Issue 24 / May 2008
The quarterly magazine
for nurses and midwives

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The UK's first nurse minister talks to NMC News

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NMC News

Talking in Code

Introducing the new Code for nurses and midwives

Editorial

A real May Day for nurses and midwives

Andy Jaeger
Editor in chief

1 May is an important day, as the Code: Standards of conduct, performance and ethics for nurses and midwives comes into force across the UK. Your new Code is enclosed with this magazine, and on the front cover is a small card. It's not your pin card, though from this month pin cards will carry a summary of the Code. You told us in the consultation that too few members of the public know you even have a Code, so here's your opportunity to tell them. The card is for you to give away.

Incidentally, we hope you like your new look NMC News. Across the NMC, the way we look is changing. It's not a "big bang" – it would be far too costly – so anything you have with our old logo on, like your pin card, is valid until we send you a new one at the normal time.

We're looking forward to 1 May and the difference a new Code will make for you, and most importantly the people in your care. It's one May Day for nurses and midwives that will make a real difference.

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Notes from a CNO

Martin Bradley,
CNO for Northern Ireland

There can be no doubt that the pace of change for those of us involved in the delivery of health and social care has speeded up over recent years. Within Northern Ireland the current review of public administration has seen the biggest shake-up of health, education and local government since 1972. The restructuring of 18 Trusts down to five very large combined health and social care Trusts and of four area Boards into a smaller regional health and social care Board has the potential to provide a more focused, efficient, effective and integrated service closer to the patient and local communities.

With any reorganisation comes the development of new teams and reporting structures. The registrant nurse or midwife must be clear about their accountability for the delivery of care. The recent review of advice on delegation has clarified the responsibility held by nurses and midwives.

In Northern Ireland, this advice is supported by a decision-making framework for delegation, which ensures that the task, the circumstances, the person, the communication and the feedback are all right.

This framework supports the NMC principles of delegation and as we continue to operate through periods of change and uncertainty, nurses and midwives must ensure that delegation occurs in the best interests of the people in their care; that the professional retains responsibility and accountability and that those delegated to understand their limitations. As the family of nursing grows and working relationships between and within multidisciplinary teams continues to evolve, nurses and midwives must act always in a way that protects the public.

Clarity for SCPHNs

Late last year, the NMC made the decision that all specialist community public health nurses must also be registered as a nurse or a midwife, which means you may be in the situation where your PREP requirements have changed.

The key point is this: specialist community public health nurses who are renewing their nursing registration must complete 450 hours of PREP. For those who are renewing their midwifery registration, 450 hours of midwifery PREP is required on top of the 450 hours needed for specialist community public health nursing, making it 900 hours.

Specialist community public health nurses, particularly health visitors, undertake a range of activities that may count towards their required midwifery PREP hours. These include areas such as preparing women for parenthood, providing support to women and babies with special needs, and working in partnership with women and other individuals around financial, psychological, health and child protection issues.

There may also be other areas of work that can be mapped across and we would be happy to talk these through with you. Please contact **020 7333 9333** or **advice@nmc-uk.org**.

Bullying and racist?

As readers of the nursing press will be aware, the NMC has in the past month faced serious allegations of "an ingrained culture of bullying and racism".

The allegations were made by Jim Devine MP during a debate in Westminster Hall. In response the Minister of State for Health Services, Ben Bradshaw MP, called on the Charity Commission and the Council for Healthcare Regulatory Excellence – the body that oversees all the UK's healthcare regulators – to play a role in resolving what he described as "long-standing problems at the NMC". He has not ruled out the option of an investigation by the Privy Council if a resolution cannot be found.

The NMC firmly rejects the allegations of bullying and racism. We very much welcome the Minister's intervention and the opportunity to put our case. We believe that independent scrutiny will give us a chance to demonstrate that we are a fully accountable, open and transparent organisation which does not tolerate discrimination of any kind. The NMC's workforce is extremely diverse, highly competent and committed to safeguarding the health and wellbeing of the public and delivering excellence in regulation.

While we look forward to a swift resolution to the investigations, the day-to-day work of the NMC will continue – maintaining the register, hearing allegations against nurses and midwives, setting standards for education and promoting the new Code.

Promoting the professions across the EU

A nurse prescriber in Tooting, South London, shows how it's done.

The past months have seen the NMC taking a leading role in promoting the nursing profession, patient safety and good regulatory practice in the European context.

In November, a high-level delegation from the Spanish Council of Nurses and 15 journalists attended a day of presentations on the history and workings of nurse prescribing in the UK. Speakers included Paul Robinson from the Department of Health, England, Professor Matt Griffiths of the RCN and Dr Tony Stern, a GP with many years' experience working with nurse prescribers. The talks were followed by a visit to nurse-led walk-in centres in and around London. Our Spanish colleagues have since informed us that they are confident a law currently banning non-medics from prescribing will be amended by the Spanish government very shortly.

In December, NMC Chief Executive Sarah Thewlis accepted an invitation to Charleroi in Belgium to give a talk about the UK model of nursing regulation. The profession in Belgium is in the process of setting up an independent nursing council, and is keen to learn from the UK as one of the pioneers of professional self-regulation. In Berlin, former NMC president and alternate Council member Sandra Arthur spoke at the European Midwives Association's Educational Conference. Sandra spoke about the need for greater cooperation and information exchange between European midwifery regulators and competent authorities.

December also saw a General Assembly meeting of the European Federation of Nursing Regulators (FEPI). The meeting in Dublin confirmed NMC President Nancy Kirkland as Treasurer of FEPI. Topics discussed included the implementation of the European Directive on the Recognition of Professional Qualifications, which came into force in October 2007 (see NMC News 22/2007). Members also debated a new EU law, which is currently in draft form, which could allow patients to seek healthcare in another EU member state and claim for reimbursement in their home country.

Statement of values

The NMC has been working with the General Teaching Council and the General Social Care Council to produce a statement of values underpinning interprofessional work with children and young people. The statement, supported by people and organisations from the health, education and social care sectors, is available with supporting information on the NMC website for use, where appropriate, by people across the children's workforce.

Contact Cathy Cairns, Professional Adviser, Children's Nursing and Child Health for more information: **cathy.cairns@nmc-uk.org**

Policy update

A round-up of NMC circulars

Circulars issued by the NMC since our last edition cover a wide range of nursing issues. Circular 33/2007 sets out the principles for the sharing of personal information necessary to maintain continuity of assessment and to ensure safe and effective practice through the 'ongoing achievement record'. Two circulars are concerned with registration matters, with one laying out the criteria for migration via portfolio to Specialist Community Public Health Adviser – Sexual Health Advisers (34/2007), and the other detailing the programme requirements for the said Specialist Community Public Health Adviser – Sexual Health Advisers (35/2007).

Two circulars address pre-registration nursing. Circular 36/2007 sets out the arrangements for using simulated practice learning as an adjunct to the safe and effective application of clinical skills in direct care in the practice setting, while 37/2007 removes the minimum age of entry requirement for pre-registration nursing and midwifery programmes. Finally, 38/2007 establishes standards of educational preparation for prescribing from the Community Nurse Prescriber's Formulary for nurses without a Specialist Practitioner Qualification – V150.

Detailed information on all the latest circulars can be found at **www.nmc-uk.org**

Dad's the word

DAD is a new information service for expectant and new dads, which midwives and antenatal teachers can pass on to fathers, completely free.

The DAD service includes information cards raising key issues to consider before birth, for midwives and antenatal teachers to hand out to dads, along with posters aimed at creating a father-inclusive environment.

There is also a state-of-the-art website for fathers, www.dad.info, covering all the key issues relating to pregnancy, childbirth and baby care .

Dads can sign up to get emails throughout the pregnancy from Dr Mark Hamilton, from Radio 1's Sunday Surgery, and emails after the birth, produced in association with Mumsnet.

The DAD information service was set up on the basis of research that consistently showed the huge impact – for better or worse – that fathers can have on the health of mother and baby. Engaging with fathers is a core component of supporting the health and safety of mother and baby.

Flying the flag, answering the phone

The registration advice centre at the NMC has been accredited as a "global best practice service provider" by the leading authority on best practice in call centres, the Customer Contact Association (CCA). We are currently the only UK healthcare regulator to have achieved this prestigious accolade.

To gain the award the NMC had to demonstrate that systems and processes are in place that meet the requirements of the CCA global framework for best practice, and be independently audited by the British Standards Institute.

Project Manager Jonathan Harris, commented, "We have had excellent feedback from staff and callers about receiving this award and we hope that it demonstrates to nurses and midwives our commitment to providing the highest possible standards of service."

This accreditation entitles the NMC to fly the CCA flag, which we shall do with pride.

CCA
CUSTOMER CONTACT ASSOCIATION

Keep on nursing

The May Day for Nurses hardship fund comprises donations from footballers and the public and aims to help nurses stay in or return to nursing. You can apply for a one-off award to assist with a shortfall or for a specific cost. Assistance may be given for essential outgoings not covered by current income or statutory benefits. Nurses on low incomes can apply for grants towards disability equipment, household repairs, adaptations or other essential household items that they would not otherwise be able to afford.

The fund is being administered by the RCN.
To apply call **020 7647 3880** between 10am and 1pm, Mon–Fri or email **maydayfornurses@rcn.org.uk**

Far-reaching NMC

Following the increase in the registration fee (paid in annual instalments of £76), which came into effect in August 2007, some of you have been in touch to ask what your money is being spent on. The NMC's role is more extensive than it appears on the surface, but as, like all UK healthcare regulators, our funding comes solely from those of you on our register, it's important that we account for how that money is spent.

The standards we set for education and training, and the advice we produce on how to best implement those standards, form the basis of how we safeguard the wellbeing of the public and uphold the reputation of the two professions. Since our last edition we have published Modern supervision in action, a practical guide for midwives in collaboration with the LSA Midwifery Officers National (UK) Forum, and Standards for medicines management.

We know, because you've told us, that we need to be much more visible as an organisation, engaging with you more openly on many aspects of our work. That's why improving our contacts with nurses and midwives is one of our key strategic themes. We've already put this into practice in the work that went into the production of the new Code (see page 16).

The Fitness to Practise team has been working hard to reduce the backlog and most cases are now being heard within a period of six months from the time the investigating committee determines that a case needs to go to a hearing.

On the political front we have been working hard to make sure the UK's position on EU directives as they relate to the regulation of healthcare professionals is known and incorporated into new legislation. It is vital that we strike an appropriate balance to ensure the level of standards for skills and training in the nursing and midwifery professions is maintained while at the same time complying with our obligations to fully implement each directive.

Closer to home, we are continuing to work closely with the Department of Health, trade unions and the Healthcare Commission. At the end of 2007 we reached a new agreement with the Healthcare Commission on the way in which we work together while carrying out our regulatory duties in England and Wales.

In the coming months we'll be developing a new system of revalidation and new standards for records management. Initial scoping exercises are already underway to improve our information technology so that we can improve our services to our stakeholders. While some of this work links directly with the Trust, Assurance and Safety White Paper, it is an opportunity for us to expand the ways in which individuals can access our current services, as well as consider new areas for development.

Our full accounts will be published and put before parliament before the summer recess, after which they will be available on our website **www.nmc-uk.org**

The NMC's role is more extensive than it appears on the surface.

Funding your research

Two nursing trusts have been in touch with NMC News to ask us to publicise the funding opportunities for nurses undertaking training or involved in research.

Research scholarships are available from the Florence Nightingale Foundation to enable nurses and midwives to study research methods or to undertake a research module or dissertation within a degree course. Applications are received up to the beginning of June and interviews take place in August and September. Travel scholarships take people far and wide to study a large range of subjects, covering every aspect of nursing and midwifery. The closing date for applications is early in September with interviews taking place in November each year.

The Foundation also organises a service, held annually at Westminster Abbey in May, to commemorate the life and work of Florence Nightingale, and to celebrate the professions of nursing and midwifery. All staff, both qualified and unqualified, working in these services, are invited to attend. Entrance to the service is by ticket only. Tickets are free and available during April.

For further details go to: www.florence-nightingale-foundation.org.uk

The General Nursing Council for England and Wales Trust works to promote and advance the science and art of nursing.

The Trust's board meets biannually, usually in June and December, to consider grant applications. They aim to make financial support available to research projects that could contribute to the art and science of nursing in a changing society. In addition, they can fund practitioner-led small-scale research projects and support nurses who may be new in the art and practice of research and development in nursing-related fields.

Could that be you? Contact **020 8345 5379** or email **gnct@koroma5824.fsnet.co.uk**

Research scholarships are available from the Florence Nightingale Foundation

Changing perceptions

At the NMC, the changes we've made to the way we look – as illustrated by the design of the new Code and this edition of NMC News – is just one outcome of a project called "Changing perceptions". Others include changes to the language we use to describe our work, with a greater emphasis on the ways we safeguard the health and wellbeing of the public through professional regulation, as well as our work in support of nurses' and midwives' professional development and day-to-day practice.

Over the coming months, you'll see changes to our website, other publications and the information we send you. These may not be big (or costly) changes, but they are important to us as we strive to serve both the nursing and midwifery professions and the public.

“You shouldn’t have to be fearful of speaking out about healthcare”

Ann Keen MP

Ann Keen has made history as the first nurse to ever hold ministerial office at the Department of Health. The NMC’s Craig Turton talks to Ann about the ways in which her background continues to inform her view of the professions.

Craig Turton Ann, how did you start off in the NHS, and what prompted you to enter the nursing profession?

Ann Keen I first worked in the health service as a clerk in outpatients, preparing clinics and spending most of my time searching for medical records that weren’t where they were meant to be. This was at the Chester Royal Infirmary in the 1970s. I enjoyed the atmosphere and the comradeship of a hospital, and working in all the different departments was very interesting, as was being part of a multi-cultural team for the first time. I loved every moment of it but I knew I wanted to have closer involvement with patients. I started working in Casualty, as it was then called, and then applied to a nurse training school. But I did so without the required educational qualifications, so I had to take something called a DC test. It was just me and a tutor in a room, with pages and pages of multiple choice questions and a big alarm clock to signal when I could turn each page over. I was terrified. But I passed the test, just.

CT Looking back over your career since the mid 1970s, do you believe that nurses and midwives face more or less pressure in the 21st century?

AK It’s a different kind of pressure. You use the knowledge and skills that you learn at the time. Thirty years ago treatments were not as complicated as they are now and we didn’t have many of the treatments available today. You had high dependency and much more convalescence, with patients gradually improving before being allowed home. It was a different kind of pressure. In common with today, staffing levels were an issue. After just one year’s training I was left one night in charge of a surgical ward, which wasn’t safe. I was put into many situations in which I was just not competent to deliver the best care. Partly this was because I was older than my peers – I was 26 or 27 in my first year – so I was considered able to cope on my own.

CT Did you raise your concerns about staffing levels and the potential negative impact on patient care with your managers?

AK I would challenge these situations but unlike today, there were no official channels for complaining. So I complained to everyone – the school, the tutors, the night superintendent and the nursing officer who used to come through all the wards. In those days questioning wasn’t part of the training; it was all about following orders. Occasionally someone would listen to your concerns but mostly you were expected to cope. I felt – as I’m sure the NMC would agree – that it was my duty to speak out.

CT Oh, yes – absolutely. In May this year, the NMC will be launching a new version of the Code: Standards of conduct, and performance ethics for nurses and midwives. Did you ever use the Codes of the NMC’s predecessor bodies as a tool with which to challenge inadequate staffing levels when you were a nurse?

AK Yes, I used the Code to challenge situations because it stated very clearly that you should be the patient’s advocate, that you should respect the patient and that you should see no harm done. To do that, you need the correct skill mix and you need to be listened to. If I say my patient requires something, I should be listened to. I believe very passionately in the Code. Later in my career when I was teaching, I’d encourage nurses to use it to question and to challenge. The Code is not a big stick with which to beat nurses and midwives but is an enabling tool for them to improve patient care.

> “I believe very passionately in the Code … When I was teaching, I’d encourage nurses to use it to question and to challenge.”

CT You were in the vanguard of Project 2000, what do you think of the criticism that in moving towards an all-academic profession, nurses have lost some of the basic caring, practical skills and values? Is nursing now too academic a profession?

AK Nurses should have the opportunity to have the best education and knowledge necessary to enable them to provide the best practice for patients. My knowledge base was developed more after training, through professional development, experience and reading. Basic training then (the 1970s) was more task orientated. It was just about delivering a routine around a ward area. However, I was able to benefit from post-qualification training when I trained as a district nurse in 1980. People were experiencing poor health because of high unemployment, economic recession and their living conditions. I’d visit people who could not afford to heat their homes properly and I had one patient who died of hypothermia. These people would be living in just the one room and you could see your breath in front of you as it was so cold, even though they had put the electric fire on when they had seen my blue hat coming up the path. The NHS’s increasing ability to cure and to treat has made a huge difference but we should also remember that the biggest changes in health have come through economic progress, improved income, housing and education.

CT Had publications such as the landmark Black Report of 1980 into health inequalities enhanced your knowledge and training?

AK On my course I read Peter Townsend’s Inequalities in Health, I studied sociology for the first time and my thesis was on unemployment and health. I had done nothing like this on my basic training. Traditional nurse training was about doing a task. It’s exceptionally important that today’s nurse knows about these issues, as well as all the science and the art of caring. Do nurses with diplomas care? Yes they do, but where that is not happening, people must be called to account. I hate it when I hear people saying, “My mother isn’t being cared for properly. I found her food on the locker. Her tablets were in her nightclothes.”

CT What should we be doing about this?

AK We need to be honest, look at how our teams are operating and make sure leadership is strong. Where there is systemic failure, like Maidstone, that must be looked at. You shouldn’t have to be brave when you go to work. You shouldn’t have to fear for your security, or be fearful of speaking out about healthcare. However, there’s no excuse for poor staffing levels in nursing as the resources and money are there.

CT And midwifery? Media reports over the last few months suggested there are insufficient numbers of midwives in the UK. If so, how is the government addressing this problem?

AK Whilst vacancy rates in nursing are at the lowest historical rate ever, employers are struggling to recruit midwives. We are doing a lot of work with the Royal College of Midwives to encourage midwives to return to practise. There are a number of reasons that midwives may have left the profession – for family reasons or maybe because it wasn’t the right working environment for them at the time. We are working hard to show that management is different and flexibility has improved. It’s not the easiest area to recruit to and it is a challenge, but we are working with Dame Karlene Davis and the RCM to improve the situation.

> “Prevention is going to be a huge area of work going forward from the 60th anniversary of the NHS.”

CT In January, the prime minister announced that the 60th anniversary of the NHS would be marked by a written constitution for the NHS. What will the constitution contain?

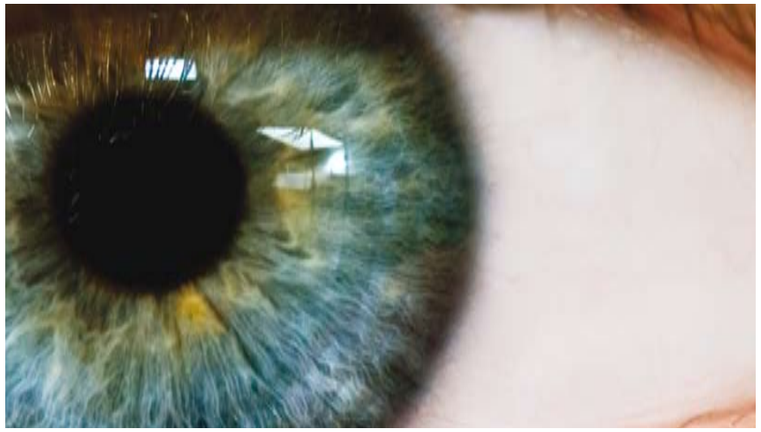
AK The constitution will be about acknowledging rights and responsibilities, which is a two-way process. For instance, patients should take responsibility for keeping appointments in order to contribute positively to the NHS. It’s not going to be a prescriptive document saying that if you don’t lose weight you won’t get treatment. However, it is about saying that if – for example – you need to lose weight to protect your health, you need to work with us. Prevention is going to be a huge area of work going forward from the 60th anniversary of the NHS.

CT There are lots of barristers in the House of Commons, but only four MPs who have a background in nursing or midwifery. Why so few?

AK That’s about image, I think, and I struggled with this myself. “Why would you want to go into politics?” But I believe nurses have all the skills required for politics; in particular commitment. And, of course, a sense of humour.

The vision thing

Sight is the sense we fear losing the most. So why are healthcare professionals neglecting it, asks **Anne Fedrick** of the Eye Health Alliance.



It's easy to take sight for granted. Millions of us wear glasses or contact lenses to correct our vision. So why did Mary, who is housebound and visited by nurses and carers daily, have to live for years without glasses that would enable her to see?

"It was only when my granddaughter asked me whether I could see the television that I admitted that I couldn't. I hadn't wanted to fuss. She arranged for an optometrist to visit me at home. I feel a fool now – I should have got this sorted much earlier. Please tell everyone that it's a mistake not to say that you are having problems seeing."

Optometrists see patients like Mary every day and they know that there are many more people who should be seen. "Sight tests are vitally important," says optometrist Dawn Roberts. "Not only do they determine whether a patient needs glasses but they include checks for signs of eye conditions or diseases, many of which can be treated if detected early."

Glaucoma is one of the leading causes of sight loss in the UK. "Nurses come into contact every day with patients who are at risk of eye disease such as glaucoma ," says Heather Waterman, Professor of Nursing and Ophthalmology at the University of Manchester. "Nurses are therefore in an excellent position to raise awareness of the importance of having a sight test. We know that approximately half the people with glaucoma (about half a million) aren't diagnosed. People need to be encouraged to have an eye test every two years, especially close relatives of people with glaucoma and people from the Afro-Caribbean community who are most at risk. If glaucoma is detected early then it can be treated with eye drops and patients' sight can be saved."

So what can you do to help improve the sight and wellbeing of your patients? Across the UK nurses are involved in initiatives which bring eye care and vision awareness into the heart of patient care.

The stroke unit at Ulster Hospital makes sure that patients' vision is assessed, not only to detect sight loss attributable to the stroke but to check for pre-existing sight problems which, if not treated or corrected, might adversely affect the patient's successful rehabilitation.

When assessing a patient who is at risk or has suffered a fall, specialist falls practitioners like Mary Leahy at Brighton's Falls Prevention Service routinely include vision in their raft of checks. "Impaired vision is a major risk factor for falls ," says Mary. "Having regular eyesight reviews will assist in preventing more falls and subsequent hospital admissions."

For the past four years ophthalmic nurses Mary Shaw and Agnes Lee have been running highly successful low vision awareness sessions in five Manchester hospitals for student and qualified nurses, porters and clerical staff. So successful are they that their team won a "Getting the Message Across" award. Agnes explained, "All those attending the sessions commit to changing their practice and it shows – signs are bigger and clearer, lighting has been improved and patients' needs are addressed from the moment they arrive at reception."

> "Nurses are in an excellent position to raise awareness of the importance of having a sight test."

Wouldn't it be wonderful if that commitment to change practice was implemented throughout the UK in all healthcare settings?

EYE HEALTH ALLIANCE

Just the right medicine

Medicines management is fundamental to good nursing. With the rise of nurse prescribing coinciding with growing concerns about the numeracy and literacy skills of some newly qualified nurses and midwives, we look at a Fitness to Practise case where the maladministration of medicines was a major concern.

An experienced Grade D staff nurse working in a burns rehabilitation unit was struck off the register after she was found to have failed in the administration of a controlled drug.

The nurse in question faced six charges: failing to administer a prescribed controlled drug in accordance with a patient's prescription chart; signing two documents recording the administration of the drug; failing to comply with the hospital's storage policy in respect of a sachet of the controlled drug; asking a colleague to dispose of the said drug; asking the colleague to sign the controlled drug register and patient prescription chart to indicate that it had been given; and intending from the outset to cover up her failure to administer the medicine.

All six charges were proven, with the panel finding the registrant's fitness to practise impaired by reason of her misconduct. Citing the NMC's Code of Professional Conduct, as well as relevant standards, the nurse was deemed "to have failed in her duties to her patients, her colleagues, her profession and the public generally".

> "...failed in her duties to her patients, her colleagues, her profession..."

Nurses should operate within an open culture, where the immediate reporting of errors or incidents and the central importance of immediate and honest disclosure in the patient's interests is understood and in evidence. The panel found this nurse's behaviour to be in contravention of this approach and these values.

And yet she had over 40 years' experience. She was said to have been popular and well respected in the area. At the time of the misconduct, she claimed to have been under pressure as a result of her husband's illness.

Whilst the panel considered these points, they also noted that there had been two previous relevant disciplinary findings against her, one of which had occurred just four months previously and had involved her failing to give a prescribed drug. Other than her own statement and a letter from her husband, the panel received no other references or testimonials in her defence.

The panel decided the nurse's behaviour amounted to serious misconduct. She had continued with her denial until she was faced with the truth. Only then did she admit to what she had done, offering profuse apologies. Drug errors and record keeping are areas of practice where retraining may offer a solution, but the misconduct in this case also involved deliberate deceit and the dangerous disposal of a controlled drug. "The registrant's misconduct is in our judgement fundamentally incompatible with continuing to be registered with the NMC ... The panel is satisfied that confidence in the Council would be undermined if the registrant is not struck off the register. Sanction: striking off."

Way to go

February and the Oval Cricket ground in South London is the venue for the NMC's summit on the regulation of healthcare support workers. An apt setting, given that cricket matches can go on for days before anyone knows what the outcome is likely to be, says **Andrew Bence**

"What do we mean by regulation, anyway?" said one of the delegates around mid-morning. Discussing whether healthcare support workers (HCSWs) should be regulated, and if so how, prompted a cricket score of tricky questions, some bordering on the philosophical, at this event held in the Ashes Suite overlooking the famous ground.

It's a clue as to why this issue, which has been moving up the healthcare agenda in recent years and is the subject of a pilot project underway in selected NHS Board areas in Scotland, remains unresolved. It also explains why the NMC organised this summit. As Sarah Thewlis, our chief executive said, "This isn't just an NMC issue; it concerns every agency and individual with a stake in the UK's healthcare system, and it's time we took it out of the 'too difficult' box." Sarah's hopes for the event, which attracted a high-powered guest list of some 175 health and social care professionals, were simple enough: "We're looking for a way forward."

As debate got underway, difficulties and differences of perspective emerged. Peter Carter of the RCN said HCSWs were part of the broad church of nursing and should be regulated. Failings involving an over-reliance on untrained, unregulated colleagues, as happened at Maidstone and Tunbridge Wells NHS Trust, reinforced the need for action now. The diversity of workplace settings, with 65% of the estimated 600,000 HCSWs now working in the independent sector, meant an employer-led regulatory framework was not appropriate. But whatever the approach, it would have to be realistic and practical, perhaps phased in gradually beginning with level four HCSWs before incorporating lower grades.

Alistair Henderson of NHS Employers was more cautious, and questioning. "What problem are we trying to solve here? Are we talking about the need to raise standards, or establish a regulatory framework?" Employers needed to be involved, but we should remember how diverse they are, from the small care home proprietor to the NHS hospital Trust. As for the pragmatic approach of starting with the regulation of level four HCSWs, "Practical it may be, but was it logical?"

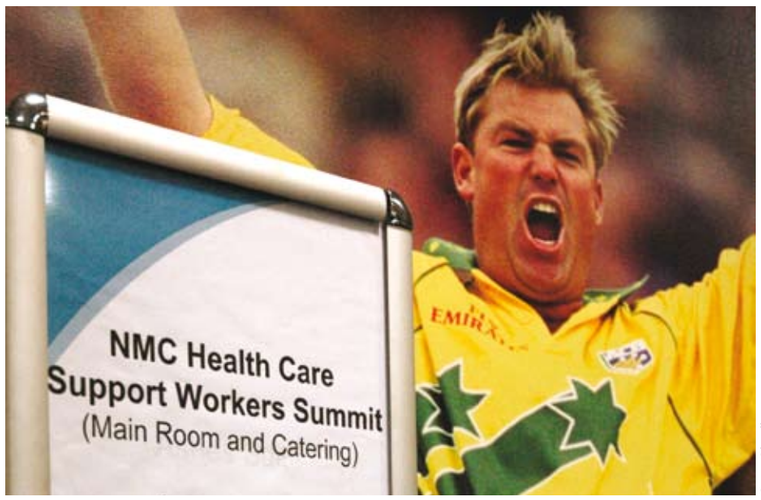
In campaigning mode, Lucia McEver, a HCSW from Northern Ireland with 30 years' experience, insisted, "We are professional too, and I ask that you listen to and respect us. Support the regulation of HCSWs." Elizabeth Manero of the patients' group Health Link agreed with this, but said the "support" in HCSW should refer primarily to that which is given to the patient. "The person doing that support must be accountable, and lay people needed to be involved in any such regulation."

> Identifying the best way to regulate healthcare support workers is not going to be easy.

The word "complex" kept cropping up throughout the day. Sarah got the ball rolling when she said, "Regulation is complex. The relationship between health and social care is increasingly complex. And the UK's healthcare environment is ever more complex, with developments such as those brought about by devolution."

On a couple of things most delegates were agreed: the status quo was not an option, and identifying the best way to regulate HCSWs is not going to be easy. Through workshop sessions and "Quizdom", the interactive voting system, delegates wrestled with the details. Were we talking about those involved in direct patient care, or a much wider group? If the latter, would the title HCSW still apply, and if not, how should this group be defined? What model of regulation should be used, and who should run it? The options were – you won't be surprised to hear – fiendishly complicated. The annotation of registers, occupational licensing and something called distributive regulation gives you a flavour. All had their advantages and disadvantages.

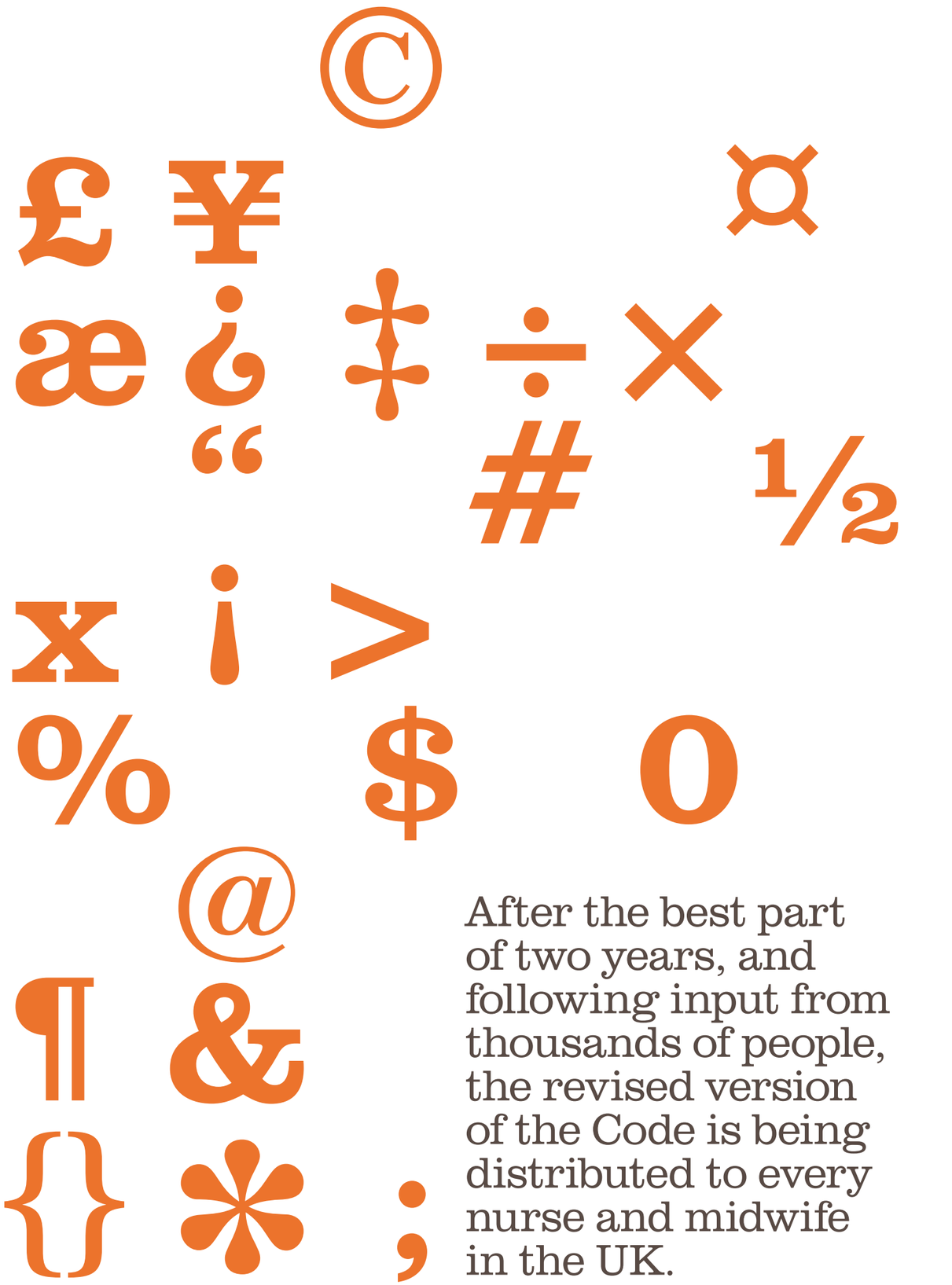
Inside, NMC President Nancy Kirkland thanked delegates for contributing "blue sky thinking" to this collective search for a way forward. Outside, a solitary groundsman prepared his pitch for the long, hard season ahead.



Sam Shiell

Talking in Code

Adam Hill introduces the Code: Standards for conduct, performance and ethics for nurses and midwives



After the best part of two years, and following input from thousands of people, the revised version of the Code is being distributed to every nurse and midwife in the UK.

It has been a difficult task, not least because the Code has to do several jobs at once: as well as being a public statement of the principles enshrined in nursing and midwifery practice – a source of confidence to patients and pride to the professions – it is also a set of easily understood ideas which can be interpreted in a variety of working environments and situations.

The changing framework of healthcare and the increasing role of nurses in providing treatments and working within the private sector demanded a reappraisal of the Code. "Things have moved on," says NMC president Nancy Kirkland. "The shift in emphasis from the acute to the community setting has a great impact on the work of nurses and midwives and has given us a golden opportunity to reflect."

From January to March 2007 we developed a consultation programme, and later that year a small team of NMC staff dedicated to engaging with nurses and midwives travelled from the Shetland Isles to Jersey, Plymouth to Aberystwyth, Norwich to Londonderry and several points in between to canvass views. We set up conferences and focus groups for nurses, midwives and patient representatives, initiated an online consultation on the NMC website, talked to delegates at NT Live in Manchester and held round-table discussions with other regulators, unions and employers.

The result is a new Code which is shorter and sharper – it is also physically smaller, contained in an A6 booklet. "The challenge for the NMC is getting the Code from being a document that sits on a shelf to a living, breathing thing," says Andy Jaeger, the NMC's marketing manager. In addition to being more concise and accessible than its predecessor, the new Code also comes with a card to give away to members of the public, summarising the key points of the Code. You can find the card on the cover of the magazine.

You can be competent in technical skill, but how you deliver care is important.

The Code sets out the benchmark for ethics and conduct which all nurses and midwives must follow. Martine Tune, the NMC's professional lead on the Code project, says, "You can be competent in technical skill, but how you deliver care is important. That's why the first statement in the new Code is 'Make the care of people your first concern'. It's fundamental to what we all do."

The language of the new Code, which has been amended and re-amended during the consultation process, is deliberately punchy, with some of the windier sections of old consigned to the bin. For example, the Code used to say, "You are personally accountable for ensuring that you promote and protect the interests and dignity of patients and clients, irrespective of gender, age, race, ability, economic status, lifestyle, culture and religious or political beliefs." Quite a mouthful. The new Code addresses all these areas by simply stating, "You must not discriminate in any way against those in your care." One simple sentence carries the same effect.

There is also a positive duty in the Code to promote equality and diversity. "It's not enough to talk about not discriminating," says Andy. "It's quite a powerful statement."

There is a view that the brevity of the new Code means that it may be more open to interpretation. Some have seen it as "patronising", while others consider its simplicity to be a positive attribute. But perhaps it is worth thinking about the new Code as a document which recognises the nurse as a professional in their own right – as an autonomous decision-maker – rather than as a technician who simply does what they are told.

Natasha Folkes works in the birth centre at King's College Hospital in South London. She qualified as a midwife in 2003 and has practised in various hospital and community midwifery settings.

Why do concepts like "conduct" and "ethics" matter?

Because we have to place emphasis on the way we provide care to patients. From professional accountability through to confidentiality and informed consent, these are all critical to the way nurses and midwives deliver care.

Can you give me an example of where the new Code will work well as far as you are concerned?

"You must deliver care based on the best available evidence or best practice" puts the responsibility on the nurse and midwife in becoming a reflective and questioning practitioner in the way we do things. It also puts responsibility on employers to facilitate a working culture that focuses on delivering care that is evidence based and effective rather than how we've always done it.

Elizabeth Manero is director of Health Link, a patient group she set up in 2004.

Why is the Code important to your organisation?

As a patient representative we have a significant interest in something that improves the accountability of the nursing and midwifery profession.

Can you pick out any statements which you're particularly pleased with in the finished Code?

"Collaborate with those in your care" is not in the old Code and is very important. The patient is at the head of the team that's providing care and everyone else should follow their lead. Collaboration implies engagement with the patient – they don't want to leave their dignity at the door and they have the biggest stake in the successful outcome of any treatment and the deepest knowledge of their condition, because it is they who are experiencing it.

"It's about being professional, being accountable and having the ability to justify your decisions."

Nancy Kirkland President of the NMC

Focus groups were keen for the Code to highlight this need for personal responsibility and accountability. "The new Code allows people to use their professional judgment," Nancy says. "These are a wide set of principles you can use to carry out duties in your own area. It's about being professional, being accountable and having the ability to justify your decisions through the Code." It is true that, if you come up against a Fitness to Practise panel, the Code will be one of the key things you are judged against. But she insists, "It is not a tool to beat nurses and midwives. It is there to help you in ethical, moral and professional dilemmas."

From what nurses told us about the things that kept them from staying within the Code, it was clear that employers also needed to understand their responsibilities. For example, a key area of concern was effective delegation, which led to that section being beefed up to include an emphasis on supervision. Now everyone you're responsible for has to be supervised and supported, so if you're a ward manager or director of nursing, the Code means you must have a supervision structure in place.

Continuous professional development was also seen as problematic and the new Code restates that nurses "recognise and work within the limits of your competence". Staff are generally open to being moved around but employers must provide appropriate training in new areas of work.

Managing risk was also crucial and the new Code ensures that the escalation of risk is appropriately dealt with, saying, "You must report your concerns in writing if problems in the environment of care are putting people at risk." This was not so explicit in the old Code.

"One area I hope we've made clearer is around nurses and midwives working in 'commercial practice', also nurse prescribers, independent midwives and private practice," says Andy. "The old Code wasn't clear in terms of how you can or can't use your professional status."

At the Code focus groups, only one of which was held in London, roughly half of all respondents were NHS employees; one-tenth came from universities and higher education institutes, and one in twenty were from the independent sector.

Some of the changes that were made following their deliberations were straightforward. Record keeping has been a key area of concern, and "You must clearly sign any entries you make in someone's records" from the first draft became "You must clearly sign and date any entries you make in someone's records" in the finished Code – a sensible addition to the original.

However, the early draft of the Code also threw up problems when it suggested that nurses and midwives could not change patient records at all. On the face of it, this sounds reasonable enough – but what if an honest mistake is made and needs to be amended? By replacing "alter" with "tamper with", the revised Code makes it clear that legitimate changes are acceptable.

Perhaps surprisingly, another worry for nurses and midwives was over the acceptance of presents. The first draft of the new Code said, "You must refuse any gifts, favours or hospitality that you are offered in the course of your work." This threw up questions about whether a cup of tea with a grieving relative would now be out of bounds. Opinions on the matter from people in focus groups were, to say the least, robust.

The new Code is shorter and sharper – it is also physically smaller.

Gavin Fergie, professional officer for Unite-CPHVA Community Practitioners' and Health Visitors' Association (CPHVA), in Scotland since 2005 and a registered nurse since 1990.

Why is the Code important to your organisation?

It is the benchmark for the professions covered by the NMC, underscoring a nurse's practice. Some may see the Code as a stick to beat practitioners with but it's a valuable tool to maintain the professional standards of the register. It has to be a robust document so that our members are aware how they can maintain their professional conduct and have an understanding of their professional limitations.

Can you pick out any statements which you're particularly pleased with in the finished Code?

The first line of the Code is very important: "The people in your care must be able to trust you with their health and wellbeing." Those on the register don't just deal with ill health; this is a positive message and a fundamental one.

Michelle Jackson is practice development sister at Southmead Hospital in Bristol. She has worked for Bristol North PCT since 1995 in the neonatal intensive care unit, with one year out on general nursing, and has been a practice development sister since 2002.

Why is the Code important to you?

It helps set standards. My job involves writing competencies and guidelines and I am able to refer to the Code as part of that. It helps to encourage us as a profession – I am able to quote the Code to colleagues on things like mentoring students, for example. It shows us that, as a nurse, this is the way I should work. Also, when management are trying to impose things on us that we feel are unfair we can refer to the Code again and say: what you're doing is against my Code and the principles of good patient care.

Is there anything not in the Code which you'd like to see in it in the future?

I don't feel there is enough about working as a team. The Code says: "You must work cooperatively within teams and respect the skills, expertise and contributions of your colleagues" but I still see instances of harassment and bullying and the Code could have gone further to address that.

The Code has been a collaborative effort involving 3,000 people.

"If we cannot have a free sandwich when a rep comes to demonstrate new products, or accept a box of chocolates for the team when a patient is discharged then this is a sad situation," said one. Another put it rather more bluntly: "'You must refuse any gifts, favours or hospitality...' Are you mad? This will insult and alienate many patients."

Another point, that patients of some ethnic backgrounds would be hurt to have a simple token of gratitude refused, was well made. Putting all these thoughts into the mix, the final statement reads "You must refuse any gifts, favours or hospitality that might be interpreted as an attempt to gain preferential treatment."

The Code's use of language has to reflect the standing of the nursing and midwifery professions while also being easily understood. Nowhere was the tension between these elements more apparent than in the debate between "you must" and "I will".

There is a significant stylistic change in the way the new Code is presented: every clause starts with "You must". "It's deliberate," says Andy. "We presented Council with two different versions of the Code, one saying 'You must' and one saying 'I will'.

"In the focus groups, some felt that 'you must' gave the document a clear sense of accountability, with a service user representatives' group particularly liking the use of the term. On the other hand, some professionals said it sounds like the NMC carrying a big stick.

"Council decided that it's important for the NMC to be absolutely clear about what it wants from the two professions," Andy continues. "We could have written that nurses and midwives should 'make every endeavour to…' but a standard is a standard. You are professionally accountable for the decisions you make for the people in your care."

"It's getting the message across about what our role as a regulator was about," adds Nancy. "We're here to protect the public. As a nurse myself, when I see 'You must', I think 'Okay, I will'."

Despite all the time and effort taken over the consultation, the NMC admits that there'll always be issues that aren't covered. "So yes it's an agreed document and the standard by which everyone should be judged, but it must also be a work in progress," concedes Andy. "We employ a lot of experienced nurses and midwives who work in policy development and know the issues, so in the main there's nothing you can throw at us we haven't heard before. But next week, a nurse could find herself in a situation that hasn't been envisaged. If that's the case, talk to us, tell us what works."

And to those who are still unsatisfied with aspects of the Code, it is worth bearing in mind that this has been a collaborative effort involving 3,000 people. The NMC consulted with over 2,500 individuals and a wide range of organisations. The document therefore represents the culmination of a significant process of participation. And that has to be a good thing.

"The challenge for the NMC is getting the Code from being a document that sits on a shelf to a living, breathing thing."

Andy Jaeger NMC Marketing Manager

Inside Fitness to Practise

Leila Harris on how the NMC upholds the reputation of nursing and midwifery

It's a bone of contention for many nurses and midwives. It's costly and if you've ever been through it, it can be a very stressful and uncertain time. Are Fitness to Practise investigations and hearings just another stake in the heart of a vocation that many say is undervalued and under-supported?

If you stop and actually look at the figures, the number of complaints received by the NMC last year, just 1,620, is tiny in comparison to 683,000 on the register and the number of those that ever make it to a hearing is less than 1%.

Complaints
The majority of complaints received by the NMC's Fitness to Practise department come from employers following the completion of their local disciplinary procedures. It is our statutory duty to investigate all allegations of misconduct, provided we receive them in the proper format, including, name and PIN number of the person being accused, name of the complainant, specific details about the incident, or incidents, and evidence to back up the allegations from the preliminary investigation. We do this in order to protect nurses and midwives from malicious and unfounded complaints.

Investigations
The investigating committee can take up to 18 months (this includes the preliminary investigation stage) to either gather sufficient evidence, to call for a hearing or decide that there is no case to answer, though many cases are now being completed much sooner.

The nurse or midwife will be informed by letter of the decision by the investigating committee and in those few instances where they determine that the case should go to a hearing, a date will be set.

Hearings
Hearings are generally scheduled for a period of one to five days depending on the complexity of the case. The majority are held in public. We aim to hold hearings within six months but there are circumstances that may prevent this. The ability to co-ordinate the schedules of all parties, sickness of participants and, in some cases, legal tactics by the nurse's or midwife's representative to purposefully draw out the proceedings, can all lead to cases taking a disproportionate length of time to be completed. Hearings cost between £5,000 and 6,000 per day which increases when an adjournment is granted for any of these reasons.

Thanh Ngo

Decisions
Panel decisions can range from time-specific caution orders and suspensions through to a striking off order. Last year 144 individuals were struck off the register. The allegations ranged from stealing controlled drugs for personal use, sleeping on duty, having an inappropriate relationship with a patient, poor record keeping and various types of patient abuse. In each case the independent panel assessed the evidence presented to it and based their decision on the facts proved. By striking these people off, the integrity of the professions are maintained and the care of future patients is safeguarded.

Publicity
As the majority of hearings are held in public there can often be a court reporter in the room. This means that details of the hearing may appear in the news (usually local to where the nurse or midwife lives) and in some cases this may happen before the hearing is even complete. It also means that there are times when a nurse or midwife who has chosen not to attend their hearing learns the outcome via their local news source rather than by the official letter sent by the NMC. The NMC often issues a press release to the media citing the results of hearings which are also published on our website for a period of three months, after which they are removed.

And where do you fit in? We recognise – and are proud of the fact – that the vast majority of those on the register practise to a very safe and high standard. However, for as long as there are instances where the conduct of some nurses and midwives fall far below what is expected of members of a caring profession, then action will need to be taken. This is in the interests of both professions as well as the public, making the NMC's Fitness to Practise function doubly worthwhile from your point of view.

"Fitness to Practise is about ensuring that registrants do not put patients and others or the reputation of the profession at risk."

Liz McLean Director of Fitness to Practise

Recent developments

Ensuring Fitness to Practise remains fit for purpose has led to several significant recent developments.

Panels
From October 2007 Council members were no longer allowed to sit on Fitness to Practise panels, with the exception of those hearings that had not been completed prior to that date. This change was made to ensure a clear separation between panels and the NMC Council, making the former truly independent of the organisation.

There are currently 180 panellists from various backgrounds, both cultural and professional. This number is continuously reviewed to ensure that we have the required numbers of people in order to meet the current workload.

Panellists are appointed for a term of up to four years and can be reappointed for a maximum three terms.

The NMC has a duty to guarantee true impartiality by appointing the best people and ensuring they are properly trained in order to provide the best service, not just to the organisation, but to any nurse or midwife who appears before them.

Civil standard of proof
At the December 2007 meeting of Council, it was decided that the NMC would move to the civil standard of proof when the Health and Social Care Bill becomes law, expected in late summer 2008. The civil standard of proof is a sliding scale, based on the balance of probabilities, rather than a criminal standard which is beyond all reasonable doubt. In the meantime, we have been in contact with the relevant professional bodies who will be invited to comment on the advice that will be provided to panellists about how to apply the civil standard of proof.

The sliding scale of proof, quoted above, means the more serious the allegations, the higher the standard of proof that will be required. Implementing this change will entail an initial cost for the NMC to train panellists on how to apply the standard, but there will be no additional costs to run hearings.

As for the effect the move from the criminal to the civil standard of proof will have on the outcome of hearings, it is not expected to have a significant impact on outcomes. Any hearing scheduled after the implementation date will automatically use the civil standard of proof.

Home sweet home?

Andrew Bence visits a care home for older people

Ashcroft Hollow Care Home looks ordinary enough, situated in the gritty, somewhat forgotten middle England of Huntington, near Cannock in Staffordshire, an old mining area more easily defined by its past than its present. This suits my purposes as I'm looking for the ordinary: today's average care home, delivering a good – but not by definition exceptional – standard of care for a few dozen of the hundreds of thousands of older people in the UK currently living in residential care settings.

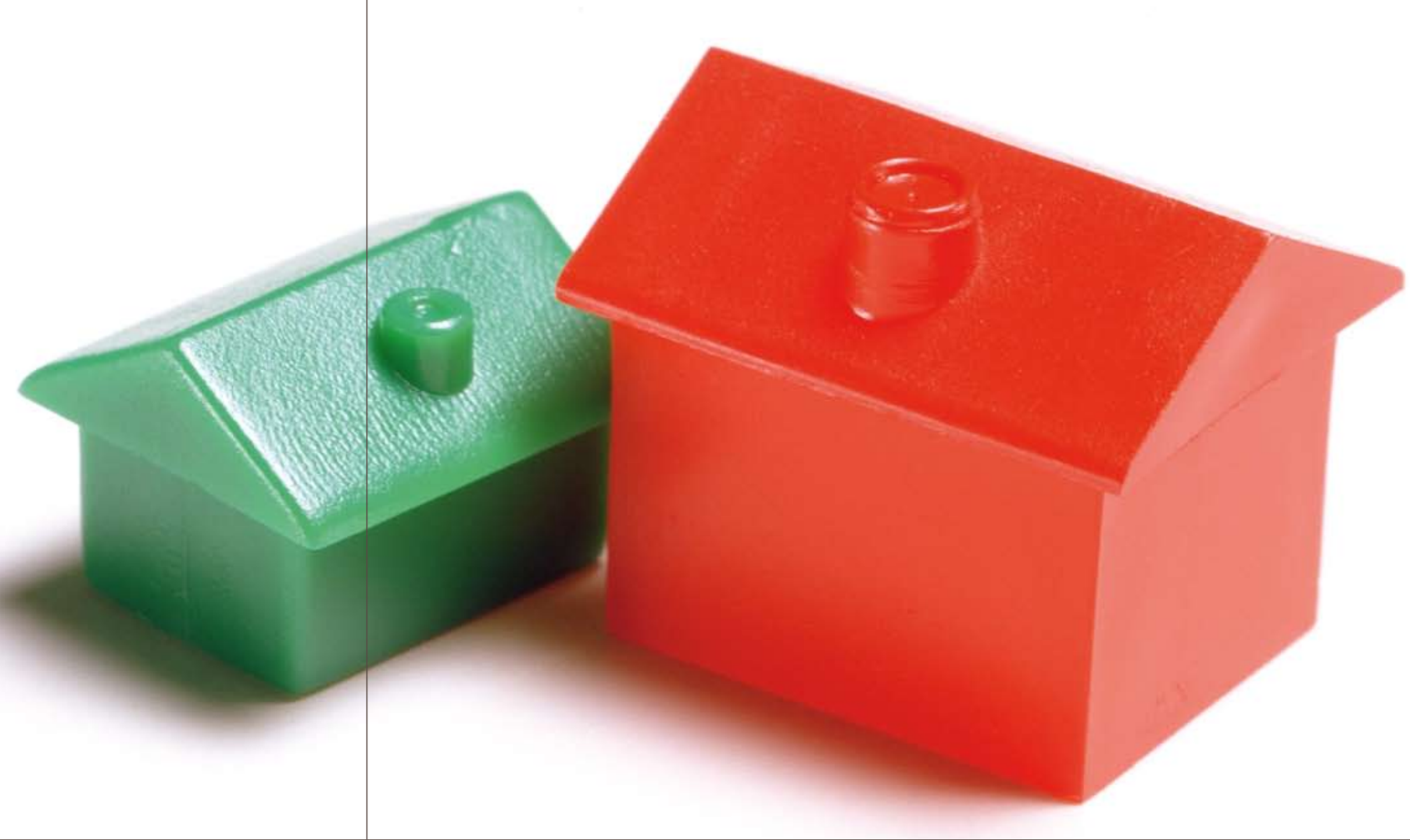
As a family, privately-run, dual registered residential and nursing home, Ashcroft Hollow provides accommodation for the frail elderly and the terminally ill, as well as some over 65s with physical disability and, in two cases, mild dementia. Relatively small in size, it has 45 places and a small core nursing team supported by a larger pool of care workers and ancillary staff. Fees range from £360 to £600 per week and many of the residents are funded in part or in full by social services.

"Increasingly homes like ours are being asked to provide care for people with higher dependency needs and conditions."

Jacqui Roberts and husband Ron started the business in 1997. She came to the care home business with a huge amount of relevant experience. "I was the youngest pre-nursing student to go to North Staffs Royal Infirmary, and I still hold that title, I believe.

"Before Ashcroft Hollow we'd run a smaller home, but by 1996 we wanted to expand, although not by too much – keeping a human scale is important, especially if, like us, you want to get away from the tag 'institution'."

That said, there are plans to extend Ashcroft Hollow. "In recent years, health and safety developments have changed nursing practice greatly. Many of my residents now use recliners, for example." But recliners take up a lot of space, as do the home's three hoists, each capable of being manoeuvred around the building and into every room. Jacqui has submitted plans to enlarge the lounge and the garden, as well as improve provision for relatives to stay overnight.



Pam with Brian, an Ashcroft Hollow resident

Jacqui explains that there have been other changes, too. "Care in the community is terrific. In theory. But before they came here many of our residents had spent years sitting at home, alone all day just staring at the four walls. End of life issues may be a big part of our work here, but so too is quality of life."

She goes on to describe how, in the last week alone, while the book and film clubs met and quiz and exercise sessions were held, trips to the theatre were planned and the pat-a-pet scheme paid a therapeutic visit, the home was also nursing two residents through their final days.

In such circumstances, and with such challenges, leadership from the nursing team must be even more important. "Teamwork and training are key to ensuring we maintain the highest standards of care," says Jacqui. "We have five registered nurses on the books, myself included, although I'm taking more of a back seat these days, aren't I, Pam?" There's a wry smile from Matron Pam Williams, stepping back into the office having attended to the needs of a resident in the lounge across the way.

Pam Williams trained as a nurse in Manchester in 1974, and has worked in elderly care ever since. "I just fell in love with them. As a group they've had a raw deal. Some people see them as a drain, but they all have something to offer, something to teach us. And they all deserve the care, respect and dignity in old age that we hope for ourselves. It's funny, I've always been a forward-thinking person – I wanted to be a nurse when I was four!"

I ask Pam about the day-to-day challenges of nursing at Ashcroft Hollow. "We're part of a multi-disciplinary team,"

Clockwise from top left: Jacqui, Pam and Eunice Letsipa, Deputy Matron

says Pam. "The district nurses, GPs, our Macmillan nurse, and all the care staff here working together for the benefit of the residents, many of whom have complex needs. It's time people stopped thinking of care home nursing as second-rate nursing.

"They all deserve the care, respect and dignity in old age that we hope for ourselves."

"Actually, Jacqui is an excellent proprietor – and I'm not just saying that because she's here! She has always provided me with whatever I've asked for for our residents and staff. With training, for example, I've been able to do my registered manager's award. My deputy matron, Eunice, and I have both completed a care of the dying course. Another colleague has recently been on a continence course, and our Macmillan nurse regularly updates our care staff, all of whom have at least level two NVQ, with some level three."

Is staffing a challenge? "Continually," says Jacqui. "This is the most poorly paid sector in healthcare. So we train our care workers to level two and three and what do they do? Move on to mental health and social services. Or do agency, at which point we can no longer afford them. I don't blame them. Our care workers could earn more working at ASDA."

Do registered nurses fare any better in this sector? Salaries are presumably competitive, but, conscious of the usual sensitivities, I choose not to delve further into this. What's clear is that both Jacqui and Pam believe an ongoing funding shortfall blights this area of work, with repercussions for all concerned. "Many homes this size are closing down," says Jacqui, "or selling out to larger providers, where economies of scale pay dividends for some, if not for others."

If the government persists in undervaluing and therefore underfunding the care of vulnerable older people, might that be a reflection of this society's attitude towards them? "I've had student nurses here who haven't put in the effort I'd have expected," says Pam. "It's as if it's not important to them." "There are no babies in residential care, and no young men in orthopaedics," says Jacqui, mysteriously, before adding, "It's never going to be glamorous, is it?" Pam agrees. "It has to be something you really want to do; not just need to do."

Jacqui and Pam have been at the helm of Ashcroft Hollow for the last seven years. They share a resilience, down-to-earth realism and commitment to care that by all accounts has served the home well. On the wall in reception the Investors in People Award jostles for space with the Matrix Excellence Award, a maximum five stars from the local environmental health officer and numerous other accolades, including a noticeboard groaning under the weight of thank you cards. The Commission for Social Care Inspection's (CSCI) latest report concluded, "The manager and her staff provide excellent care in a warm and homely environment." Congratulating them on their success, a GP from a local practice wrote, "We would like to congratulate you on achieving such a high assessment. This confirms the clinical impression that we all have when we visit our patients in your care. It is reassuring to know that our patients are being so well looked after."

In the lounge, Pam introduces me to Brian, a former electrical engineering lecturer from Walsall. Brian has Parkinson's disease and has only recently moved into Ashcroft Hollow. "My first impressions are good. Food is excellent, the staff are all excellent. Especially the boss," he says, smiling at Pam. I meet Elsie in reception. Born locally, she lived in Wales for many years with her husband before they decided to move into Ashcroft Hollow together, some two years ago. Unfortunately, her husband died before the move. "It was a difficult time for me but I decided to go ahead with the move. The staff have been very good – absolutely golden, nursing me through a stroke. I especially like sitting here in reception, chatting with everyone, watching the comings and goings."

Pam kindly gives me a lift back to the station. I'd come in search of an ordinary care home, and was leaving with many positive impressions. But a comment made by Jacqui earlier is playing on my mind. "The reality is that all of our residents would rather be at home, but they can't go home." On the surface, it seems a stark, pessimistic assessment. But is it? When it's our turn to be old and frail, perhaps in failing health, will we not wish we could be younger, stronger, more independent? It would probably be more worrying if Jacqui's residents didn't experience these feelings from time to time. This is life, after all, and life goes on, at Ashcroft Hollow as elsewhere. The final note in this reporter's pad is from Pam: "Ashcroft Hollow is a happy home, and a happy place to work." That's no ordinary achievement.

Jacqui and Pam share a resilience, down-to-earth realism and commitment to care that has served the home well.

Home improvements

At any one time, there are around 450,000 older people living in care homes in the UK. With an ageing population, this figure is unlikely to fall in the foreseeable future. Whilst care homes have improved substantially in recent decades, few would deny this is still a relatively neglected area of health and social care.

With government policy in England focusing on its priorities of greater emphasis on choice, prevention and care closer to home, where does that leave the frail elderly living in residential care?

According to charity Help the Aged, there are too few affordable, quality care home places and older people's choices are being eroded. They claim care homes are seen as the "option of last resort" instead of a positive choice, and that the government – whilst saying it wants older people to be cared for in their own homes – fails to provide the social care funding that would provide them with the companionship and security they need. Care homes, meanwhile, struggle to provide good quality care because of a dwindling workforce, increased costs and poor image. The charity is campaigning for the proper planning and funding of long-term care, and to see those who live and work in care homes "valued and brought into the mainstream health and social care system".

The NMC has begun work on a project to produce new guidance for nurses caring for older people across the spectrum of healthcare settings. A literature review is being carried out and consultation events are being planned. As this work develops, we hope to explore some of the key issues in NMC News.

Dear candidate

Lindsey Wilson
RN

I've never been great at interviews. Confronting a bunch of strangers, attempting to convince them I know what I'm talking about, and hoping desperately to remember everything I've ever learned about nursing is not my idea of a great afternoon!

I completed my mental health nursing training in January 2007 with excellent feedback from tutors and mentors. I knew jobs were hard to come by these days, and had heard of past graduates failing to find positions, but I was sure I wouldn't fall into the same trap. I was wrong. Dozens of job applications, several botched interviews, and months of unemployment later I received the latest invitation and felt the now familiar feelings of anxiety combined with anticipatory disappointment.

The next two weeks were filled with frantic cramming, searching the internet for the latest research and policy changes, and hounding my partner to test my knowledge through repeated question and answer sessions. I think he now knows more about Part II of the Mental Health Act than he cares to. As the interview date got closer my anxiety grew; I now had chronic feelings of nausea.

On the day of the interview I went over the key subjects again in my mind. After so many previous interviews I have a fairly good idea of the questions they like to ask. But still my nerves grew. This wasn't helped by the fact I ended up being an hour late due to an accident on the motorway. You can imagine my horror, but two phone calls, and many apologies later, I finally made it to the interview, and was thankfully greeted with sympathy and understanding.

The interview itself wasn't as bad as I'd expected, possibly due to the friendliness of the interviewers. I was pleasantly surprised to be asked to show my portfolio (the first time ever!). Previously I'd wondered what the point was in keeping it updated, since no one ever asked to see it. I experienced the usual dry mouth, stuttering and mind-block I am now accustomed to. The question "Where do you see yourself in a year's time?" threw me a little. "With a job!" was my instinctive, if almost reproachful reply. But somehow I managed to give a good interview. And they made all the right noises and smiled a lot, anyway.

The days after the interview were hell. Two weeks later I received the dreaded phone call. I prepared myself for the usual "You did really great, but…" speech. So imagine my disbelief when I was offered the position! I almost screamed with delight. I'd done it! Finally I had a job. Staff Nurse at Fieldhead, Wakefield. My joy was nothing compared to my relief; and that goes for my partner, too!

> Two weeks later I received the dreaded phone call.

All bar none

David Keating
RMN, SRN, CPN cert

Imagine having to decide who should have treatment. In your own order of preference rank these patients: a woman with breast cancer, a child with meningitis, a man with emphysema, a woman with depression, a child with learning difficulties, an adolescent with spinal injuries, a man with alcoholism, a lady with a coronary and a man with dementia. Who would get first preference? Who'd be the least deserving? Obviously it is a personal decision but I suspect many would have the man with alcoholism as the lowest priority, because often it is viewed as self-inflicted, under the control of the person and not really a disease but a behavioural problem.

During my career I have worked with many of the cases listed. Currently, I work as a community addiction nurse, primarily with alcoholics but also drug addicts. The work is difficult and challenging, with patients in denial of the extent of the problem, a deterioration of their personality, poor engagement, false dawns of improvement and apparent insight only for relapse and the revolving door of re-referral.

Alcoholism is a family disease presenting major problems to the loved ones. What other disease causes mothers and fathers to disown their own children because they have an illness, alcoholism?

There is a perception that alcoholics enjoy drinking. Many justify it this way but the reality is that often they hate alcohol, hate what it does to them and to their families. When the craving to drink is so intense, nothing else really matters – children, health, safety, finance, or job. One patient recounted how he knelt, crying, praying aloud that he would not go to the pub but the compulsion was simply overwhelming.

As a nurse and a human being it is not easy to disassociate yourself from their pain and that of their families. It seems you are trying to hold back the tide at times, but there are successes. Many come to accept their addiction and obtain remission, which is as rewarding as any other patient's recovery.

John, not his real name, was referred with alcoholism. His partner said he would not even go to the ice-cream van unless he had a half bottle of vodka in him. He had a number of detox admissions with little success, but then something changed and he began working at his sobriety. He's been abstinent for some years now and is involved in local social and sporting groups with his young family. With the support of AA he's enjoying life again. Successes like this give me and my colleagues much satisfaction.

People with addiction are the most challenging group I've worked with. But it can be rewarding. They're entitled to treatment as much as any other, for their sake and their families.

> As a nurse and a human being it is not easy to disassociate yourself from their pain.

Have your say

Consultation plays a significant part in many NMC projects. We recently completed an extensive consultation programme as part of our on-going review of pre-registration education, and, as described elsewhere in this edition, some 3,000 people were involved during the development of the new Code.

Exhibitions

Visit our stand at the following events:

April 14-16	Unison Health Conference, Manchester
April 28-30	RCN Congress Exhibition, Bournemouth
April 29	LSA Annual Conference, Nottingham
May 21-22	Primary Care Exhibition, Birmingham
June 1-5	ICM Triennial Congress/Exhibition, Glasgow
June 18-20	NHS Confederation Exhibition, Manchester
November	NMC Annual Midwifery Conference
November	CM Students Conference, London
November	HS Employers Annual Conference, Birmingham
November	CPHVA Conference, Harrogate

Events

NMC Council meetings
Thursday 12 June
Thursday 4 September
Thursday 4 December

For further details on Council meetings, contact David Sykes on **020 7333 6974**, email **david.sykes@nmc-uk.org**

Education

In April and May we are hosting a series of education roadshows targeted at NMC programme leaders, lead midwives for education and placement provider leads who are responsible for local mentor arrangements, updating and the maintenance of registers.

Topics covered will include pre-registration nursing and midwifery general entry requirement, the review of pre-registration nursing education consultation, and a look at the implementation issues around standards to support learning and assessment in practice.

A summary of the presentations given during these roadshows and feedback from those attending will be presented on the NMC website for anyone who cannot make the events.

Equality and diversity

We are holding a series of small events across the UK, inviting nurses, midwives and others to have their say on equality and diversity at the NMC.

In particular, we want to find out what you consider important in relation to equality and diversity.

We also want to provide an opportunity for you to find out more about the Fitness to Practise process and in particular the role of the panellist.

We want to explore with nurses and midwives what barriers there may be in attracting and recruiting Fitness to Practise panellists from diverse backgrounds.

Events already held in Cardiff, London and Birmingham are to be followed by Wednesday 30 April in Glasgow, Thursday 15 May in Belfast, Tuesday 20 May in Bradford.

The one-day events are restricted to 30 people per meeting, so places are being allocated on a first come first served basis. For more information contact **diversity@nmc-uk.org**

> "I would recommend these sessions to anyone."

> "A really good day that I hope will contribute to the work of the NMC."

‘Letters & Emails’

Old-school nurse

I totally agree with the view of Peggy Sherwood (First Person, News 23) regarding the changes to the levels of respect on the wards today. I am only 45 but certainly class myself as “old school”, where sister was the disciplinarian and much respected. We took a pride in our patient care and the fact that being late on duty and not delivering the right level of personal care (eg water to clean their teeth or a bowl after using the bedpan) just weren’t options. I now work in a school for children with severe learning and physical disabilities, and because I am the only nurse in the school I can use my skills learnt in that “old school” training once again with pride.

I also wanted to respond to the article in the same section by Irene Munro and again find myself in total agreement. The amount of paper or rather computer work that nurses have to do now is growing out of control. Political correctness has its place in any society but we are getting obsessed by it and it is getting out of control. Paperwork keeps nurses in the office instead of at the bedside where we belong. I trained in the 1980s and spent many a night shift sitting at the side of the bed of a very anxious or frightened patient giving them support, but also still able to write the old kardex card – because I just took them with me! Not possible with the present systems. Bring back many of the ward methods and staff structures from the 1980s and I believe in many respects we would have a much more efficient NHS, certainly more patient-friendly.

MICHELE HUNTER, School Nurse, Portland School, Sunderland, Tyne and Wear

Polyclinics

I was very interested to read the article Back to the future from both a personal and professional viewpoint. Sir Owen Williams (1890–1969), the architect of Peckham Health Centre, was my step-grandfather, of whom the family was very proud. He was an architect and engineer designing, besides the Health Centre, the Empire Exhibition at Wembley, the Daily Express building, the Boots factory, the M1 motorway and “Spaghetti” junction, to name but a few.

His client at Peckham was the Pioneer Health Centre Ltd. The doctors had two objectives for the project, (1) to make a biological and sociological study of mainly “working class” family units, and (2) to offer leisure and health-promoting facilities for the local community, in a search for an understanding of the nature of health. The two objectives were to be continuous in a recreational and health educational centre to which families would subscribe one shilling per week to come and join in sports activities and receive regular medical check-ups and health education. Also much research would be undertaken. (Socio-medical concepts of the Peckham Experiment – a study in the living structure of society. Pearce and Rocker, 1943.)

The centre was an inspiring and extremely modern building. It was said by the Architectural Review in 1935 that “Williams’ radical functionalist design principles seemed perfectly tailored to the client’s radical sociological brief.”

As a retired health visitor and community practice teacher, I was extremely interested to learn that my relative had been so involved in setting up this community health project as early as 1933, and that this idea in different guises has resonated through the Health Service again. There are different needs now, different demographics, pathologies and treatments; communities have greater expectations and are more able to articulate these in a forceful and knowledgeable way. Also, perhaps today, they would not take too kindly to being a “sociological experiment”!

I endorse the polyclinic ideal. However, polyclinics and the attendant NHS changes must not be a money-saving exercise and must be set for the long term, away from the short-term political fads and fancies so that these ideas can settle down, change when necessary, and bring the community along with them so the nation as a whole can take pride in the health service, and people, with support, can feel responsibility towards their own health.

ROSEMARY A. ALLAN, Rutland, Leics

Learning disability

I recently received the latest NMC News magazine. As a learning disability nurse I was extremely disappointed. Out of thirty pages, no reference was made to this branch of nursing. When was the last major piece of work on learning disability nursing in the magazine? When will learning disability get the promotion and attention it deserves instead of the persistent and repetitive fixation on general/adult nursing?

DAVID KIRKMAN, Lockerbie

The editor replies:

David is right. A feature focusing on learning disability nursing is overdue. Recently we got in touch with some nurses from this branch to ask for their ideas regarding such a feature, so we’re on the case. If any reader would like to suggest a setting or specific focus for this article, we will be happy to consider it.

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