			
244 – 250	2 6	<p>Common information practices, shared data and electronic records Various recommendations made for common information practices and electronic patient information services and for annual quality accounts information.</p>	<p>We support those recommendations which will assist in enabling regulators and other organisations to share data and intelligence about individuals and settings giving rise to serious patient safety concerns.</p> <p>See Summary of Planned Actions on page 7.</p>