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Health Committee

Annual accountability hearing with the Nursing and Midwifery Council

Seventh Report of Session 2010–12

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written evidence*

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

Membership

Rt Hon Stephen Dorrell MP (*Conservative, Charnwood*) (Chair)¹
Rosie Cooper MP (*Labour, West Lancashire*)
Yvonne Fovargue MP (*Labour, Makerfield*)
Andrew George MP (*Liberal Democrat, St Ives*)
Grahame M. Morris MP (*Labour, Easington*)
Dr Daniel Poulter MP (*Conservative, Central Suffolk and North Ipswich*)
Mr Virendra Sharma MP (*Labour, Ealing Southall*)
Chris Skidmore MP (*Conservative, Kingswood*)
David Tredinnick MP (*Conservative, Bosworth*)
Valerie Vaz MP (*Labour, Walsall South*)
Dr Sarah Wollaston MP (*Conservative, Totnes*)

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Committee staff

The staff of the Committee are David Lloyd (Clerk), Sara Howe (Second Clerk), David Turner (Committee Specialist), Steve Clarke (Committee Specialist), Frances Allingham (Senior Committee Assistant), and Ronnie Jefferson (Committee Assistant).

Contacts

All correspondence should be addressed to the Clerk of the Health Committee, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 5466. The Committee's email address is healthcom@parliament.uk.

¹ Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).

Contents

Report	<i>Page</i>
1 Introduction	2
2 Fitness to practise	5
3 Revalidation of nurses	9
Re-registration of nurses	9
Revalidation	10
Nurses who qualify overseas	12
4 Proactive regulation	14
5 The future of regulation	16
Conclusions and recommendations	18
Formal Minutes	22
Witnesses	23
List of printed written evidence	23
List of Reports from the Committee during the current Parliament	24

1 Introduction

1. The nursing and midwifery professions are amongst the oldest established and the longest regulated professions in the UK.² Regulation of these professions has taken many different forms and has been undertaken by several different organisations over the last one hundred or so years. The current regulator, the Nursing and Midwifery Council (NMC) has been fully operational since April 2002 and is the statutory regulator for the 660,000³ nurses and midwives in the UK, the Channel Islands and the Isle of Man.

2. The aims of the NMC are to set standards of education, training, conduct and performance for nurses and midwives, to ensure that these standards are maintained and that the health and wellbeing of the public is safeguarded. It discharges these functions by maintaining a register of nurses and midwives, setting standards for education and practice, and giving guidance and advice to the professions.⁴

3. The legislative basis for regulation of the professions is set out in the Nursing and Midwifery Order of 2001⁵ and subsequent amendments.⁶ **The NMC has requested Department of Health support for further amendments to the legislation that governs its operation. The Committee broadly supports this request, as improvement to the performance of the NMC in some key areas is hampered by its current legal framework. The Government must prioritise this work if it wishes to see further improvement in the performance of the NMC.**

4. Both the NMC and its predecessor organisation the United Kingdom Centre Council for Nursing, Midwifery and Health Visiting (UKCC) have from time to time encountered significant operational difficulties. In the 1990s the UKCC got into financial difficulties and had built up significant levels of debt which were then taken on by the NMC on its establishment.⁷ Since then a financial recovery plan has been put in place. This entailed efficiency savings, reducing costs and raising the three-yearly registration fee to £129 from August 2004. In 2007 the three-yearly fee was raised to £228 (now paid in annual instalments of £76). The annual report and accounts for the year ending March 2011 indicate that the NMC's financial recovery plan has been achieved and that it now has adequate free reserves.⁸ **The Committee welcomes the improved financial performance of the NMC in recent years, but is concerned about the affordability of the registration fee for many lower paid registrants. We would urge the NMC to avoid further fee rises and to consider fee reductions for new entrants to the register.**

5. From time to time since its foundation, various allegations have been made about the performance of the NMC and the conduct of its Council. In 2008, the then Minister of

2 Sixth Report from the Health Committee, Session 1998–99, *Adverse Clinical Incidents*, HC 549–I, ACI 189

3 Ev 16

4 Nursing and Midwifery Council, *Annual report and accounts for the year ending 31 March 2011*, HC 335, July 2011

5 Nursing and Midwifery Order 2001 (2001/235)

6 Amended by, for example, the Nursing and Midwifery (Amendment) Order 2008 (2008/1485)

7 Ev 16

8 Nursing and Midwifery Council, *Annual report and accounts for the year ending 31 March 2011*, HC 335, July 2011

State for Health Services, Ben Bradshaw MP, commissioned the Council for Healthcare Regulatory Excellence (CHRE), the regulator of health professions regulators, to undertake a special review into the conduct of the NMC. The report found that there were:

[...] serious weaknesses in the NMC's governance and culture, in the conduct of its Council, in its ability to protect the interests of the public through the operation of fitness to practise processes and in its ability to retain the confidence of key stakeholders.⁹

6. The report highlighted a poor level of service to complainants (sometimes insensitive or misleading information was being given to them) significant delays in communication with complainants, poor quality correspondence and long delays in fitness to practise hearings.¹⁰ The report also found evidence of inappropriate conduct of the Council and a lack of confidence in the NMC from its stakeholders.¹¹

7. The Government accepted the findings of the report and subsequently the Council membership has been entirely replaced and the number of members reduced. There are now seven lay and seven professional members, all of whom are now appointed, and the Council has adopted an appraisal system for all its members.¹²

8. The CHRE undertakes an annual review of the NMC and other regulators. Its 2010–11 report considers the progress that the NMC has made since the publication of the special review in 2008 and finds that some “significant improvements” have been made. The report goes on to say:

However, we remained concerned about the number and nature of the improvements that the NMC still had to make, particularly around its customer care and, its management of serious cases and the timeliness of its case progression.[...] Due to the importance of these areas that are still in need of considerable improvement, we agreed with the NMC that we would work alongside it over the coming months to ensure that improvements continued to be made.¹³

The CHRE go on to say that:

We can see that it [the NMC] is taking the necessary steps to address the areas of concern in our progress review [...] We support the NMCs intentions and recognise that the NMC is committed to improving its performance.¹⁴

9. The NMC is now leaving behind its previous organisational and financial instability, and is improving in many areas of its work. There remains however a significant amount of work to be done in order for it to be an effective regulator that has public protection as its principal concern.

9 The Council for Healthcare Regulatory Excellence, *Special report to the Minister of State for Health on the Nursing and Midwifery Council*, 11 June 2008

10 *Ibid.*

11 *Ibid.*

12 Nursing and Midwifery Council, *Annual report and accounts for the year 2009–10*, February 2010

13 The Council for Healthcare Regulatory Excellence, *Performance review report 2010–11*, HC 1084-II, June 2011

14 *Ibid.*

10. Although, therefore, the Committee recognises that the NMC is developing a higher level of operational competence, it remains concerned that the leadership function of the NMC remains underdeveloped, particularly in the areas of fitness to practise, revalidation, education and training and proactive regulation. The Committee hopes that the NMC will embrace more ambitious objectives for professional leadership, some of which are described in this report.

2 Fitness to practise

11. The NMC issues a Code of Conduct for Nurses and Midwives. “The Code” sets out the “foundation of good nursing and midwifery practice, and is a key tool in safeguarding the health and wellbeing of the public”, and as such establishes the bar for fitness to practise.¹⁵ Members of the public, employers, nurses or midwives or others who think that a nurse or midwife is in breach the code, or whose practice is thought to be impaired¹⁶ can make a formal referral to the NMC.

12. In the last three years there has been a 102% increase in referrals about nurses and midwives, and a 41% increase in the last year alone.¹⁷ We asked the NMC why there has been such a significant increase in referrals. The NMC has stated that there is an upwards trend in referrals across the health professions, but they were not able to articulate a satisfactory reason for this:

We are being proactive. We are saying to the people who matter, “This is what we do and we are here to regulate nurses and midwives and deal with the most serious concerns.” The NMC profile has been raised in the last couple of years, which may explain it, but this is guesswork because I do not think we or the other regulators really know.¹⁸

13. The General Medical Council has analysed its fitness to practise cases and found that doctors who qualified overseas were over-represented in its statistics, prompting further research.¹⁹ Fitness to practise statistics are published annually by the NMC, and an analysis of the register has been published up to and including the year 2007–08.²⁰ However, neither data set is broken down by profession i.e. nursing or midwifery, or by the ethnicity of the registrant. The CHRE has stated that the NMC started to collect ethnicity about registrants in July 2009²¹ and in a Freedom of Information request the NMC had stated that this data would be available in autumn 2010.²² In June 2011 the NMC Council minutes note that:

We are about to commence a programme of analysis of this data in relation to the nurses and midwives on our register. However, we cannot currently cross-refer this data to fitness to practise cases. We hope to begin collecting equality and diversity data for each of the six strands at each of the significant stages of our FtP [fitness to practise] process in the near future.²³

15 Nursing and Midwifery Council, *The Code*, December 2007

16 For example, impairment may mean lack of competence, convictions or cautions, poor physical or mental health

17 Ev 17

18 Q 114

19 Health Committee, Eighth Report of the Session 2010–12, Annual Accountability Hearing with the GMC, HC 1429-II

20 “Statistics about nurses and midwives”, *NMC website*, 23 February 2010, www.nmc-uk.org/about-us/statistics/

21 The Council for Healthcare Regulatory Excellence, *Performance review report 2010/11*, HC 1084-II, June 2011

22 “Freedom of Information disclosure log July–December 2009”, *NMC website*, www.nmc-uk.org/Documents/FoI/Freedom-of-Information-Disclosure-Log_July-December-2009.XLS

23 Nursing and Midwifery Council, *Meeting of the NMC Council*, 23 June 2011

The Committee is very concerned about the recent dramatic rise in the numbers of NMC referrals of nurses and midwives, and that NMC reports make it difficult to distinguish between referrals made about nurses or midwives. We are surprised that the NMC has no clear answer to why referrals are increasing, and recommend that the NMC undertakes urgent research to establish the reasons for this increase. This data could and should be used to support the development of revalidation and a more proactive approach to regulation.

14. **The Committee is also concerned that an analysis of ethnicity data on the nursing and midwifery register is still not available despite having made assurances that this would take place in 2010. Of more concern is the fact that, according to its own records, the NMC is still not recording ethnicity or other diversity monitoring in fitness to practise cases. Without this, neither the professions nor the public can have confidence that the NMC discharges its functions in a manner that is fair and equitable to minorities.**

15. There are a number of sources of evidence which suggest significant problems with poor care. The ongoing public inquiry into the Mid Staffordshire NHS Foundation Trust is uncovering poor standards at one Foundation Trust; unfortunately it is unlikely that the experience of this Trust is unique. The Health Service Ombudsman has raised significant issues with the care of older people, particularly in acute hospitals.²⁴ Following our report into complaints and litigation,²⁵ the Committee remains very concerned about the standard of basic nursing care for older people in hospital.

16. The NMC has published guidance to the professions on the care of older people²⁶ and in November 2010 on how they can raise concerns about fellow registrants.²⁷ However, the response from within the nursing and midwifery professions to declining standards is disappointing. Despite poor standards of practice in some clinical areas at the Mid Staffordshire Trust, not one nurse or midwife reported concerns to the NMC.²⁸ The NMC has approximately 40 fitness to practise cases open on registrants from the Mid Staffordshire Trust, some of which are related to failure to report another registrant to the NMC.²⁹ The Patients' Association are concerned about the lack of referrals to the NMC from Mid Staffordshire NHS Foundation Trust:

In light of the scale and durations of concerns about nursing care the extremely low number of referrals is concerning. It suggests a very low level of awareness amongst patients and the public, at least in respect of the care being delivered at Stafford hospital.³⁰

24 Health Service Ombudsman, *Care and compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people*, HC 778, 14 February 2011

25 Health Committee, Sixth Report of the Session 2010–12, *Complaints and Litigation*, HC 786-1

26 Nursing and Midwifery Council, *Guidance for the care older people*, 16 March 2009

27 Nursing and Midwifery Council, *Raising and escalating concerns: Guidance for nurses and midwives*, 1 November 2010

28 Q 93

29 Q 97

30 Ev 27

17. **Following our earlier report into complaints and litigation, the Committee remains very concerned about the existence of low standards of basic nursing care in our acute hospitals and care homes, which appear to be in breach of the code of conduct for nurses and midwives. We are particularly concerned about this in light of the ongoing inquiry into Mid Staffordshire NHS Foundation Trust, the Winterbourne View scandal and the recent Health Service Ombudsman report into care of the elderly in hospital.**

18. **This evidence presents a challenge to the NMC which is responsible for professional standards in the nursing and midwifery professions. Based on its existing guidance on care of the elderly, we propose that the NMC should develop a programme of action to deliver a demonstrable improvement in outcomes for this vulnerable group.**

19. **Furthermore, the NMC needs to send a clear signal to nurses and midwives that they are at as much risk of being investigated by their regulator for failing to report concerns about a fellow registrant as they are from poor practice on their own part.**

20. The Commission for Healthcare Regulatory Excellence (CHRE) conducts a performance assessment of regulators every year. Its March 2011 report has found that only two-thirds of cases are resolved within the fifteen month deadline.³¹ The CHRE has also undertaken an audit of fitness to practise activity by the NMC and has found:

[...] continuing significant weaknesses in the NMC's handling of fitness to practise matters. *These weaknesses create significant risks that the NMC will not always protect the public or maintain confidence in the professions* (our emphasis).³²

The performance of the NMC in handling fitness to practise has been raised with the Committee by Unison who told us that:

Nurses and Midwives continue to wait a significant (and often unacceptable) amount of time for their case to be heard and concluded.³³

Unison do acknowledge that the NMC is making progress on this matter and that new systems and processes will take time to address the backlog in fitness to practise cases.³⁴

21. NMC has stated that it cannot make much more progress on this without reform of the Nursing and Midwifery Order. In its memorandum of written evidence it told the Committee that:

In order for these [proposals for improved fitness to practise] to become reality we need legislative changes to the Nursing and Midwifery Order 2001. We have approached ministers and Department of Health officials on a number of occasions with requests for these changes, even to the extent of offering to fund any associated

31 The Council for Healthcare Regulatory Excellence, *Performance review report 2010/11*, HC 1084-II, June 2011

32 The Council for Healthcare Regulatory Excellence, *Fitness to practise audit report*, March 2011 p48

33 Ev 24

34 *Ibid.*

legal costs that would be required to make this happen. We have had a disappointing response to date.³⁵

22. The Government is proposing to have one Act of Parliament that establishes the core functions of professional regulators, leaving them to decide how they discharge these. The Committee welcome the Governments plans for simplification of the legislation that underpins professional regulation in the UK.

23. However, in the light of criticisms by the CHRE about “significant weaknesses” with the process, the Committee urges the Government to bring forward amendments as soon as possible to the Nursing and Midwifery Order 2001 so that the NMC can streamline its fitness to practise procedures.

24. The NMC also requests that the Nursing and Midwifery Order 2001 be amended to allow nurses and midwives to remove themselves from the register voluntarily, so called voluntary erasure.³⁶ This differs from what currently happens in that nurses and midwives can allow their registration to lapse. In cases where an allegation has been made about them, a registrant is unable to allow their registration to lapse.³⁷ If an allegation was made about a registrant who had allowed their registration to lapse and subsequently then applied to rejoin the register, this allegation would be flagged for investigation by the NMC:

The NMC permanently holds records of registrants who have removed themselves from register [...] If a registrant applied to restore themselves to the register having removed their name during an ongoing FTP investigation, the application for restoration would fall to FTP to consider and not the Registrar. FTP would then pick up their investigation from the moment when the registrant removed their name from the register.³⁸

25. The Committee supports the proposal that nurses and midwives be able to voluntarily remove themselves from the register. However, where concerns have been raised about a nurse or midwife seeking erasure, or where an investigation is taking place into fitness to practise, erasure must only take place with the consent of the complainant and on publication of the full details of the case against the registrant.

35 Ev 17

36 Ev 17

37 Ev 31

38 *Ibid.*

3 Revalidation of nurses

Re-registration of nurses

26. Nurses and midwives pay their retention fee annually, and once every three years they must re-register with the NMC, so called “periodic renewal”. This requires that a registrant state on a Notification of Practice form that they have undertaken 450 hours or more of practice in the last three years, and that they have undertaken 35 hours of continuous professional development (CPD) activity over the same period.³⁹ Collectively, these are known as the Post-registration education and practice (PREP) standards. The NMC recommends that registrants keep a portfolio of their CPD activity and states in its handbook that PREP portfolios will be audited.⁴⁰ However, the CHRE has recently stated that:

The NMC does not audit registrants’ continuing professional development (CPD) portfolios.⁴¹

27. When asked about this, the NMC told us:

We have, as you know, nearly 700,000 registrants so we largely have to take that on trust. We now use a risk-based approach for calling in PREP information but we do not have the resource to do it systematically across the entire register. The risk-based approach we would use would be if a nurse or a midwife comes to our attention for some other reason. For example, if they have had a caution or a conviction from the police then we might call in their PREP evidence; in other words, certificates of attendance, they have to write something to say what they have learnt from a particular educational initiative, and that sort of thing. The PREP system, in a way, leads into revalidation. What we are working on now is revamping that for 2014 when we start revalidation proper.⁴²

28. In supplementary evidence to the Committee the NMC told us that they have looked in more detail at the registration renewal evidence of around 115,000 nurses and midwives over the last five years.⁴³ This equates to an average of 23,000 per year or less than 4% of all registrants annually.

29. The Council for Healthcare Regulatory Excellence has also stated that it supports the NMC’s approach in not auditing CPD as the NMC:

[...] is looking at what evidence would be required to audit outcome based CPD in terms of professional development value rather than auditing what professional development has been undertaken.⁴⁴

39 “Meeting the PREP standards” *NMC website*, 7 June 2010, www.nmc-uk.org

40 *Ibid.*

41 The Council for Healthcare Regulatory Excellence, *Performance review report 2009–10*, HC 7-II, July 2010, p65

42 Q 71

43 Ev 21

44 The Council for Healthcare Regulatory Excellence, *Performance review report 2009–10*, HC 7-II, July 2010, p65.

30. The NMC also relies on other registrants informing the NMC when a fraudulent Notification of Practice has been made:

The interesting thing is that, increasingly, colleagues whistleblow if they feel somebody they know has not done that. We would then refer those people to fitness to practise because, in fact, they have submitted a fraudulent entry.⁴⁵

31. The current standard for re-registration—completing 450 hours of practice and 35 hours of professional development—is wholly inadequate, as this tells patients and the public nothing about the quality of nursing and midwifery practice undertaken by the registrant. There is also no routine assessment of whether nurses and midwives have even met this minimal standard. The NMC instead relies on honesty within the profession and “whistle-blowing” when registrants are dishonest. For many nurses and midwives this may well be adequate, but for a significant minority, including those most at risk of manifesting low professional standards, it may not be.

32. The Committee supports the NMC’s risk-based approach to the current re-registration process. However, we are concerned that there are nurses and midwives who could be failing to meet the already unacceptably low standards for re-registration but who do not come to the attention of the NMC and are therefore re-registered unchallenged. Registrants must feel that their regulator could call in their re-registration evidence at any time and as such the NMC should undertake an annual random audit of the registration renewal evidence supplied by a sample of registrants.

Revalidation

33. The NMC, along with other regulators and the CHRE were involved in a working group led by the Department of Health in England on non-medical revalidation i.e. the new process through which nurses, midwives and other professions would in future seek re-registration. The NMC has told us that its revalidation system will be in place by 2014.⁴⁶ **The Committee will monitor progress against the 2014 deadline for the introduction of revalidation by the NMC at subsequent accountability hearings.**

34. The process of revalidation will be constrained by the number of registrants that the NMC will have to revalidate. As they told us in oral evidence:

I know one or two other regulators have done a lot of work with calling in paper-based information. We will never be able to do that unless we very significantly raise registration fees, which is not something we wish to do. Therefore, our system will always have to be risk based and online.⁴⁷

35. Instead, the NMC is proceeding with an online, risk-based approach to revalidation that will focus on areas of practice where the consequences of poor practice may not become evident:

45 Q 77

46 Ev 21

47 Q 85

In brief, those are environments that we would regard as “not managed”. By that, I do not mean not managed at all but that they are not within a large managed system. For example, I would be less worried—and I think people would be a lower risk—about those working generally in a well-run NHS environment or a military environment than perhaps a very small, independently-run nursing home.⁴⁸

36. In its Command Paper “Enabling Excellence, Autonomy and Accountability for Healthcare Workers”, the Department of Health has stated:

For those professions where there is evidence to suggest significant added value in terms of increased safety or quality of care for users of health care services from additional central regulatory effort on revalidation, the Government will agree with the relevant regulators, the Devolved Administrations, employers and the relevant professions the next steps for implementation.⁴⁹

37. The Committee notes that in addition to re-registration and eventually, revalidation, every midwife must also have a named supervisor of midwives (SoM). SoMs are experienced practising midwives who have undertaken additional education and training to support, guide and supervise midwives. SoMs develop and maintain safe practice to ensure protection of women and their babies. They meet regularly with midwives with the aim of ensuring that a high standard of care is provided.⁵⁰

38. Local Supervising Authorities are impartial organisations responsible for ensuring statutory supervision of midwives is undertaken according to NMC’s standards. LSAs are based within Strategic Health Authorities in England. SHAs are due to be abolished in 2013 and the arrangements for statutory supervision of midwives during the transition and beyond 2013 are not yet in place.

39. Revalidation of nurses and midwives is a significant undertaking that the NMC is progressing with due caution. The Committee notes that statutory supervision of midwives is a tried and trusted means of assuring the quality of midwifery practice. The NMC should consider the costs and benefits of extending the statutory supervision framework as a potential means of delivering an effective revalidation process for all registrants.

40. The NMC needs to ensure that it monitors the number of nurses and midwives who retire, leave the profession, have conditions placed on their practice or fail revalidation. It must develop and share this evidence with employers to ensure that the future workforce planning includes the developing outcome of the revalidation process.

41. The Department of Health must clarify how it will maintain the continuity of statutory supervision of midwives through Local Supervising Authorities once Strategic Health Authorities are abolished.

48 Q 85

49 Department of Health, *Enabling excellence, autonomy and accountability for healthcare workers*, Cm 8008, 16 February 2011, p 19

50 “The supervision of midwives”, *NMC website*, 9 March 2010, www.nmc-uk.org

Nurses who qualify overseas

42. The NMC is prohibited by law from systematically testing the language competence of nurses and midwives who have trained within the EEA (EU27 plus Iceland, Liechtenstein and Norway) and Switzerland. Nor can it request training transcripts or test the knowledge or competence of nurses and midwives from these places.⁵¹ They told us that they have made some efforts to pick up language deficiencies through aptitude tests that can only be administered to some potential registrants:

For those who have major shortfalls, we have found a solution within the legislation and we introduced aptitude tests this year, which started in April. These are tests like the PLAB test, more or less, that the GMC described earlier on, based on multiple choice but also OSCE simulation and a reading assessment. The language competence will be picked up through that because there will be written and oral communication in English. For those who meet automatic recognition, we are not allowed to ask any additional requirements there.⁵²

43. In 2010 the European Commission asked the NMC to lead on a review of the EU directive that has prevented systematic language and competence testing.⁵³

44. The NMC told us that the EU minimum standards for training were established in the 1970s and that these standards are not as high as those in the UK at present.⁵⁴ The NMC is working with the other regulators, the Government and with the EU to address these issues. Additionally, the NMC has stated that:

We have worked collaboratively with the Department of Health and the European Commission (EC) and have provided recommendations to amend the legislation governing the mobility of healthcare professionals within the EU (EU Directive 2005/36/EC on the recognition of professional qualifications)⁵⁵

45. Nurses and midwives from the European Economic Area and Switzerland seeking to practice in the UK cannot routinely be language and competence tested by the NMC. The NMC, along with other professional regulators and the Government is working towards resolution of this with partner organisations across Europe. The Committee takes the view that the current legal framework is at odds with good clinical practice, which is clearly unacceptable.

46. The Government, the NMC and the other health professions regulators must now grasp this as a significant risk to patients and dramatically pick up the pace in resolving or mitigating it.

47. The Committee is concerned that waiting for regulatory action at a European level will expose patients to a high risk over an unacceptably long period of time. We would

51 "Nurses and midwives trained abroad", *NMC website*, March 2010, www.nmc-uk.org

52 Q 143

53 Ev 18

54 Q 135, 136

55 *Ibid.*

like to see prompt action on this matter along the lines taken by the GMC where Responsible Officers sign off a doctor as competent and fit to practise.

4 Proactive regulation

48. The fitness to practise activities of the NMC are by the far its most labour and resource intensive. In the Command Paper on professional regulation the Department of Health stated that:

[...] fitness to practise amounted to £19.7 million out of a total expenditure of £36.7 million. This amounted to around 54% of the NMC's entire expenditure over the year.⁵⁶

49. The size and scope of the nursing and midwifery professions present the NMC with the unique challenge amongst professional regulators of regulating two key professions in a way that is both effective and affordable.

50. In light of this challenge, and scandals such as that at Mid Staffordshire NHS Foundation Trust, the NMC has been examining ways in which it can be more proactive in its protection of the public, as opposed to waiting for fitness to practise allegations to be made. The NMC has opened 153 fitness to practise cases about nurses and midwives in this manner, and recently suspended two nurses from the register that were working at the Winterbourne View care home in Hambrook.⁵⁷ **We welcome the NMC's initiative in opening proactive investigations into registrants without a formal referral from an employer, a member of the public or another professional.**

51. The NMC has conducted at least two extra-ordinary reviews of pre-registration nurse education in NHS Trusts: North West London Hospitals NHS Trust in 2005,⁵⁸ and Basildon and Thurrock University Hospitals NHS Foundation Trust in 2009.⁵⁹ This latter review was in response to concerns raised by the CQC and Monitor about the leadership, quality of care and governance arrangements in the organisation.⁶⁰

52. In 2009 the NMC commissioned Dame Elizabeth Fradd to consider how the NMC could proactively safeguard patients either within its existing powers or through extending them.⁶¹ Based on this report, the NMC has concluded that:

Whilst NMC has overarching duties to establish and maintain standards of education, training, conduct and performance of nurses and midwives, there is no clear power which permits the NMC to intervene to investigate healthcare organisations. Lawyers advise that in order to limit the risk NMC should agree the nature and scope of proposed interventions with other regulators.⁶²

56 Department of Health, *Enabling excellence, autonomy and accountability for healthcare workers*, Cm 8008, 16 February 2011

58 "Nurse policing is to be 'more proactive'", the Health Service Journal, 16 December 2009

59 The Nursing and Midwifery Council, *Report on the extraordinary review of nursing (adult) education and the maternity services at Basildon and Thurrock University Hospitals NHS Foundation Trust*, December 2009

60 *Ibid.*

61 The Nursing and Midwifery Council, *Critical standards intervention project final report*, September 2010

62 *Ibid.* p4

53. In response to Dame Elizabeth's report, the NMC will be establishing a Critical Standards Intervention unit that aims to "identify, assess and act upon systemic failures".⁶³ The unit will require a significant change in how the NMC operates in order for it to become more proactive and for sections of it to work together:

There has been little history of doing this in the past. Pockets of information are currently kept in silos i.e. in the sections that receive the information, which significantly, may not necessarily be the section that can make best use of it.⁶⁴

54. The NMC acknowledges the cultural shift that will be required to deliver on proactive regulation.⁶⁵ The Critical Standards Intervention project has been reviewing options for further proactive actions that the NMC could take. It recently reported that the NMC should use and "stretch" its existing powers to investigate standards of training in healthcare providers. The NMC told us:

[...]we do have powers to appoint visitors to look at the quality of the education environment within a healthcare organisation, refer concerns to our investigating committee for fitness to practise action and review arrangements to protect the public from practitioners whose fitness to practise is in doubt.

The NMC will also develop memoranda of understanding with the CQC and other organisations to enable information sharing.⁶⁶

55. The NMC's plans for investigation of and intervention in a healthcare organisation where concerns are being raised is a creative and interesting approach to regulating what is a large group of professionals working across a variety of settings. It offers the NMC another tool to strengthen public protection.

56. We do feel however that whilst the power to look at the quality of educational environments gives the NMC "a foot in the door", clear power must be established in law for further expansion of this role, and we encourage the Government and the NMC to work together to develop this approach. The Committee would particularly like to see the NMC responding to trends in outcome and complaints data from NHS and social care providers.

63 Ev 18

64 The Nursing and Midwifery Council, *Critical standards intervention project final report*, September 2010

65 "NMC opens up 153 new cases following media reports of poor care", NMC website, 26 June 2011, www.nmc-uk.org

66 The Nursing and Midwifery Council, *Critical standards intervention project final report*, September 2010 <http://www.nmc-uk.org>

5 The future of regulation

57. Several witnesses to our earlier inquiry into complaints and litigation expressed concerns about care of older people, particularly when they are undergoing treatment in acute hospitals.⁶⁷ The Committee has followed this up with the NMC in light of the transition to an all-degree nursing profession by 2013 and the perception that nurses may have “stepped back” from basic nursing care.⁶⁸

58. The NMC told us about the recruitment and retention benefits that have accrued from having an all-degree profession in Wales,⁶⁹ where nurse education has been to degree-level since 2004.⁷⁰ The NMC also told us that there was “extremely positive” evidence for an all-degree profession from other countries.⁷¹ In written evidence to the Committee they stated:

There is no evidence that a degree level nursing profession leads to diminished standards of basic care in fact quite the opposite. Studies from the USA reveal that a high proportion of degree qualified registered nurses has been associated with lower mortality in surgical units.⁷²

59. However, the Committee raised the issue that many basic nursing care tasks that used to be undertaken by registered nurses are now undertaken by healthcare assistants. The NMC estimates that there are 300,000 unregistered healthcare support workers and an unknown number of assistant practitioners currently working in the UK.⁷³ The NMC has “growing concerns” that healthcare assistants (HCAs) are increasingly working on tasks previously undertaken by registered nurses but remain unregulated. This means that there is little control over entry to employment and no final sanction of removal from a register when competence or conduct are not of a sufficiently high standard.⁷⁴

60. The NMC commissioned a scoping review of HCA registration which found that there is evidence of HCAs taking up work having been dismissed from other roles for misconduct, and that they are undertaking tasks for which they have not been trained. Based on these findings, the report states that a strong case exists for regulating HCAs. Voluntary registration was thought to be too weak as it would “be avoided by the people about whom there is most concern.”⁷⁵ The recent scandal at Winterbourne View in Bristol underlines the issues around registration of healthcare assistants.

67 Health Committee, Sixth Report of the Session 2010–12, *Complaints and Litigation*, HC 786-I, Q 1 for example

68 Following on from the Darzi review of the NHS, the document “Framing the Nursing and Midwifery Contribution” set out the trajectory for the transition of nursing to a graduate-level profession. The then Health Minister Ann Keen MP announced that the profession would require a degree-level qualification for entry to the register from 2013.

69 Q 105

70 Swansea University, “*Nursing. An all-graduate profession – the Welsh experience*”, <http://www.publicserviceevents.co.uk>

71 Q 105

72 NMC 02

73 NMC 02

74 Kings College London, *Moving forward with healthcare support workforce regulation. A scoping review: evidence, questions, risks options*, July 2010

75 *Ibid.*

61. In its recent Command Paper on regulation of the healthcare workforce, the Government has stated that statutory regulation of health workers has often been the first rather than the last resort.⁷⁶ The Government now proposes to:

[...] enable a system of assured voluntary registration to be developed for professionals and occupational groups which are currently not subject to statutory professional regulation.⁷⁷

62. The Committee notes that under clause 212 of the Health and Social Care Bill that the Government is proposing to give powers to the professional regulators to establish voluntary registers for unregulated professionals and workers.⁷⁸ The NMC expressed concerns about this proposed approach.

We believe that health care support workers should be regulated, not necessarily in an identical manner to nurses and midwives but there should be a regulatory framework that is not voluntary. I do not believe that people who are unpleasant want to join voluntary registers, so we believe it should be mandatory.⁷⁹

They went on to tell us about assistant practitioners who undertake complex procedures such as suturing and giving drugs, but are also unregulated. In its written submission to us the Patients Association has endorsed mandatory statutory regulation of healthcare assistants and support workers.⁸⁰

63. As previously mentioned, the Committee has ongoing concerns about the care and treatment of older people both in hospitals and care homes. Of particular concern to the Committee is the lack of regulation of a range of groups who undertake many basic nursing care tasks.

64. The Committee endorses mandatory statutory regulation of healthcare assistants and support workers and we believe that this is the only approach which maximises public protection. The Committee notes that the Government intends to give powers to the relevant regulators to establish voluntary registers for non-regulated professionals and workers, but would urge it to see healthcare assistants, support workers and assistant practitioners as exceptions to this approach who should be subject to mandatory statutory regulation. However, the NMC needs to make significant improvements in the conduct of its existing core functions (such as in how it manages fitness to practise cases) before powers to register these groups are handed to it.

76 Cm 8008

77 *Ibid.*

78 Health and Social Care Bill, Clause 212

79 Q 108

80 NMC 06

Conclusions and recommendations

Introduction

1. The NMC has requested Department of Health support for further amendments to the legislation that governs its operation. The Committee broadly supports this request, as improvement to the performance of the NMC in some key areas is hampered by its current legal framework. The Government must prioritise this work if it wishes to see further improvement in the performance of the NMC. (Paragraph 3)
2. The Committee welcomes the improved financial performance of the NMC in recent years, but is concerned about the affordability of the registration fee for many lower paid registrants. We would urge the NMC to avoid further fee rises and to consider fee reductions for new entrants to the register. (Paragraph 4)
3. The NMC is now leaving behind its previous organisational and financial instability, and is improving in many areas of its work. There remains however a significant amount of work to be done in order for it to be an effective regulator that has public protection as its principal concern. (Paragraph 9)
4. Although, therefore, the Committee recognises that the NMC is developing a higher level of operational competence, it remains concerned that the leadership function of the NMC remains underdeveloped, particularly in the areas of fitness to practise, revalidation, education and training and proactive regulation. The Committee hopes that the NMC will embrace more ambitious objectives for professional leadership, some of which are described in this report. (Paragraph 10)

Fitness to practise

5. The Committee is very concerned about the recent dramatic rise in the numbers of NMC referrals of nurses and midwives, and that NMC reports make it difficult to distinguish between referrals made about nurses or midwives. We are surprised that the NMC has no clear answer to why referrals are increasing, and recommend that the NMC undertakes urgent research to establish the reasons for this increase. This data could and should be used to support the development of revalidation and a more proactive approach to regulation. (Paragraph 13)
6. The Committee is also concerned that an analysis of ethnicity data on the nursing and midwifery register is still not available despite having made assurances that this would take place in 2010. Of more concern is the fact that, according to its own records, the NMC is still not recording ethnicity or other diversity monitoring in fitness to practise cases. Without this, neither the professions nor the public can have confidence that the NMC discharges its functions in a manner that is fair and equitable to minorities. (Paragraph 14)
7. Following our earlier report into complaints and litigation, the Committee remains very concerned about the existence of low standards of basic nursing care in our

acute hospitals and care homes, which appear to be in breach of the code of conduct for nurses and midwives. We are particularly concerned about this in light of the ongoing inquiry into Mid Staffordshire NHS Foundation Trust, the Winterbourne View scandal and the recent Health Service Ombudsman report into care of the elderly in hospital. (Paragraph 17)

8. This evidence presents a challenge to the NMC which is responsible for professional standards in the nursing and midwifery professions. Based on its existing guidance on care of the elderly, we propose that the NMC should develop a programme of action to deliver a demonstrable improvement in outcomes for this vulnerable group. (Paragraph 18)
9. Furthermore, the NMC needs to send a clear signal to nurses and midwives that they are at as much risk of being investigated by their regulator for failing to report concerns about a fellow registrant as they are from poor practice on their own part. (Paragraph 19)
10. The Government is proposing to have one Act of Parliament that establishes the core functions of professional regulators, leaving them to decide how they discharge these. The Committee welcome the Governments plans for simplification of the legislation that underpins professional regulation in the UK. (Paragraph 22)
11. However, in the light of criticisms by the CHRE about “significant weaknesses” with the process, the Committee urges the Government to bring forward amendments as soon as possible to the Nursing and Midwifery Order 2001 so that the NMC can streamline its fitness to practise procedures. (Paragraph 23)
12. The Committee supports the proposal that nurses and midwives be able to voluntarily remove themselves from the register. However, where concerns have been raised about a nurse or midwife seeking erasure, or where an investigation is taking place into fitness to practise, erasure must only take place with the consent of the complainant and on publication of the full details of the case against the registrant. (Paragraph 25)

Revalidation of nurses

13. The current standard for re-registration—completing 450 hours of practice and 35 hours of professional development—is wholly inadequate, as this tells patients and the public nothing about the quality of nursing and midwifery practice undertaken by the registrant. There is also no routine assessment of whether nurses and midwives have even met this minimal standard. The NMC instead relies on honesty within the profession and “whistle-blowing” when registrants are dishonest. For many nurses and midwives this may well be adequate, but for a significant minority, including those most at risk of manifesting low professional standards, it may not be. (Paragraph 31)
14. The Committee supports the NMC’s risk-based approach to the current re-registration process. However, we are concerned that there are nurses and midwives who could be failing to meet the already unacceptably low standards for re-registration but who do not come to the attention of the NMC and are therefore re-

registered unchallenged. Registrants must feel that their regulator could call in their re-registration evidence at any time and as such the NMC should undertake an annual random audit of the registration renewal evidence supplied by a sample of registrants. (Paragraph 32)

15. The Committee will monitor progress against the 2014 deadline for the introduction of revalidation by the NMC at subsequent accountability hearings. (Paragraph 33)
16. Revalidation of nurses and midwives is a significant undertaking that the NMC is progressing with due caution. The Committee notes that statutory supervision of midwives is a tried and trusted means of assuring the quality of midwifery practice. The NMC should consider the costs and benefits of extending the statutory supervision framework as a potential means of delivering an effective revalidation process for all registrants. (Paragraph 39)
17. The NMC needs to ensure that it monitors the number of nurses and midwives who retire, leave the profession, have conditions placed on their practice or fail revalidation. It must develop and share this evidence with employers to ensure that the future workforce planning includes the developing outcome of the revalidation process. (Paragraph 40)
18. The Department of Health must clarify how it will maintain the continuity of statutory supervision of midwives through Local Supervising Authorities once Strategic Health Authorities are abolished. (Paragraph 41)
19. Nurses and midwives from the European Economic Area and Switzerland seeking to practice in the UK cannot routinely be language and competence tested by the NMC. The NMC, along with other professional regulators and the Government is working towards resolution of this with partner organisations across Europe. The Committee takes the view that the current legal framework is at odds with good clinical practice, which is clearly unacceptable. (Paragraph 45)
20. The Government, the NMC and the other health professions regulators must now grasp this as a significant risk to patients and dramatically pick up the pace in resolving or mitigating it. (Paragraph 46)
21. The Committee is concerned that waiting for regulatory action at a European level will expose patients to a high risk over an unacceptably long period of time. We would like to see prompt action on this matter along the lines taken by the GMC where Responsible Officers sign off a doctor as competent and fit to practise. (Paragraph 47)

Proactive regulation

22. We welcome the NMC's initiative in opening proactive investigations into registrants without a formal referral from an employer, a member of the public or another professional. (Paragraph 50)
23. The NMC's plans for investigation of and intervention in a healthcare organisation where concerns are being raised is a creative and interesting approach to regulating

what is a large group of professionals working across a variety of settings. It offers the NMC another tool to strengthen public protection. (Paragraph 55)

24. We do feel however that whilst the power to look at the quality of educational environments gives the NMC “a foot in the door”, clear power must be established in law for further expansion of this role, and we encourage the Government and the NMC to work together to develop this approach. The Committee would particularly like to see the NMC responding to trends in outcome and complaints data from NHS and social care providers. (Paragraph 56)

The future of regulation

25. As previously mentioned, the Committee has ongoing concerns about the care and treatment of older people both in hospitals and care homes. Of particular concern to the Committee is the lack of regulation of a range of groups who undertake many basic nursing care tasks. (Paragraph 63)
26. The Committee endorses mandatory statutory regulation of healthcare assistants and support workers and we believe that this is the only approach which maximises public protection. The Committee notes that the Government intends to give powers to the relevant regulators to establish voluntary registers for non-regulated professionals and workers, but would urge it to see healthcare assistants, support workers and assistant practitioners as exceptions to this approach who should be subject to mandatory statutory regulation. However, the NMC needs to make significant improvements in the conduct of its existing core functions (such as in how it manages fitness to practise cases) before powers to register these groups are handed to it. (Paragraph 64)

Formal Minutes

Tuesday 19 July 2011

Mr Stephen Dorrell, in the Chair

Rosie Cooper
Dr Daniel Poulter
Chris Skidmore

David Tredinnick
Dr Sarah Wollaston

Draft Report (*Annual accountability hearing with the Nursing and Midwifery Council*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 64 read and agreed to.

Resolved, That the Report be the Seventh Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

[Adjourned till Tuesday 6 September at 10.00 am

Witnesses

Tuesday 14 June 2011

Page

Professor Dickon Weir-Hughes, Chief Executive and Registrar, **Dr Katerina Kolyva**, Assistant Director for Nursing and Midwifery Policy, and **Jackie Smith**, Director of Fitness to Practise, Nursing and Midwifery Council.

Ev 1

List of printed written evidence

1	Department of Health	Ev 11
2	Nursing and Midwifery Council	Ev 16
3	Nursing and Midwifery Council supplementary	Ev 20
4	Royal College of Midwives	Ev 21
5	UNISON	Ev 23
6	A Dignified Revolution	Ev 25
7	The Patients Association	Ev 26
8	Campaign Against Unnecessary Suspensions and Exclusion (UK)	Ev 29
9	Nursing and Midwifery Council supplementary	Ev 31

List of Reports from the Committee during the current Parliament

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2010–12

First Report	Appointment of the Chair of the Care Quality Commission	HC 461-I
Second Report	Public Expenditure	HC 512 (Cm 8007)
Third Report	Commissioning	HC 513 (Cm 8009)
Fourth Report	Revalidation of Doctors	HC 557 (Cm 8028)
Fifth Report	Commissioning: further issues	HC 796 (Cm 8100)
First Special Report	Revalidation of Doctors: General Medical Council's Response to the Committee's Fourth Report of Session 2010–11	HC 1033
Sixth Report	Complaints and Litigation	HC 786
Seventh Report	Annual accountability hearing with the Nursing and Midwifery Council	HC 1428
Eighth Report	Annual accountability hearing with the General Medical Council	HC 1429

Oral evidence

Taken before the Health Committee

on Tuesday 14 June 2011

Members present:

Mr Stephen Dorrell (Chair)

Rosie Cooper
Yvonne Fovargue
Andrew George
Mr Virendra Sharma

David Tredinnick
Valerie Vaz
Dr Sarah Wollaston

Examination of Witnesses

Witnesses: **Professor Dickon Weir-Hughes**, Chief Executive and Registrar, **Dr Katerina Kolyva**, Assistant Director for Nursing and Midwifery Policy, and **Jackie Smith**, Director of Fitness to Practise, Nursing and Midwifery Council, gave evidence.

Q67 Chair: Good morning and thank you for coming. Could I ask you to open the session by introducing your team?

Professor Weir-Hughes: Certainly. I am Dickon Weir-Hughes. I am the Chief Executive and Registrar of the NMC. On my left I have Jackie Smith, Director of Fitness to Practise. On my right I have Dr Katerina Kolyva, who is our Assistant Director for Policy but here specifically to talk about European and international issues in which she is an expert.

Q68 Chair: Thank you very much. I would like to open the questioning, if I may, by asking you to speak briefly about the background to how the NMC got to where it is now. The phrase that was used some years ago was that there was “a serious weakness in its ability to protect the interests of the public”, following which there were changes in the board level and internal changes. Could you simply update the Committee as to where you feel you have got to in the process of sorting out the internal affairs of the NMC?

Professor Weir-Hughes: Certainly. The NMC and its predecessor bodies have been in existence since 1919. The NMC itself has been in existence since 2001 and inherited a rather a large financial problem from its predecessor organisation. That is detailed in our written submission.

The problem to which you are alluding, I think, was in 2007–08 and culminated in a special review by CHRE in 2008 which did, as you say, indicate quite a lot of issues, particularly in the area of fitness to practise. It is important to point out that fitness to practise is one of several statutory obligations we have. It is a very important one, but it is just one. It was in that area that CHRE found the majority of the issues. A new Chairman was appointed, a new Council was appointed and we have made some very significant changes to Council, then and since in fact. I started in November 2009. Since then, on the operational side, we have made a tremendous number of changes, which I could bore you with all day, but it is a very different style of operation and a very different organisation than the one I walked into in November 2009.

Q69 Chair: We will want to spend the majority of the time, probably, on fitness to practise and associated issues, but you said that there are other issues, implying they were potentially of equivalent importance, which perhaps slightly surprised me.

Professor Weir-Hughes: Not in terms of problem, but in terms of duty: our duties around midwifery—supervision, for example—which are in our Order and our legislation; our duties around education, which have always been there; and standard setting, which has always been there. As we move forward and as we have really tackled our fitness to practise issues, we hope it will enable us to spend much more time on those other areas of our duties, which, I think it could be argued, could prevent things happening. Fitness to practise is terribly important, but you are really closing the stable door. I am much more interested in prevention. As we move forward, that is the area we would like to be seen to be focusing on.

Q70 Chair: The area of concern the Committee will want to explore is the extent to which your fitness to practise procedures are effective and, against the background of a commitment to move towards revalidation, whether this is a process that actually delivers improved standards of delivery of care by nurses and midwives.

Professor Weir-Hughes: Would you like me to talk about fitness to practise?

Chair: Yes, please.

Professor Weir-Hughes: I will start and then hand to my colleague. The fitness to practise team consists of 160 people. We deal with thousands of cases. Jackie will give you the details. Certainly, in the last year, we have seen a dramatic improvement, and that has been recognised by CHRE and others. In the next couple of weeks, CHRE will be publishing their latest audit. It is a shame it was not published before today, but I think, once again, that will demonstrate we have really tackled many of the key issues. We can demonstrate that. We are certainly on the right path.

There are some things that we have detailed in our submission we would like help with and those relate to our legislation, in particular with fitness to practise. When I look at that legislation and compare it to that

which many of the other regulators use, I sometimes think it was written by somebody who wanted to make life difficult for us. Frankly, if you wanted to make it the most awkward, inconvenient and time-consuming legislation, you would have written it like that. We have been working with the Law Commission, as you know, who have recently been asked to look at the legislation used by all of us. We have also made some very particular requests for changes to the Department of Health, and those are detailed in our submission, but we will happily discuss them in more detail. We are acutely aware that we can do a lot in terms of improving operational processes, but we will reach a point fairly soon where we cannot do any more to improve efficiency without a change in legislation.

Chair: We will come on to that but Virendra will start on the detail.

Q71 Mr Sharma: The NMC recommends that registrants keep a portfolio of their CPD activity and states, in its handbook, that PREP portfolios will be audited. At the same time, CHRE says that: "The NMC does not audit registrants' continuing professional development (CPD) portfolios." How many continuing professional development portfolios has the NMC audited in each of the last five years?

Professor Weir-Hughes: The PREP portfolio has been something that nurses have been required to do since 2001. I do one myself, and I am pretty familiar with the process. Each three years, the nurse or midwife signs to say that they have done a minimum number of hours of education and a minimum number of hours of practice. We have, as you know, nearly 700,000 registrants so we largely have to take that on trust.

We now use a risk-based approach for calling in PREP information but we do not have the resource to do it systematically across the entire register. The risk-based approach we would use would be if a nurse or a midwife comes to our attention for some other reason. For example, if they have had a caution or a conviction from the police then we might call in their PREP evidence; in other words, certificates of attendance, they have to write something to say what they have learnt from a particular educational initiative, and that sort of thing. The PREP system, in a way, leads into revalidation. What we are working on now is revamping that for 2014 when we start revalidation proper.

Q72 Mr Sharma: At present, if I take it in general terms, you do not have planned or routine check-ups or reviews.

Professor Weir-Hughes: As I say, we are doing it on a risk-based approach. We could not possibly call in 700,000 PREP portfolios. It would be completely unmanageable.

Q73 Chair: Virendra's specific question was a number, how many?

Professor Weir-Hughes: I would have to write to you with the exact number. I do not know off the top of my head.

Q74 Mr Sharma: But you agree that there may be cases which escaped without knowledge, where they might have been found. I worked in the social care field, so I am quite familiar with how the system works at local authority level. There is a fear that there might be staff members who are guilty of something, who may not be in a position to stay in the job but, because of the lack of resources, they escape that route.

Professor Weir-Hughes: No. I think there are two different issues here. In terms of CPD—continuing professional development—and whether or not people have worked a sufficient number of clinical practice hours, that is one thing. If people are "guilty" of something, then they would be dealt with through our fitness to practise process.

Q75 Mr Sharma: I said I am quite familiar with the system and that is why I am putting it in general terms, that they can escape those hours as well.

Professor Weir-Hughes: Theoretically, they could.

Q76 Chair: How many reviews have you done?

Mr Sharma: They will give that in writing.

Chair: You will give that in writing.

Professor Weir-Hughes: Yes.

Chair: Fine.

Q77 Mr Sharma: How satisfied are you that registrants, in returning their Notification of Practice forms, have actually undertaken 450 hours of practice in the previous three years?

Professor Weir-Hughes: The interesting thing is that, increasingly, colleagues whistleblow if they feel somebody they know has not done that. We would then refer those people to fitness to practise because, in fact, they have submitted a fraudulent entry. That is the way in which we deal with it. I do not know what I do not know, so I cannot tell you how many may have done that.

Q78 Mr Sharma: Do you have any examples where you think the whistleblowers came around and told the seniors that this did not happen?

Professor Weir-Hughes: Examples of whistleblowers, you said?

Mr Sharma: Yes.

Professor Weir-Hughes: Yes, absolutely. I cannot give you examples of whistleblowers, obviously, because they are whistleblowers.

Q79 Mr Sharma: No, I do not want the names. But you can give us the figures.

Professor Weir-Hughes: Again, I would have to write to you. I do not have those figures in my head.

Mr Sharma: Thank you.

Q80 Andrew George: I want to raise questions about your role in monitoring what is going on in the service itself. Clearly, your responsibility is not to advocate on behalf of those who are registered with you. On the other hand, all of the inputs into what is frontline nursing suggest that there must be intense stresses at the frontline in certain circumstances: in terms of staffing ratios on acute wards; the acuteness of

14 June 2011 Professor Dickon Weir-Hughes, Dr Katerina Kolyva and Jackie Smith

patients on those wards as they are discharged at an earlier and earlier rate; and in terms of patient throughput. The Royal Colleges—certainly the Royal College of Midwives—have identified serious shortages of midwives, for example. There is also evidence that, as a result, in certain circumstances, on the margins, professional standards may be being compromised because of those pressures. Could you comment on what you see—in both your validation and also monitoring of the profession—as the pressures under which nurses and midwives operate and to what extent they are the cause for the compromising of professional standards, or whether the issue of concern is, if you like, simply of low competence levels? Could you comment on that kind of tension?

Professor Weir-Hughes: Yes. It is quite a big topic but a very interesting question. Let me make it very clear that, in my opinion and the opinion of the Council, there is never an excuse for poor quality care. We have and always have had a mechanism for people to escalate their concerns. It is quite clear—

Q81 Andrew George: Do you mean registered nurses?

Professor Weir-Hughes: Yes, absolutely, and midwives. It is perfectly clear in the code of conduct, and it always has been—back to the days of the UKCC—that a nurse or midwife who believes that care is being compromised must escalate their concerns. I clearly remember the day, as a student nurse, when I was taught about how to do that. That has been commonly known in nursing for years.

We thought that people did not perhaps grasp that and, last year, we published and sent to every single registrant detailed guidance that we wrote with “Public Concern at Work” on how nurses should escalate their concerns and when they should involve their director of nursing, their trades union, us and so on. We have had a very good response to that. In fact, I personally receive calls and correspondence as a result of that guidance.

In terms of the numbers of issues we see, it is quite difficult. There are certainly nurses and midwives—but more often nurses—whose competence one could call into question, and we have seen evidence of that in the last few weeks. It is important to point out that that is a very small number of the whole. Less than 1% get referred to us. Therefore, whilst those particular cases are hideous, they are, thankfully, small in number. That is quite important. We are very much out there now. I try and go to a hospital at least once a week somewhere across the four countries of the UK. We communicate very frequently with directors of nursing, human resource directors and heads of midwifery. We do a huge amount of stakeholder engagement and people do talk to us and tell us things.

I do not know if that goes some way to answering your question or whether I need to enlarge on something.

Q82 Andrew George: That is very helpful. But I wonder to what extent you are content about the opportunity for registrants to escalate, as you put it,

in those circumstances. Are you confident that can be escalated without risks both to their career and their professional position within the organisation itself? There are suggestions that there is a certain amount of intimidatory behaviour that happens in circumstances where there is an attempt to raise concerns in that manner.

Professor Weir-Hughes: First of all, it is important to point out that we are not a systems regulator, so, of course, we would work with a systems regulator such as the CQC in these sorts of situations. We have certainly seen situations where people have raised their concerns locally and no action has been taken. I am confident that if somebody contacted us—and I have evidence of this—we would do something about it. Certainly, in relation to Winterbourne View, when we had a whistleblowing call about that, we acted within the hour. That is one case.

Q83 Andrew George: On that point, are you saying that a registrant can go directly to you?

Professor Weir-Hughes: Yes, and we make that clear.

Q84 Andrew George: As the first activity—

Professor Weir-Hughes: We would prefer them not to come to us first. In our guidance, we clearly set out exactly what they should do.

Andrew George: How to escalate it, yes.

Professor Weir-Hughes: But we also say that, if they get no satisfaction locally, they must tell us. I probably get about one a week of those. Occasionally, they are vexatious, it has to be said, but those are in the minority.

Q85 Andrew George: The system of revalidation is due for implementation by 2014. In the meantime, what steps are you taking to ensure that standards are maintained to instil confidence in the Council itself?

Professor Weir-Hughes: It is a multi-faceted approach. Revalidation is only one element. Certainly, our revalidation work will always have to be risk based because we are two such enormous professions. I know one or two other regulators have done a lot of work with calling in paper-based information. We will never be able to do that unless we very significantly raise registration fees, which is not something we wish to do. Therefore, our system will always have to be risk based and online.

We have collected quite a lot of data already about the sorts of areas which we believe are risky. In brief, those are environments that we would regard as “not managed”. By that, I do not mean not managed at all but that they are not within a large managed system. For example, I would be less worried—and I think people would be a lower risk—about those working generally in a well-run NHS environment or a military environment than perhaps a very small, independently-run nursing home. We are beginning to be clear about that. I accept the concern that perhaps we should have moved more quickly on revalidation, but, in fact, one of the benefits of letting the GMC go first is that we can learn from them and learn, perhaps, from some of their mistakes.

Q86 Andrew George: In terms of that, obviously, there is going to be a great cost to revalidation. All those costs are going to be met by the registrants, are they?

Professor Weir-Hughes: They will be met by registrants.

Q87 Andrew George: Could you clarify what the cost is at present and what it is likely to be? Is that going to be affected as a result of the revalidation process?

Professor Weir-Hughes: We are not sure exactly what it is going to cost yet, but we believe we can use quite a lot of our existing IT systems to enable registrants to contact us for the purposes of revalidation. We have started that already, in fact, with quite a few other things that they can do online. We believe that is the only way we can do it. Our registrants currently pay £76 a year, which, together with the HPC, is the cheapest, by a very long chalk, of all the professional regulatory bodies. Although we may eventually have to put that up a little, of course, because one does, and we would not want to get into the situation that the UKCC did, we would not want to hike that up. Whatever we do needs to be proportionate and we are very much in support of the piece that was in the Command Paper about proportionality in relation to revalidation, making sure it is risk based and so on.

Q88 Andrew George: As practitioners, they are not, with respect, GPs and a lot of them are working part-time. On part-time nurses' salaries, with all of the registration, the training and the requirements on an annual basis, one has to call into question whether some of them can continue to afford to practise as nurses. Is that not a concern of yours?

Professor Weir-Hughes: I suppose it is. Certainly nurses that I speak to out there all the time, generally, are comfortable about paying £76 a year. They understand the aim of regulation and most are quite proud to be regulated and registered. That is positive. They know that if they were a dental hygienist, for example, they would be paying £120 a year on a significantly lower salary. Most understand that we are probably reasonable value for money.

Q89 Andrew George: I have one last question on this. The local supervising authorities are responsible for statutory supervision and, of course, they are based with the SHAs. The SHAs are being abolished, so what is going to happen? What have you been told in terms of the supervision side of the activity?

Professor Weir-Hughes: We are extremely concerned about it. We have written numerous letters to try and seek clarification. We have made some suggestions about where the LSAMOs could be physically located and to whom they should report. We have also discussed it with the CQC, which was a possible home for them. The view of the CQC is that they would not want to take that on. They believe that, in fact, they should work directly to us, which is something that is perfectly possible and we have made that suggestion to the Department of Health. They report to us in terms of the legislative framework within which they

work anyway, so it would be a case of us employing them as well, if you see what I mean.

Andrew George: I see.

Professor Weir-Hughes: It would not be an enormous change.

Q90 Andrew George: But that only applies to midwives and not to nurses. Is that right?

Professor Weir-Hughes: It does. It is about midwifery supervision.

Q91 Andrew George: Is it your view that that role should be extended not merely to midwives but to other—

Professor Weir-Hughes: That is very interesting, because it is one of the things we have been discussing. The difference is, of course, that there are less than 40,000 midwives and there are about 630,000 nurses. It is a monster, really. We are very interested in being proactive and midwifery supervision is proactive. I think there are some hallmarks of midwifery supervision that we could pull through into nursing to very good effect. We are certainly thinking about that.

Andrew George: Thank you.

Q92 Rosie Cooper: May I quickly jump in and return to part of the earlier questioning from Andrew? I would like to ask you how many calls you got from Mid Staffordshire and what action you took, both before and since the matter became public?

Professor Weir-Hughes: Like the Chief Executive of the GMC, I go to Mid Staffordshire on 27 June. We have detailed, in our submission there, the very small number of contacts that we had from Mid Staffordshire. I think it was three.

Q93 Rosie Cooper: Three nurses contacted you. What action did you take?

Professor Weir-Hughes: These are cases that go back quite some time. Jackie, do you want to speak on this?

Jackie Smith: In fact, there were three complaints. There weren't three nurses who contacted us. I do not think our records show that nurses made contact with the NMC.

Rosie Cooper: Therefore, that would suggest nurses were quite happy with the level of care that was being delivered at Mid Staffordshire. That is the point I am getting to.

Q94 Chair: It suggests something slightly different, doesn't it—I know you were in during the GMC session as well—that the nurses there had a professional obligation to report something that they should have seen going on around them and they did not respect that professional obligation?

Professor Weir-Hughes: Precisely.

Q95 Chair: The question then, for the NMC, is what it is going to do to follow up that principle in Mid Staffordshire and in Winterbourne View of the nurses whose individual practice may have been blameless but who did not respect their professional obligation to be interested in the care going on around them.

14 June 2011 Professor Dickon Weir-Hughes, Dr Katerina Kolyva and Jackie Smith

Professor Weir-Hughes: Where we can identify individuals, we have opened files. We currently have about 40 files open on nurses at Mid Staffordshire. Some of those are people who are quite senior and should have been reporting things. Others, of course, relate to clinical matters and so on. There is a whole range of things. The number is 40 now. We have had more than 40 in total, if that makes sense. Some have finished and others, I expect, will come into the system. It is quite a lot.

Q96 Chair: I am surprised by how few it is. How many nurses are employed in Mid Staffordshire Trust?
Professor Weir-Hughes: Several hundred.

Chair: Precisely.

Professor Weir-Hughes: In respect of whether or not people should have escalated things, I suppose it is few.

Andrew George: But it was a narrow set of specialties.

Q97 Rosie Cooper: In those cases that you have looked at, what action did you take?

Professor Weir-Hughes: There is a whole range.

Jackie Smith: Yes. There were three cases that we were able to identify, looking at our system going back in the past, but, as Dickon says, we have about 40 that are open at the moment and they are at various stages in our fitness to practise process.

Q98 Rosie Cooper: How long will that take? How do the public get confidence in a system where the results are there for all to see and in the public eye and yet the authorities seem to take for ever to get to sorting it out?

Jackie Smith: How long it will take is a very good question. Of course, one has to understand that, when we talk about this, we are talking about removing the individual's right to work. It is a necessarily legalistic process, which means it is lengthy. Our legalistic process, I am afraid, is very cumbersome, as we have stated in our submission. It is not quick.

Q99 Rosie Cooper: I genuinely don't know how to respond in the sense that if I was a member of the public I would be suggesting you streamlined your processes and got on with it.

Professor Weir-Hughes: We would love to.

Jackie Smith: We have written, on a number of occasions, for changes to our legal framework because that is precisely what we wish to do.

Q100 Rosie Cooper: Again, is that the same as the General Medical Council in that you need the Department of Health?

Jackie Smith: We do.

Professor Weir-Hughes: Absolutely.

Q101 Chair: It is also true, is it not, to say that the obligation to report that rests on every professional—failure to deliver, in some circumstances, anyway—does not necessarily lead to removal of fitness to practise? There are a range of sanctions.

Jackie Smith: That is true. Not every breach of the Code necessarily means that fitness to practise is

impaired. But, in circumstances where someone turns a blind eye or colludes with activity, that is something that we would take very seriously.

Professor Weir-Hughes: Or, indeed, designs activity in such a way, which was the case.

Q102 Rosie Cooper: Have you dealt with any cases which did not require this long legalistic process where the sanction might have been a lot less severe? Have you dealt with those? Have any gone through the bar yet?

Jackie Smith: In Mid Staffordshire?

Rosie Cooper: Yes.

Jackie Smith: No, not yet. However, unlike the GMC, we have not decided to wait until the outcome of the public inquiry. We have decided to pursue our investigations, mindful of the fact that it is a long process and the public, quite rightly, should expect us to do our business effectively and quickly, but we need the tools to be able to do that. We do not believe we have that at the moment.

Q103 Chair: Can I ask a broader but related question? Do you believe that nurses take seriously the obligation they have to be interested in professional practice going on around them? Do you think they take that sufficiently seriously?

Professor Weir-Hughes: In my own experience as a nurse, yes. Certainly, in places I have worked, yes. As I go around the four countries of the UK, the vast majority of nurses and midwives I meet do take it very seriously. Indeed, some have become unpopular as a result of taking things forward, so I believe that they do. My view is that that is not really enough. We need all of them to be committed to that rather than just the majority. Perhaps that is a rather idealistic standpoint, but we need people to believe in the Code of Conduct—it clearly states what they have to do—and we need them to take things forward if they see things that are not right.

Q104 Chair: If you are going to deal with those who do not embrace it as a concept positively, they have to understand that they are open to professional criticism and sanction if they do not respect the obligation which is intrinsic to being a professional person in the delivery of health care.

Professor Weir-Hughes: Yes, and we do push out that message on a very regular basis in our materials and when we are talking to nurses and midwives. We really make that clear but, of course, we need people to act rather than listen to us.

Q105 Dr Wollaston: I think we would all accept that there is a crisis of confidence, particularly around care of the elderly in hospitals and nursing homes. Could you comment on where you see the role of switching to an all-degree profession has come into this? The public perception is that nurses have stepped back from some of those roles in providing basic nursing care, such as helping to feed patients. Are we then having a group of people carrying out those—previously nursing—roles who are not covered at all by the NMC? Do you have any plans to address this or make recommendations? Where do you see it going?

Professor Weir-Hughes: Thank you for asking that question. We are positive about the fact that registered nursing is now degree based. We have seen the benefits of that in Wales, and they are very real benefits. Their recruitment figures are way up and their attrition numbers are way down. It has been an enormous success. We are very positive about that, and, of course, we have looked at the evidence from other countries where it has also been extremely positive.

However, that is not to say that that has necessarily been communicated very effectively to the public. There is an interesting discussion I have with people as I am out and about around the fact that, "Isn't it a shame, Dickon? This person is so nice—she is not very bright, but she is very nice—and she'd make a great nurse." When you say, "She's not very nice but she'd make a great surgeon," or, "She's not very nice, but she'd make an airline pilot," would that be acceptable? We have this rather peculiar notion still, I think—and perhaps it is a peculiar comment to come from a man in nursing—which is rather sexist. I am not sure what motivates that, but it is very interesting and I am not sure we have done a very good job in communicating the importance of having well-educated nurses.

Q106 Dr Wollaston: Sure, but what I am saying is that you now have a group of people carrying out roles that, in the past, were traditionally carried out by perhaps the state enrolled nurse grade who are now not covered at all by the NMC, whereas the SEN grade was covered by the NMC.

Professor Weir-Hughes: It was.

Q107 Dr Wollaston: It is a group of people, and a particular area of nursing that is of huge public concern at the moment—and rightly so—that has no professional oversight at all.

Professor Weir-Hughes: Absolutely, and I completely agree with you.

Q108 Dr Wollaston: How are we going to address that?

Professor Weir-Hughes: We believe that health care support workers should be regulated, not necessarily in an identical manner to nurses and midwives but there should be a regulatory framework that is not voluntary. I do not believe that people who are unpleasant want to join voluntary registers, so we believe it should be mandatory. Certainly we believe that there should be a differentiation between regular health care support workers and this new grade in the NHS called "an assistant practitioner" which we detail in our submission. For the sake of everybody, assistant practitioners are senior health care support workers who function at a level that one would typically have thought of as the state enrolled nurse. They are doing things that most members of the public would regard as nursing. They are putting up drips; they are suturing in A&E departments and this sort of thing; and they do fairly invasive procedures—giving drugs—but they are not regulated.

Q109 Dr Wollaston: But it is the basic things that people are concerned about—feeding patients, washing them, helping them, taking them to the toilet.

Professor Weir-Hughes: I agree and that is why I said a health care support worker should be regulated. But I think this other group should be slightly differently regulated because if one is using a risk-based approach, they are performing higher risk activities.

The other piece of all of that—what we have seen, certainly, in the nursing home sector—is that while those individuals that you are talking about are not necessarily performing high risk activities, they are in a high risk environment because they are not being well supervised. That is the other piece that we worry about and is the other motivation for us to ensure that those people are regulated.

Q110 Dr Wollaston: You use the term "high risk". It is very high risk to the patients.

Professor Weir-Hughes: It is. I agree.

Q111 Dr Wollaston: It might not be high risk in terms of technical ability to put in a drip, but this is the area that we absolutely have to address.

Professor Weir-Hughes: I agree.

Q112 Dr Wollaston: Do you think there is a case for saying that all of this should come under the umbrella of the NMC?

Professor Weir-Hughes: Yes, I do. The reason I say that is because a number of other precedents have been set. The other regulators who have assistant roles—the dentists, for example, the opticians and the pharmacists—all regulate the people to whom they delegate. It would, therefore, make most sense for us to regulate the people to whom we delegate. Certainly, we would be very interested indeed in taking that work forward.

Dr Wollaston: Thank you.

Q113 Chair: I understand the logic of that. Can I put the counterpoint, because it certainly would be put to us, that, within the nursing and midwife population already, we have been discussing the fact that the vast majority of your registration processes leading into revalidation you have to take on trust? Therefore, I wonder whether extending the process of registration in the way you have been suggesting in response to Sarah is the most effective way of introducing real quality checks—quality guarantees—into the care of those vulnerable patients. Are there other steps—for example, around the ownership by the registered professionals, who already work in those homes, of the concept of quality care delivery—that might be more effective ways of delivering the objective that we all share?

Professor Weir-Hughes: I do not know about more effective, but they would certainly be a way. I suppose that is why I carefully used the term "regulatory framework" rather than "regulation". I firmly believe that those more senior people should be registered. However, maybe for the rest there is a framework that could be developed which achieves the same goal. Implicit in that is ensuring that there is standardised training, that there are standards around recruitment

14 June 2011 Professor Dickon Weir-Hughes, Dr Katerina Kolyva and Jackie Smith

and induction, which we do not currently have, and that there is some mechanism for dealing with people who do not perform. Of course, right now there is not and we get a lot of calls, as we said in our submission, from people wanting to refer a “nurse”. The person is not a nurse at all but a health care support worker. We, therefore, can do nothing about them. We are very concerned about all that. I don’t think we have one fixed model in our heads of how this might look. What we would welcome is a robust debate and I think now is the right time to have that debate.

Chair: I think it is happening anyway.

Q114 Valerie Vaz: Let us turn now to complaints because our evidence is that complaints against nurses and midwives have increased by 102%. How do you account for that?

Professor Weir-Hughes: I am going to turn to Jackie in a moment, but all the regulators have seen an increase, although not quite as significant as ours, it has to be said. We have provided some detail particularly about those cases we have opened using our proactive agenda.

Jackie Smith: In fact, the number of referrals for this year compared to last year is up 41%. It was 4,211. The reasons for that are very complex. All the regulators struggle to answer the question, “Why is it that more people complain?” It is quite a difficult thing. It can often be because there is a public inquiry going or a programme has gone out which illustrates poor care, but it is also about the regulator being proactive, as Dickon says. We are being proactive. We are saying to the people who matter, “This is what we do and we are here to regulate nurses and midwives and deal with the most serious concerns.” The NMC profile has been raised in the last couple of years, which may explain it, but this is guesswork because I do not think we or the other regulators really know.

Q115 Valerie Vaz: What sorts of complaints are coming through?

Jackie Smith: It is a mix of things. Sometimes it is around poor care, sometimes misconduct, police convictions and cautions or social behaviour which does not necessarily fit with the profession—a range of things. There is no particular area where we are seeing a dramatic increase.

Q116 Valerie Vaz: Do you see use of complaints as a way—because my colleague Rosie never sees things as complaints but as ways to improve situations—to improve quality of care?

Professor Weir-Hughes: We definitely do. That is quite a new thing for the NMC, though, and it was important that we focused on getting fitness to practise sorted out. Certainly, we are very interested in the analysis of complaints. We have a statistician working with us at the moment from St George’s Medical School. He has taken the cautions and convictions as a starter and is looking at where those are from, who committed those things, whether they are relevant to fitness to practise and so on. But we are going to extend that. We know, for example, that some of those competence problems, rather than conduct problems, relate to assessment and decision making. As a result

of that, we have kicked off a piece of work this year to revamp a document that was called “Records and Record Keeping,” which was a bit old fashioned, frankly, and did not really hit the nail on the head. That is going to be changed into something which is about a standard for assessments, decision making and care planning. That is a good example.

The other area is delegation, which we have touched on, but in fact we are taking the three lines from the Code of Conduct and turning that into a standard for delegation because we know, from some of these incidents we have seen, that delegation is a problem. Colonel Wendy Spencer, who was Matron-in-Chief of the Army, has joined us on secondment to do that piece of work over the next year.

Q117 Valerie Vaz: We all know that Wales had a degree entry level for nurses since 2004. Do you see a difference in the number of complaints coming through from Wales than from England?

Professor Weir-Hughes: We have very few complaints from Wales anyway, and always have because it is a small country. But I think it is a little too early to tell. We are very interested to pick up on complaints or referrals about a nurse in their first year of registered practice. The reason for that will be obvious, that it would indicate they probably should not have registered in the first place—particularly if it is a competence-type issue. We are very mindful of that. As the years go by, of course, we will be able to track more of those complaints.

Q118 Valerie Vaz: In terms of your fitness to practise, it is extraordinary that they take over two years—it is not good for the profession and it is not good for the person being investigated—but almost one-third of them have no case to answer. Could you break down why that is and what category of cases they are?

Jackie Smith: Yes. I am going to sound like I am boring you with the same response but, unlike the GMC, we are not able to assess a referral at the outset and say, “This is something where there clearly is not an issue here that we need to investigate because it does not raise a fitness to practise concern.” It has to go to our investigating committee and the investigating committee will then make a decision as to whether there is a case to answer. At the moment, in 45% of cases that go to the first stage, the investigating committee decide there is no case to answer.

What we have recently done with our Council is to suggest, in those cases, that there is a better way of establishing that: through early engagement with employers—seeking information from employers about whether there are some wider concerns and engaging with them about that original referral. If the investigating committee decides it is something that should be investigated, it then goes off for an investigation but it then has to go back to another investigating committee to decide whether there is a case to answer. If they decide there is a case to answer, it goes off to another three-stage process before we can have a final hearing. That is our legal framework.

Q119 Valerie Vaz: What sort of categories are there in terms of your fitness to practise cases?

Jackie Smith: Lack of competence, ill health, misconduct and overseas determinations, or a determination by another body.

Q120 Rosie Cooper: When was that legal framework designed?

Jackie Smith: It was 2004.

Q121 Chair: I thought you were going to say about 1840. That sounded like three or four—I have lost count—processes that the case has to go through, whereas, in the GMC, the issue was almost the other way round, that the panel made a decision they had no right of appeal from at all.

Jackie Smith: We would love to have a legal framework that mirrors the GMC because what they have is the ability to investigate within a short period of time and make a decision at the end of that investigation process as to whether a case goes to a public hearing. We have to go through a number of committee stages before we can make that decision.

Q122 Chair: Is that in primary legislation?

Jackie Smith: Yes.

Q123 Chair: It requires a change in primary legislation to change it.

Professor Weir-Hughes: It does.

Q124 Rosie Cooper: Did you support that at the time?

Jackie Smith: I used to work at the GMC. I have been at the NMC for 10 months.

Q125 Rosie Cooper: No. Did the NMC support that at the time?

Jackie Smith: I don't know.

Professor Weir-Hughes: We can't answer that. None of us was there then.

Q126 Rosie Cooper: If I may come back to it, do you think—and please do not be offended at this question—as an organisation that your fitness is good to go to get more of these powers when, historically, you have had a chequered past in the last, certainly to my knowledge, three to four years, and in 2009–10, I think it was, the CHRE found that you still had some serious problems? Yes, you want to change all this and get to be a more authoritative, dynamic and decision-making body, but if you cannot regulate yourselves, what confidence can people have in you getting more powers and being able to deliver better quality for the public?

Jackie Smith: That is, obviously, a very fair question. What the CHRE did identify was that the NMC was not able to prioritise and identify high risk cases. It did not have a system in place for doing that. That is something we have addressed. We have had a system in place since January this year which identifies high risk cases and prioritises them. That is our core function. Our core function is to protect the public. We have a system in place now which allows us to do that early-warning assessment and allows us to take

action on an interim basis, where we need to, while we investigate.

One of the changes that we are seeking, however, is to allow the registrar to refer to an interim order panel to make that decision. At the moment, the legal framework is such that we have to go to a committee to ask if we can go to another committee to make an interim order. Can I answer your question by saying that I think part of our process is much, much better? There is still some work that needs to be done, but, in terms of making that early risk assessment, we are in a much better place and much more fit to practise to do that.

Q127 Rosie Cooper: Rather like the Health Bill, I reckon you should rip it up and start again. We have been doing a complaints and litigation inquiry and we have heard about a significant number of cases of the failure of nursing care with older people. In fact, I have seen it myself. The Ombudsman highlighted similar fears and it has been all over the press. What do you think is causing that crisis in the nursing of older people?

Professor Weir-Hughes: I thought Jackie would turn to me for that. It is a very big question. It is certainly a very big concern for us. Many of the systems that we have in health care are simply not geared up for the length of time that people now live and the increased technologies that are available—drug therapies and so on. In a way, that was predictable. We have seen, of course, the closure of those large care-of-the-elderly hospitals, which was thought to be a good thing at the time and, similarly, the closure of the large learning disability and mental health institutions, which was thought to be a good thing at the time. Perhaps, for a system which is in some places better but in other places not, one of the things we have been very focused on with our new degree standard for nurses entering the profession is that a very heavy chunk of that has to be about care of the elderly. Moving forward, I would hope that those people would be more focused and more interested in the fundamentals of care, and so on.

Q128 Rosie Cooper: I think that most members of the public would fundamentally disagree with what you have said. I was surprised at your description of anybody who is not degree based in nursing. The reality is that there are very intelligent people who do not want to have a degree, who have a very caring attitude and would make great nurses. It is perhaps condescending to attribute everybody with being unintelligent if they do not have a degree. That is quite worrying. The question I would ask you is: in the hospital that I used to chair, what percentage of nurses today have masters degrees? Is that absolutely necessary for lots of people in their job?

To come back, what nurses would say to me, today, is that they are now stuck dealing with protocols and stuck at the nurses' station and the real caring is the caring that you are trying to tell me a degree-based nurse would do—spending their time on a ward feeding a patient and plumping up pillows. Frankly, that is not reality and it is not reality today. They see themselves as doing the more difficult things.

14 June 2011 Professor Dickon Weir-Hughes, Dr Katerina Kolyva and Jackie Smith

Andrew George: As clinicians.

Rosie Cooper: Yes, as clinicians. That is absolutely right. I am trying not to use a phrase I normally use when I am describing this. They would see themselves doing that. They do not see themselves doing the things you have just talked about, which is the basic day-to-day care of the elderly. How having a degree can make you do that better leaves me genuinely bewildered.

Professor Weir-Hughes: That is not my experience as a nurse. I have to follow my own experience, and it is certainly not my experience as a director of nursing.

Q129 Rosie Cooper: I think you will find the country will be screaming when they see this transmitted. They will be screaming in disagreement with you.

Professor Weir-Hughes: Perhaps, but I have to follow my own experience. My own experience is that there are a lot of graduate nurses who are excellent.

Q130 Rosie Cooper: Absolutely. I am not saying that there aren't. You are trying to say that being a graduate, wanting to be a clinician and wanting to go down that line will mean a lot of nurses will want to do the caring bit. I am suggesting that is not the same.

Chair: Andrew wants to come in on this point as well.

Q131 Andrew George: What both Sarah and Rosie have shown in the nature of their questions is this clear blurring of the distinction between care and clinical nursing. Part of the question is: do you not think that clear confusion on the part of the public that does apply on a very regular basis—a lot of people refer to nurses when in fact they mean care assistants—in the caring role is part of the reason why there is such a difficulty in conveying what clinical nursing is to the general public and being able to distinguish between their role and a lot of the failings in the caring professions which are also going on?

Professor Weir-Hughes: I agree with you. There is a huge confusion. Often it is not helped by the fact that people look very similar. It is difficult—

Q132 Andrew George: They are dressed very similarly.

Professor Weir-Hughes: They are, and we have certainly spoken to hospitals about that. It is very difficult, particularly when everyone is wearing scrub suits and this sort of thing, to know who anybody is. In fact, it was a major topic at our last Council meeting: how do we encourage hospitals to make sure they give people something to wear that clearly indicates who they are? We are firm believers in that. When I was speaking earlier about the state enrolled nurse, our desire would be to have, clearly, a registered nurse who was a graduate but to have enrolled nurses—or an equivalent to the enrolled nurse—who was there in support of those people. That is what we have been saying pretty consistently for the last 18 months.

Q133 Rosie Cooper: I wouldn't disagree with that.

Professor Weir-Hughes: To bag it up, these assistant practitioners, most of whom are desperate to be regulated, would like to be nurses. They want to be

seen as part of the nursing family, but can't do that right now. We would warmly welcome that. Then there is the health care support worker piece which also needs to be dealt with. Hospitals need to be clear with the public that, "This person is a health care support worker" and "This person is a nurse", both are valuable but they have slightly different roles. From where we sit, it is difficult for us to insist that all hospitals and health care providers do that.

Q134 David Tredinnick: I would like to move on, if I may, to language and competence testing issues. As I understand it, nurses from outside the European Economic Area, plus Iceland, Liechtenstein, Norway and Switzerland, are tested for competence in the English language and must meet a basic standard. However, the NMC is prohibited by law from systematically testing the language competency of nurses and midwives who trained within the European Economic Area. Do you see that as an alarming situation?

Dr Kolyva: It is indeed. If I can maybe make the distinction, the EEA will mean the EU27 plus Norway and Liechtenstein, and the same rules apply to Switzerland, so Switzerland is considered to be within that EU Directive. Any other country outside the European Economic Area would be considered what we call "overseas". Like the GMC, we have different standards for these applicants, so, for overseas applicants, or those who have been trained outside an EU Member State, we will ask them to provide evidence of IELTS 7—International English Language Testing System—which is a proficient user standard. We will also ask all of them to go through an Overseas Nurses Programme, which is a standard we set. For midwifery, there is an equivalent called Adaptation to Midwifery. There is a minimum of 20 days to a month, or it can be a maximum of a few months, and it is a period of supervised practice supported by theory. All overseas applicants to our register will follow that process.

For EU-trained applicants there are three routes. The first one is automatic recognition. This legislation is set by the European Union so these applicants will go automatically on the register because they fulfil requirements that have been set at the European level, and these are minimum training requirements. As to those who have considerable shortfalls, we have a lot of experience in this area, unlike the GMC, because nursing and midwifery are professions that vary considerably across EU Member States. Their scope of practice varies considerably. To give you an example, a midwife in the UK cares for a woman from the beginning of her pregnancy up to 10 days or two weeks after birth, or even longer, or looks after her for a long period of time. In several European countries, it would be a few days before birth and some hours after. They have a very different scope of practice. Therefore, yes, we do have concerns. Language is part of them, but it is a larger issue around minimum training requirements and scope of practice as well.

Q135 David Tredinnick: Broadly, you are satisfied with the status quo with minor quibbles. Is that right?

Dr Kolyva: We are not satisfied. We are satisfied with what we are allowed to do for overseas, because we follow our own rules, but with regard to the European Union, we seek support from you for changes to the legislation. The EU Directive on the recognition of professional—

Q136 David Tredinnick: I am sorry to interrupt, but do you think that nurses and midwives across the EEA, generally speaking, are trained to UK-equivalent standards?

Dr Kolyva: They are trained to EU minimum standards, which were set many, many years ago. They date back to the 1970s and they are minimum EU standards.

Q137 David Tredinnick: They are not to the high standards that we require as a country. Is that right, Professor?

Professor Weir-Hughes: Yes.

Q138 David Tredinnick: There is a difference.

Dr Kolyva: There is.

Q139 David Tredinnick: I would suggest to you that perhaps that is why we have had these highly publicised cases in recent years of nurses who have apparently not met the standards through confusion over language and different standards. Is that right?

Professor Weir-Hughes: Yes.

Q140 David Tredinnick: What additional powers do you require to ensure that the EEA or Swiss nurses and midwives, and the others who wish to practise in the UK, are able to speak English proficiently? What do you need to make sure that that language barrier is dissolved, please?

Dr Kolyva: Changing the UK legislation—guidance rather than legislation.

Q141 David Tredinnick: It is primary legislation—

Dr Kolyva: We need to work closely with the Department of Health, and we are.

Q142 Chair: It is more difficult than that, isn't it, because this is about free movement within the EU?

Professor Weir-Hughes: It is.

Dr Kolyva: It is.

Q143 Chair: It is about what you call a nurse and, if you qualify in one country, whether you can practise throughout the EU. Do you have a resolution to that problem?

Dr Kolyva: For those who have major shortfalls, we have found a solution within the legislation and we introduced aptitude tests this year, which started in April. These are tests like the PLAB test, more or less, that the GMC described earlier on, based on multiple

choice but also OSCE simulation and a reading assessment. The language competence will be picked up through that because there will be written and oral communication in English. For those who meet automatic recognition, we are not allowed to ask any additional requirements there.

Q144 Chair: That presupposes that the word “nurse”, for example, or the word “midwife”, to take the example you chose, has the same meaning in terms of the custom and practice in the UK as it does in Spain, Italy or in the Czech republic.

Dr Kolyva: Absolutely, yes.

Q145 Chair: That is not, in fact, the case.

Dr Kolyva: This is why we are working collaboratively with regulators across the European Union. We chair a network of European competent authorities for nursing and we have 25 countries collaborating in that. Likewise, in parallel, we have a network of midwifery regulators and we sit at that as well. We try to understand the differences. They are global concerns, European concerns, not just concerns within the UK. There are other countries that support us in changes for the minimum training requirements. They need a review.

Q146 Chair: You have made quite a strong case that they need a review. Until the moment that that review is carried out, we are bound by existing EU law—

Dr Kolyva: We are.

Chair: —with people, under freedom of movement, able to practise in a way that does not reflect the same standards of competency we would apply to somebody qualifying for the first time in the UK.

Dr Kolyva: Yes, this is partly true. We are working with the European Commission on this. There is a working group representation from the Chief Nursing Officer in the UK sitting on that and working with other countries and the European Commission on the minimum training requirements for nursing and midwifery.

Q147 Chair: Thank you. Are there any other questions? I have one very small point. You said that you need primary legislation. In fact, in your evidence, in paragraph 43, you referred to the Nursing and Midwifery Order, which implies that it is in fact secondary legislation and easier, therefore.

Professor Weir-Hughes: I thought that was primary.

Q148 Chair: An Order in Council, in my understanding—

Jackie Smith: The Order is primary, I am sure.

Chair: We will review that outside this context, but there is a convenient summary of the changes you are looking for at the end of your paper. Thank you very much.

Written evidence

Written evidence from the Department of Health (NMC 01)

INTRODUCTION

1. This memorandum has been prepared by the Department of Health in England in response to the Commons Health Select Committee's call for evidence to assist it in it exercising on behalf of Parliament the power held by the Privy Council to hold the health professional regulatory bodies to account. The first such session is to consider the performance of the General Medical Council (GMC) and Nursing and Midwifery Council (NMC). The Department is grateful for the opportunity to contribute to this process, and looks forward to contributing to similar work relating to the other health professional regulatory bodies in due course, should the Committee wish.

BACKGROUND

Accountability of the Health professional regulatory bodies to Parliament

2. The health professional regulatory bodies¹ are accountable to Parliament through the Privy Council. Provisions in their enabling legislation (the Medical Act 1983 and the Nursing and Midwifery Order 2001 in the case of the GMC and NMC respectively), require the regulators to report to the Privy Council on a number of matters relating to their performance. These include financial performance, how they comply with their duties as a public body in terms of equality and diversity matters, and strategic planning for future years. This material should be submitted to the Privy Council and laid before Parliament.

3. The Department has an interest in this process because, firstly, it acts as advisor to the Privy Council on policy and legal matters arising from the activities of the health professional regulatory bodies and, secondly, has a legitimate interest in the regulators' performance from the perspective of public safety and protection.

CHRE annual performance review

4. The Council for Healthcare Regulatory Excellence (CHRE) conducts an annual review of the performance of all of the health professional regulatory bodies, including the GMC and NMC. This report, submitted to the Privy Council and laid before Parliament, also ensures that the activities of the GMC, NMC and the other regulators are subject to scrutiny.

5. The CHRE performance review is an annual check on how effective the health regulatory bodies have been in discharging their statutory duties. It has two important purposes which are relevant in the context of the work of this Health Select Committee:

- it drives improvements in the work of the regulators (through CHRE's identification of their strengths, weaknesses, and recommendations as to changes in processes which are needed); and
- it provides assurance to Parliament, the public, health professionals, and the wider regulatory community about the regulators' performance.

6. The latest CHRE Performance Review for 09/10 was published in July 2010,² with the next report due for publication in the forthcoming weeks. The Performance Review considers the performance of the health professional regulatory bodies in relation to their core statutory duties, being:

- setting standards of education and training for the professions that they regulate;
- maintaining a register of those who demonstrate they meet these standards;
- setting standards of conduct, ethics and competence required to remain on the register; and
- investigating concerns about professionals who are registered and taking appropriate action where individuals might present a risk to the public.

CHRE annual audit of initial stages of Fitness to Practise procedures

7. For the past two years CHRE have also conducted a yearly audit of the initial stages of the health professional regulatory bodies' fitness to practise processes, looking at a sample of the decisions made by each regulator to close a case without referral to a formal hearing in front of a fitness to practise panel. CHRE do this to ensure that the regulators' fitness to practise decisions protect the public and maintain public confidence. Fitness to practise procedures are key public protection safeguards, hence the importance of this audit in terms of public confidence in this key area. The latest audit was published in March 2011.³

¹ General Chiropractic Council (GCC), General Dental Council (GDC), General Medical Council (GMC), General Optical Council (GOC), General Osteopathic Council (GOsC), General Pharmaceutical Council (GPhC), Health Professions Council (HPC), Nursing and Midwifery Council (NMC), Pharmaceutical Society of Northern Ireland (PSNI).

² See: <https://www.chre.org.uk/satellite/311/>

³ See: <https://www.chre.org.uk/satellite/387/>

 CHRE review of all final Fitness to Practise decisions

8. CHRE also review all final decisions made by health professional regulatory body fitness to practise panels. CHRE have statutory powers under Section 29 of the National Health Service Reform and Health Care Professions Act 2002 to refer to the higher courts any such decisions that they consider to be “unduly lenient” or where a decision should not have been made and so it would be desirable for the protection of the public for such an appeal to be brought. As a general trend, the number of fitness to practise cases being dealt with by the health professional regulatory bodies has risen steadily over the past few years. However, the number of cases where CHRE have had to utilise their Section 29 powers has fallen. This could indicate that the feedback on performance that CHRE provides to the health professional regulatory bodies is contributing to an improvement in quality of decision making across the sector. Legal changes, such as the move to the civil standard of proof in fitness to practise cases, have certainly had an effect. In addition, high courts jurisprudence is also likely to have had an influence in this area—with its guidance on the necessity for giving reasons for decisions, interpreting what is meant by misconduct/deficient performance, and guidance on how impairment should be assessed all making a contribution in assisting in improved decision making in the sector.

Wider Regulatory Reform

9. In February 2011 the Government published a Command Paper detailing its strategy for professional regulation: *Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers*.⁴

10. In *Enabling Excellence* the Government signalled its intention to engage the Law Commission⁵ to conduct a review of how the current complex legislative system which governs the operation of the health professional regulatory bodies is arranged, with a view to them making recommendations (and developing a draft Bill for consultation) on how this might be simplified. The Government welcomes the willingness of the health professional regulatory bodies (including the GMC and NMC) to contribute to this process.

11. It is the Government’s intention, through the Law Commission work, to explore the possible benefits of seeking Parliament’s agreement to a single Act of Parliament to create an enabling framework for all the health professional regulatory bodies. Parliament would continue to set out in law a high level framework of powers and duties for the regulators, but as independent bodies they would be empowered to decide on, and take responsibility for, how regulatory outcomes would be delivered in practice. However, greater autonomy must be balanced against strengthened accountability. To this end the decision of the Health Select Committee to scrutinise the performance of the health regulatory bodies is strongly welcomed by the Department.

12. In line with the wider Government policy to reduce regulatory burdens, *Enabling Excellence* also challenges the health professional regulatory bodies to consider in what ways they might reduce costs of regulation in the sector, which are borne by registrant health professionals. The Department has commissioned CHRE to lead research on how this is achieved and we look forward to working with CHRE and the health professional regulatory bodies on these issues in due course.

13. *Enabling Excellence* also sets out the Government’s approach to unregulated parts of the Health and Social Care Workforce, including development of a system of assured voluntary registration.⁶

PERFORMANCE OF THE GMC

CHRE 2009–10 Performance Review

14. CHRE’s main conclusions as to the performance of the GMC were that:

“The GMC has continued to perform well, demonstrating excellence in several areas across its functions in a year of significant change. It is impressive that the GMC has maintained its commitment to continuous improvement, even in areas where it was already performing to a good standard, and to addressing challenges in medical regulation.”

15. In relation to its core statutory functions CHRE found that the GMC:

- continued to demonstrate excellence through its focus on improving its registration processes;
- reviewed its fitness to practise procedures and changed its rules, which CHRE considered “should ensure that the fitness to practise process is focused on appropriate cases and that the GMC is able to make decisions which are in the interests of public protection”;
- in terms of education and training published standards and outcomes for undergraduate medical education which CHRE considered to be “clear, comprehensive, focused on patient safety”; and
- coped well with the change associated with the merger of the functions of the Postgraduate Medical Education and Training Board (PMETB) into the GMC.

⁴ See: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124374.pdf

⁵ See Chapter 3 of *Enabling Excellence*.

⁶ See Chapter 4 of *Enabling Excellence*.

CHRE findings in relation to the GMC in their March 2011 fitness to practise audit

16. CHRE's audit concluded that the GMC maintained:

“a well managed system of casework with no evidence of significant risks to patients or to the maintenance of public confidence in the system of regulation and the profession.”

17. CHRE did isolate a small number of cases where they had minor concerns as to the action the GMC took. However, after discussing these cases with the GMC, CHRE noted that they were pleased that the GMC addressed these “*few issues of slight concern*”.

Revalidation

18. The House of Commons Health Committee published “*Revalidation of Doctors*”: Fourth Report of Session 2010–11 on 8 February 2011 HC 557. The Government published its response in March 2011 in the form of a Command Paper Cm 8028. Progress on the Committee's recommendations since March is outlined below.

19. The England Revalidation Delivery Board has agreed clear milestones for moving towards organisational readiness that will allow the Board to assure itself and the GMC that progress is on track for the Secretary of State's assessment of readiness in 2012. Health bodies in England have been invited by SHAs to complete a self assessment to give an indication of the current state of preparation and to help prioritise their developmental work.

20. The Responsible Officer Regulations set out particular connections and functions for Responsible Officers in PCTS and SHAs that would be affected by the proposed changes to the NHS architecture. The Department is currently developing proposals in the light of these proposed changes. Subject to the outcome of the listening exercise in relation to the Health and Social Care Bill 2011, the Department intends to consult on its proposals before recess.

21. Training for those doctors appointed as Responsible Officers is underway and covers the statutory responsibilities and provisions of the role, obligations on a designated body to resource the Responsible Officers' work, and how to deal with potential conflicts of interest or appearance of bias. Training also addresses monitoring of clinical quality and performance, identifying concerns and quality assurance processes to support appraisal systems and organisational governance.

22. The Revalidation Support Team, the operational delivery arm of the Department's revalidation policy team, is developing practical and operational guidance for use by doctors, appraisers, Responsible Officers and others involved in the appraisal process. This takes account of the GMC's recently published appraisal framework for revalidation based on the principles laid out in Good Medical Practice and new guidance on the supporting information a doctor will be required to bring to their appraisal.

23. The new guidance on supporting information makes clear that patient and colleague feedback is expected and the GMC has developed a colleague and patient questionnaire that any doctor can use if their organisations do not already use such a tool. They have made available the latest version in draft form and expect to publish the final version with user guidance in mid 2011. As part of the second year of testing, the Revalidation Support Team are looking further at approaches to patient and public involvement in revalidation.

24. The Revalidation Support Team has developed the testing and piloting strategy for 2011–12 and this includes doctors with non-standard careers.

25. The Secretary of State wrote to the GMC in response to their consultation on revalidation in June of 2010. In the letter, he outlined his decision to extend the piloting and testing period for an additional year. The pathfinder pilots have now completed and the Department is expecting the external evaluation report by 30 June 2011. This will enable the extended year of piloting to be focused to ensure we have clear evidence for the assessment of readiness in 2012. This assessment will cover the three areas outlined in the government Command Paper in March 2011:

- design readiness: medical revalidation is right for doctors and for patients and has been properly streamlined and made proportionate;
- organisational readiness: the health sector has the systems in place to be able to move to implementation (Responsible Officers, appraisal, clinical governance); and,
- business case readiness (testing the components of revalidation): so that we can have clear evidence of the benefits that revalidation will deliver and that it can be implemented in a way that is cost effective and affordable.

Fitness to Practise Adjudication

26. Under the previous administration plans to establish the Office of the Health Professions Adjudicator (OHPA), which would have taken over the fitness to practise adjudication function currently performed by the GMC, were well advanced. However, in December 2010, after carrying out a public consultation, the Government announced that it intended to abolish OHPA.

27. Provisions relating to the abolition of OHPA are contained in the Health and Social Care Bill 2011, which is currently being considered by Parliament.

28. In light of escalating costs in terms of the establishment of OHPA, and the improved performance of the GMC in dealing with fitness to practise matters (indicated by the very low rates of challenge to decisions in the higher courts), the Government believes that the abolition of OHPA and the modernisation of the GMC's adjudication processes (followed by a review of the position for the other health professional regulatory bodies) is the most proportionate way of enhancing independence of adjudication whilst continuing to adequately protect patients and the public. The GMC is in the process of publicly consulting on proposals it has developed to deliver modernisation of its adjudication process.⁷

29. Some of the potential changes that the GMC proposes would require legislative change to deliver. Following consultation, and analysis of the results by the GMC, the GMC and the Department will be working together to develop legislation and will consult publicly on this in due course.

European Issues

30. The GMC continues to make a valuable contribution to debate across Europe regarding migration of Health Professionals. It was one of three of the European regulators of doctors who collaborated on a review of Directive 2005/36/EC on the mutual recognition of professional qualifications from the perspective of Competent Authorities.

31. A key issue for the GMC has been the matter of language testing of EEA doctors. The Department and the GMC have been working closely to explore options for strengthening language checks on EEA migrants, including consideration of a role in overseeing a strengthened system of proportionate local checks in the NHS in England, through the proposed new NHS Commissioning Board. Consideration is also being given to how the new statutory role of Responsible Officer could contribute to facilitating proportionate language assessments.

Fitness to practise trends: increased referrals to the GMC

32. As CHRE recognised in their 2009–10 Performance review “one of the most striking aspects of the regulators' activity is the rapid growth in the number of fitness to practise cases reaching a final determination”. The reasons for this increase, as CHRE recognises, are likely to be multi-factorial and complex. For instance, there are more regulated health professionals than ever before, there may be a greater public awareness of the role of the health professional regulatory bodies, and the regulators themselves may well have become more efficient in holding professionals to account.

33. The GMC recently reported experiencing an increase in serious fitness to practise cases, caused by rise in referrals of nearly a third in the last year—including an increase in the proportion of referrals from statutory bodies. The GMC have reacted proactively to this by commissioning research to try and establish underlying trends. They have also launched a campaign to recruit more fitness to practise panellists to give greater capacity to hear cases.

Conclusions in relation to the GMC

34. CHRE's Performance Review for 2009–10 (published July 2010) and latest fitness to practise audit (published March 2011) suggest that the GMC is fully and effectively discharging its statutory duties to deliver patient and public protection. It is also working closely with Government and European partners to further the development of health professional regulation in the UK and across Europe.

PERFORMANCE OF THE NMC

Progress since the 2008 CHRE Special Report into the NMC

35. On 14 March 2008 the then Minister of State for Health Services, Ben Bradshaw MP, wrote to the Chief Executive of CHRE asking it to expedite its annual performance review of the NMC to address “the central question of whether the NMC is fulfilling its statutory functions”. This step was taken following a debate in Parliament in which concerns were raised regarding the NMC. Following this letter, CHRE reported in June 2008 making recommendations for improvements. The NMC subsequently implemented an action plan to address these issues.

36. The leadership of the NMC has changed substantially since the 2008 Special Report by CHRE. The NMC appointed a new chair (Professor Tony Hazell) on 1 January 2009. It moved to an independently appointed Council (made up of equal lay and registrant members) from the same date, and it appointed a new chief executive (Professor Dickon Weir-Hughes) on 2 November 2009.

37. In February 2010, CHRE published its first annual audit of the initial stages of the health professional regulatory bodies' fitness to practise processes. The period covered by this audit was 1 April 2008 to 31 March 2009, before recent changes in governance and leadership at the NMC had been made. Many of the points

⁷ See: http://www.gmc-uk.org/concerns/fitness_to_practise_consultations.asp

raised were historic, but CHRE raised concerns that the processes used by the NMC did not appear to have improved significantly since the 2008 Special Report.

38. In April 2010, the NMC invited CHRE to undertake a review of progress in relation to their tackling of the Special Report's recommendations. CHRE reported their findings in January 2011.⁸ This Review of progress noted that significant improvements have been made since the 2008 Special Report, including the introduction of an electronic case management system (CMS) and improved training for fitness to practise panellists. However, CHRE considered that improvements still needed to be made, especially in the areas of caseload management and the implementation of standard operating procedures.

CHRE 2009–10 Performance Review

39. CHRE's headline assessment in its July 2010 report was that the NMC, in common with all the regulators, are meeting their statutory obligations.⁹ Their main conclusions as to the performance of the NMC were as follows:

“Nursing and Midwifery Council continues to maintain good performance across a number of its functions including the development and communication of its standards ...[and]...continues to make progress in those areas of weakness identified in our Special Report for the Minister of State for Health Services particularly in relation to case progression. However, we remain concerned about the customer service provided by the fitness to practise department and the quality and consistency of decisions made and recorded by fitness to practise panels.”

40. In the July 2010 report CHRE reflected back on recommendations they had made in relation to the NMC in the previous year, and progress as to implementation. In their performance review for 2008–09 CHRE identified eight areas where they were looking for improvement from the NMC (eg reducing the time it takes to process fitness to practise cases, implementation of IT based case management).¹⁰ CHRE reported that they were “satisfied” as to progress in these eight areas, but that there was “room for improvement” in others (such as consistency and quality of decision making in fitness to practise cases and improving the NMC's culture of customer focus).¹¹

41. Whilst fitness to practise issues inevitably get much focus because of the close nexus to public safety, the 2009–10 Performance Review also acknowledges wider successes of the NMC, such as:

- its review of pre-registration nursing education which was informed by specific patient groups in partnership with organisation such as Mencap and the Alzheimer's Society;
- the fact it has maintained good performance across a number of its functions including the development and communication of its standards;
- its good performance in terms of processing and checking registration applications; and
- its continued improvements in terms of approaches to stakeholder engagement.

CHRE findings in relation to the NMC in their March 2011 fitness to practise audit

42. In its latest fitness to practise audit CHRE again raised concerns issues in relation to the handling of fitness to practise cases at the NMC. CHRE were concerned about the NMC's performance in dealing with fitness to practise concerns in a number of areas, including: inconsistent reviewing of new cases to identify and prioritise high risk cases, poor record keeping, poor customer service, delayed decision making, concerns about inadequate investigation, and poor analysis by decision-makers. However, it is important to recognise (as CHRE did in this audit) that improvements have taken place in this area in comparison to past years, and that further improvement work is ongoing.

43. Following publication of the March 2011 audit, Ministers have sought, and been given, written assurances by the NMC's leadership that necessary actions are and will be taken to address these concerns. The NMC are providing quarterly updates to CHRE on progress made.

Revalidation

44. *Enabling Excellence* asked the regulatory bodies for the non-medical healthcare professionals to continue to develop the evidence base that will inform their proposals for revalidation.

45. The NMC is the biggest healthcare professionals' regulator and has significant logistical challenges due to the number of registrants (665,599 as of March 2010) and the fact that considerable numbers do not work within the NHS.

46. For the past two years, the NMC has concentrated on developing a robust evidence base for revalidation by commissioning research to assess the potential risks relating to the practice of their respective registrant

⁸ See: https://www.chre.org.uk/_img/pics/library/110124_NMC_Progress_Review_Report.pdf

⁹ See: https://www.chre.org.uk/_img/pics/library/100806_Performance_review_report_2009-10_tagged_1.pdf—at para 8.1

¹⁰ For the eight areas see: https://www.chre.org.uk/_img/pics/library/100806_Performance_review_report_2009-10_tagged_1.pdf—at para 15.3

¹¹ For these areas see: https://www.chre.org.uk/_img/pics/library/100806_Performance_review_report_2009-10_tagged_1.pdf—at para 15.4

groups. This research has included looking closely at what their fitness to practise data (historical and current) could tell them about the risk. This piece of work is essential in allowing the NMC to develop a risk-based and proportionate proposal for a framework for revalidation.

Conclusions in relation to the NMC

47. It is clear from the detailed assessments of CHRE in a number of reports that there are still outstanding issues at the NMC, especially in relation to handling of fitness to practise cases. It is further clear that changes of governance and leadership in 2009 have led to considerable improvements, and that the NMC's wider performance is on an upward trend. The energy and tenacity that the NMC's current Chief Executive has brought to the organisation has certainly contributed to this.

48. However, neither the Department, CHRE, nor indeed the NMC are complacent. There is still more work for the NMC to do to get to the stage where current areas of concern surrounding fitness to practise work are resolved, as recent activity in this area is yet to fully yield substantial improvements.

49. The NMC are currently engaged in constructive discussions with the Department as to whether and how legislative change could support continued improvement in their fitness to practise function could deliver further benefits.

50. CHRE continues to receive quarterly progress updates on the NMC's actions in these areas. The forthcoming CHRE performance review for 2010–11 will be a further indication as to whether previous progress is being effectively maintained and built upon. In the Department's view the NMC has significant challenges facing them and are working hard to tackle them. Therefore, it is essential that their focus is maintained on meeting their existing statutory duties.

June 2011

Written evidence from the Nursing and Midwifery Council (NMC 02)

THE NURSING AND MIDWIFERY COUNCIL (NMC)

1. The NMC is the regulator of nurses and midwives in England, Wales, Scotland, Northern Ireland and the Islands. We were established by Parliament under the Nursing and Midwifery Order 2001 (the Order).

2. Our main objective is to safeguard the health and well-being of people using or needing the services of nurses and midwives. We do this by:

- 2.1 registering all nurses and midwives and ensuring that they are properly qualified and competent to work in the UK. There are currently around 660,000 registered nurses and midwives on the register;
- 2.2 setting standards of education, training, conduct and performance for nurses and midwives;
- 2.3 ensuring that nurses and midwives maintain those standards;
- 2.4 ensuring that midwives are safe to practice by setting rules for their practice and supervision; and
- 2.5 maintaining fair processes for investigation of allegations made against registered nurses and midwives.

3. We are independent from Government and are funded by the fees paid by the nurses and midwives on our register.

GOVERNANCE

4. In 2009, we were the first of the nine professional healthcare regulators to restructure our governing Council reducing its size from 35 to 14 independently appointed rather than elected members. Our Council has an equal balance of seven lay and seven members from the nursing and midwifery professions. We also took the opportunity to reduce and streamline the number of our committees resulting in a saving of £500,000. We are actively considering reducing the size of our governing Council further to make it a more board like decision making structure.

FINANCES

5. In 2002, the NMC inherited a deficit from our predecessor body the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), which at its height was more than £7 million. Through implementing a rigorous financial recovery plan we turned this around and by 2011 we secured financial stability. This level of financial stability has enabled us to improve key operations and to initiate a number of projects that will assist us in achieving our primary purpose: to safeguard the health and well being of patients and the public. Due to the Government's decision to make the Council for Healthcare Regulatory Excellence (CHRE), a self funding organisation which will raise a levy on professional regulation we may reluctantly have to increase our registration fee.

FITNESS TO PRACTISE

6. We have actively addressed a number of the areas which were of concern to the CHRE in their reviews. It is important to recognise that fitness to practise is a complex and necessarily legalistic process which, under our current legal framework, requires considerable resource to deliver it. So we have a team of 160 staff including clinical and legal experts managing 10 concurrent hearings across the four countries of the UK every day.

7. Recognising the need to respond to the CHRE's concerns we set up a screening team which came into effect in January of this year. It is tasked with carrying out an immediate risk assessment of all new referrals, which it does with input from a lawyer and our clinical advisors. Screening has delivered a dramatic improvement in our ability to take action in areas where there is an immediate threat to patient safety and it has allowed us to more effectively prioritise our work. We have made improvements in a number of other areas in fitness to practise such as, for example, setting up a team to deal with high profile cases.

8. We have also recently approved a policy of engaging with employers on referrals which in isolation, do not appear to raise fitness to practise concerns. This new initiative aligns itself with the Command Paper and the call for regulators to demonstrate effectiveness and efficiency. However, we will not be able to demonstrate greater efficiency and effectiveness until we secure the time and co-operation of the Department of Health in changing our Fitness to Practise Rules and Order. Despite a 57% increase in referrals to the NMC at the beginning of this year, we have still managed to reduce our overall caseload.

9. The table below provides information on referrals received from 2007–10 and the source of those referrals:

<i>Source</i>	<i>2007–08</i>		<i>2008–09</i>		<i>2009–10</i>	
Employer	785	53%	847	48%	1,197	40%
Police	429	29%	404	23%	576	19%
Members of the public	131	9%	296	17%	651	22%
Other professionals (organisations or individuals)	14	1%	27	2%	58	2%
Other	119	8%	185	11%	506	17%
Total	1,478	100%	1,759	100%	2,988	100%

10. The data demonstrates a steady increase in the volume of complaints up to 2009–10 and the subsequent significant increase during 2010–11 which has seen complaints rise to an historic high of 4,211. All healthcare regulators have experienced a similar increase in the volume of their complaints although there is currently no conclusive evidence to explain the reasons. A contributory factor could be the increased media focus on failures of care by healthcare professionals. This may have led to greater awareness amongst the public of the role of professional healthcare regulators. It might be appropriate for CHRE to research the underlying reasons for the increase in complaints across health regulators.

11. In early 2009 we reviewed our processes for dealing with concerns about nurses and midwives in the absence of any formal referral. We decided that we should make greater use of the investigatory powers given to us under Article 22(6) of the Nursing and Midwifery Order 2001. These powers allow us to investigate a nurse or midwife when we are made aware of concerns about their fitness to practise, including concerns arising from formal reports in the public domain from other regulatory bodies.

12. This policy change has allowed us to open a number of investigations into nurses without having first received a formal referral. So far in 2011, we have pro-actively opened 153 cases.

13. We have made considerable inroads and improvements since 2008 and we know what needs to be done to deliver effective fitness to practise. However, our ability to provide the sort of service the public, registrants and employers should expect of us will continue to be hampered by our cumbersome legal framework.

14. We have identified a number of actions and opportunities that would help us to protect the public in a more timely and effective manner. These are:

- the Registrar to refer directly to an interim orders panel; and
- in cases where the criteria applies and not in cases where the public interest demands, there should be powers for the NMC to agree with a nurse or midwife that they can voluntarily erase themselves from the register.

15. In order for these to become reality we need legislative changes to the Nursing and Midwifery Order 2001. We have approached ministers and Department of Health officials on a number of occasions with requests for these changes, even to the extent of offering to fund any associated legal costs that would be required to make this happen. We have had a disappointing response to date.

MAINTAINING PROFESSIONAL STANDARDS

16. In 2009 we commissioned Dame Elizabeth Fradd DBE to help us develop our approach to identifying potential systemic failures in health organisations. In September 2010, she recommended that we should

establish a critical standards intervention (“CSI”) system to help us identify, assess and act upon systemic failures.

17. We will be setting up a CSI unit within the NMC to implement Dame Elizabeth’s recommendations. As a statutory body, we can only act in a manner permitted or required by the powers and duties provided by legislation. Whilst there are no clear powers allowing us to investigate healthcare organisations, we do have powers to appoint visitors to look at the quality of the education environment within a healthcare organisation, refer concerns to our investigating committee for fitness to practise action and review arrangements to protect the public from practitioners whose fitness to practise is in doubt.

18. Nurses and midwives have always had a professional obligation to raise concerns where they believe someone or something is putting people at risk, in accordance with the code. Employers have a responsibility to set up systems allowing staff to raise any concerns they may have about patient safety. In November 2010 we sent every single nurse and midwife on the register a document mapping out the steps they should take to raise their concerns appropriately and safely. We did this because we had evidence that nurses and midwives were either not raising concerns appropriately or not raising them at all.

Revalidation

19. A system for post registration education and practice standards (Prep) has been in operation since 2001. Prep sets the requirements for revalidation within the framework provided by the code of conduct. We are committed to delivering an effective system of revalidation for all nurses and midwives by 2014. We will deliver a proportionate, evidence based and affordable system, delivered via an online portal that will enable us to confirm that nurses and midwives are fit and safe to practise, that their skills and knowledge are up to date and that they will actively strive for continuous improvement of their practice in the interests of patient safety.

Europe

20. Nursing and midwifery are global professions. We welcome freedom of movement within the European Union (EU) and recognise the positive contribution that EU trained nurses and midwives make to healthcare provision in the UK. Likewise our standards allow for UK trained nurses and midwives to spend part of their training or gain work experience in other European countries.

21. We have worked collaboratively with the Department of Health and the European Commission (EC) and have provided recommendations to amend the legislation governing the mobility of healthcare professionals within the EU (EU Directive 2005/36/EC on the recognition of professional qualifications). As part of this collaborative process the EC invited the NMC in 2010 to lead the review of the directive for the nursing profession. We have established and chair an informal network of 25 European competent authorities for nursing.

22. Along with other regulators in the UK such as the General Medical Council (GMC), and other European nursing regulators, we share the concern that the current legislation does not allow us to systematically test the language competence of applicants to our register. Language competence is a shared responsibility of the individual nurse and midwife, the regulator and the employer. We have raised awareness of this issue with a number of stakeholders in the UK and Europe and have issued specific guidance to employers in the UK reminding them of their responsibilities when recruiting EU trained nurses and midwives. Having looked at available evidence of the risks poor language skills can pose to patient safety, we are working collaboratively with the Department of Health to find the best possible way to enhance public protection in this area.

23. Language competence should not be considered in isolation. Training and scope of practice for nursing and midwifery varies considerably across Europe. In recent years we have experienced an increase in the number of applications to our register from EU trained nurses who do not meet automatic recognition and who have considerable shortfalls in their training. These applicants can undertake a period of supervised practice and since April 2011 an aptitude test. Both supervised practice and the aptitude test assess the overall competence of the applicant including their linguistic competence.

EDUCATION

24. We are responsible for the quality assurance of over 1,000 nursing and midwifery education programmes delivered by 86 universities and higher education institutions across the UK. These programmes must prioritise the fundamentals of nursing care including dignity, compassion, attending to personal hygiene and nutrition. We require all newly qualified nurses and midwives to leave their programmes competent, confident and fit to practise and look after people in their care.

25. In September 2010 we introduced new standards of pre-registration nursing and midwifery education. From September 2013, all newly qualified nurses trained in the UK will have been educated to degree level. Scotland, Wales and Northern Ireland have already moved to degree nursing courses, as have many developed countries, including Australia, New Zealand, Scandinavia, and Italy.

26. Developed after five years of consultation and close collaboration with the Department of Health and other partners, the standards are designed to produce registered practitioners who are highly knowledgeable, highly skilled, able to work autonomously and able to meet the increasingly complex and demanding expectations of modern healthcare. The new degree programmes follow minimum EU legislative requirements where training includes 50% theory and 50% clinical practice.

27. There is no evidence that a degree level nursing profession leads to diminished standards of basic care—in fact quite the opposite. Studies from the USA reveal that a high proportion of degree qualified registered nurses has been associated with lower mortality in surgical units. There is also evidence of higher retention rates for graduate nurses as they tend to be more certain about their career path and have a higher commitment to the profession.

28. We believe that degree level training will have a positive impact on future workforce numbers as evidenced in Wales. Nurses in Wales have been trained to degree level since 2004 and the result has been an increase in demand for degree course places. In a recent Nursing Times survey of more than 80 universities and higher education institutions, 62% said they were planning to raise their entry requirements because of the high volume of applications from students.

HEALTHCARE SUPPORT WORKERS

29. There are an estimated 300,000 healthcare support workers in the NHS in England alone and more in the independent sector. They are an important part of the healthcare workforce and are increasingly taking on duties and tasks traditionally undertaken by registered nurses. Their role is to support registered nurses in delivering the fundamentals of basic care such as feeding and personal hygiene.

30. There are two types of healthcare support worker: assistant practitioners and health care assistants. There are no consistent training standards for healthcare assistants. We are aware of training courses ranging from an hour long induction right through to NVQ level 3. Assistant practitioners are experienced healthcare assistants and could be considered to be broadly equivalent to the old state enrolled nurse. They may have received training up to NHS level band 4 but again there is no consistency across the UK.

31. Whilst health care assistants focus on the fundamentals of care, assistant practitioners often perform a much wider range of tasks including invasive and complex procedures such as insertion of IV drips, wound management and drug administration. These tasks are usually but not exclusively carried out under the delegated authority of a registered nurse. We have anecdotal evidence that in some clinical environments delegation can be from a non-clinician such as a general manager. Evidence also exists that healthcare support workers undertake tasks for which they are not trained.

32. As a result of this we are strengthening the delegation standard and taking steps to ensure a more robust approach is taken by nurses when delegating authority to healthcare support workers.

33. We have received hundreds of complaints about poor care delivered by unregistered healthcare support workers. When nurses or midwives breach their professional code of conduct, we are the only body with the power to remove them from practice. However, there are no such equivalent processes for unregistered healthcare support workers.

34. The committee will be aware of BBC Panorama's Undercover Care: the Abuse Exposed (Tuesday 31 May), which documented the serious abuse of vulnerable adults with learning disabilities at Winterbourne View care home. This was the latest in a series of reports of serious abuse and failures in care involving healthcare support workers. Whilst we were able to deal swiftly with allegations against registered nurses working at Winterbourne View, we are unable to take any action against the unregistered health care support workers involved. We are surprised that the public is not more aware and concerned about this group given the wide range of tasks that they perform without the benefits of any national minimum standards of training and conduct.

35. In 2010 we commissioned a scoping report focusing on the regulation of healthcare support workers carried out by the National Nursing Research Unit at Kings College London. Among the findings was the ease with which healthcare support workers previously dismissed by an employer were able to find alternative employment in healthcare and working with vulnerable people. Since receiving this report we have commenced a project to develop our approach to a regulatory framework for this group.

36. We believe that a regulatory framework for healthcare support workers is vital in order to protect the public. The absence of any regulatory framework means that those who may represent a risk to the public will remain free to work with vulnerable people. We will continue to encourage the government to consider a more robust model of regulation for this group of workers.

THE FUTURE OF REGULATION

37. The future development of health professions regulation has been clearly mapped out in the Command Paper Enabling Excellence which we welcome. We share the vision of professional healthcare regulation being cost effective, evidence based and proportionate.

38. We support the proposed review of the framework to give greater autonomy to regulators to discharge their statutory duties. We are at the very early stages of engagement with the Law Commission to help create a single Act of Parliament to reduce the number of complex pieces of legislation by 2014.

39. The Nursing and Midwifery Order 2001 requires us to regulate midwifery practice. This is done via local supervising authorities which are independent organisations geographically located and overseen by strategic health authorities. We are concerned that the proposed demise of strategic health authorities in the Health and Social Care Bill will impact on arrangements for midwifery supervision locally. We have agreed with the Care Quality Commission that in the interests of public protection, midwifery supervision should reside directly with the NMC.

40. A second concern regarding the demise of the strategic health authorities is the removal of the SHA chief nurses who have a vital role in providing leadership to trust nurse directors—particularly those new in post. Some NHS foundation trusts have sadly chosen to discourage their nurse directors from responding positively to the leadership and networking opportunities provided by the SHA chief nurses which can leave them isolated from colleagues—a recent example of which can be seen at the Mid Staffordshire NHS Foundation Trust (under a previous administration).

41. In the meantime we continue to work constructively with the Department of Health to see how our existing legislation could be improved to allow us to be more responsive to patients' complaints. We would like to have powers similar to other regulators whose legislation gives them the ability to take quick and decisive action on matters of conduct and competence.

42. A modern legislative framework will enable us to discharge our statutory responsibilities more swiftly and more effectively and will strengthen our ability to protect the public.

RECOMMENDATIONS

43. The NMC requires changes by the Department of Health to the Nursing and Midwifery Order (2001). As per paragraph 14 above, a modern legislative framework will enable us to discharge our statutory responsibilities more swiftly and more effectively and will strengthen our ability to protect the public.

44. We share the views of the Patients' Association, the Royal College of Nursing and Unison that the absence of any regulatory framework for healthcare support workers represents a risk to the public. We ask that the Department of Health continue to engage in constructive dialogue to find an appropriate and proportionate regulatory framework in the interests of public protection.

45. We ask that the UK government continues to support our recommendations to amend the legislation that governs the mobility of healthcare professionals within the EU and continues to work with us on a model of language testing that is appropriate for the nursing and midwifery professions.

June 2011

Supplementary written evidence from the Nursing and Midwifery Council (NMC 02A)

1. This document provides further information to supplement our previous written evidence provided on 8 June and oral evidence provided on 14 June. The document is categorised into the following sections:

- 1.1 Direct responses to further information requested by committee members during the oral evidence session.
- 1.2 Corrections of facts given to date.
- 1.3 Recommendations, elaborating on those in our initial written evidence.

DIRECT RESPONSE

2. In response to question 71 of the oral evidence session asking, "*How many continuing professional development portfolios has the NMC audited in each of the last five years?*"

- 2.1 As we explained in the oral evidence to the committee, we do not systematically audit all of the continuing professional development portfolios for each of the 667,000 (approximate) nurses and midwives on our register.
- 2.2 Due to the significant numbers involved we have to take a risk based approach to assessing a nurse or midwife's fitness to continue to practise. We send out annually 220,000 renewal requests asking nurses and midwives to self declare that they meet the requirements for renewal of their registration. This is a process each nurse or midwife must undertake every three years.
- 2.3 Where there are discrepancies or other concerns relating to their renewal application, we write to the relevant nurse or midwife seeking further information and evidence.
- 2.4 We also insist on seeing full developmental histories whenever we become aware that a nurse or midwife's ability to deliver high quality care has been brought into question, for example when they have received a criminal conviction.

- 2.5 From April 2006 to April 2011 we carried out an assessment of the registration renewal evidence of around 115,000 nurses and midwives. A similar number were assessed from April 2002—April 2006 when the NMC was created and began using the post registration education and practice (Prep) system.
- 2.6 Prep is a set of standards and guidance designed to help nurses and midwives provide a high standard of practice and care and helping them to demonstrate that they are keeping up to date and developing their practice. It is in essence the forerunner of a more comprehensive revalidation system.
- 2.7 We were one of the first health professions regulators to use such a system and were five years ahead of the call for revalidation in the Department of Health White Paper, *Trust, Assurance and Safety—The Regulation of Health Professionals in the 21st Century* in 2007 (see chapter 2).
- 2.8 In April 2011 we began to pilot a more detailed Prep assessment sheet to assess those in high risk categories in preparation for the move to a revalidation system. Already 21 in-depth assessments have been carried out. If this number is extrapolated across the year approximately 200 detailed assessments will be undertaken in 2011.
- 2.9 This work builds on our risk based system of checks. By 2014 our revalidation programme will deliver a proportionate, evidence based, affordable system that will enable us to confirm, on a continuous basis, that nurses and midwives are fit and safe to practise and their skills and knowledge up to date in relation to their current area and scope of practice. We will be piloting a significant proportion of the system in 2013.

CORRECTIONS

3. In our oral evidence in response to questions 122 and 123 we refer to the Nursing and Midwifery Order 2001 as primary legislation and requiring primary legislation to change it.
 - 3.1 Correction: The Nursing and Midwifery Order 2001 (SI 2002/253) is our governing legislation but is in fact an order in Council made under powers contained in Section 60 and Schedule 3 of the Health Act 1999 and is amended by another order in Council made under the same powers.
 - 3.2 Correction: The changes we wish to be made to the Order, as referenced throughout our written and oral evidence, can in fact be made through secondary legislation.
4. Paragraph 25 of our initial written evidence explains that “*In September 2010 we introduced new standards of pre-registration nursing and midwifery education.*”
 - 4.1 Correction: The new standards apply to pre-registration nursing only. New standards for pre-registration midwifery education were introduced in 2009.

RECOMMENDATIONS

5. As an extension to the recommendation made in paragraph 44 of our initial written evidence:
 - 5.1 We believe that any regulatory framework must go further than the voluntary register proposed in clause 225 of the Health and Social Care Bill which we do not consider a sufficiently robust model to ensure vulnerable people can be fully protected (clause 225 is not among those re-committed to the Public Bill Committee as of 21 June 2011).
6. In addition to the recommendations made in our initial written evidence:
 - 6.1 We ask that the Department of Health engage in further dialogue with the NMC to find a proportionate and lasting solution to the future location of LSAMOs in England as and when SHAs are abolished.

June 2011

Written evidence from the Royal College of Midwives (NMC 03)

SUMMARY

1. The Royal College of Midwives (RCM) believes that the regulation of midwifery is vital to ensuring safe care for mothers and babies. Indeed it was the RCM that successfully campaigned for such regulation, resulting in the 1902 Midwives Act.
2. The RCM does however fear that the NMC does not give full and proper regard to the nature of midwifery, distinct from nursing, in its work, and this is exacerbated by the dominance of nursing interests on its Council and amongst its staff.
3. We hope that the Committee will, using this submission, challenge the NMC’s representatives on this issue when they appear before members on Tuesday 14 June 2011.

SUBMISSION

4. The RCM was established in 1881 to campaign for the regulation of midwives to ensure that women giving birth in the United Kingdom had access to a trained caregiver. The RCM continues to see this public protection as the key purpose of regulation.

5. The Central Midwives Board, established in 1902, was the body that laid down the foundations for the regulation of midwives in England and Wales, with subsequent legislation establishing similar boards in Scotland and Northern Ireland. These bodies were however dominated by doctors and others who were not directly connected with maternity services and it was not until midwives were in the majority on these boards that midwifery regulation became truly effective.

6. During their time in place, up until 1983, the boards demonstrated remarkable prescience and forward thinking in continuing to develop the rules and standards for entry into the profession and for the maintenance of the midwife's role. Key developments in education included the requirement for mandatory updating in the 1936 Midwives Act, and specific qualifications for midwife teachers and for those supporting students in clinical practice.

7. The role of the midwife (as developed by the International Confederation of Midwives (ICM) and endorsed by the World Health Organization (WHO) and the International Federation of Gynaecologists and Obstetricians (FIGO)) lays down that the midwife is fully responsible for the care of mother and baby from the point that the woman realises she is pregnant until long after the birth, when the midwife oversees the woman's transition to parenthood and the baby's life in its early weeks. It is because of this extended responsibility that particular regulatory processes are put in place to ensure that women in the UK receive the highest standards of care from midwives.

8. These provisions include the supervision of midwives. As a part of the process of supervision, every midwife indicates that she will be practising in a particular area and her work is overseen by a midwifery supervisor whom she sees at least once a year and who can at any point examine her practice, records and equipment. Supervisors of midwives work with midwives in practice to ensure that they are fully up-to-date and to offer them help and support should they feel that their practice is falling in any way short of the standard required. In addition, supervisors form a network which enables mothers and women who wish to access midwifery services, particularly in respect of birth at home, to gain quick and easy access to a midwife. Supervisors of midwives in the UK are themselves overseen by the Local Supervising Authorities (LSA) each of which has a Local Supervising Authority Midwifery Officer (LSAMO) employed to oversee the standards of midwifery practice in the areas for which they are responsible.

9. Since 1983, midwives have had shared regulations with nursing. During this time midwives have been in a constant battle to ensure that the regulatory processes recognise the distinct way in which they work with women in order to maintain high standards of education and practice. UK midwifery regulation has in the past been held up as a high international standard to which others should aspire. It is a great regret that the recently launched Global Standards for Midwifery Regulation produced by the ICM show that UK midwifery is already falling considerably short of the higher standards in this area. The ICM, together with the WHO, recognises that appropriate and high quality regulation of education and practice is a huge contributor to the way of ensuring high quality care with the concomitant reductions in maternal and neonatal mortality. The ICM standards for midwifery regulation can be found at <http://goo.gl/B5wFY> (which is a shortened version of <http://www.internationalmidwives.org/Documentation/ICMGlobalStandardsCompetenciesandTools/GlobalStandardsEnglish/tabid/980/Default.aspx>)

10. The RCM supports many of the provisions that are laid down in the recent Government Command Paper on the future of regulation of health professions. Indeed we have been calling for some time with some harmonisation of procedures between statutory bodies to enable members of the public more fully to understand how their complaints and concerns can be dealt with and to avoid different standards being applied for different professional groups. We value the input of service users (indeed this is a central part to the planning not only of midwifery services but also midwifery education programmes). Additionally, we fully support the deletion of unnecessary bureaucracy. We do have concerns however that the Nursing and Midwifery Council (NMC) may wish to use the approach to simplifying education to extend to midwifery those processes and procedures designed to suit nursing (two totally different professions).

11. Under existing legislation there are specific provisions for midwifery including the establishment within the NMC of a midwifery committee. This committee should make decisions on midwifery matters but it is purely advisory and indeed currently seems to have a very minimal role within the workings of the NMC. Whilst recognising the need not to have reserved places on the NMC Council, the RCM is concerned that there is no provision at all for there to be any midwife, which seems to us somewhat odd as this is a council for two professional groups. The staffing structure within the NMC Council has no senior practising active midwife at director level and the most senior person is an assistant director who has to report via a nurse into the corporate management team. We believe that this does not demonstrate that midwifery is an equal profession to nursing and that whilst we do recognise that there are some commonalities between nurses and midwives, the different role of midwives and the potential risk where care is not of the optimum means that particular provisions need to be made for the smaller profession.

12. A recent issue has arisen regarding the wish of the NMC to remove the provisions under Rule Five for the Midwives Rules and Standards (Nursing and Midwifery Council Midwives Rules and Standards (NMC 2004)). These enable an LSAMO to suspend from practice a midwife where there are major concerns that she presents a risk to public safety. This is on top of the ability of any employer (should the midwife be employed) to suspend a person from their employment. This process which can be put in place in a maximum of seven days does prevent a midwife from putting at risk the care of mothers and babies elsewhere. We recognise that the NMC itself has fitness to practice provisions which enables it to put in place interim orders of suspension. However the fastest that these can be in place is 28 days. The RCM believes and in fact the NMC now agrees that their provisions to remove rule five were premature and that these must await the agreement of Ministers to a rapid suspension from practice for all nurses and midwives which can be activated by the registrar of the NMC. We believe that the concern over the premature action of the NMC demonstrates that they do not fully understand issues of midwifery practice. It is quite clear that many times they think about midwifery through the lens of the NHS as an employer. It is important to maintain public protection wherever the midwife is working and indeed in the future with plurality of provision, it is quite likely that midwives will be part of social enterprises, not-for-profit organisations, local authorities or indeed working as individual practitioners who have contracted with the NHS. The provisions for suspending midwives, supervising their practice, laying down detailed practice rules against which their practice can be measured we believe remain a vital part of the modern NHS and are totally vital to ensuring the health of mothers and babies.

13. The concerns of the RCM currently about the processes of regulation are that we are not assured that the difference in the ways in which midwives work and operate in providing care to mothers and babies from the ways in which the vast majority nurses are employed is fully recognised by the NMC despite 109 years having passed since the RCM achieved the regulation of midwives in England and Wales.

14. We believe that regulation of midwifery is under threat and would look to the Health Committee to seek assurances from the NMC that midwifery provisions in the regulation and regulatory processes which have demonstrated to ensure the public protection of women and families using maternity services are maintained and supported within the organisation.

June 2011

Written evidence from UNISON (NMC 04)

1. INTRODUCTION

1.1 UNISON is the largest public sector union with over 1.4 million members working across a range of public services who help and care for the most vulnerable in our society. In the health service, UNISON has 450,000 members employed across the NHS. We are pleased to have the opportunity to make a submission to the Health Committee in relation to its scrutiny of the Nursing and Midwifery Council (NMC).

1.2 As a leading voice for health and social care staff, UNISON is instrumental in influencing policy at regional, national and international level. We work collaboratively with Government and other UK and international unions on health and social care issues, including areas of practice and care. UNISON also works closely with each of the health regulators to establish standards and policies in education and patient care. UNISON is a diverse organisation, enabling us to have a broad perspective of health and social care services. We are a key stakeholder and value the opportunity to participate in any attempts to improve patient care and public protection.

1.3 We hope that the Health Committee will take into account the weight of UNISON's views. We have sought to include information which we believe the committee will find helpful.

2. EXECUTIVE SUMMARY

- UNISON is pleased that our concerns regarding the past performance of the NMC have been heard by both the Department of Health and the CHRE.
- UNISON welcomes the significant progress the NMC has made since the publication of the CHRE's report in 2008, including improvements to the management of cases, oversight and scrutiny, however we remain concerned about the significant amount of time registrants must wait for their case to be heard and concluded.
- UNISON believes that more work needs to be done by the NMC to utilise equality monitoring information relating to fitness to practise cases and to ensure the NMC offers value for money for registrants and the public.
- UNISON also supports the Government's proposal to require regulators such as the NMC to work more collaboratively.
- Given the recent high-profile instances of safeguarding failures in health and social care organisations, UNISON would like to take this opportunity to raise with the Health Committees our desire for a renewed focus on the regulation of health and social care support workers involved in delivering personal, hands-on and intimate care. It is UNISON's view that these staff should be subject to statutory regulation.

- The plethora of job titles that are in use, as well as the huge inconsistencies around the responsibilities and standards that being applied to these roles is not in the best interests of public protection.
- UNISON asks that urgent action be taken to introduce consistent standards across these roles and to provide robust training and development opportunities for these staff.

3. NMC PERFORMANCE OVERVIEW

3.1 In 2008, the Council for Regulatory Healthcare Excellence¹² (CHRE) published a special report on the NMC which was commissioned by Government. The report highlighted a number of serious failings within the organisation at that time. Healthcare trade unions including UNISON, Royal College of Midwives (RCM) and Royal College of Nursing (RCN) worked closely together and offered to work with the NMC to help implement effective changes. However, we also raised concerns over the management of the NMC at that time and their failure to act upon the issues that were being raised regarding the NMC's performance.

3.2 Following the publication of the CHRE report, UNISON has worked with both Chairs of the NMC and the three Chief Executives, to address and resolve the issues identified in the CHRE report. We welcomed the appointment of the current Chief Executive and believe that significant progress has been made. The NMC has many committed staff, however as experience demonstrates, effective leadership is key to a successful organisation.

3.3 As a major stakeholder in the regulation of healthcare professionals, UNISON has sought to be engaged in the ongoing review of the NMC and we are pleased that our concerns have been heard by both the Department of Health and the CHRE. We believe that the CHRE annual report of the NMC is a fair reflection of both its progress and the remaining challenges it faces.

3.4 While the primary statutory function of the NMC is to support public protection, it is funded by registrants and must offer a good service from a customer and business perspective. In these times of austerity, where 665,599 registrants are paying an annual fee of £76.00, registrants have a right to expect value for money.

3.5 UNISON strongly advocates a regulatory system where all healthcare regulators work together and we support the Government's recommendation contained in the command paper "*Enabling Excellence: autonomy and accountability for health and social care staff*"¹³ which aims to require regulators to work collaboratively.

3.6 The NMC is showing significant progress in relation to its management of fitness to practise cases, however a large number of cases still remain outstanding. In May 2011, the NMC had 3,698 cases however, only 544 of these were at substantive hearing stage. The new systems introduced following the appointment of the Director of Fitness to Practise have had a significant impact on the management of cases, oversight and scrutiny. Despite this, Nurses and Midwives continue to wait a significant (and often unacceptable) amount of time for their case to be heard and concluded. We believe that the new systems introduced should ensure that cases are heard more quickly but acknowledge that it will take some time for the overall number of cases to reduce.

3.7 UNISON welcomed the move by the NMC to begin collecting equality monitoring information. This move was long overdue and we look forward to seeing the first report on the information gathered. This work will need to be progressed further to include equality monitoring of fitness to practise cases, as there is anecdotal evidence that a disproportionate number of black and ethnic minority registrants are referred to the NMC.

3.8 UNISON believes that significant work has been achieved since the CHRE report in 2008. We remain committed to working closely with the NMC and remain fully committed to improving public protection.

4. REGULATION OF SUPPORT WORKERS IN HEALTH AND SOCIAL CARE

4.1 The Government's command paper, "*Enabling Excellence: autonomy and accountability for health and social care staff*", outlined plans for the regulation of support workers within health and social care. These staff include healthcare assistants (HCAs) and assistant practitioners—the majority of whom are involved in providing personal and intimate care to the most vulnerable in our society. Many of these staff work in isolated parts of an organisation or the community and often have limited access to supervision. There is also plethora of different job titles in use for these staff (UNISON has counted upwards of 120) which makes it difficult for patients to understand the responsibilities and skills of those caring for them.

4.2 UNISON is the leading professional organisation for healthcare support workers with over 100,000 HCAs in membership. In 2010, UNISON published the results of a major survey of HCAs¹⁴ which found that 72% of respondents felt that they should be subject to professional regulation. These results are further backed up by research from Said Business School at Oxford University.¹⁵

¹² CHRE, 2008 Special Report to Minister of State for Health Services on the Nursing and Midwifery Council, London.

¹³ Department of Health (England) *Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers*, Command Paper, February 2011.

¹⁴ UNISON Dedicated to healthcare, survey of HCA members July 2010.

¹⁵ Kessler, I, Heron, P, & Dopson, S (2010). *Evaluating the Healthcare Assistant role in acute care*, Oxford University.

4.3 UNISON's survey also confirmed that, increasingly, HCAs are undertaking tasks that were previously done by nurses, including elements of personal, intimate and hands-on care. As well as making beds, distributing meals and bathing and feeding patients, a significant proportion of everyday tasks included taking blood samples and carrying out complex dressings, catheterisation and cannulation.

4.4 Some health care organisations provide training for HCAs, including class room knowledge and work place assessment. However, a significant number offer little or no training. The lack of adequate training for this vital group, coupled with the problem of confusing job titles are issues which we believe must be urgently addressed by Government and employers. In workplaces where HCAs have been given developed roles or added responsibilities it is often not been introduced systematically, nor is it monitored. As a result there are huge inconsistencies both within and across organisations, causing confusion to patients and their carers.

4.5 The recent BBC Panorama television investigation into abuse at Winterbourne View private hospital in Bristol, reinforces the need for urgent action on the regulation of health and social care support staff who are not currently subject to statutory regulation. UNISON strongly believes that support workers involved in delivering personal and intimate care should be subject to statutory regulation via a system that is consistent across health and social care and which has consistent standards of conduct and competency. We acknowledge the Government's support for voluntary regulation, however, we have strong reservations that such a system could provide the same level of consistency and safeguarding as statutory regulation.

4.6 We also believe that urgent action should be taken to introduce national standards for the workplace inductions of health and social care support staff when they begin new roles, as well as national guidelines to ensure that robust training and development programmes are in place for these groups of staff.

June 2011

Written evidence from A Dignified Revolution (NMC 05)

A Dignified Revolution (ADR) is concerned about that the Nursing & Midwifery Council is failing to protect the public and the reputation of the nursing profession. These include:

- Failures to investigate complaints.
- The length of time it takes for an investigation to be processed.
- The fact that few nurses appear to be struck off.
- Inconsistent fitness to practice outcomes of investigation.
- Monitoring of pre-registration nurse education.

1. FAILURE TO INVESTIGATE

A Dignified Revolution receives correspondence from members of the public and nurses who have reported individuals to the NMC. Many have been extremely concerned at the NMC's decision not to investigate, when it was clear that the complaint is valid. The reasoning given was that there were no nursing issues to address. After receiving support from ADR the individuals complaint was accepted and is now being investigated.

2. PROLONGED INVESTIGATIONS

ADR asked NMC whether this case was being investigated
<http://www.dailymail.co.uk/news/article-1255858/Neglected-lazy-nurses-Kane-Gorny-22-dying-thirst-rang-police-beg-water.html>.

NMC reported that it was opening a case file and we would be kept informed. We have prompted updates since our initial contact—the latest being that the case is on hold whilst the police investigate. We assume that the nurses involved continue to practice.

3. FEW STRUCK OFF THE REGISTER

Following a Freedom of Information request NHS Reform found that few nurses are actually struck off the register <http://www.nhsreformgroup.com/PA-Funding/Promised-Purge-of-Cruel-NHS-Nurses-Empty-Promises/56.htm>

4. LITTLE OPPORTUNITY TO APPEAL

We recently contact the council for Health Regulatory Excellence about a case that was reported
http://www.getreading.co.uk/news/s/2087765_nurse_who_punched_pensioner_escapes_ban

The nurse who clearly abused a vulnerable patient was let off with a caution rather than being struck off—particularly when the panel “could not be satisfied that such misconduct would not be repeated”. And yet, Margaret Heywood was struck off the register in 2009 for breaching patient confidentiality to protect patients.

CHRE responded and said:

We were very concerned indeed about the outcome of this case. As a result we fully reviewed the transcript and evidence, and commissioned a legal report on the matter. We held a formal Case Meeting to consider whether we should use our powers to refer the matter to the High Court.

Regrettably the threshold for successful appeal to the High Court has been set very high over the years. This is as a result of earlier decisions by the courts on the interpretation of the regulators' rules, and of our own powers of appeal. We reluctantly concluded that we could not appeal the case to the courts.

We are currently finalising a report on our consideration of this case. Once this is done, we will publish it on our website. We will also write to you with a more detailed explanation of our decision.

It appears that there is little that can be done once the NMC has made its decision and it raises concerns about those who are allowed to continue to practice.

We believe that it would be useful for the Health Select Committee to request evidence from CHRE to ascertain its effectiveness in monitoring the regulators.

5. REVIEW OF FITNESS TO PRACTISE

CHRE has recently carried out a review of NMC Fitness to Practise to which ADR has submitted evidence. The report that was produced indicates that NMC is struggling. We would recommend the findings of the review be taken into account by the Committee.

http://www.chre.org.uk/_img/pics/library/110426_FTP_audit_report_2010-2011_amended.pdf

6. MONITORING OF PRE-REGISTRATION NURSE EDUCATION

ADR is concerned about the monitoring of pre-registration nurse education. It has been announced that NMC will in future be taking the monitoring in house. What mechanisms has it in place to ensure that this will be effective and involve stakeholders?

The monitoring reports of the various universities give little indication of quality/progress

<http://www.nmc-uk.org/Educators/Quality-assurance-of-education/Reviewing-and-monitoring/QA-monitoring-reports/>

For example—University of Staffordshire

<http://www.nmc-uk.org/Educators/Quality-assurance-of-education/Reviewing-and-monitoring/QA-monitoring-reports/>

June 2011

Written evidence from The Patients Association (NMC 06)

1. The Patients Association welcomes the opportunity to contribute to the scrutiny of the activities of the Nursing & Midwifery Council (NMC). The Patients Association is a national healthcare campaigning charity aiming to represent the interests of patients, working under the motto "listening to patients-speaking up for change."

2. We welcome the decision taken to conduct these annual hearings and support them as an important tangible mechanism of accountability. We would ask the Committee to do what it can to encourage any future formations of the Committee to continue this approach in the next Parliament and in all those that follow.

3. We would also seek to outline a number of areas for the Committee to consider in relation to the activities of the NMC.

4. Many of the public including patients are not aware of the role and function and existence of the NMC and therefore the NMC has a responsibility to ensure that this lack of knowledge is put right. Information about the satisfaction of patients and the public with NMC decisions, the regulation of senior Board level nurses and instances of service failure and the regulation of healthcare assistants.

RE REGISTRATION FOR NMC REGISTRANTS

5. Whilst the higher profile focus for revalidation has been on doctors, the principles of requiring evidence of ongoing performance meeting the standard for registration applies equally to all regulated healthcare professionals. The NMC should consider a similar revalidation process has been operationalised by the GMC in terms of the revalidation of medical practitioners.

6. As the largest part of the healthcare workforce therefore it is particularly important that patients and the public can have confidence that all NMC registrants maintain their competence throughout their career.

7. We believe that registrants should be required to collect robust evidence about their performance, and in particular evidence about the experiences and outcomes of patients, as part of the revalidation process.

8. There are currently less detailed proposals available to scrutinise how the NMC plan to approach revalidation but we would expect evidence to be collected in a way that is robust and rigorous.

9. This can only be considered the fair and appropriate approach to take, recognising the difficulties in developing a system that must be manageable for the diverse settings and roles in which registrants works.

10. We noted the following findings from the NMC Revalidation survey stage one that concludes that “Patient involvement is only a small part of the appraisal process” and “A relatively narrow range of evidence is used to inform performance decisions”. As the mechanisms for appraisal will inevitably form the basis of revalidation it is vital that these areas of weaknesses are considerably strengthened.

11. We urge members to inquire as to the progress of the revalidation agenda and to seek reassurance that this is moving towards the improvement of protection for patients and public, in particular, whether the reported consultation and pilot date of Spring 2012 (Revalidation, Prep and CPD, Dr Linda Burke, 20 April 20011) is sufficiently ambitious.

AWARENESS OF THE NMC AMONGST PATIENTS AND THE PUBLIC

12. The Committee will be aware of the high profile concerns about the quality of nursing care over a long period of time that occurred at a number of hospitals including Stafford Hospital. This latter of which is subject to a separate Public Inquiry, but information already placed into the public domain as a result of the inquiry may be of interest.

13. In particular, in opening submissions to the inquiry Mr Tom Kark QC (Counsel to the Inquiry) stated that:

“The NMC has searched its fitness to practise database and identified only three cases of allegations against nurses working at the Mid Staffordshire trust brought to their attention between 2001 and March of 2009. Those cases have now been closed, but more information is being sought on behalf of the inquiry. However, since the HCC report, a further 21 investigations were opened. The NMC is currently in the process of collating information about those cases.” (Transcript of evidence, Tuesday 9 November 2010)

14. In light of the scale and durations of concerns about nursing care the extremely low number of referrals is concerning. It suggests a very low level of awareness amongst patients and the public, at least in respect of the care being delivered at Stafford hospital.

15. Awareness is a undoubtedly a challenge for all regulators. We would like to draw the Committee’s attention to the remarks made by Sir Robert Francis during the ongoing Mid Staffordshire Public Inquiry in response to evidence being given by the Patients Association:

“It strikes me that information of the sort you suggest (information about how to complain and the role of professional regulators) could quite easily be incorporated with other information that gives rather mundane information about where to get out of the hospital...and where the canteen is.”

16. We would encourage all those involved in regulation to think about how they might better inform patients and the public about their role and activities. Whilst perhaps not something you would expect every member of the public to be aware of, we feel that introducing at least the concepts of complaints and regulation (along with ways of finding out more) to those using healthcare services as a reasonable objective.

INFORMATION ABOUT THE SATISFACTION OF PATIENTS AND THE PUBLIC WITH NMC DECISIONS

17. According to the NMC Annual Report 2009–10 the NMC:

“Conducted our first in-depth, qualitative research with participants in the FtP process. Telephone interviews with 21 referrers, witnesses and registrants focused on their information and communication needs. The findings from the research have helped us to produce new information for employers and witnesses, which we will publish shortly, as well as information for nurses and midwives, which we will be publishing next year.”

18. We would encourage the Committee to explore whether there are any plans for the more widespread and timely use of qualitative and quantitative measurement of the views and experiences of referrers, in particular measuring their satisfaction with the decisions relating to referrals. No such measure is listed in the Annual Report 2009–10 or Fitness to Practise annual report 1 April 2009 to 31 March 2010.

19. At a time when NHS organisations and individual professionals are being asked to prioritise the measurement of experience of service users, we would seek a similar priority for this issue amongst regulators.

THE REGULATION OF SENIOR BOARD LEVEL NURSES AND INSTANCES OF SERVICE FAILURE

20. Committee members will be aware of the widespread concerns about the quality of nursing care being provided, particularly for older patients.

21. High profile examples include Mid Staffordshire NHS Foundation Trust, Basildon and Thurrock NHS Foundation Trust, our own case story reports based on concerns coming to our Helpline (Patients not Numbers, People not Statistics (2009) Listen to Patients, Speak up for Change (2010)), the Parliamentary & Health Service Ombudsman Report Care and Compassion (2011), and the recent findings of the Dignity and Nutrition Inspection programme undertaken by the Care Quality Commission.

22. The Patients Association continues to have significant concerns about evidence of widespread shortfalls in the standards of nursing care that provide evidence of cultural and system failings, that are unlikely to be explained by isolated incidents of the failings of individual nurses.

23. We would encourage the Committee to explore with the NMC its views on this problem and in particular its approach to applying regulatory standards to senior nurse managers where evidence of service failure arises for example any action it has taken in relation to Mid Staffordshire NHS Foundation Trust.

24. Patients and the public deserve to understand the approach in a way that maximises transparency and understanding and ensures a consistent application across NHS organisations, irrespective of the level of media interest.

25. Specifically it may be useful to ask what proactive action is taken when a referral is received which indicates a system failure as opposed to individual practice failings.

26. The Patients Association encourages all healthcare professional regulators to recognise that they play an important role in communicating to the professions that they are ultimately individually responsible for the quality of care they provide and should not consider circumstantial pressures to be a *carte blanche* defence of poor standards, particularly if robust proactive action (eg whistle blowing) is not undertaken as per their professional responsibilities.

REGULATION OF HEALTHCARE ASSISTANTS

27. The NHS employs over 150,000 healthcare assistants and many are employed in social care. Healthcare assistants carry out duties that have historically been carried out by nursing staff. No qualifications are required to carry out the role. A role description is available on the NHS careers website and states that responsibilities include washing and dressing, feeding, helping people to mobilise, toileting, bed making, generally assisting with patients overall comfort, monitoring patients conditions by taking temperatures, pulse, respirations and weight.

28. A number of complaints about poor care received on the Patients Association Helpline have described poor care given by healthcare assistants but more often those contacting us are unaware of whether their concerns relate to a nurse or a healthcare assistant. There should be a responsibility that staff are easily identifiable.

29. Two examples below come from an account of care included in our 2010 Report *Listen to Patients, Speak up for Change*. Kim Denman and Jayne Johnson contacted our Helpline concerned about the poor care their father received in hospital in 2010.

“One of the most worrying incidents during Dad’s stay happened during this time. My nephews were visiting one evening in March when a care assistant went into the room and Dad asked her to move him up the bed. In front of them, she grabbed him by his neck and hauled him up into a more sitting position. She did not ask a colleague for help, she did not use a slide sheet or take any notice of his medical history that would have told her that he had broken the top two vertebrae in his neck five years earlier.”

“Our father was in severe pain but it did not stop her nor did the alarm expressed by my nephews. We complained about this incident to the nurse in charge but the next day whilst I was visiting the healthcare assistant came into Dad’s room and challenged him about getting her into trouble. His response was ‘I don’t get people into trouble, they get themselves into trouble when they don’t do their jobs properly’.”

30. The Government has recently announced that it will not be moving forward with the mandatory regulation of healthcare assistants. We are extremely disappointed that the Government has decided that it isn’t “proportionate” to ensure healthcare staff caring for some of the most vulnerable members of society are publicly and professionally accountable.

31. We would encourage the Committee to explore whether the NMC offers sufficient protection to the public in the circumstances where HCAs are working under the supervision of registered nurses.

THE REGISTRATION OF NURSES AND MIDWIVES FROM EUROPE

32. We are concerned about the inherent assumption in the free movement of labour principles applied to EU healthcare professionals, that the training and regulation of such individuals is equivalent across Europe.

33. The Patients Association maintains a degree of uncertainty about the actual tangible implications for patients and the public but is concerned that changes being made might indicate a reduction in the strength of

regulatory activity for European nurses and midwives. We would encourage the Committee to explore this issue with the NMC.

34. Specifically, the Committee might explore how the NMC decides which institutions in Europe provide a level of training that mean nurses trained there “gain automatic entry to the Nursing and Midwifery Council (NMC) register”, and whether the use of “automatic entry” reflects a change in practice.

June 2011

**Written evidence from Campaign Against Unnecessary Suspensions and Exclusion (CAUSE) UK
(NMC 07)**

SUMMARY

Through our website www.suspension-nhs.org we hear from nurses, midwives and health visitors who believe they have been wrongfully suspended from work.

As the Department of Health refuses to require organisations to report their suspensions, no one knows at this time, how many staff are currently suspended, why, for how long, and how the situation is being dealt with.

At present malfunctioning and/or incompetent managers are unaccountable for their actions.

When staff are dismissed and are referred to the Nursing and Midwifery Council (NMC) the NMC is in an ideal position to identify trusts that are failing in their duties of care to the public and staff when ignoring due policies and processes and who take action based on unsubstantiated, possibly malicious allegations.

This was seen very clearly in their report into the case of Nurse Margaret Haywood.

Dame Elizabeth Fradd and a working group looked for ways to assist [the] NMC to be more proactive in its protection of the public, within existing powers. We believe it will have no effect regarding the performance of malfunctioning managers.

1. Through our website www.suspension-nhs.org we hear from nurses, midwives and health visitors who believe they have been wrongfully suspended from work, with enormous cost to them and to the public purse.

2. Often these are whistleblowers or outspoken critics of their organisations. Sometimes they have been at fault but not to the degree of being suspended from work. The trusts have failed to use the Incident Decision Tree of the National Patient Safety Agency or used Root Cause Analysis to check there was no systems failure to blame in part or full. English organisations also fail to follow the English Chief Nurses guidance called Handling Concerns about the Performance of Healthcare Professionals: Principles of good practice.

3. If the outcome of the disciplinary process is dismissal, then they are referred to the Nursing and Midwifery Council (NMC).

4. It is our experience, both personal to those team members who have been reported to the NMC and from people who have contacted us through the website and kept in touch, that the NMC can see poor management processes but ignore them.

This was clearly seen in Nurse Margaret Haywood’s case.

5. The reasons given by the NMC’s Fitness to Practise panel for their decision to strike off N Haywood demonstrated the panel’s failure to grasp the issues and protect the public. There was also a grave miscarriage of justice.

CAUSE concluded that they are not currently fit for purpose for the following reasons:

6. Patients, relatives and staff “made complaints and raised concerns about fundamental basic nursing failures... occurring on Peel and Stewart Ward in summer and autumn 2004”. The panel described these failures as “of an exceptionally serious nature” (p3) and “dreadful” (p8). By their very nature they were putting patients’ lives at risk and may even have caused premature deaths.

7. The head of matrons took no action about these complaints and concerns until 17 December, when he “carried out an inspection of the ward” (p2). Matrons are supposed to be aware of what is happening on their wards. Why didn’t the matron for that ward already know there were significant problems? Why had he or she not taken any action?

8. Why didn’t the NMC pick up this failure? Why did they show no concern that it took the head of matrons so long from the initial complaints until December to make any response? Why did they think “an inspection of the ward” was a satisfactory way to investigate the serious complaints?

9. The head of matrons took until April 2005 to write a report.

Why did the panel express no concern at the length of time taken to write a report regarding exceptionally serious and dreadful failures?

10. The panel said that the “report and recommendations therein contained was in the view of the panel not very impressive”. So why did the panel not consider the report and recommendations as a major failure by the trust to protect patients—the fundamental duty of the NMC and reason for the hearing?

11. It took the showing of the *Panorama* programme before “much more significant recommendations were made”, said the Director of Nursing (p3). So Margaret Haywood’s case had been made. She had also expressed her concerns to the new ward manager before filming without any change occurring.¹⁶

12. The NMC said she should have used the trust’s whistleblower’s policy and taken it to various levels of management or to the NHS counter fraud unit or the Department of Health¹⁷ directly, if necessary.

Why did the NMC panel think anyone would take action if all the complaints and concerns had thus far failed to bring about any change? Why couldn’t they see that the trust had had an opportunity to take action, had made a very poor attempt to investigate and had therefore failed completely in its duty of care to patients, as other trusts have been found to fail, resulting in patient deaths?

13. Margaret Haywood had to answer a second charge of failure to assist a call for help by a fellow nurse.

The panel failed to comment on the punitive behaviour of the head of matrons who “was seeking information concerning the behaviour of the registrant on the ward” (p4) and made an allegation 14 months later. “There was no criticism of her [Margaret Haywood’s] behaviour at the time by any of the protagonists in the incident.” (p4). Why?

14. CAUSE has found this behaviour to be common. People who are failing in their duty of care try to deflect their poor practice by making false allegations about the whistleblower and, worse still, their trust upholds their actions. In other words, there is a culture of cover up and unjust investigations and disciplinary hearings.

15. This will not have been the first time the panel has met this, but once again they fail to denounce the practice. Why? Why did they not see this as a denigration of the registrant’s character and reputation, as well as a waste of everyone’s time? It is also a very distressing experience to be falsely accused, and takes immense amounts of time and energy¹⁸ to write a defence.

16. Margaret Haywood believed the protocol established with the BBC meant that patients would not be included in the programme without their or their relatives’ consent. She avoided filming patients’ faces and that where that had been unavoidable, the faces were blurred during transmission.

The panel seemed unable to understand this. They seemed unable to understand that Margaret Haywood genuinely believed she was acting in the best interests of the patients and that filming the evidence was the only way to stop this terrible suffering and possible loss of life. Why?

The panel seemed to find it hard to believe that she could trust the BBC to keep to its word and protect patients’ identity. They did not establish any reason why she should not have done so. Why?

17. The reason for striking the registrant off the register (p7 and 8) were very poor. Margaret Haywood’s belief that she was acting to protect patients was ignored. Her integrity was denied. The public interest was ignored. The fact that Margaret Haywood stood by her claims was seen as a ‘lack of any real insight into her misconduct’ (p8).

Why did the panel fail to look at the bigger picture of public protection from these “exceptionally serious and dreadful failures”?

18. The message the panel gave to nurses was destructive to the cause of changing the culture of blame and looking instead at the failure of systems to protect patients.

19. From the *Nursing Times* report (21 Sept 10) Dame Elizabeth Fradd led the NMC’s working group looking “to find ways to assist [the] NMC to be more proactive in its protection of the public, within existing powers”.

Her final report recommended “hold[ing] nursing directors to account¹⁹ for the quality of their patient care” by asking them to make an annual report on how they were meeting NMC standards. The report also said NMC staff felt there was a need for a “philosophical” change at the NMC to make it “become a more proactive organisation and for each section to work more closely together”.

“Informal networks do exist across [the] NMC but the organisation is highly dependent on personal recall, because of the lack of systems for proactive sharing,” it said.

¹⁶ <http://www.nursingtimes.net/5000769.article>

¹⁷ <http://www.nursingtimes.net/5000769.article>

¹⁸ <http://www.nursingtimes.net/5000769.article>

¹⁹ <http://www.nursingtimes.net/5019398.article?referrer=e26>

Dame Elizabeth recommended the NMC set up an IT system to collect information on trusts. But she urged the council to wait and see how the regulatory regimes of other bodies developed before asking for new legal powers.

CONCLUSION

We believe this action will not prevent individual malfunctioning, incompetent managers silencing whistleblowers and outspoken staff who care about the treatment of their patients. We therefore have no confidence in the NMC's current systems, that it will identify and take action against poorly performing trusts to protect the public and save lives.

June 2011

Supplementary written evidence from the Nursing and Midwifery Council (NMC 02B)

Please see below responses to the three further questions which the Committee had regarding its scrutiny of the NMC.

Q: What is the difference between the NMC's request for powers to allow voluntary erasure of registrants and the existing system where registrants write to the NMC to remove themselves from the register?

A: Voluntary removal/erasure is a process which would apply to registrants who have an ongoing FTP investigation and the concerns about their fitness to practise relate either to their health or their competence. It would not be a mechanism available to registrants who were being investigated for serious misconduct allegations. Our fundamental aim is to protect patient safety and by allowing registrants to remove their name from the register in appropriate circumstances is one of the most effective ways of delivering patient safety and reducing the burden on the FTP process. All registrants are able to let their registration lapse but they cannot do so if there is an on-going FTP investigation.

Q: Does the NMC hold the records of registrants who have removed themselves from the register, and if so, for how long?

A: The NMC permanently holds records of registrants who have removed themselves from register and there is no time limit on the length of time such information is held (ie; it is "forever"). In FTP we would continue to hold investigation information on those registrants who voluntarily removed their name from the register during an investigation.

Q: If an allegation is made about a nurse or midwife after they have removed themselves from the register and who then seeks to return to practice, is this allegation recorded against the registrant's name and considered as a part of their return to practice request?

A: If the allegation is received after the registrant has removed themselves from the register, current practice is that FTP flag the registrants entry as "will be under investigation". Therefore if and when the individual applies for readmission following a return to practice course, the application is reviewed by the Registrars Advisory Group (RAG) for consideration for readmission. If a registrant applied to restore themselves to the register having removed their name during an ongoing FTP investigation, the application for restoration would fall to FTP to consider and not the Registrar. FTP would then pick up their investigation from the moment when the registrant removed their name from the register.

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