

# **A new start: Consultation on the changes to the way CQC regulates, inspects and monitors care**

## **Nursing and Midwifery Council response**

- 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:
  - 1.1 We set standards of education, training, conduct and performance for nurses and midwives across the UK.
  - 1.2 We hold the register of those who have qualified and meet those standards.
  - 1.3 We have fair and effective fitness to practise processes to investigate and deal with nurses and midwives who fall short of our standards.
- 2 We welcome the opportunity to take part in this consultation and have provided answers to those questions that are within our remit as a professional regulator. Our response is framed within the context of the work that we are currently undertaking with CQC, and the work that we would like to undertake in the future.
- 3 The Francis Review recommended that professional regulators should work more closely with systems regulators and share information and analyses on the organisations in which nurses and midwives are active. To this end we have started working with CQC on developing a new operational protocol 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.
- 4 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 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.
- 5 We will also be working with CQC to review our respective criteria for cross-referrals and exchange of information relating to education practice settings.
- 6 Alongside these new developments, our existing contact points with CQC remain in place, and we continue to make and receive referrals about fitness to practise cases and patient safety issues.
- 7 We are pleased to note the firm endorsement in the government's response to the Francis Report of the need for strong appraisal procedures, including annual appraisals, and hope to see strong support for such arrangements from the CQC.

## Section 2

- 8 The NMC is broadly supportive of the changes that the CQC is proposing to make to the way that it regulates, inspects and monitors care.
- 9 We welcome the CQC's focus on learning disabilities and would be interested to see how this model will be responsive to the needs of all vulnerable groups.

### The five questions

- 10 We wholly support the move away from numerous regulations and outcomes to a smaller number of key questions as it will make the system far less complicated and easier for people to understand. As well as gathering feedback from patients, we would suggest that the views of staff should also be taken into consideration in order to assess the quality of services and the safety of care. Qualitative as well as quantitative input from staff should be sought as part of CQC's 'tier one' indicators for NHS acute hospitals.
- 11 We feel that the definition of 'well-led' could be expanded to cover leadership on the front-line, as well as at a boardroom level. The definition of well-led could also cover effective delegation, that is, ensuring the appropriate delegation of activities, ensuring that delegated actions are carried out by appropriately trained and supervised staff, and communicating the important role of mentors and others who act as role models to staff.
- 12 The definition of well-led should also include an appropriate system of appraising staff. As mentioned previously, we hope to see strong support for such arrangements from the CQC. 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 look forward to working with the CQC on this.

### Fundamentals of care

- 13 We support the recommendation made in the Francis Report that the NHS constitution should enshrine fundamental standards which should be applied to all those who work and serve in the healthcare system. Once the final standards have been developed by the CQC we will take steps to ensure that, where appropriate, these are referenced in the Code<sup>1</sup> for nurses and midwives.
- 14 We are largely supportive of the examples of fundamental standards that the CQC has proposed in the consultation document (fundamentals of care), as they reflect the broad principles that are covered in the Code and appear relevant and appropriate to all groups of people and settings. We feel, however, that listening to, and respecting, the patient could be made more explicit in the fundamentals of care, not only in the context of complaining. We would also suggest that consideration is given to expanding the first standard to read 'I will be cared for in a clean and safe environment'.

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<sup>1</sup> The code: Standards of conduct, performance and ethics for nurses and midwives (Nursing and Midwifery Council, 2008)

- 15 The fundamentals of care are patient focused, in that they set out expectations of the standards of care and treatment that patients can expect. Caution, therefore, needs to be exercised as to how these might be interpreted and how breaches might be proved and appropriate action taken. To give an example, the need to be provided with pain relief "when I need it" might be read as a subjective requirement of an individual patient (that is, a patient may believe they "need" pain relief when in fact it is not appropriate for it be provided). If the fundamentals of care are to enhance public protection they will need to be objective, and in this case, focus on the need to provide appropriate medication as required in the best interests of the patient. Equally, however, a patient may objectively "need" medication, but wish to refuse such treatment. More clarity may, therefore, be needed on what is meant by 'need' as it is important that the fundamental standards are objective rather than subjective. Balanced with this is the importance for health professionals to take into account patient choice, as well as the wishes and feelings of the patient.
- 16 We recognise that some of the fundamentals of care are more difficult to measure than others, such as harm. We understand the sentiment behind including harm and, after recent events, we acknowledge it needs to be included in the fundamentals of care. It is important however to strike a balance so as to express this standard in a way that will not penalise staff who have to make necessary interventions and treatments.
- 17 We would like clarity around how the fundamentals of care will link to the Essence of Care benchmarks which were introduced by the Department of Health in response to concerns about the quality of fundamental and essential aspects of care concerning patients and carers in 2001 (and updated in 2003 and 2010). The Essence of Care benchmarks inform the skills framework within our education standards.

### **Expected standards**

- 18 We agree with CQC that some areas of the 'existing standards' could be reflected in the new expected standards. However, while it is possible to determine basic thresholds of whether or not care is safe, effective, responsive and well-led, it is more difficult to measure if care is caring. A definition of caring may need to include the attitudes and behaviours of healthcare workers, as well as the care environment, that is, working conditions or any other factors that could play a part in impacting on the way that care is provided.

### **Section 3**

- 19 We broadly welcome the changes to the way that CQC proposes to regulate, inspect and monitor, including the involvement of patients. However, whilst patient experience is important, we are mindful of the fact that this is an under-researched area. We would encourage CQC to undertake more research into the use of patient feedback and to support the development of more effective patient feedback tools.
- 20 We welcome that CQC will share information about hospitals with local partners including professional regulators. As mentioned previously, we are working with CQC towards developing a new operational protocol and data sharing agreement.

We would welcome a commitment from CQC to use evidence from professional regulators, including any relevant fitness to practise information and information about the quality assurance of education, to inform their inspections. The new protocol will also ensure that any issues involving individual registrants can be addressed at the earliest opportunity.

- 21 We welcome the CQC's progress towards developing a rating scale for NHS trusts and services. We would, however, suggest that consideration should be given as to whether 'No governance or finance issues from Monitor or NHS TDA' which is currently a descriptor of an *outstanding* rating should also be a requirement for trusts and services that are rated as *good*.
- 22 We welcome the move from a yes/no compliance model to a model that is based on professional, intelligence based judgments and ratings. However, a clear judgment on whether or not a service is compliant with the standards is still needed and should be used as a minimum.
- 23 We also welcome the move away from generalist inspectors carrying out short inspections to a system of longer and more thorough inspections that are carried out by specialist experts.
- 24 In relation to the commentary on the ratings scale, it should be recognised that breaches that occur as a result of isolated human error or misconduct can have catastrophic implications. We appreciate that making a distinction between isolated human error and systematic failure is important but how an organisation addresses such individual failure must be part of the assessment of their compliance with the standards.
- 25 Please note that there is a missing sentence in the Ratings Table section of your consultation document (the first line of 'Requires improvement').

## **Section 4**

- 26 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.
- 27 We would express caution with regard to how the duty of candour is defined and in particular, what levels of harm it covers, how it deals with incidents which do not lead directly to harm, and whether it covers incidents that are categorised as near misses. We would also be interested to know how the CQC plans to encourage candour among health and social care providers.
- 28 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.

- 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
- 30 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 that a consequence of introducing criminal sanctions would be to drive problems underground as people might be deterred from raising concerns because of the potential consequences for their colleagues. There were also concerns that a duty of candour would not encourage the reporting of “near misses” which do not result in death or serious harm but should nevertheless be disclosed to enable lessons to be learned. These issues should also be considered in introducing a board-level duty.