The Council of Deans of Health is the representative voice of the 85 UK university health faculties providing education and research for nursing, midwifery and the allied health professions. The Council seeks to play an influential leadership role in improving health outcomes through developing an expert health workforce and utilising its collective expertise to inform innovative educational practice and translational research.

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A Common Culture Made Real:
The higher education contribution to putting patients first

Council of Deans of Health
Response to the Final Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

July 2013
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Executive Summary

The Francis Inquiry’s dissection of the appalling care experienced by patients at Mid Staffordshire NHS Foundation Trust and the system failure that allowed it to continue will provoke serious reflection from every organisation involved in healthcare, its regulation, and in educating and training its workforce.

This paper sets out the response of the UK Council of Deans of Health to the final report of the public inquiry. We have endeavoured not only to reflect on the specific recommendations that relate to nursing education but to consider the broader implications of the ‘common culture’ that the Inquiry’s final report has argued is at the heart of responding to the events at Mid Staffordshire.

The first section focuses on this common culture, identifying seven areas in which higher education has a vital role to play in supporting service providers to embed positive cultures of care in their organisations. This includes promoting the value of caring for older people, the crucial role of clinical learning environments in shaping professional practice, the need to support leadership in the existing workforce and the importance of research.

In the second section we turn to the Inquiry’s specific recommendations for nursing education, set in the context of the NMC’s overhaul of the Standards for Nursing Education in 2010. Aiming to get at the intention behind the recommendations, we consider the questions of consistency of education, care and compassion (looking at the curriculum, recruitment and aptitude tests) and the question of practical experience.

Finally, we look at the recommendations for healthcare support workers. Many universities are engaged in educating support workers (particularly those in higher support roles, such as assistant/associate practitioners) and in the progression of support workers into pre-registration programmes. Higher education also has an important contribution to make to research into the roles and impact of this workforce.

The litmus test of the impact of the Inquiry will be what individuals, organisations and networks do as a result, not only in the short term but over the coming years. This response signals the commitment of higher education institutions involved in nursing, midwifery and AHP education and research to continue to work with service providers and policy makers to strengthen and embed a common culture in which the patient is the first priority, for the benefit of both the public and the health workforce.
1. Introduction

The Council of Deans of Health is the representative voice of the 85 UK university health faculties providing education and research for nursing, midwifery and the allied health professions. The Council seeks to play an influential leadership role in improving health outcomes through developing an expert health workforce and utilising its collective expertise to inform innovative educational practice and translational research.

In responding to the Francis Inquiry’s final report we have considered in detail the status of the Council in light of the report’s first recommendation, that: ‘all commissioning, service provision, regulatory and ancillary organisations in healthcare should consider the finding and recommendations of this report and decide how to apply them to their own work’ (Recommendation 1). Although it is possible to debate whether universities are ‘ancillary organisations’, on the grounds that they accept NHS funds to educate and train NHS staff, universities are autonomous institutions and are not ‘organisations in healthcare’. We have therefore responded to the report on behalf of our membership not as a formal ‘ancillary organisation in healthcare’ but as a representative association that is listening to the report’s recommendations and reflecting seriously on its implications for our work. Each section contains concrete actions that we will take in response to the report.

Our response also deliberately seeks to take a broad perspective on the implications of the report for our members. This affects two immediate questions of scope: the place of midwifery and the allied health professions and consideration of certain recommendations aimed at medical education and training.

Midwifery and the allied health professions were almost entirely absent from the Inquiry. In the case of the allied health professions, there was a brief discussion of the Health and Care Professions Council (pp. 1042-1044) but the Inquiry concluded that: ‘The HCPC informed the Inquiry that it had no direct knowledge or information with regard to events at the Trust. It had received no complaints about its registrants there. Therefore, no further evidence was sought’ (p. 1044). However, as many of the recommendations of the report are highly salient across all professions, our response takes a broader view to include discussion of the implications of the Inquiry for the other professions covered by our network. This is in line with the approach taken by the Chief Health Professions Officer for England and the Health and Care Professions Council (HCPC), both of which have convened meetings to discuss the implications of the report. Similarly, where recommendations for medical education and training are relevant for the professional groups covered by the Council we have considered their application to our work.
2. Responding to the heart of the report: the HE contribution to positive cultures of care

2.1 Introduction

In his introductory letter to the Secretary of State for Health, Robert Francis QC summarised the causes of the appalling care of patients at Mid Staffordshire along two lines: first, the ‘serious failure on the part of a provider Trust Board’, above all in ‘fail[ing] to tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities’. Second, that ‘a system which ought to have picked up and dealt with a deficiency of this scale failed in its primary duty to protect patients and maintain confidence in the healthcare system’ (p. 3-5). The letter also underlines why warning signs were not picked up, significantly: ‘a culture focused on doing the system’s business – not that of patients’ and ‘a failure to tackle challenges to the building up of a positive culture, in nursing in particular, but also within the medical profession’. The ‘essential aims’ of the recommendations are therefore:

‘To foster a common culture shared by all in the service of putting the patient first…’ and to ‘enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do’ (p. 4-5).

The report’s case that culture was at the heart of what went wrong at Mid Staffordshire is compelling. However, culture can be a nebulous concept: difficult to pin down and to analyse what needs to change as a result. We have therefore picked out seven strands identified within the Inquiry where higher education can play a particular role in supporting service providers to address the problem of poor cultures of care.

2.2 Putting patients first

‘The NHS and all who work for it must adopt and demonstrate a shared culture in which the patient is the priority in everything done’ (Recommendation 2).

‘The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos’ (Recommendation 4).
We fully support the drive for a shared culture in which the patient is the priority, underpinned by the core values set out in the NHS Constitution. However, this must be driven through all activities undertaken by and in support of the health service, not only in pre-registration education but in post-registration education and continuing personal and professional development for the existing workforce. Given the strong evidence for socialisation into poor care practice over time, existing staff should be a particular focus of work in this area.

Service users and carers must also be engaged as active partners in care rather than passive recipients. This ‘co-production’ should underpin both education and practice. There is much that could be learnt from higher education institutions with strong track records in engaging service users and carers in student recruitment, assessment and curriculum development.

- We will promote existing good practice in patient and service user engagement in curriculum design, student recruitment and student assessment among our membership, giving members opportunities to learn from one another and from best practice in this area.
- We will continue to support the HCPC in introducing a standard on service user/carer engagement into its standards for pre-registration education and will work with our members on the implementation of this standard.

### 2.3 Valuing the care of older people

‘Nursing of the elderly in particular needs to be recognised for its high value to the patients, and the distinct skill set required to lead its provision. One way such recognition could be provided, and good and effective nursing practice incentivised, would be the creation of a registered older persons nurse status’ (p.1521 and Recommendation 200).

We fully support seeing care for older people as a valued role that requires great skill. Higher education has an important role to play in raising the profile of caring for older people and developing skilled staff across the professions. However, setting up a separate part of the register for older people’s nursing would be problematic, simply because most adult and mental health nursing is older people’s nursing. This approach also overlooks the crucial role of the allied health professions and other professional groups in high quality care for older people and the need for this to be valued alongside the contribution of nursing.

We therefore do not support the creation of an additional section of the register. Instead, greater attention should be given to how care for older people can continue to be mainstreamed across education and training throughout professionals’ and support...
workers’ careers. With programmes increasingly using the evidence from research into relationship-centred care in both pre- and post-registration education to support students in gaining positive experiences of caring for older people, this should be at the foreground of discussions at national level. Greater attention must also be paid to ways in which education and training needs to adapt to service reconfiguration, including provision in community settings, intensification of specialist services and the integration of health and social care.

- We will create opportunities for members to share good practice and discuss the best available evidence on how education programmes (both pre-registration and post-registration, across nursing and the allied health professions) can promote the value of caring for older people.
- We will use our Council meetings to explore the implications for education of integrated care and greater health provision in community settings, looking across professional groups and at the interface between health and social care.
- We will work with national dementia leads to ensure that dementia is a high priority on the curriculum.

2.4 Challenging negative cultures: students, practice placements and new registrants

‘…A system which ensures the delivery of proper standards of nursing requires:

- Training and experience in delivery of compassionate care
- Leadership which constantly reinforces values and standards of compassionate care…’ (Recommendation 185).

'It is likely that most of those entering the nursing profession do so because of a wish to undertake work helping and caring for others. Even in a well-run organisation, the stark differences between nursing as they imagined it to be and the reality will challenge their ability to maintain their motivation. This can be seen even more so in the stresses of working in an understaffed, badly led environment… In other words, the internal drive to insist on proper standards of care can all too soon degenerate and be replaced by a meek acceptance of the mediocre or worse’ (p.1513).

We welcome the acknowledgement of the positive motivation of the vast majority of those who aspire to be nurses and we agree that a key attribute for new registrants across the professions is an ability to challenge cultures of poor care and retain their professionalism. The critical thinking skills and research base that are woven through undergraduate curricula, particularly through the new NMC Standards for Education (2010) are central to this. However, there are two areas where further work is urgently needed: first, ensuring a consistent, high quality practice placement environment that
reflects the changing shape of services for patients and second, supporting new registrants to make a successful transition into employment. Each of these relies on an equal partnership between universities and service, sharing responsibility for the student and working together to ensure consistent high standards of learning.

The quality of the clinical learning environment for students is of first importance. With student nurses (and other professionals) spending 50 per cent of their time in clinical environments, this is where culture is modelled and codes of behaviour learnt. Mechanisms that provide assurance on the quality of clinical learning require a whole system rather than uni-professional approach, with consistency in methods of measuring quality and joint audit. The quality of the clinical learning environment is also heavily reliant on frontline leadership, on the quality of the mentors/practice educators that supervise students and on the staffing skill mix that allows registered staff time to teach.

Beyond the assessment of the quality of individual clinical placements, discussion is also needed to ensure that there are sufficient placements available in areas that reflect the emerging shape of health and social care services, for example in the community.

Second, new registrants need greater support as they make the transition to employment. We strongly support more detailed consideration of how new registrants can be supported in practice. In line with the Willis Commission’s report, we believe that new nursing registrants should be supported through preceptorship and other measures to ensure successful transition into employment. These preceptors, however, need to be role models who will challenge, lead and help new registrants to understand how best to bring about change in practice as required.

- We will work with regulators and national bodies to raise the importance of Board level oversight of the quality of learning environments in clinical settings, ensuring that those in responsible positions in NHS organisations and other placement provision recognise that culture of care and quality of learning go together.
- We will make the quality and supply of clinical placements a central theme of our forthcoming work, seeking further opportunities to work with leaders in service to ensure high quality practice learning and adequate supply.
- We will advocate for greater investment into new registrants across professional groups and consideration of how preceptorship programmes can be increased and sustained, ensuring preceptors that are good role models for the delivery of compassionate care.
- We will support work that seeks to develop the embedding of patient safety cultures, particularly where the focus is on the experience of students within the practice placement environment.
• We will work to support mentorship of students in practice, sharing good practice and advocating for greater national support of mentorship across nursing, midwifery and the allied health professions.

2.5 Patient safety: utilising student feedback to challenge poor care

‘The General Medical Council should amend its standards for undergraduate medical education to include a requirement that providers actively seek feedback from students and tutors on compliance by placement providers with minimum standards of patient safety and quality of care, and should generally place the highest priority on the safety of patients’ (Recommendation 158).

‘Surveys of medical students and trainees should be developed to optimise them as a source of feedback of perceptions of the standards of care provider to patients’ (Recommendation 159).

In challenging poor care students can be a positive catalyst for change: part of the solution, not the problem. There is much about quality of care that lies outside the influence of students. However, they should be seen as ‘fresh pairs of eyes’ in the clinical environment for innovation and improvement in patient care. The Inquiry report considers in some detail the importance of medical students and trainees as a source of safety information, concluding that:

‘Trainees are invaluable eyes and ears in a hospital setting. They come without preconceptions, are not likely to be immediately infected by any unhealthy local culture, and are therefore perhaps more likely than established staff to perceive unacceptable practices’ (p. 1258).

There is no reason why this rationale and approach could not be applied to other health professions. There is therefore significant work to be done to ensure that all students’ feedback on clinical placements is used effectively to shape both higher education and clinical practice and to ensure that students raising concerns have the appropriate support. In particular, there needs to be clear expectations that Boards will receive student feedback with sufficient granularity to identify variation within the organisation and monitor trends so that appropriate action can be taken.

• We will work with partners to look at the possibilities of common core feedback questions across the professions and across geographical boundaries, and explore how this data could be used by service providers and HEIs.
• We will explore the opportunities to introduce patient safety-focused questions to student feedback for nursing, midwifery and AHPs.
2.6 Working with the 90 per cent – supporting leadership in the existing workforce

‘Ward nurse managers should operate in a supervisory capacity... Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team’ (Recommendation 195).

‘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’ (Recommendation 197).

Despite the focus on pre-registration students, students make up only a small proportion of the workforce: if problems in care are being experienced now then it is the existing workforce that should be a primary focus of activity. Supporting ward or unit managers and other leaders within clinical settings is therefore not only critical for quality of care but also a crucial component of getting education right, both at pre- and post-registration levels, across the professions.

Universities have a long tradition of supporting leadership development within the NHS and an important role to play both in delivering research and development on effective leadership that can be used by health and social care providers and in providing leadership programmes directly. This experience has shown the importance of supporting whole teams to facilitate change. We also believe that developing leadership capacity within the health professional academic workforce is a key responsibility of our sector and one that should be seen alongside the development of clinical leadership.

- We will engage with leadership development programmes within the health service and will advocate for a strong focus on clinical leadership at both Board level and at the frontline, as an essential underpinning to high quality education.
- We will develop opportunities for leadership development within our own network, targeted particularly at those stepping into their first leadership position within nursing, midwifery and AHP education.

2.7 Escalation procedures (England)

‘The CQC and Monitor should develop practice and procedures with training regulators and bodies responsible for the commissioning and oversight of medical training to coordinate their oversight of healthcare organisations which provide regulated training’ (Recommendation 154).
The Francis Inquiry report proposes a number of changes to escalation procedures to ensure better communication between medical educators and regulators. No mention is made of nursing or AHP education in this context; however the question of escalation of concerns is equally pertinent to other professions. Consideration should therefore be given as to how these recommendations might apply in other contexts. This is particularly important in England, where the significant changes in NHS structures from 1 April carry a greater risk of fragmentation. For example, there is work to be done on the role of higher education within Quality Surveillance Groups to ensure that higher education institutions can input information and receive timely information on issues of care quality that might impact on the placement of students.

- We will engage with relevant bodies (including the NMC, HCPC, HEE and CQC) to seek clarity on the role of HEIs in escalation procedures around quality of care.

2.8 The importance of a research-led culture

The Francis Inquiry’s final report paints a picture of a closed and negative environment where challenge was not tolerated and whistle-blowers marginalised and intimidated. The development of research-led and evidence-based organisations within health and social care is key to addressing this, encouraging questioning, reflective practitioners who want to improve care and can use the best available evidence to do so. Across the UK, policymakers are increasingly looking at the options to increase research capacity and clinical academic research careers for nurses, midwives and AHPs as a central part of building quality of care. We strongly support this and believe that both increased research capacity and growth in clinical academic careers will be instrumental in tackling the variation in quality of care, not only between but within organisations.

- We will continue to advocate for investment in clinical academic careers across the four UK home nations, supporting the development of robust strategies to deliver increased research capacity.
- We will support investment in research focused on quality of care and on understanding culture within healthcare organisations.
3. Nursing Education

3.1 Introduction

The Inquiry report makes a number of recommendations that specifically concern nursing education (largely pre-registration) and these merit a detailed response. However, the events at Mid Staffordshire addressed in the Inquiry occurred before the introduction of the new NMC Standards for Education in 2010 and this major revision of the framework for all pre-registration nursing education was therefore not taken into account in the drafting of the report.

The recommendations for nursing education fall broadly into three categories: those that deal with consistency in the standards of education; those that deal with the extent to which current education models take into account care and compassion; and those that advocate for a higher level of practical work experience.

3.2 Recommendations on consistency:

‘The NMC and other professional and academic bodies should work towards a common qualification assessment/examination’ (Recommendation 189).

‘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’ (Recommendation 190).

We agree that there should be a consistent UK-wide framework for pre-registration nursing education. The NMC Standards for Education provide just such a framework. Since universities are still in the process of introducing new curricula in line with the 2010 changes, no significant further changes to the overall framework for pre-registration nursing education should be made until the impact of those standards has been evaluated.

The link between professional practice and standards for education is complex. Evidence suggests that the main areas of risk lie in the quality of students’ experience in their practice placements: this plays a crucial role in modelling professional behaviour as well as in acquiring technical skills. The responsibility for ensuring that this is a consistently high quality experience is jointly shared between higher education and service providers and is overseen by the professional regulators. It is this partnership between education and practice that should be a primary focus for further work rather than duplication of existing standards, for example through regulators supporting Board-level accountability for clinical learning environments.
• We will establish an advisory group including service providers and service users to give strategic advice to the Council on how best to align higher education and health and social care agendas around benefit to patients.

3.3 Recommendations on care and compassion

3.3.1 Curriculum

‘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’ (Recommendation 186).

The 2010 NMC Standards for Education are heavily directed towards the areas discussed in the Francis Inquiry and it is unfortunate that no reference to this was made within the Inquiry report. In order to meet the NMC Standards, all pre-registration nursing students spend a significant amount of time on fundamental care. The criteria for students to meet the first progression point on a course include the following three points:

- ‘Demonstrates safe, basic, person-centred care, under supervision, for people who are unable to meet their own physical and emotional needs.
- Meets people’s essential needs in relation to safety and security, wellbeing, comfort, bowel and bladder care, nutrition and fluid maintenance and personal hygiene, maintaining their dignity at all times.
- Seeks help where people’s needs are not being met, or they are at risk.’

These are mandatory standards: it is not possible for students to progress further into their pre-registration programmes without having met these requirements in the practice setting. The NMC Standards are also very clear on the value of care and compassion – one of the essential skills clusters around which the programmes are structured is entitled ‘Care, Compassion and Communication’. It includes the following criteria:

- ‘As partners in the care process, people can trust a newly registered graduate nurse to provide collaborative care based on the highest standards, knowledge and competence.
- People can trust the newly registered graduate nurse to engage in person centred care empowering people to make choices about how their needs are met when they are unable to meet them for themselves.
- People can trust the newly registered graduate nurse to respect them as individuals and strive to help them the preserve their dignity at all times.

1 http://standards.nmc-uk.org/Documents/Annexe2_progression_criteria_20100916.pdf p. 2

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- People can trust the newly registered graduate nurse to engage with them in a warm, sensitive and compassionate way.
- People can trust the newly registered graduate nurse to protect and keep as confidential all information relating to them.
- People can trust the newly registered graduate nurse to gain their consent based on sound understanding and informed choice prior to any intervention and that their rights in decision making and consent will be respected and upheld.\(^2\)

In light of this analysis we do not consider that it is necessary to impose additional standards for pre-registration nursing education. However, we are keen to work on consistent delivery and application of these standards and share good practice between our members in doing this.

- We will engage fully in any plans to revise the NMC Standards for Education, supporting rigorous evaluation of the revised standards and their impact on pre-registration education as a stimulus to continuous improvement.

### 3.3.2 Recruitment

‘A system which ensures the delivery of proper standards of nursing requires selection of recruits to the profession who demonstrate:

- Possession of the appropriate values, attitudes and behaviours, the ability and motivation to enable them to put the welfare of others above their own interests;
- The drive to maintain, develop and improve their own standards and abilities;
- The intellectual achievements to enable them to acquire through training the necessary technical skills’ (Recommendation 185).

Across the UK there is a huge amount of activity on student recruitment, particularly in nursing. In Scotland, NES has supported a number of initiatives looking at recruitment. The Department of Health in England has recently sponsored a project looking at student recruitment in nursing and Health Education England has also announced its intention to work in this area. NIPEC in Northern Ireland is about to start the second phase of its Gateway to Nursing project which will consider student recruitment.

We agree that ensuring that students have the right values is an essential element of recruitment. However, there are potential pitfalls in the current focus on student recruitment. First, it implies that the values of students are a material issue in poor quality care, when there is no evidence for this; second, there is a danger that it overlooks the existing work that HEIs undertake to ensure that the best possible students enter their

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\(^2\) [http://standards.nmc-uk.org/Documents/Annexe3_%20ESCs_16092010.pdf](http://standards.nmc-uk.org/Documents/Annexe3_%20ESCs_16092010.pdf) pp. 3-10

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programmes and may unduly constrain the work of universities in selecting students. In a context where the current evidence base on tests is still relatively weak, there is a risk of a disproportionate investment of time and money into an area without a full understanding of how this would contribute to increasing care quality.

- We will establish an internal working group to examine current practice in student recruitment for nursing, midwifery and AHPs, disseminating evidence collected through our on-going project on innovation in teaching and learning to support members.

3.3.3 Aptitude tests at point of registration

‘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’ (Recommendation 188).

The Francis Inquiry did not present any evidence to show that recent registrants are responsible for poor care: evidence outside of the report (such as the Willis Commission) suggests that students come into the workforce with the right knowledge and attitudes, committed to care. By contrast, the emphasis on culture suggests that the major task is to work to support the existing workforce to deliver the best possible care. In addition, if employers are recruiting new registrants appropriately, attitudes and professional values will be assessed through this route. We are therefore cautious about the added value of aptitude tests at the point of registration, particularly given the weak evidence base for particular tests and tool. Given the investment that it would take to realise universal aptitude tests for nurses, the case for the added value of this should be compelling.

- We will work with the NMC to ascertain their views on aptitude tests at registration, bearing in mind the need for there to be clear and compelling added value.

3.4 Greater practical experience for nurses

‘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’ (Recommendation 185).

‘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’ (Recommendation 187).
The Government’s response to Recommendation 187, with the proposal that nursing pre-registration students would have to spend up to a year working as a healthcare assistant prior to starting a pre-registration programme, has provoked heated debate: from whether this is an appropriate response to a report focused largely on organisational culture and system failure, to how it will be funded and whether it will be workable.

We have challenged the assumptions behind the interpretation of the recommendation by Government, including whether it was aimed at existing student nurses (who spend 50 per cent of their time in clinical placements) rather than prospective students. The evidence suggests that most student nurses already have prior care experience, which is routinely assessed as part of the recruitment process. The injection of additional unqualified staff into already pressurised clinical environments could cause serious problems for patient safety, as well as damaging widening participation and affecting the provision of clinical placements for students. Decisions on the application of this recommendation must therefore be taken in light of robust evidence that demonstrates clearly what problem this measure is designed to solve and with due regard to unintended consequences.

- We will engage with the pilot projects looking at pre-degree care experience through membership of the project steering group, advocating for evidence-based decisions and clear evaluation.
- We will support the principle that prospective healthcare professional students should have prior care experience (and advocate for more action to give prospective candidates appropriate opportunities to gain this experience), either voluntary or paid and across diverse providers. We will argue for greater flexibility in the amount of time this would occupy and the setting, recognising the potential value of experience in social care or caring for a family member.

4. Healthcare Support Workers

‘A registration system should be created under which no unregistered person should be permitted to provide for reward direct physical care to patients currently under the care and treatment of a registered nurse or registered doctor… in a hospital or care home setting’ (Recommendation 209).

‘There should be a common set of national standards for the education and training of healthcare support workers’ (Recommendation 211).

Many members of the Council of Deans of Health are engaged in support worker education, largely working with higher support worker roles such as assistant practitioners. The most common award is the foundation degree (in England) but there are a variety of awards, including Diplomas in Higher Education and Certificates in Higher Education. The education and training of healthcare support workers is therefore of significant interest to our members.

We strongly support the value of support workers in their own right and the importance of their education and training. We have engaged in the Skills for Health and Skills for Care project looking at the minimum training standards and code of conduct. We are also in the process of publishing joint research with Skills for Health that explores the contribution of the higher education sector to healthcare support worker education and highlights the challenges associated with funding support for the education and training of this workforce.

The Council’s current position on regulation of support workers is that registration would only be possible in the context of a mature national framework for education and training: such a national framework could pave the way for regulation, but not the reverse. The focus in the first instance should therefore be on establishing high quality education and training with sustained funding and national leadership, with regulation addressed once this is in place. We have also suggested that assistant/associate practitioners should be a priority for attention. However, the findings of the Francis Inquiry and on-going research with our membership means that we need to consider this position carefully and engage in a discussion as to whether this should change.

- We will consider our position on support worker regulation and engage in a dialogue within the Council to consider whether this should change in light of the Inquiry report and other developments in the sector.
- We will work with organisations such as the sector skills councils to promote high quality education and training for support workers, including gaining a better understanding of the role of the higher education sector.
• We will promote the value of the higher education sector in support worker education, for example in robust quality assurance and the interface with pre-registration professional programmes.
• We will advocate for more research into the support workforce to provide the underpinning evidence on impact and effectiveness.

For further information on this response and the work of the Council of Deans of Health:
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Annexe 1: Summary of Recommendations and Actions

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<tr>
<th>Final Report Recommendation</th>
<th>CoDH Response and Actions</th>
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<tbody>
<tr>
<td>1  It is recommended that all commissioning, service provision, regulatory and ancillary organisation in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work.</td>
<td>The Council of Deans of Health is responding to the report not as a formal ancillary organisation in healthcare but as a representative association reflecting on the report and its implications for our work. In our response we have set out a number of concrete actions that we will be undertaking to embed findings from the Francis Inquiry into our current and future work.</td>
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| 4  The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first and everything done by the NHS and everyone associated with it should be informed by this ethos.                                                                 | • We will promote existing good practice in patient and service user engagement in curriculum design, student recruitment and student assessment among our membership, giving members opportunities to learn from one another from best practice in this area.  
• We will continue to support the HCPC in introducing a standard on service user/carer engagement into its standards for pre-registration education and will work with our members on the implementation of this standard.                                                                 |      |
| 154 The CQC and Monitor should develop practice and procedures with training regulators and bodies responsible for the commissioning and oversight of medical training to coordinate their oversight of healthcare organisations which provide regulated training. | In England, the question of escalation procedures between medical educators and regulators is important and should be discussed in relation to other professions, particularly concerning the role of HE within QSGs.  
• We will engage with relevant bodies (including the NMC, HCPC, HEE and CQC) to seek clarity on the role of HEIs in escalation procedures around quality of care.                                                                                                                              | 10-11|
| 158 The General Medical Council should amend its standards for undergraduate medical education to include a requirement that providers actively seek feedback from students and tutors on compliance by placement providers | This recommendation should apply equally across the professions and student feedback should be looked at holistically rather than in professional siloes. There needs to be a clear expectation that Boards will receive student feedback with sufficient granularity to identify variation within the organisation and monitor trends so that appropriate action can be taken.                                                                                                                                                                         | 9    |
with minimum standards of patient safety and quality of care, and should generally place the highest priority on the safety of patients.

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<td>159</td>
<td>Surveys of medical students and trainees should be developed to optimise them as a source of feedback of perceptions of the standards of care provider to patients.</td>
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<td>185</td>
<td>A system which ensures the delivery of proper standards of nursing requires:</td>
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<td>- Training and experience in delivery of compassionate care</td>
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<td>- Leadership which constantly reinforces values and standards of compassionate care</td>
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- We will work with partners to look at the possibilities of common core feedback questions across the professions and across geographical boundaries, and explore how this data could be used by service providers and HEIs.
- We will explore the opportunities to introduce patient safety-focused questions to student feedback for nursing, midwifery and AHPs.

- We will work with regulators and national bodies to raise the importance of Board level oversight of the quality of learning environments in clinical settings, ensuring that those in responsible positions in NHS Trusts and other placement provision recognise that culture of care and quality of learning go together.
- We will make the quality and supply of clinical placements a central theme of our forthcoming work, seeking further opportunities to work with leaders in service to ensure high quality and consistent practice learning and adequate supply.
- We will advocate for greater investment into new registrants across professional groups and consideration of how preceptorship programmes can be increased and sustained, ensuring preceptors that are good role models for the delivery of compassionate care.

We agree that ensuring students have the right values and behaviours is an essential element of recruitment. However, there is a risk that the existing practice of HEIs in testing for values will be overlooked. In a context where the current evidence base on particular tests is still relatively weak, a disproportionate amount of time and money may be invested without evidence for returns in increasing care quality.

- We will establish an internal working group to examine current practice in student recruitment for nursing, midwifery and AHPs, disseminating evidence collected through our on-going project on innovation in teaching and learning to support members.
| 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. |
| 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. |

- We will support work that seeks to develop the embedding of patient safety cultures, particularly where the focus is on the experience of students within the practice placement environment.
- We will work to support mentorship of students in practice, sharing good practice and advocating for greater national support of mentorship across the nursing, midwifery and allied health professions.

The 2010 NMC Standards for Education, which govern all pre-registration nursing education in the UK, are heavily focused on fundamental care, including an Essential Skills Cluster entitled Care, Compassion and Communication. Students cannot progress beyond the initial stages of their course unless they fulfil a series of criteria, which includes aspects such as meeting people’s essential needs in relation to bowel and bladder care, nutrition and fluid maintenance and personal hygiene. We therefore do not believe that it is necessary to impose additional standards.

- We will engage fully in any plans to revise the NMC Standards for Education, supporting rigorous evaluation of the revised standards and their impact on pre-registration education as a stimulus to continuous improvement.

- We will engage with the pilot projects looking at pre-degree care experience through membership of the project steering group, advocating for evidence-based decisions and clear evaluation.
- We will support the principle that prospective healthcare professions students should have prior care experience (and advocate for more action to give prospective candidates appropriate opportunities to gain this experience), either voluntary or paid and from diverse settings. We will argue for greater flexibility in the amount of time this would occupy and the setting, recognising the potential value of experience in social care or caring for a family member.
| 188 | 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. | The Francis Inquiry did not present any evidence to show that recent registrants are responsible for poor care. If employers are recruiting new registrants appropriately, attitudes and professional values will be assessed through this route. We are therefore cautious about the added value of aptitude tests at the point of registration. **We will work with the NMC to ascertain their views on aptitude tests at registration, bearing in mind the need for there to be clear and compelling added value.** | 15 |
| 189 | The NMC and other professional and academic bodies should work towards a common qualification assessment/examination. | We agree that there should be a consistent UK-wide framework for pre-registration nursing education. The NMC Standards for Education, overhauled in 2010, provide this framework. No significant changes to this overall framework should be made until the impact of the new standards has been evaluated. **We will establish an advisory group including service providers and service users to give strategic advice on how best to align higher education and health and social care agendas around benefit to patients.** | 12-13 |
| 190 | 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. | We strongly support the emphasis on leadership, particularly at Board and first line management (e.g. ward or unit) level. Universities have an established tradition of supporting leadership development within the NHS and an important role to play both in leadership research and programme delivery. **We will engage with leadership development programmes within the health service and will advocate for a strong focus on clinical leadership at both Board level and at the frontline, as an essential underpinning to high quality education.** **We will develop opportunities for leadership development within our own network, targeted particularly at those stepping into their first leadership position within nursing, midwifery and AHP education.** | 10 |
| 195 | Ward nurse managers should operate in a supervisory capacity… Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team. | We do not support the creation of a Registered Older People’s Nurse as a separate part of the register, as most adult and mental health nursing is older people’s nursing by definition. Greater attention should be given as to how care for older people can continue to be mainstreamed throughout education and training (across the health professions and support workforce). **We will create opportunities for members to share good practice and discuss the best available evidence.** | 6-7 |

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Council of Deans of Health: July 2013
Response to the Francis Inquiry
| 209 | A registration system should be created under which no unregistered person should be permitted to provide for reward direct physical care to patients currently under the care and treatment of a registered nurse or registered doctor... in a hospital or care home setting |
| 211 | There should be a common set of national standards for the education and training of healthcare support workers |

- We will use our Council meetings to explore the implications for education of integrated care and greater health provision in community settings, looking across professional groups and at the interface between health and social care.
- We will work with national dementia leads to ensure that dementia is a high priority on the curriculum.
- Many of our members are engaged in support worker education, largely working with higher support roles such as assistant/associate practitioners. We strongly support the value of support workers and the importance of their education and training.
  - We will consider our position on support worker regulation and engage in a dialogue within the Council to consider whether this should change in light of the Inquiry report.
  - We will work with organisations such as the sector skills councils to promote high quality education and training for support workers, including gaining a better understanding of the role of the HE sector.
  - We will promote the value of the higher education sector in support worker education, for example in robust quality assurance and the interface with pre-registration professional programmes.
  - We will advocate for more research into the support workforce to provide the underpinning evidence on impact and effectiveness.

- The Francis Inquiry paints a picture of a closed and negative culture where dissent was not tolerated. We believe that the development of research-led cultures within health and social care is a central part of the remedy to this.
  - We will continue to advocate for investment in clinical academic careers across the four UK home nations, supporting the development of robust strategies to deliver increased research capacity.
  - We will support investment in research focused on quality of care and on understanding culture within healthcare organisations.
The Council of Deans of Health is the representative voice of the 85 UK university health faculties providing education and research for nursing, midwifery and the allied health professions. The Council seeks to play an influential leadership role in improving health outcomes through developing an expert health workforce and utilising its collective expertise to inform innovative educational practice and translational research.

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Healthcare support workers in England:

Five proposals for investing in education and development to deliver high quality, effective and compassionate care

Council of Deans of Health
Working Paper

July 2013