hcpc health & care professions council

Council meeting, 27 March 2013

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

Executive summary and recommendations

Introduction

In February 2013, the Mid Staffordshire NHS Foundation Trust Public Inquiry reported to the Secretary of State for Health.

The attached paper reviews the inquiry report and its recommendations, identifying and discussing the HCPC's response and actions.

Decision

The Council is invited to discuss the attached paper (see section four).

Background information

- Mid Staffordshire NHS Foundation Trust Public Inquiry www.midstaffspublicinquiry.com/

Resource implications

There are no additional resource implications as a result of this paper.

Financial implications

There are no additional financial implications as a result of this paper.

Appendices

- See paper

Date of paper

15 March 2013

hcpc health & care professions council

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

1. Introduction

1.1 In February 2013, the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry was published. The terms of reference of the Public Inquiry were to examine the 'operation of commissioning, supervisory and regulatory organisations and other agencies…in relation to their monitoring role of Mid Staffordshire NHS Foundation Trust' (page 10 of the report; referred to as 'Mid Staffordshire' in the remainder of this paper).

1.2 The report recommends the following for organisations in implementing the recommendations.

'It is recommended that:

- 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;

- 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.' (1; Introduction).

1.3 The Executive has reviewed the Inquiry report with the following aims.

- To review the recommendations which are relevant or most salient to the role of the HCPC as a regulator of health and care professionals.

- To review the other recommendations which might be relevant to the HCPC as an organisation.

- To discuss and identify the HCPC's actions in response to the Inquiry's recommendations.

1.4 This paper is divided into six sections.

- Section one introduces the document.

- Section two summarises references to the HCPC in the Inquiry report.

- Section three describes the approach taken in grouping and analysing the recommendations.

- Section four outlines the discussion / decisions of the Council.

- Section five looks at the recommendations relevant to the HCPC's core functions.

- Section six looks at the recommendations relevant to the HCPC as an organisation.

- Appendix 1 is the complete set of recommendations from the report.

1.5 Please note that the recommendations of the report are specific to delivery, oversight and regulation in England, rather than to other parts of the UK (although the recommendations are likely to be of wider relevance).

1.6 Paragraph and page references are references to the Inquiry report.

2. The Inquiry report and the HCPC

2.1 None of the recommendations in the report refer to the HCPC directly. Those that are most directly relevant to professional regulation are made with specific reference to the role of the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC).

2.2 The HCPC is referenced in Chapter 23 of the report. The report outlines the HCPC's statutory functions and aims, noting that, like the GMC and the NMC, the HCPC has 'no general powers of inspection or oversight'. (Paragraph 12.124; page 1043)

2.3 The overarching statements of the HCPC's standards of conduct, performance and ethics are reproduced. They are described in the report as 'somewhat less sophisticated than those produced by the GMC and the NMC' owing to the need for them to be 'common to a varied collection of professions'. (Paragraph 12.126; page 1044)

2.4 The HCPC provided written evidence to the Inquiry. The report says: '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.' (Paragraph 12.127; page 1044)

3. Analysis of report

3.1 The report makes 290 recommendations.

3.2 The tables that follow breakdown the recommendations relevant to the HCPC in two areas.

- The recommendations which are most directly relevant to the HCPC's role as a professional regulator in fitness to practise; education; policy and standards; and communications.

- The recommendations or themes which, although not specific to our regulatory role, are nonetheless relevant to us as an organisation.

3.3 Each section of the tables that follow includes:

- a summary of the background, evidence or conclusions informing the recommendations made (where helpful);

- the recommendations relevant to that area (either as direct quotations or paraphrased where necessary);

- the HCPC's response / actions; and

- an indication of whether legislation would be required to implement the recommendations.

4. Discussion

4.1 The Council is invited to discuss this paper and to consider the following questions.

Q. What actions should the HCPC take as a result of the Inquiry report?

Q. Are there any topics which should be considered further by the Council or its Committees?

4.2 In light of the Council's discussion at this meeting, the Executive will prepare a shorter, more concise 'policy statement' for consideration at the next meeting, which will describe in clear, accessible terms our response to the report, including the following.

- The recommendations which are relevant to us.
- The actions we have taken or will take as result.
- The timescales for implementation.
- Arrangements for reporting progress (i.e. at least annually).

4.3 An event will take place after the Council meeting in May 2013 to engage with stakeholders about the HCPC's response to the report. Further revision of the statement will be informed by at that event. The intention would be to publish the statement on the HCPC website.

5. Recommendations about the core functions of the HCPC

Fitness to practise

1	Sharing information – fitness to practise	
	Summary and recommendations	**Summary** The report highlights overall concern about the extent of meaningful information sharing between the Healthcare Commission (HCC) and others, including other organisations which had carried out investigations into aspects of care at Mid Staffordshire. With respect to professional regulation, the report focuses on the sharing of information relevant to fitness to practise and patient safety between the GMC, NMC and the Care Quality Commission (CQC), the regulator of health and adult social care services in England (and successor body to the HCC). **Recommendations** 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.' (Chapter 9) 224: 'Steps must be taken to systematise the exchange of information between the Royal Colleges and the GMC and to issue guidance for use by employers of doctors to the same effect.' (Chapter 12) 234: 'Both the GMC and the NMC must develop closer working relationships with the CQC – in many cases there should be joint working to minimise the time taken to resolve issues and maximise the protection afforded to the public.' (Chapter 12)

	HCPC response / actions	The HCPC has a ‘Memorandum of Understanding’ (MOU) with the CQC which was last reviewed in summer 2012. The MOU sets out the framework of the working relationship between HCPC and the CQC. It is suggested that further work is done with the CQC of the kind suggested by the Inquiry to develop the template suggested to ensure mutual benefit. It is also suggested that this activity is undertaken with the equivalent organisations in Scotland, Wales and Northern Ireland.
	Legislation required?	No

<table>
<tr><td>2</td><td colspan="2">Investigation of systemic concerns (when required)</td></tr>
<tr><td></td><td colspan="2"></td></tr>
<tr><td></td><td>Summary and recommendations</td><td>Summary

A theme of the report is the role of the professional regulators in investigating ‘systemic concerns’. Such matters include those where it may not be possible to identify concerns about a named individual from the outset, but where nonetheless there are concerns which merit further investigation. The report identifies a number of issues with respect to the GMC and the NMC including the following.

• The GMC and NMC were not established to be ‘proactive investigative regulator[s]’.

• The GMC and NMC did not have a clear policy for how they will deal with ‘systemic’ or ‘generic’ complaints.

• It should be possible for the regulators to interrogate data so that trends can be identified systematically – for example, by employer.

The recommendations acknowledge the resource implications of investigating such cases and that closer working with the CQC would be required.

Specific recommendations

222: ‘The GMC should have a clear policy about the circumstances in which a generic complaint or report ought to be made to it, enabling a more proactive approach to monitoring fitness to practise.’ (Chapter 12)

225: ‘The GMC should have regard to the possibility of commissioning peer reviews … where concerns are raised in a generic way, in order to be advised whether there are individual concerns. Such reviews could be jointly commissioned with the CQC in appropriate cases.’ (Chapter 12)

226: ‘To act as an effective regulator…the NMC needs to be equipped to look at systemic concerns as well as individual ones… It should not have to wait until a disaster has occurred to intervene with its fitness to practise procedures.’ (Chapter 12)</td></tr>
</table>

	HCPC response / actions	The HCPC's fitness to practise powers allow it to investigate concerns regarding individual registrants. It does not have the power to investigate concerns which are about systems. The HCPC's 'Standard of acceptance for allegations' acknowledges that a member of the public may make a complaint about a registrant but may not be able to identify them by name. In such cases it provides that if sufficient information is provided the HCPC will make reasonable efforts to trace the registrant concerned. This policy document also refers to signposting complainants to other more appropriate sources if a complaint does not fall within the HCPC's powers and remit. In England, the power to regulate health and adult social care providers rest with the CQC. It will remain important that the HCPC has an effective working relationship with the CQC to ensure that professional and system regulation work together effectively.
	Legislation required?	Yes (if the professional regulators were to have a broader statutory role in investigating systemic concerns)

3	Lowering barriers to complaints	
	Summary and recommendations	**Summary** The report describes the barriers to ensuring that the complaints and feedback of patients are heard. These include awareness and accessibility of the complaints process and the provision of support for complainants. The report concludes that both the GMC and NMC: '…need constantly to have in mind the need to explain to complainants what is happening, why it is happening and what is being done about the complaint. While the regulatory process requires the regulator to represent the public interest not the complainant, the latter must be fully supported and, so far as possible, treated as a partner.' (Paragraph 12.130; page 1045) **Recommendations** 109: 'Methods of registering a comment or complaint must be readily accessible and easily understood.' (Chapter 3) 110: 'Actual or intended litigation should not be a barrier to the processing or investigation of a complaint at any level.' (Chapter 3) 111: 'Provider organisations must constantly promote to the public their desire to receive and learn from comments and complaints.' (Chapter 3) 112: 'Patient feedback which is not in the form 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.' (Chapter 3)
	HCPC response / actions	We are continuing to look at mechanisms to ensure that our fitness to practise processes are accessible and easily understood. Our 'Standard of acceptance for allegations' sets out a modest and proportionate

		threshold which allegations must normally meet before they will be investigated by the HCPC. As part of the Fitness to Practise Department work plan for 2013-2014, there is a work stream looking at improving the fitness to practise experience for complainants and witnesses.
	Legislation required?	No

4	Complaints handling	
	Summary and recommendations	**Summary** The Patients Association has been working with Mid Staffordshire to review a sample of the complaints they have handled. They have identified 12 standards for good complaints handling, including an impartial and fair investigation; a single point of contact for complainants; and complaints being used to learn lessons across the organisation. **Recommendations** 113: 'The recommendations and standards suggested in the Patients Association's peer review into complaints at the Mid Staffordshire NHS Foundation Trust should be reviewed and implemented in the NHS.' (Chapter 3)
	HCPC response / actions	We hope to work with the Patients Association (PA) in the coming months to undertake a similar peer review of how the HCPC has handled fitness to practise complaints. We will also review the PA's peer review into complaints at the Mid Staffordshire in order to assess any learning for the HCPC in our own fitness to practise processes. The Fitness to Practise Committee will be asked to consider this review at its meeting in May 2013.
	Legislation required?	No

5	Support for complainants	
	Summary and recommendations	**Summary** The report emphasises the importance of independent advocacy and support for patients making a complaint via the NHS complaints process. The report makes a number of conclusions including that all patients should be entitled to support if they request it, not just those who are particularly vulnerable; advocates should have access to expert advice; and that patients should be signposted to other sources of independent advice and support. **Recommendations** 116: 'Where meetings are held between complainants and trust representatives or investigators as part of the complaints process, advocates and advice should be readily available to all complaints who want those forms of support.' (Chapter 3) 117: 'A facility should be available to Independent Complaints Advocacy Services advocates and their clients for access to expert advice in complicated cases.' (Chapter 3)
	HCPC response and actions	We will review the sources of advice and support that are available to those who make a complaint to the HCPC and the applicability of this recommendation as it relates to our work. The Fitness to Practise Committee received a paper at its February 2013 meeting which set out the arrangements in place to support witnesses throughout the process. As previously mentioned, we are also looking at ways in which we can improve the fitness to practise experience for all those who interact with it.
	Legislation required?	No

6	Co-ordination with internal procedures	
	Summary and recommendations	**Summary** The report notes (with specific reference to the GMC and the NMC) that there is a perception that the internal disciplinary action of employers should await the outcome of GMC and NMC proceedings. For example, that employers are prevented from dismissing poorly performing doctors if a GMC investigation is on-going. **Recommendation** 231: 'It is essential that, so far as practicable, NMC procedures do not obstruct the progress of internal disciplinary action in providers. In most cases it should be possible, through co-operation, to allow both to proceed in parallel. This may require a review of employment disciplinary procedures, to make it clear that the employer is entitled to proceed even if there are pending NMC proceedings.' (Chapter 12)
	HCPC response / actions	We have not detected any similar concerns from employers with respect to the professions we regulate and our fitness to practise processes. A focus of events with employers over recent years has been exploring the threshold for referral, and how we work with employers in handling and investigating matters referred to us. Article 32(3) of the Health and Social Work Professions Order 2001 requires panels to conduct fitness to practise proceedings expeditiously and it is in the interest of all parties that allegations are heard and resolved as quickly as possible. As a general principle, whilst it may be appropriate for HCPC fitness to practise proceedings to be postponed if the person concerned is being tried concurrently for related criminal charges, postponement will rarely be appropriate simply because the person concerned or the subject matter of the allegation is the subject of civil proceedings. In certain instances, the HCPC will await the conclusion of employer proceedings before it commences its own processes but this will be assessed on a case-by-case basis. As part of the Fitness to Practise Department and Policy and Standards Department work plans for 2013-2014, it is anticipated that guidance for employers on referring cases to the HCPC will be developed.

	Legislation required?	No

7	Employment liaison officers	
	Summary and recommendations	**Summary** The GMC has recently introduced a network of ‘employment liaison officers’ to act as a point of contact between responsible officers (senior managers such as medical directors) and the GMC on matters regarding fitness to practise and revalidation. The report notes this role, with reference to the ‘reach’ or ‘visibility’ of the regulators and their role within the NHS. One witness to the inquiry linked the employment liaison officer arrangements to the ability to be more proactive in fitness to practise investigations. The role of directors of nursing in ensuring ‘compliance with the nursing code’ is also noted in the report. **Recommendation** 232: ‘The NMC should 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.’ (Chapter 12)
	HCPC response / actions	This suggestion may not be appropriate to the HCPC’s context. These arrangements arguably rely upon a relatively homogeneous NHS employment context for a large majority of registrants, whereas the professionals registered by the HCPC work in an increasingly diverse range of settings. Such a model may not be proportionate in our case or meet the HCPC’s needs. Our assessment at this moment in time is that there is not a ‘gap’ which similar arrangements would help to fill. We plan to develop guidance for employers on when to make fitness to practise referrals to us which will assist in addressing the concern that underpins this recommendation. We will also continue to engage with employers through our communications activities.
	Legislation required?	No

8	Joint proceedings	
	Summary and recommendations	**Summary** The report concludes that the separate codes of conduct and procedures operated by different regulators mean that even where concerns about the conduct or competence of professionals arise from the same episode of care, there is 'the possibility of inconsistent outcomes'. The creation and abolition of the Office of the Health Professions Adjudicator (OHPA) is noted. The report concludes that 'the abolition of the OHPA…need not inhibit the Professional Standards Authority (PSA) from considering the economic and public interest gains' of a 'common independent tribunal' for fitness to practise cases (Paragraph 12.133; page 1046) **Recommendation** 235: 'The 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. Whilst 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.' (Chapter 12)
	HCPC response / actions	In previous reports discussing adjudication it has been highlighted by the Council that in terms of sharing adjudication services, arguably, the HCPC can already be seen to do this through the regulation of 16 different professions. The Fitness to Practise Department quality assurance framework provides for regular review of decisions and there are a range of practice notes in place in an effort to ensure openness, transparency and consistency. The concern that different regulators may make inconsistent decisions about different registrants in the same or similar circumstances is an understandable one. However, it is also important to recognise (and

		this is noted in recent research on the meaning of public protection, undertaken for us by the Picker Institute Europe), that cases should be assessed on a case-by-case basis and on their own merits. Although the facts of a case arising from the event may be the same, a panel still needs to consider whether this amounts to one of the grounds of allegation set out in Article 22 of the Health and Social Work Professions Order 2001 and furthermore whether this amounts to the fitness to practise of the individual registrant, being impaired. We will work with the relevant organisations on any further developments in this area.
	Legislation required?	Yes (with respect to implementation of independent adjudication).

Education

9	Medical training and education	
	Summary and recommendations	**Summary** The report makes a number of recommendations with specific reference to the GMC's role in quality assuring post-graduate medical training - this includes the foundation programme undertaken by junior doctors, through to specialist training leading to admission in the GMC's specialist or GP registers. The report identifies a number of issues about how the regulation and oversight of postgraduate medical education and training failed to identify or take action in relation to concerns about standards of patient care at Mid Staffordshire. **Recommendations** 152: 'Any organisation which in the course of a review, inspection or other performance of its duties, identifies concerns potentially relevant to the acceptability of training provided by a healthcare provider, must be required to inform the relevant training regulator of those concerns.' (Chapter 18) 153: A statutory duty to co-operate must apply to all medical education and training regulators. Information sharing should take place between deanery, commissioners, GMC, CQC and Monitor with regards to 'patient safety issues'. (Chapter 18) 155: The oversight of healthcare organisations which provide regulated training should be co-ordinated and all levels should be involved (including the deanery, the Royal Colleges and relevant information from the CQC and other reviews). (Chapter 18)
	HCPC response / actions	The recommendations in the area of education are made with specific reference to the GMC's role in regulating post-graduate medical education and training. This is supported by an infrastructure including royal colleges and medical deaneries. Medical trainees are employed by the NHS whilst undertaking their training. These arrangements are not directly analogous to many of those in the HCPC's context,

		where the majority of programmes are delivered by education providers in higher education, with students on those programmes going on placement in the practice environment. We have previously acted on information we received from another regulator about a CQC report which may have led to concerns about a practice learning environment used by an approved education provider. We took steps to assure ourselves that the standards of education and training continued to be met. The Education Department is reviewing how it might routinely identify trends in practice learning environments, including the development of formal information sharing arrangements across other professional and systems-based regulators. This forms part of the Education Department work plan for 2013-2014. Further information about information sharing in this area is included in tables 11 and 12.
	Legislation required?	No

10	Lay or patient representation	
	Summary and recommendations	**Summary** Lay or patient representation is identified as a key principle for the quality assurance visits of local medical education providers. **Recommendation** 155: ‘There should be lay or patient representation on visits to ensure that patient interests are maintained as the priority.’ (Chapter 18)
	HCPC response / actions	The HCPC consulted last year on a proposal to amend the standards of education and training to make the involvement of service users in HCPC approved programmes a mandatory requirement. The Education and Training Committee agreed the new standard (for ‘service user and carer involvement’) in principle at its recent meeting, subject to further discussion and approval of the finalised standard at its meeting in June 2013. Subject to Council agreement at its meeting in July 2013, the new standard will become effective from the 2014-2015 academic year. The Education and Training Committee is also considering the involvement of service user / carer visitors in its approval and monitoring processes. This may include the introduction of a pilot of service users and carers as part of approval visits in 2014-2015.
	Legislation required?	No

11	Matters to be reported to the GMC	
	Summary and recommendations	**Summary** The report notes a failure to share information about failings at Mid Staffordshire with the GMC, which could have affected the GMC's assessment of the suitability of the Trust as a provider of medical training. **Recommendation** 157: The GMC should set out 'a clear statement' of matters which should be reported to them. (Chapter 18)
	HCPC response / actions	The standards of education and training (SET 5: Practice placements) ensure that the education provider maintains overall responsibility for placement environments and has appropriate mechanisms in place to gather information to assess the quality of placement provision on a regular basis. The primary focus of these standards is the quality assurance of a student's placement experience. Education providers are required to inform us through our monitoring processes of any changes which significantly affect how our standards of education and training are met. In relation to practice placements, this would also include notifying us when placement opportunities have been significantly affected by the availability of suitable placement environments. We would consider any changes with a view to whether the programme still meets the SETs and can ensure all individuals meet the relevant standards of proficiency upon completion of the programme. Any implications for broader concerns about the safety of service users would be dealt with appropriately as part of this process. The extent to which the SETs or supporting guidance might include a specific expectation that education providers report broader concerns about service user safety to the HCPC might be a topic best considered as part of the next SETs review. The Executive plans to develop proposals for the structure and format of the review and present proposals to the Education and Training Committee by the end of 2013.

	Legislation required?	No

12	Training and training establishments as a source of safety information	
	Summary and recommendations	**Summary** The report's recommendations emphasise the importance of identifying and sharing information in this area – for example, so that issues picked up by the inspection of a healthcare provider can inform the oversight and regulation of medical training via the deanery and the GMC, and vice versa. **Recommendations** 158: 'The GMC 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.' (Chapter 18) 159: 'Surveys of medical students and trainees should be developed to optimise them as a source of feedback of perceptions of the standards of care provided to patients.' (Chapter 18) 160:'Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns.' (Chapter 18) 161: 'Training visits should make an important contribution to the protection of patients', including 'obtaining information directly from trainees'….'Visits to, and observation of, the actual training environment would enable visitors to detect poor practice from which both patients and trainees should be sheltered.' (Chapter 18) 162: 'The GMC should in the course of its standards and regulatory process ensure that the system of medical training and education maintains as its first priority the safety of patients. It should also ensure that providers of clinical placements are unable to take on students or trainees in areas which do not comply with fundamental patient safety and quality standards.' (Chapter 18)

	HCPC response / actions	The existing standards of education training relevant to patient safety and the practice learning environment are as follows. • 'The practice placement settings must provide a safe and supportive environment.' (SET 5.3) • 'The education provider must maintain a thorough and effective system for approving and monitoring all placements.' (SET 5.4) • 'There must be regular and effective collaboration between the education provider and the practice placement provider.' (SET 5.10) • 'A range of learning and teaching methods that respect the rights and needs of service users and colleagues must be in place throughout practice placements.' (SET 5.13) With reference to student or trainee feedback, the guidance to SET 5.4 refers to education providers providing evidence such as: '…an explanation of how you collect, analyse and act on feedback from students.' However, this does not specifically refer to feedback on standards of care for service users. The extent to which the SETs or supporting guidance might include an expectation that education providers specifically ensure placements are safe and supportive from a service user perspective (rather than as a consequence of ensuring a placement is suitable for a student) and how such concerns would be gathered and reported to HCPC might be a topic best considered as part of the next SETs review. The Executive plans to develop proposals for the structure and format of the review and present proposals to the Education and Training Committee by the end of 2013. Expectations of students to be open in reporting concerns are included in the HCPC's 'Guidance on conduct and ethics for students' which says: 'If you are worried about a situation which might put someone at risk, you should speak to a member of the placement team or your education provider.' The guidance is based on the structure of the existing standards of conduct, performance and ethics and will be revised and consulted on at the end of the review of those standards.

	Legislation required?	No

13	Safe staff numbers and skills	
	Summary and recommendations	**Recommendation** 163: ‘The GMC’s system of reviewing the acceptability of the provision of training by healthcare providers must include a review of the sufficiency of the numbers and skills of available staff for the provision of training and to ensure patient safety in the course of training.’ (Chapter 18)
	HCPC response / actions	These points are addressed in relation to programmes approved by the HCPC in the standards of education and training which say the following. • ‘There must be an adequate number of appropriately qualified and experienced staff in place to deliver an effective programme.’ (SET 3.5) • ‘There must be an adequate number of appropriately qualified and experienced staff at the practice placement setting.’ (SET 5.6) The standards do not prescribe what the ratio of students to staff should be, but the education provider is required to justify this at the visit and satisfy the visitors that the arrangements that are in place are sufficient to meet these standards.
	Legislation required?	No

14	Nursing education – culture of caring	
	Summary and recommendations	**Summary** The report overall highlights consistently poor standards of nursing care and professionalism at Mid Staffordshire. The report concludes: 'The experience from Stafford…suggests that the current university-based model does not focus enough on the impact of culture and caring.' (Paragraph 23.48; page 1513) **Recommendations** 185: '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.' The system requires the following. • Selection of students based on values, attitudes and behaviours; ability and motivation to put others' interests above their own; driven to maintain, develop and improve; intellectual ability to enable them to acquire the necessary technical skills. • Training and experience in the delivery of compassionate care. • Leadership which constantly enforces 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 through recognition of achievement; feedback; and encouragement to report concerns. (Chapter 23)
	HCPC response / actions	Similar concerns have not been identified to date in the professions regulated by the HCPC, many of whom have been degree level trained for a number of years. The standards of education and training require education providers to demonstrate that they have robust admissions procedures including criminal records and health checks (where necessary) and appropriate 'academic and/or professional entry standards' (SET 2.5). The SETs do not prescribe specific requirements to be met in these areas, nor do they specify how themes of compassionate care are addressed through the admissions process and structure of the curriculum. However, such

		expectations are normally set out in the curriculum framework or guidance for the professions. SET 4.2 requires education providers to reflect the 'philosophy, core values, skills and knowledge base as articulated in any relevant curriculum guidance'. In addition, the following standards also ensure that professional aspects of practice are embedded into HCPC approved programmes. • 'The curriculum must make sure that students understand the implications of the HCPC's standards of conduct, performance and ethics'. (SET 4.5) • 'Learning, teaching and supervision must encourage safe and effective practice, independent learning and professional conduct.' (SET 5.12) • 'Professional aspects of practice must be integral to the assessment procedures in both the education setting and practice placement setting.' (SET 6.3) This recommendation also links in with the HCPC's activities in the area of professionalism. The first report from researchers at Durham University describes a study of student and student educators' perceptions of professionalism, and in particular their views on what constitutes unprofessional behaviour. This report has been widely used both by the HCPC and by others to generate debate amongst undergraduates as well as practitioners on the nature of professional practice, with particular reference to values and attitudes. A second study from Durham University will be complete in 2015. This study is trialling tools to measure professionalism and to explore the relationship between students' behaviour before and after graduation. There is on-going dialogue with educators about how best to embed clear descriptions and definitions of professionalism into the curriculum.
	Legislation required?	No

15	Nursing education - Practical hands-on training and experience	
	Summary and recommendations	**Summary** The report records concerns about nurse students gaining an inadequate amount of practical experience of nursing care from an early stage. The report emphasises that so-called ‘basic nursing tasks’ nonetheless require skill and that it remains important that nurses are competent and compassionate in carrying these tasks out. **Recommendation** 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.’ (Chapter 23) 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.’ (Chapter 23) 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.’ (Chapter 23)
	HCPC response / actions	Similar concerns have not been identified to date in the professions regulated by the HCPC, many of whom have been degree level trained for a number of years. The standards of education and training include the following standards which ensure that practice learning is integral to programmes.

		• ‘Integration of theory and practice must be central to the curriculum.’ (SET 4.3) • ‘Practice placements must be integral to the programme.’ (SET 5.1) • ‘Learning, teaching and supervision must encourage safe and effective practice, independent learning and professional conduct.’ (SET 5.12). The SETs do not prescribe a set minimum amount of time for practice placements, but such expectations are normally set out in the curriculum framework or guidance for the professions. SET 4.2 requires education providers to reflect the ‘philosophy, core values, skills and knowledge base as articulated in any relevant curriculum guidance’.
	Legislation required?	No

16	Nursing education: Aptitude test for compassion and caring	
	Summary and recommendations	**Summary** The report concludes that it is necessary to ensure that those entering the nursing profession are ‘willing and able to undertake fundamental nursing tasks and are not merely interested in the more technical competencies of the profession’. (Paragraph 23.60; page 1516) **Recommendation** 188: ‘The NMC, working with universities, should consider the introduction of an aptitude test to be undertaken by aspirant registered nurses into the profession, exploring, in particular, candidates’ attitudes towards caring, compassion and other necessary professional values.’ (Chapter 23)
	HCPC response / actions	The concerns which underpin this recommendation have not to date been raised about the professions regulated by the HCPC. However, we would certainly be interested in the development of any such test or tool and note the movement in some areas (such as in recruitment by some employers) to a values-based approach to selection.
	Legislation required?	No

17	Nursing education: consistent training	
	Summary and recommendations	**Recommendation** 189: 'The NMC and other professional and academic bodies should work towards a common qualification assessment / examination.' (Chapter 23)
	HCPC response / actions	The standards of education and training do not prescribe a common qualification assessment / examination, but such expectations are normally set out in the curriculum framework or guidance for the professions. SET 4.2 requires education providers to reflect the 'philosophy, core values, skills and knowledge base as articulated in any relevant curriculum guidance'. In addition, the following standards also ensure consistency in the area of assessment when considering thresholds for safe and effective practice. • 'The learning outcomes must ensure that those who successfully complete the programme meet the standards of proficiency for their part of the Register.' (SET 4.1) • 'The assessment strategy and design must ensure that the student who successfully completes the programme has met the standards of proficiency for their part of the Register.' (SET 6.1) The overall purpose of the approval process is to ensure that there is consistency – that all programmes meet the standards of education and training and successfully deliver the standards of proficiency – whilst avoiding unnecessary prescription in how that is best achieved between different programmes and professions.
	Legislation required?	No

Policy and standards

18	English language proficiency	
	Summary and recommendations	**Summary** The English language proficiency of doctors was not identified as a specific concern at Mid Staffordshire. However, the report identifies the inability of the GMC to language test doctors from the European Economic Area (EEA) as a general matter of concern which should be addressed. **Recommendation** 172: 'The Government should consider urgently the introduction of a common requirement of proficiency in communication in the English language with patients and other persons providing healthcare to the standard required for a registered medical practitioner to assume professional responsibility for medical treatment of an English-speaking patient.' (Chapter 18).
	HCPC response / actions	The HCPC is also unable to systematically require health and care professionals from the EEA who are seeking registration to provide evidence of their English language proficiency. The only exception to this is for speech and language therapists for whom evidence is required as language competence is considered to be a core professional skill. We have actively participated in the review of the European Directive on Professional Qualifications. The revised directive is being considered by the European Parliament. It is expected (subject to possible procedural safeguards) that once implemented in UK law the new Directive is likely to allow the HCPC to extend a language test requirement to this group of applicants.
	Legislation required?	Yes

19	Reporting and escalating concerns	
	Summary and recommendations	**Summary** The report details a number of instances where the principles of ‘honesty, transparency and candour’ were not met at Mid Staffordshire. This included instances of misleading information being provided to regulators; ‘gagging clauses’ being added to contracts; a failure of health professionals to report concerns; and a lack of support for those that did. **Recommendations** 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. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.’ (Chapter 2) 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 and truthful.’ (Chapter 22) 181: ‘A statutory obligation should be imposed to impose a duty of candour… • On healthcare providers… • On registered medical practitioners and registered nurses and other registered professionals who believe or suspect that treatment or care provided to 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 is reasonably practicable.’ (Chapter 22). 183: This statutory obligation would be underpinned by the creation of a criminal offence to obstruct the performance of these duties; to provide misleading information to patients; and to be wilfully dishonest in statements to regulators or commissioners. (Chapter 22)

	HCPC response / actions	The HCPC's standards of conduct, performance and ethics (SCPE) make the following requirements of registrants. 'You must protect service users if you believe that any situation puts them in danger. This includes the conduct, performance or health of a colleague. The safety of service users must come before any personal or professional loyalties at all times. As soon as you become aware of a situation that puts a service user in danger, you should discuss the matter with a senior colleague or another appropriate person.' (Paragraph 1) The standards also require registrants to tell us and any other relevant regulators if they have important information about others they work with, and to cooperate with any investigation or formal inquiry into their own conduct, the conduct of others, or the care or services provided to a service user. (Paragraph 4) The Executive has also published information on raising and escalating concerns on the HCPC website and has written articles on this for the HCPC 'In Focus' newsletter. The SCPE is currently under review. Whilst the content as it stands is sound, the Executive has identified that we will want to strengthen and restate our requirements around raising and escalating concerns, including whistleblowing. A thorough revision of the structure of the current document will also help in making our expectations more accessible. A paper looking at a 'duty of candour' being considered at this Council meeting indicates the areas of the SCPE that might be strengthened. The review is on-going with efforts being made in 2012-2013 and 2013-2014 to seek the views of key stakeholders, including via commissioned research with registrants and service users. A PLG is planned to take place from the beginning of the 2014-2015 financial year (timed to take account of the anticipated restructure of the Council in January 2014).
	Legislation required?	No

20	Regulation of healthcare support workers	
	Summary and recommendations	**Summary** The report makes a number of observations and conclusions in this area including the following. • There are no minimum standards of training or competence for healthcare support workers. • A healthcare support worker dismissed from one employer could move to another without a process for preventing this from happening. • There are no common titles for healthcare support workers and this is confusing for members of the public. • Regulation on its own is not enough – improvements in and standardisation of training and support are required. • A voluntary register would 'have little or no advantage for the public'. (Paragraph 23.134; page 1536). • A 'minimal' system of regulation might be introduced and linked to CQC regulated activities, and then reviewed to see whether it was necessary to develop a system more akin to how nurses are regulated. **Recommendations** 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 a registered doctor in a hospital or care home setting.' (Chapter 23) 210: 'There should be a national code of conduct for healthcare support workers.' (Chapter 23) 211: 'There should be a common set of national standards for the education and training of healthcare support workers.' (Chapter 23)

		212: ‘The 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.’ (Chapter 23) 213: ‘Until such time as the NMC is charged with the recommended regulatory responsibilities, the DH should institute a nationwide system to protect patients and care receivers from harm. This system should be supported by fair due process in relation to employees in this grade who have been dismissed by employers on the grounds of a serious breach of the code of conduct or otherwise being unfit for such a post.’ (Chapter 23)
	HCPC response / actions	The 2011 Command Paper ‘Enabling Excellence’ said that the Department of Health would ‘explore scope for the HPC to establish a voluntary register of [adult] social care workers [in England] by 2013.’ The HCPC has developed proposals for the regulation of adult social care workers in England including the following. • Statutory regulation of CQC Registered Managers. • A statutory code of conduct which would apply to the whole of the adult social care workforce. • A process for investigating concerns about the practice or conduct of adult social care workers in England. • A ‘negative register’ of those found unfit to work in adult social care in England. The conclusion that voluntary registers lack value; the acknowledgement that regulation is one part of improving safety and quality; and the suggestion that regulation might be linked to CQC regulated activities in some way, are all very much consistent with our thinking as described above about the regulation of adult social care workers in England. We were recently asked to talk about this work at a meeting convened by the Department of Health to inform its response to the Inquiry report. Although the decision about whether and how healthcare support workers should be regulated is a matter for the Government, should the proposals above be implemented this could act as a pilot for whether such arrangements should also be extended to healthcare support workers.

		Since the publication of the report, the Department of Health has announced that a Times journalist, Camilla Cavendish, will be asked to lead an independent inquiry into the training, support and recruitment of healthcare support workers.
	Legislation required?	Yes

21	Accountability and regulation of board-level NHS managers	
	Summary and recommendations	**Summary** The report identifies two main issues that arise from the lack of regulation of board-level leaders and managers, including the risk that someone found unsuitable will be able to move between employers; and tensions between those senior managers who are accountable to a regulator by virtue of their registered professional background, and those who are not. A role for Monitor, the regulator of NHS Foundation Trusts, is suggested in which, as part of licensing requirements for NHS Foundation Trusts, it would be able to disqualify someone found not to be 'fit and proper' from holding a post as a Director of an NHS organisation. **Recommendations** 215: 'A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it.' (Chapter 24) 218: 'Serious non-compliance with the code, and in particular, non-compliance leading to actual or potential harm to patients, should render board-level leaders and managers liable to be found not to be fit and proper persons to hold such positions by a fair and proportionate procedure, with the effect of disqualifying them from holding such positions in the future.' (Chapter 24) 219: 'An alternative option to enforcing compliance with a management code of conduct, with the risk of disqualification, would be to set up an independent professional regulator. The need for this would be greater if it were thought appropriate to extend a regulatory requirement to a wider range of managers and leaders. The proportionality of such a step could be better assessed after reviewing the experience of a licensing provision for directors.' (Chapter 24)
	HCPC response / actions	The recommendation that 'board level leaders and managers' might be subject to some kind of disqualification, akin to that of company directors, and that a code of conduct should be produced, is

		conceptually similar to the HCPC's suggestion of a negative registration system for adult social care workers in England. In 2012 the Professional Standards Authority published standards of personal behaviour, technical competence and business practices for members of NHS boards and Clinical Commissioning Group (CCG) governing bodies in England, work commissioned by the Department of Health in England. The Department has yet to implement these standards
	Legislation required?	Yes

22	Revalidation	
	Summary and recommendations	**Recommendation** 229: ‘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 administrative and leadership skills to ensure that this does not detract from its core function of regulating fitness to practise of nurses.’ (Chapter 12)
	HCPC response / actions	In order to retain a licence to practice with the GMC, doctors are now required to participate in medical revalidation. This involves a doctor collecting information about their CPD; quality improvement activity; significant events; colleague and patient feedback; and a review of complaints and compliments. This then informs an annual workplace appraisal, with ‘responsible officers’ in the workplace making recommendations to the GMC every five years about whether a doctor should be revalidated. This form of revalidation relies upon an infrastructure including specific legislation and statutory rules; a system of responsible officers; and guidance and standards from the Royal Colleges. This infrastructure does not directly or legally extend to any the professions we regulate and any changes in legislation would be a policy decision for government. In a similar way, in order to retain registration with the HCPC, registrants must comply with standards on continuing fitness to practice. The HCPC has had CPD standards in place since 2006. Audits take place every two years and successful participation is linked to continued registration. The HCPC made a commitment to building the evidence base in this area, as there has been little research undertaken to date in this area with reference to the professions regulated by the HCPC. This work has yet to reach completion and HCPC will use the findings to inform future decisions about whether an additional layer of inspection, over and above what is already in place through audits of CPD activity, is necessary.

		Enabling excellence (2011) recognised that the risk involved in different professions varied and said that the Government would only consider additional legislation ‘where there is evidence to suggest significant added value in terms of increased safety or quality or care for users of health care services from additional central regulatory effort on revalidation’. (Paragraph 5.3; page 19) A Professional Standards Authority (PSA) report recently concluded that regulators should be able to ‘provide assurances of the continuing fitness to practise’ of their registrants. However, it also concluded that: ‘…this can and, in most cases, should be achieved by means other than formal revalidation.’ (Paragraph 3.4; page 5.) A paper covering both the HCPC’s work to date and the PSA report will be brought to the Council’s May 2013 meeting.
	Legislation required?	Yes (if any additional measures considered necessary could not be implemented under existing legislation).

Communications

23	Raising the profile of the regulators	
	Summary and recommendations	**Recommendations** 230: '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 and care, of the existence and role of the NMC, together with contact details. The NMC itself needs to undertake more by way of public promotion of its functions.' (Chapter 12) 233: 'Whilst both the GMC and the NMC have highly informative internet sites, both need to ensure that patients and other service users are aware at the point of service provision of their existence, their role and their contact details.' (Chapter 12)
	HCPC response / actions	Overall it is an on-going challenge for all the regulators including the HCPC to raise public awareness of their existence, but also importantly the role they play compared to other organisations. The HCPC has always taken a proportionate and targeted approach to this area, having concluded on the basis of previous research that often the public most want to know about us when they need to know – for example when they have a concern or complaint that they would like to raise with us. Some activities in this area have included and continue to include the following. • Publication of a joint leaflet with the other regulators about our roles. • Public-facing events (including stands and distribution of leaflets). • Materials to encourage registrants to promote their registration to users of their services at the point of service provision – for example, a leaflet about how to promote registration is included in all renewal mailings and resources, including a downloadable logo, are available from the website.

		• Mailings of leaflets to GP surgeries and independent pharmacies (for display in waiting areas). • Advertisements on 'Google' and in printed editions of the yellow pages (physiotherapists and chiropodists sections; targeted by age profile of population and density of registrants). • Targeted campaigns – e.g. this year we will be refreshing our 'Be sure' campaign targeted at older people and their carers and advocates (a high user group of many of our registrants' services). • An easy read publication on how to raise a fitness to practise concern with us. • Signposting – work with other organisations to ensure that members of the public are appropriately signposted to us. For example, we recently worked with the Citizens Advice Bureau in Scotland to develop a training package for advisors about our role.
	Legislation required?	No

6. Recommendations relevant to the HCPC as an organisation

<table>
<tr><td>24</td><td colspan="2">Complaints about the HCPC</td></tr>
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<tr><td></td><td>Summary and recommendations</td><td>Summary

The recommendations made in the report about effective NHS complaints handling are also relevant to how the HCPC handles complaints about itself. The section in the recommendations about this area identifies that '…patients should be 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.' (page 96, Executive summary).

Recommendations

Recommendations in this area are listed in tables 3, 4 and 5 (Fitness to practise). In addition, the following additional recommendation specific to learning from NHS complaints was made.

118: 'Subject to anonymisation, a summary of each upheld complaint, in terms agreed with the complainant, and the trust's response should be published on its website. In any case where the complainant or, if different, the patient, refuses to agree, or for some reason publication of an upheld, clinically related complaint is not possible, the summary should be shared confidentially with the Commissioner and the CQC.' (Chapter 3).</td></tr>
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	HCPC response / actions	Complaints about the HCPC are centrally logged and reported on at monthly meetings of the Executive Management Team (EMT). Every 6 months a review of the trends and themes in complaints over the previous 6 months is also undertaken. This is reported to the Finance and Resources Committee. The overall focus of this activity is on ensuring that complaints are correctly identified and answered in an appropriate and timely fashion, but also on learning from complaints. For example, identifying trends and corrective actions to prevent complaints from re-occurring. The following actions have been identified. • A new dedicated role of 'Service and Complaints Manager' has been created and will be filled with effect from 1 April 2013. This role will report to the Secretary to Council. This individual will be dedicated to managing and investigating complaints received about the service provided by HCPC and making recommendations based on the investigation of complaints. Furthermore, they will be responsible for designing, developing and implementing processes and best practice to support the management of complaints. • In order to ensure that communications to complainants are accessible, the Service and Complaints Manager will undertake training in complaints handling and plain English. • Whilst the recommendation about publication of a summary of each upheld complaint may not be directly applicable given the HCPC is not a direct healthcare provider, consideration will be given to incorporating a section on complaints within HCPC's annual report. This could include statistics in relation to the complaints received together with any themes arising from investigations undertaken and details of process changes implemented as a result. Consideration will also be given to increasing the accessibility of complaints information already included in papers considered by the Finance and Resources Committee.
	Legislation required?	No

25	Transparency and openness	
	Summary and recommendations	**Summary** A key theme throughout the report is transparency and openness, including the publication of accurate, useful and relevant information by organisations involved in delivering and regulating health care. This theme is about the availability of information which can then be used and shared by others, including the CQC in its inspection regime; as well as about the accountability of organisations to patients and the public. **Recommendations** A number of recommendations are relevant to this theme, but they include the following. 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 not only include statistics about outcomes, but must take advantage of all safety related information, including that capable of being derived from incidents, complaints and investigations.' (Chapter 9) 290: 'The Department of Health should promote a shared positive culture by setting an example in its statements by being open about deficiencies, ensuring those harmed have a remedy, and making information publicly available about performance at the most detailed level possible.' (Chapter 19).
	HCPC response / actions	The recommendations made above are made with specific reference to regulators who have a remit to regulate healthcare delivery. However, this theme is still relevant to the HCPC. To a significant extent we are already transparent in the information we publish. For example, the website includes copies of all Council, Committee and Professional Liaison Group (PLG) minutes; Council and Committee meetings are held in public; and we publish reports with clear information about our processes in the areas of education and fitness to practise, on a yearly basis, and for CPD audits on

		a biennial basis. However, it is certainly a challenge to ensure that information is both available as well as easy to find and accessible and this is an area that should always be kept under review.
	Legislation required?	No

<table>
<tr><td>26</td><td colspan="2">Organisational culture</td></tr>
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<tr><td></td><td>Summary and recommendations</td><td>Summary

A consistent theme in the report and in subsequent reporting and discussion about it is the issue of organisational culture and the development of a negative culture at Mid Staffordshire that tolerated appalling standards. The report notes that whistleblowing is only necessary ‘because of the absence of systems and a culture accepted by all staff which positively welcomes internal reporting of concerns’. (Paragraph 2.400; page 242)

The report advocates for the creation of creation of a ‘shared positive safety culture’, features of which include: shared values; zero tolerance to sub-standard care; empowerment of staff to deliver safe care; acceptance of professional responsibility; strong and stable ‘cultural leadership’; and expectations of openness, candour and honesty.

The report also refers to how such a culture is evidenced and measured – for example through clear information being available to patients; honesty in disclosing adverse events; and open board meetings. The report refers to the use or development of a ‘cultural barometer’. This tool is in the form of a questionnaire and has been developed by a group of nurses as a means of helping to identify and prevent the issues which occurred at Mid Staffordshire from happening again.

Recommendations

2: ‘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. This requires:
• A common set of core values and standards shared throughout the system;
• Leadership at all levels form ward to the top of the Department of Health, committed to and capable of involving all staff with those values and standards;
• A system which recognises and applies the values of transparency, honesty and candour;
• Freely available useful, reliable and full information on attainment of the values and standards;
• A tool or methodology such as a cultural barometer to measure the cultural health of all parts of the system.’ (Chapter 20).</td></tr>
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		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. Staff are entitled to receive feedback in relation any report they make, including information about any action taken or reasons for not acting.’ (Chapter 2)
	HCPC response / actions	The development and maintenance of an effective organisational culture is a key area for the HCPC and already one identified by the Executive Management Team (EMT) as requiring vigilance given the organisation’s growth over the last 11 years. This is to a great extent not a discrete area, but something that runs through all the organisation does. The HCPC has undertaken or is undertaking a number of activities relevant to this area, including the following. • The EMT and the Chair of Council explored this area at an externally facilitated workshop towards the end of 2012. This topic will form the basis of the next all employee offsite training day in May 2013. • HR surveys, departmental surveys and exit interviews are used regularly to gain the feedback of employees which can inform organisational improvement. • A range of different groups exist which act as forums for consultation, feedback and information sharing (for example, the cross directorate team of ‘middle managers’). • Internal communications activities. For example, the Communications Department is working with volunteers across the organisation to create a network of internal communications champions who will influence and increase internal communications activities. • With respect to reporting concerns, our commitments are set out in the Employee Handbook for all employees. We have in the past received information from a whistleblower and acted on it.
	Legislation required?	No