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Health Committee

2012 accountability hearing with the Nursing and Midwifery Council

Ninth Report of Session 2012–13

Report, together with formal minutes, oral and 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.

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Additional written evidence may be published on the internet only.

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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).
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Summary

The Nursing and Midwifery Council (NMC) has been subject to sustained criticism emanating from a variety of sources for a number of years. It is apparent that much of this criticism has developed due to the NMC’s basic failure to understand its core purpose and properly prioritise patient safety. We are now satisfied that as a result of the criticism it has received the NMC is beginning to prioritise its core functions. We are optimistic that the NMC will now concentrate its efforts on improving its performance in relation to Fitness to Practise (FTP) and developing an effective model for revalidation in order to achieve its objective of delivering public protection.

The NMC had allowed a substantial backlog of FTP cases to accumulate and in doing so the engine room of the organisations began to fail. The NMC has work to do in order to ensure that its FTP processes meet the standards set by the other professional regulators. A backlog of cases which have been outstanding for more than two years must be cleared and we remain concerned that cases still take too long to be resolved. There is growing evidence, however, that the NMC’s new management team has implemented reforms which will allow the NMC to tackle the problems associated with FTP. It is welcome that the NMC is on track to meet its own targets in relation to the time taken to investigate a case and the period to reach adjudication.

The inability to supply detailed and accurate management data has undermined the NMC’s ability to project the number of FTP cases it has had to manage. We remain concerned that the NMC has yet to develop a business model which will allow it to understand the likely extent of its future workload.

Serious failures in relation to financial planning have become apparent within the NMC resulting in the regulator underestimating its budget for FTP by 30%. Total budgeted expenditure for the NMC was also significantly underestimated and it is this lack of basic financial competence which resulted in the NMC proposing a substantial fee rise for registrants. It is welcome that the NMC has developed a Board level review group to scrutinise financial management data and we are keen to see evidence at our next hearing with the NMC that scrutiny in this area has improved.

Nonetheless, the NMC felt compelled to accept a grant of £20 million from the Department of Health in order to moderate the fee increase set to be imposed on registrants. In our last report we said that the registration fee should not be increased, but the financial circumstances of the regulator led to the NMC’s proposal of an increase in the annual fee from £76 per annum to £120 per annum. The grant from the Department of Health will limit the rise to a fee of £100 per annum but we recognise registrants enduring a period of pay restraint will not find an increase in fee palatable.

At the heart of the problems facing the NMC has been the failure to equip its staff with IT systems that meet the demands of the regulator’s different directorates. Most problematic has been the inability of the system used for FTP to communicate with the registration system. This has resulted in the production of insufficient and inaccurate management data and, in part, contributed to failures associated with financial planning. The NMC has
prioritised stabilising its existing IT systems before investing in newer technology and we believe that this is an urgent task for the NMC. It is not possible for the NMC to meet its targets in relation to FTP and to produce better quality management data without the foundations of an effective IT system.

The problems associated with IT have also contributed to worryingly high levels of staff turnover within the NMC. Turnover of staff stands at 36% and this is both unsustainable and an indicator of poor morale within the organisation. A culture of resigned resilience amongst staff had been highlighted by the Council for Healthcare and Regulatory Excellence (now the Professional Standards Authority) in 2012 and this must be addressed if the NMC is to deliver its responsibilities as a regulator. At our next hearing we hope to see a substantial improvement in the workplace culture evidenced by a significant reduction in staff turnover.

The high turnover of figures within senior management positions has undermined leadership and damaged staff morale within the NMC. It is very difficult to develop an effective, confident and respected organisation when there is such instability in the most senior positions. The NMC would benefit from a period of stability and management consistency. The Chair and Board should work with ministers in order to achieve this objective.

We are concerned that the roll-out of revalidation has been delayed until 2015. The NMC’s preparation appears to be at a very early stage and as yet the NMC has failed to demonstrate how revalidation will be targeted. Until the NMC is able to use its IT systems effectively it will not be possible for revalidation to target high risk groups. A proportionate and effective revalidation process should be operated by the NMC and at our next hearing the NMC should be able to provide us with a much more detailed plan for how this will be delivered.

We examined the question of language testing of Nurses and Midwives from inside the European Economic Area at our last hearing. We recommended that the NMC should work with other regulators to urgently resolve this problem as, ultimately, it represents an issue related to patient safety. It is disappointing that little progress has been made which would ensure that nursing staff can communicate with their patients. The NMC is leading on work within the EU which, in the long term, may resolve this problem, but we urge the Department of Health to support the NMC in developing a more immediate solution.
1 Introduction

1. We report below on the annual accountability hearing we held with representatives of the Nursing and Midwifery Council (NMC). We took evidence from Mark Addison CB, Chair and Jackie Smith, Chief Executive on 16 October 2012. This is the second such hearing in the series which we propose to be held annually throughout this parliament.

2. The NMC is the independent regulator for nurses and midwives in the UK and was established under the Nursing and Midwifery Order 2001. The NMC’s statutory purpose “is to safeguard the health and wellbeing of the public.”

Public inquiry into Mid Staffordshire NHS Foundation Trust

3. The accountability hearing was held, and this report largely prepared, before publication of the report of the inquiry chaired by Robert Francis QC into the Mid Staffordshire NHS Foundation Trust, which makes a number of recommendations in relation to the NMC. We have taken oral evidence from Mr Francis and shall also be taking evidence from others. We shall therefore report separately on issues arising from the Francis report and do not offer an analysis here of his proposals for the NMC.

Conclusions of the 2011 annual accountability hearing

4. The principal concern of the Committee in 2011 was the significant increase in fitness to practise (FTP) cases. We were surprised both that the NMC did not understand why FTP cases had increased in number so rapidly and that the NMC could not readily distinguish between referrals for nurses and midwives. We were also disappointed that the NMC had failed to collect ethnicity data or undertake diversity monitoring so “the public can have confidence that the NMC discharges its functions in a manner that is fair and equitable to minorities.”

5. More broadly, we were concerned that the upward trend in FTP cases was reflective of:

“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 concluded that, in light of the degree of risk this posed to patients, the NMC should:

• “develop a programme of action to deliver a demonstrable improvement in outcomes for elderly patients.”

3 Ibid, p 6
4 Health Committee, Seventh Report of Session 2010–12, Annual Accountability Hearing with the Nursing and Midwifery Council, HC 1428, para 14
5 Ibid, para 17
6 Ibid, para 18
“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.”

6. We also accepted the NMC’s argument that the Nursing and Midwifery Order 2001 should be amended to allow the NMC to improve its FTP procedures.

7. We examined the development of the NMC’s revalidation system. The Committee concluded that the requirements for re-registration — 450 hours of practice and 35 hours of professional development were “wholly inadequate”. The Committee took the view that relying on nurses to ensure that they have met these standards will not root out the dishonest minority. We agreed with the risk-based approach to revalidation but recommended that the NMC undertake an annual random audit of re-registration in order to verify the evidence supplied to the NMC.

8. The Committee also reviewed the question of language competence for overseas trained registrants. We recommended that the NMC should work with the other professional regulators to raise the urgency of resolving this problem and mitigating the risk to patients. The Committee suggested that the NMC follow the approach adopted by the General Medical Council (GMC) whereby responsible officers sign off a doctor’s competence to practice.

9. We also recommended that, over time, the NMC’s responsibilities be extended to the mandatory statutory regulation of healthcare assistants, support workers and assistant practitioners. The Committee concluded that “this is the only approach which maximises public protection” but warned that the NMC would need to improve the operation of its core functions (especially FTP) it were to take on these responsibilities.

10. Finally, the Committee expressed concern that increases in the annual registration fee would render it unaffordable for lower paid registrants. We urged the NMC to avoid further increases in fees and “to consider fee reductions for new entrants to the register.”

Council for Healthcare Regulatory Excellence’s strategic review of the NMC

11. In January 2012, Anne Milton MP, then Parliamentary Under-Secretary of State for Health, asked the Council for Healthcare Regulatory Excellence (CHRE) to undertake a strategic review of the NMC. Anne Milton explained in a written statement that the CHRE’s report on the NMC’s performance in relation to FTP had shown that the NMC was not improving at a satisfactory rate. Announcing the review the Minister said it would:

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7 Ibid, para 19
8 Ibid, para 31
9 Ibid, para 32
10 Ibid, para 47
11 Ibid, para 64
12 Ibid, para 4
look at the NMC’s organisational structure, resource allocation and operational management. It will establish what further action is needed to ensure that the NMC is effectively carrying out its statutory duties to promote high standards of conduct and practice in order to protect the public.\textsuperscript{13}

12. In its written evidence to the Committee, the Department of Health (DH) stated that the magnitude of the problems within the NMC “was not clear from the evidence the NMC gave to the Health Select Committee last year” and that this required “urgent redress”.\textsuperscript{14}

13. The overall verdict of the CHRE in its strategic review of the performance of the NMC was very unflattering. It noted in its written evidence to the Committee that the NMC had failed to meet 6 of the 24 standards of good regulation and found that:

\begin{quote}
\textit{at the heart of the NMC’s failure to succeed lies confusion over its regulatory purpose, lack of clear, consistent strategic direction, unbalanced working relationships and inadequate business systems.}\textsuperscript{15}
\end{quote}

14. The failings identified by the CHRE included weaknesses in:

- governance
- leadership
- decision making
- operational management
- financial stewardship

15. The CHRE was critical of the senior management noting that “much of what went wrong here was the direct responsibility of the NMC’s leaders and a reflection of their skill mix and capacity”.\textsuperscript{16} The relationships between the Chair, Chief Executive and Council were described as dysfunctional and it emphasised that the recruitment process for the new Chair and Chief Executive (both now appointed) should include due diligence to ensure that the new appointments “have the personal credibility, leadership behaviours, competencies and communication skills” necessary to implement the recommendations of the review.\textsuperscript{17}

16. The CHRE identified a lack of understanding of the NMC’s core purpose as a fundamental flaw in the management of the organisation. It argued that the NMC had lost sight of its role as a body designed to enforce a baseline standard “below which professional

\begin{flushright}
\textsuperscript{13} HC Deb, 26 January 2012, col 25WS

\textsuperscript{14} Ev 16

\textsuperscript{15} Council for Healthcare and Regulatory Excellence, Strategic review of the Nursing and Midwifery Council Final report, July 2012, p 4

\textsuperscript{16} Ibid

\textsuperscript{17} Ibid
\end{flushright}
practice must not fall.”18 The CHRE expressed the view that the NMC should not seek to act as an improvement agency as this responsibility lies elsewhere.

17. The CHRE found that the NMC had underinvested in FTP in comparison to other regulators and had only recently begun to address the problems with its performance in this area.19 The registration function was found to be operating more effectively but it was often hamstrung by an ineffective IT system. The CHRE reported that the FTP case management system could not properly communicate with and update the registration system meaning changes had to be made manually.20

18. Operational management was judged to be ineffective with “poor planning, an absence of clear decision making processes, unreliable management information, and a collective failure to link activity with cost” lying at the heart of the NMC’s failure.21 The lack of effective management combined with a hierarchical culture that had developed over many years resulted in an organisation whose staff were resigned to the frustration of being unable to meet their objectives and the criticism that inevitably follows.22

19. The financial management of the NMC was severely criticised by the CHRE. They concluded that:

the NMC has shown a collective lack of competence in failing to establish an appropriate link between the costs involved in delivering its planned activity, the key performance indicators it has committed to and the budget it has approved.23

20. Until 2010 the NMC maintained a policy of ensuring they held a reserve of six months operating expenditure plus their estimated share of the pension deficit. This was revised to three months reserve in May 2010, but the CHRE concluded that this policy was excessively restrictive for a monopoly organisation which enjoyed a stable, fixed income. This restrictive approach was judged by the CHRE to be contributory factor in the underinvestment in FTP.

21. As a result of its findings, the CHRE produced 15 recommendations designed to address the specific concerns identified within the report.24 The NMC has accepted the CHRE’s findings and recommendations in their entirety. The CHRE concluded by saying that they “would expect to see demonstrable improvement within two years.”25

18 Ibid, p 5
19 Ibid, p 32
20 Ibid, pp 26–27
21 Ibid, p 5
22 Ibid, p 16
23 Ibid, p 22
24 Ev 28–32
25 Ibid, p 37
2 Purpose of the NMC

Prioritising core functions

22. The CHRE’s review found that “the NMC has not understood its regulatory purpose well and as a result it has not communicated it clearly to its stakeholders.”\(^\text{26}\) This was largely the result of the fact that the previous Chair and Chief Executive had identified:

a perceived vacuum in professional leadership and so extended its activities [...] beyond the capacity of the organisation.\(^\text{27}\)

23. The CHRE added that:

the role of the regulator is to set the ‘baseline’, the standard below which professional practice must not fall. It is the role of professional bodies to seek to raise the bar and to encourage nurses and midwives to achieve excellence in practice.\(^\text{28}\)

24. The NMC’s written evidence indicates that they will continue to undertake some work that is designed to improve standards within the nursing profession.\(^\text{29}\) “The NMC publish a code which sets standards concerning communication with patients and putting their needs first, and in addition it delivers a range of education programmes for nurses and midwives. Nonetheless, the NMC’s evidence makes it clear that “the professional regulator is at a distance from the delivery of care, and there are limits to the impact it can have on the quality of care.”\(^\text{30}\)

25. The Royal College of Nursing says in its evidence to the Committee that the NMC should focus on its core responsibilities, but balance this against its work in developing education standards and revalidation as this will help to reduce future FTP cases.\(^\text{31}\) The Patients Association argued that “there remains a perception amongst some patients that the NMC is out to protect nurses rather than addressing breaches of standards.”\(^\text{32}\)

26. Over a number of years the NMC has failed to understand its function and properly prioritise patient safety and the new Chief Executive conceded this failure in evidence to the Committee.\(^\text{33}\) Ms Smith told us that the NMC’s ‘focus must now be on public protection’ and that both professionals and the public must have confidence in the NMC’s ability to deliver this.\(^\text{34}\) We are satisfied that as a result of the criticism it has received the NMC now understands that it must concentrate its efforts on Fitness to
Practise (FTP) and revalidation in order to achieve its objective of delivering public protection.

27. The NMC’s renewed appreciation of its core purpose will inevitably narrow the organisation’s focus and the scope of work it undertakes. It will to some extent restrict the NMC’s previous activity related to education and support services for Nurses and Midwives. The Department of Health’s written evidence reinforced the notion that the NMC must prioritise its core functions, noting that:

The CHRE published its Audit of the Nursing and Midwifery Council’s initial stages fitness to practise process in November 2011, which found continuing areas of significant weaknesses in its handling of cases at the initial stages of the fitness to practise process. The CHRE concluded that ‘these weaknesses create risks for public protection and public/professional confidence in the regulatory process’.

28. Given the fundamental nature of the problems at the heart of the NMC we agree with Mark Addison’s assertion that the NMC’s management has ‘no real alternative but to address the engine room’ of the organisation. We acknowledge that the NMC will have to compromise on the extent to which it can support its additional functions and accept this compromise is necessary if the NMC is to regain the trust of the public and professionals.

35 Strategic review of the Nursing and Midwifery Council Final report, p 18
36 Q 3
3 Fitness to Practise

29. Against this background the Committee believes that the key priority for the NMC is to improve the effectiveness and timeliness of its Fitness to Practise processes. The NMC has set the following key performance indicators (KPI) to monitor progress in delivering these objectives:

a) The number of ‘historic FTP cases’ (ie FTP cases received before January 2011) should be reduced to nil;

b) The average time taken to investigate FTP cases should be reduced from 22.6 months at the beginning of 2011 to no more than 12 months;

c) The average time taken to adjudicate FTP cases should be reduced from 8.9 months at the beginning of 2011 to no more than 6 months.

30. The Committee welcomes the fact that clear Key Performance Indicators (KPIs) have been set for the FTP process. It has reviewed the latest evidence from the NMC of progress against these indicators and welcomes the fact that the performance of the organisation is improving. In the Committee’s view, however, the KPI should focus on the total time taken to investigate a complaint and it remains concerned that it should not take 18 months to resolve an allegation of unfitness to practise. We urge the NMC to work to reduce this period towards an average target of 9 months as a matter of urgency.

31. The Committee also urges the NMC to set an additional KPI which determines the maximum acceptable time to determine an FTP case. The Committee finds it hard to believe there can be circumstances when it is acceptable for an FTP case to take more than 12 months to resolve.

Historic Cases

32. In order to distinguish new cases from the historic backlog, the NMC refers to a case as ‘historic’ if it arose before 2011 but involves registrants who are still practicing. Measured against this yardstick Jackie Smith told us in evidence that the NMC “expect to clear the historical backlog of cases and achieve our KPIs by 2014.” Recent evidence from the NMC reports that the ‘backlog’ has been reduced to 572 open cases.

33. Although the NMC has made progress with the elimination of its backlog it is clearly very unsatisfactory that there are 572 cases which have been outstanding for more than two years. The Committee urges the NMC to clear all these cases no later than 30th June 2013.
Current Cases

34. In recent evidence to the Committee the NMC reports the following progress in dealing with current cases:

a) The average time taken to investigate an FTP case has fallen from 22.6 months in January 2011 to 10.6 months in Q4 2012 — against a target KPI of 12 months.42

b) The average time taken to adjudicate an FTP case has fallen from 8.9 months in January 2011 to 7.4 months in Q4 2012 — against a target KPI of 6 months.43

35. The Committee welcomes this evidence of progress in securing timely investigations and decisions, and note that the total average time is now within the total KPI of 18 months. As noted in Paragraphs 30 and 31, however, the Committee still regards this process as unduly extended from the point of view of both patients and regulated professionals and urges the NMC to adopt more the demanding KPIs proposed in the earlier paragraphs.

Section 29 Referrals

36. Section 29 of the National Health Service Reform and Health Care Professions Act 2002 allows the CHRE to refer decisions of the FTP panels or committees of the nine regulators to the High Court, where it considers a ruling they have made is wrong or unduly lenient, and that it is necessary to do this to protect the public.

37. The CHRE's written evidence provided an overview of the findings from their annual review of all of the medical professional regulators’ FTP activity. The CHRE said that they are:

still referring more NMC cases to formal section 29 case meetings than cases of all the other regulators put together, due to the poor quality of their fitness to practise panel decisions (sometimes combined with poor quality investigation by the NMC).44

The CHRE is responsible for sharing lessons to be learned with all the regulators from the decisions they review. The CHRE has concluded that within the NMC there has been “a failure to implement learning successfully”.45

38. Jackie Smith told us that the NMC’s record on decision making had been questionable in the past but concerted efforts had been made to support panels and improve training for panel members.46 In recent evidence the NMC has also reported that there have been no s.29 referrals of its decisions by the CHRE (or its successor the PSA) since September 2010,

42 Ev 46
43 Ibid
44 Ev 36
46 Q 19
and that there is “objective evidence of good decision making from two recent High Court judgements”.  

39. The Committee is pleased to note that there have been no s.29 referrals of NMC decisions since September 2010, and urges the NMC to maintain this improvement in the quality of its determinations.

**NMC powers to review cases**

40. In 2011 we heard about a number of problems with the Nursing and Midwifery Order which governs its work in relation to fitness to practise cases. This year we have had a further issue with that order drawn to our attention by a case raised in the House of Commons by Rt Hon John Healey MP.

41. In cases where the NMC has made an initial judgement that there is no case to answer on a complaint raised against a registrant, it does not have the power to re-examine that case and apply a sanction unless a further complaint has been made within three years of the first. As legal advice commissioned by the NMC and quoted by Mr Healey says:

> The Order and Rules makes it plain that the NMC has no statutory power to review, re-open or reverse a disciplinary decision (in particular, a decision of the Investigating Committee that a registrant has no case to answer) beyond the specific circumstances stipulated in rule 7, namely: receipt of a fresh allegation within three years of the dismissal of a previous allegation against the same registrant […] Typically, other professional regulators have wider review powers, granted explicitly by secondary legislation.

42. As the advice notes, other regulators are able to re-examine cases; the GMC, for example was granted this power in 2004. The Department of Health’s response to the specific case raised was to draw attention to the comprehensive review of the regulatory framework being undertaken by the Law Commission which will cover all regulators, but which will not be brought forward until 2014. The Department argues that amending the Order separately would take two years and so would not be happen any sooner than the general changes.

43. We consider that the inability of the NMC to review its own initial decisions is a significant gap in its powers. We note the forthcoming general review of regulatory powers by the Law Commission, but we recommend that the Department of Health takes action now to seek to amend the Nursing and Midwifery Order to put the NMC on a par with the GMC in these matters as soon as possible.

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47 Ev 45  
48 HC Deb, 20 December 2012, col 1028  
49 The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (SI 2004/2608)  
50 HC Deb, 20 December 2012, col 1038
**External investigators**

44. The NMC told the Committee that it has decided to the end the contracts it has held with external investigators to support its FTP process. Jackie Smith told us that by the beginning of 2013, 80% of investigations would be conducted in–house and ending the use of external contractors will “reduce costs, and improve timeliness and quality.”51 Expanding on this, Ms Smith noted that outsourcing arrangements are ‘extremely expensive’ and that the GMC successfully operates an in–sourced model.52

45. The Committee accepts the principle of controlling investigations in–house and modelling the structure of the investigations unit on more successful regulators. Furthermore the Committee recognises that improved control over the quality of investigations will have contributed to the improved quality of NMC determinations. The Committee is however mindful that the decision making process of the NMC remains unduly extended and questions the wisdom of dispensing with capacity when the organisation still faces a substantial backlog of work. At the next accountability hearing we shall wish to investigate whether the removal of this additional resource has reduced the NMC’s ability to shorten its decision times.

**Projections of future cases**

46. An inability to supply effective management information led the CHRE to conclude that the NMC has been unable to forecast activity and plan for future costs accurately.53 A lack of understanding of why their FTP caseload had increased was identified as a crucial failing in their analytical performance.54

47. In evidence Mark Addison told us that the NMC’s model for the next year had projected an 8% increase in the number of FTP referrals.55 He said that the NMC had examined this ‘quite carefully’ and that the projections have been referred to an external party to be reviewed.56 The CHRE, however, reported that the assumption of an 8% increase is ‘subjective’ and “based on limited analysis of historic rates and expected future events such as the outcome of the Francis Inquiry”.57 The 8% projection is not being borne out by current activity. The NMC told us that existing referral levels remain flat and that next year “we expect some increase, but we do not know if it will be a spike or a more chronic year on year increase, following the Francis inquiry report.”58

48. While we recognise the difficulty of developing robust projections of the number of FTP cases which will be brought, it is essential that the NMC develops a business model

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51 Q 16  
52 Q 25  
53 Strategic review of the Nursing and Midwifery Council Final report, pp 33–34  
54 Ibid, pp 33–34  
55 Q 25  
56 Ibid  
57 Strategic review of the Nursing and Midwifery Council Final report, p 24  
58 Q 25
which is sufficiently flexible to allow it to accommodate fluctuations in FTP workload without an excessive impact on either the quality or timeliness of its decisions.

Improving Processes

49. Jackie Smith conceded that the NMC had not devoted the “attention, the time and the resource to fitness to practise that was needed.” Arguing the case that the NMC is beginning to rectify this, Ms Smith told us that the NMC now has a system for screening out 40% of referrals in order to prioritise cases and make an early judgement as to a registrant’s fitness to practise.

50. Nevertheless, weaknesses within the NMC’s FTP directorate persist. The CHRE’s audit of the NMC’s initial FTP processes identified a series of failings. Inconsistent record keeping, lack of active case management and poor customer care were noted. In addition a failure to provide sufficient and accurate information in decision letters in order to demonstrate the robustness off investigations was highlighted by the audit as a fundamental problem. The CHRE found that:

   Many of the weaknesses from this year’s audit are the same weaknesses that we identified in earlier audits. In response to our earlier audits the NMC said that it had implemented improvements and assured us that we would see improvements in later audits. [...] In our view, our findings mean that we have not yet seen evidence that the improvements that have been initiated since January 2011 have resolved the problems we previously identified.

51. In more recent evidence, however, the NMC has reported that it has made modest progress against KPIs which were set to encourage improved process. In particular the NMC reports that during the fourth quarter of 2012 decision letters were sent within 5 days of the decision being reached in 99% of cases and complaint letters were answered within 20 days in 86% of cases — against a KPI in both cases of 100%. Both the fact of the KPI and the performance against it reflect a welcome commitment from the NMC to deliver an improved performance.

59 Q 10
60 Qq 15, 18
61 Council for Healthcare and Regulatory Excellence, Audit of the Nursing and Midwifery Council’s initial stages fitness to practise process, December 2012, p 2
62 Ibid, p 2
4 Management & governance

Financial Planning

52. The NMC has reported persistent systematic failures in relation to financial planning. In the last financial year the organization spent £41 million in direct costs (£26 million in 2010–11) on FTP (67% of its budget) having budgeted only £31 million. For this financial year they project that FTP will represent 59% of the annual spending.

53. The broader financial management of the NMC has been called in to question by the Royal College of Nursing who cite the CHRE review which showed that the NMC had consistently failed to accurately cost activities. The CHRE strategic review found that the original budgeted expenditure for 2012–13 leapt from £56 million to a forecast of £73 million. They attribute these changes to “two key assumptions related to fitness to practise activity and a failure to deliver efficiencies that were built into the budget to the timescales originally envisaged.”

54. Serious failures associated with financial planning over a sustained period of time eventually forced the NMC to propose a major fee increase for registrants (discussed separately in Chapter 5) It is unacceptable that the NMC’s management underestimated the required budget to sustain the FTP directorate by 30%.

55. Although the NMC’s inability to accurately project its workload and financial requirements has hamstrung the organisation, the Committee notes the fact that the NMC now recognises the seriousness of these failings. The NMC said in evidence that it is now taking steps to address the long-standing and fundamental flaws in the NMC’s financial planning. The Committee will be seeking assurance at the next accountability hearing that these steps have been effective.

56. Mark Addison told us that the Council has now established “a finance review group, which consists of Council members and members of the executive, which looks very carefully at the full range of financial management data.” This review group has been established in addition to a group tasked with analysing the NMC’s FTP programme. We believe that this represents a logical development as FTP and the NMC’s financial requirements are fundamentally linked and must be subject to specific and ongoing scrutiny.

57. It is fundamental to any organisation that board members should be equipped with sufficient information to challenge the decisions taken by the executive. At our next hearing with the NMC we will seek evidence that the Council and its review groups are

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64 Ev 38
65 Strategic review of the Nursing and Midwifery Council Final report, p 23
66 Ibid
67 Q 5
68 Q 59
benefiting from the delivery of better data and are able to scrutinise and challenge management information with greater effect.

**Information Technology**

58. The CHRE concluded the NMC has “struggled with its Information Technology infrastructure” and found that the NMC’s various systems are out–dated and there is limited capacity for the two main systems — WISER which supports the register and the Case Management System (CMS) used by the FTP directorate — to interface.⁶⁹ The CHRE noted that this presented fundamental problems within the organisation and made it difficult to keep track of essential information such as the outcomes of case hearings.⁷⁰ As a result NMC staff relied on manual input of data and developing their own solutions to problems resulting from the IT systems.⁷¹

59. At the heart of the NMC’s failures has been an inability to produce accurate and timely management information. The manual input of data and bypassing of functions within the CMS resulted in the CMS “failing to accurately reflect the stage of all fitness to practise cases” and it could not “be considered to be a true reflection of all fitness to practise activity.”⁷² The CHRE reported that:

> A recent review of management information in fitness to practise carried out by KPMG recommended that, once the functionality of CMS has been reviewed by teams within the NMC, the use of CMS should be mandated to improve the quality and timeliness of the information produced.⁷³

60. Mark Addison acknowledged that the capacity of the NMC’s systems to manage financial and FTP data effectively has been called in to question and the NMC has begun to examine systems used by other regulators to rectify these problems.⁷⁴ Jackie Smith noted that extracting information from the two key systems is “extremely resource–intensive”,⁷⁵ Ms Smith explained that:

> The problem is that our two fundamental systems do not speak to each other. That is the stabilisation bit that we are doing at the moment, so that we do not have to have a massive amount of resource to produce the information that we need.⁷⁶

61. Jackie Smith told us that the focus for management is on stabilising the existing systems and that they are reluctant to “spend lot of time and money investing in something that is not going to deliver for the NMC.”⁷⁷ As such, the NMC remains at a stage whereby it is

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⁶⁹ *Strategic review of the Nursing and Midwifery Council Final report*, p 26
⁷⁰ Ibid, p 26
⁷¹ Ibid, p 27
⁷² Ibid, p 27
⁷³ Ibid, p 27
⁷⁴ Q 23
⁷⁵ Q 43
⁷⁶ *Strategic review of the Nursing and Midwifery Council Final report*, p 27
⁷⁷ Q 72
scoping its proposals for the delivery of a long–term IT strategy.\textsuperscript{78} The NMC has initiated work to stabilise its existing infrastructure but this will not come to fruition until 2014.\textsuperscript{79}

62. The NMC will not be able to operate its FTP processes with genuine efficiency until it invests in IT systems that communicate with one another and are less resource intensive and cumbersome to operate. We recognise the NMC’s desire to understand in detail what works well for other regulators but it needs to address this matter with utmost urgency. If the systems cannot meet the demands made of them then the NMC cannot meet the demands made of it as a regulator.

63. Although the NMC is working towards a deadline of 2014 to deliver improvements to its existing IT infrastructure we expect the NMC to make demonstrable progress this year. At our next accountability hearing with the NMC we will seek evidence that the systems have been stabilised, that there is a long–term plan in place to improve the IT infrastructure and that the existing systems are finally allowing staff to complete crucial tasks accurately and efficiently.

**Culture and Morale**

64. Jackie Smith revealed in evidence that overall staff turnover and turnover within the FTP directorate is now at 36%.\textsuperscript{80} Turnover of this degree indicates poor morale within the NMC. The CHRE’s strategic review identified a culture of “resigned resilience” amongst staff within the NMC: they are resilient despite enduring years of criticism but resigned to the status quo of poor standards and little in the way of positive change.\textsuperscript{81} The CHRE described the culture of the regulator as hierarchical, opaque and defined by a resistance to change.\textsuperscript{82} Staff are cynical about the potential for positive change within the NMC and many feel overlooked, overwhelmed, ignored and chronically lacking in feedback and effective guidance from management.\textsuperscript{83}

65. It is notable that when asked how the NMC hope to improve their staff retention figures Jackie Smith correctly identified implementing IT systems that work well.\textsuperscript{84} Ms Smith conceded that losing staff at this rate means that “We lose money; we lose productivity. It is not good for the reputation of the NMC.”\textsuperscript{85} In order to rectify this situation Ms Smith emphasised the importance of induction, training and, through improved IT, giving staff the tools to do their jobs properly.\textsuperscript{86} Jackie Smith concluded that

\begin{itemize}
  \item \textsuperscript{78} Ev 27
  \item \textsuperscript{79} Ibid
  \item \textsuperscript{80} Q 69 – 70
  \item \textsuperscript{81} Ibid, p 16
  \item \textsuperscript{82} Ibid, p 5
  \item \textsuperscript{83} Ibid, p 16–17
  \item \textsuperscript{84} Q 71
  \item \textsuperscript{85} Q 69
  \item \textsuperscript{86} Q 71
\end{itemize}
in order to improve morale “members of staff need to feel empowered to be able to make changes, to suggest changes, because they do the job”. 87

66. Staff turnover of 36% is unsustainable. The NMC will not improve its FTP performance if it continues to lose individual members of staff and collective institutional knowledge at this rate. Mark Addison believes that the “seeds of change” 88 are in place to tackle instability and improve the NMC’s culture and he assured us of his optimism in this regard. 89 At our next accountability hearing we will be keen to observe whether Mr Addison’s optimism has proved well founded. We expect to see a substantial improvement in the workplace culture evidenced by a significant reduction in staff turnover.

Leadership

67. Leadership has been a problem in the NMC for a number of years with high turnover in senior positions. The current Chair and Chief Executive are recent appointments: Mark Addison was appointed the NMC’s Chair in July 2012 and Jackie Smith was appointed the NMC’s Chief Executive and Registrar for a one year period in October 2012 having acted in the role since December 2011. Mr Addison noted that:

there have been, I think, six chairs and six chief executives in the last six years. One of the chief executives came round twice, so it is five people but six posts. It is quite hard to develop an organisation into one that feels confident about its direction, secure in the knowledge it is doing a good job and confident about the work it does. 90

68. It is very difficult to develop an effective, confident and respected organisation when there is such instability in the most senior positions. Discussing Jackie Smith’s appointment Mr Addison told us that the absolute focus for the coming year was to address the backlog of FTP cases and make sure the NMC is “doing its basic job better”. 91 Mr Addison added that “the appointment has been extremely well received” and that “a period of a year is exactly what we need—it may well be longer—to have the stability we need to get through this critical phase.” 92

69. We agree that the NMC needs a period of stability in senior appointments to allow it to do its basic job better. The NMC must recognise that public concern about its role will persist until it can show marked improvement in its performance. We therefore recommend that ministers should work with the Chair and Board of the NMC to ensure that the organisation benefits from a period of management consistency.

87 Q 66
88 Q 3
89 Q 3
90 Q 3
91 Q 63
92 Q 64
5 Fee Increase

Annual registration fee

70. In order to meet the increased costs of FTP the NMC proposed that for the first time since 2007 it would increase the annual registration fee. In May 2012 the NMC launched a three month consultation on its proposal to raise the annual registration fee to £120 per annum.93 The NMC said that its current annual fee of £76 per registrant provides an annual income of £53 million when, in order to cover its costs, it requires £73 million.

71. Responding to the initial proposals the Royal College of Nursing (RCN) cited a survey on the fee rise which found that of 85,720 respondents 99.3% opposed the measure.94 The RCN called for an independent audit of the NMC’s financial plans as the College desired “independent assurance that the NMC’s current assumptions around fitness to practise costings and caseloads are accurate and sound.”95

72. Following the closure of the NMC’s consultation the Department of Health warned in their written evidence to the Committee that the NMC’s case for a fee increase must be robust.96 The Department’s evidence noted that the Command Paper, Enabling Excellence, warned against regulators increasing registration fees but they did not explicitly oppose the measure. Ministers, however, wrote to the NMC “seeking further external assurances about the validity of the assumptions in the NMC’s business case for the fee increase.”97 The RCN welcomed this move and told us in written evidence that 87.3% of RCN members agreed that it was time for government to contribute to the funding of the NMC.98

Additional funding

73. It was announced shortly in advance of our hearing with the NMC that the Department of Health had offered a £20 million grant to the Nursing and Midwifery Council in order to reduce the size of the proposed fee increase. The NMC Council subsequently accepted the £20 million grant and decided that from February 2013 the annual payment would increase from £76 to £100 rather than £120 as originally envisaged.99

74. Jackie Smith told us that the NMC had invited independent analysis of the reasoning behind the proposed fee increase. Ms Smith said that:

as part of putting together the fitness to practise budget, which the Council approved this year, we had KPMG audit our assumptions and make sure that we understood how much money was needed to deliver fitness to practise. KPMG is currently

93 Ev 19
94 Ev 37
95 Ev 38
96 Ev 17
97 Ibid
98 Ev 38
validating the assumptions that we have made in relation to the 8% increase in referrals and the length of our hearings, so that when Council makes a decision on 25 October about what the fee should be, it can be as assured as it can that our assumptions are reasonable.  

75. In evidence to the Committee Mark Addison made it clear that the additional funding will be linked to the clearance of the FTP backlog and being in receipt of public money the NMC will be accountable for its use.  

We are encouraged that Mr Addison referred to the offer of public funds as being connected to “the delivery of a time–limited set of outcomes.” As Mr Addison said in evidence, however, the NMC is an independent regulator free from Ministerial interference, and the Committee believes it is important that the NMC maintains its independence from Government.

76. It is beyond doubt that the NMC’s proposals for such a substantial increase in the registration fee were founded in the incompetent financial management of previous years. The CHRE concluded that:

the NMC has shown a collective lack of competence in failing to establish an appropriate link between the costs involved in delivering its planned activity, the key performance indicators it has committed to and the budget it has approved.

77. We accept that the failure to invest in FTP in previous years now means that the NMC requires additional resource in order to meet its obligations. We welcome the intervention made by Ministers to limit the impact of the fee rise on registrants but note that nurses and midwives will still face a 32% increase in their annual payment. The accountability hearing was held in advance of the NMC Council accepting the offer of additional funding from the department, but even then Mark Addison warned that “fees will still need to go up to deliver what we need in fitness to practise.” The Committee notes the circumstances in which the new management of the NMC have found themselves but this does not make it more palatable for the registrants who must bear the increase during a period of pay restraint within the NHS. In the light of these pressures the Committee does not believe a further increase in fees can be justified and we recommend that the NMC should consider introducing a phased payment scheme for registrants.

100 Q 48  
101 Q 76  
102 Q 77  
103 Strategic review of the Nursing and Midwifery Council Final report, p 18
6 Revalidation

Implementation

78. In their written evidence to the Committee the NMC maintained that revalidation of nurses and midwives remained on track to be implemented from 2014.\textsuperscript{104} The NMC acted on our recommendation in 2011 to audit registrants’ post registration education and practice (PREP) portfolios and reviewed 100 such portfolios. The NMC said in written evidence that “assessment of the audit confirmed that our standards are inadequate in providing assurance of continuing fitness to practise.”\textsuperscript{105} This process will now “inform the development and implementation of our revalidation standards”\textsuperscript{106}. Jackie Smith told us that the audit of the PREP portfolios showed that the PREP standards “are not fit for purpose”.\textsuperscript{107}

79. The development of revalidation standards has clearly delayed the NMC’s progress in launching revalidation. Jackie Smith told us in oral evidence that revalidation will not be launched until 2015 and even then this will only constitute a limited roll–out of the new system.\textsuperscript{108}

80. Revalidation will operate as a risk–based system and not all 670,000 registered nurses and midwives will be required to participate. Nonetheless, we were concerned that the NMC could provide no evidence that they yet know which high risk groups will be targeted within the roll–out of revalidation.\textsuperscript{109} Ms Smith told us that in order to access the data which will “enable us to target revalidation”\textsuperscript{110} the NMC must first “stabilise and invest in our IT systems”.\textsuperscript{111}

81. As with other areas of the NMC’s work, successful implementation of revalidation depends upon access to an effective IT system. It is therefore vital that the NMC addresses this problem in order to avoid the roll–out date for revalidation slipping even further.

82. The Committee continues to believe that the NMC should operate a proportionate but effective revalidation process; it is concerned that the NMC’s preparation for revalidation appears to be at an embryonic stage and little progress has been made since the 2011 accountability hearing. At the next accountability hearing the NMC should be able to provide us with a plan for roll–out of revalidation, detailing the timeframes involved and the high risk groups that will be targeted early in the process.

\textsuperscript{104} Ev 21
\textsuperscript{105} Ev 24
\textsuperscript{106} Ibid
\textsuperscript{107} Q 31
\textsuperscript{108} Qq 38, 41
\textsuperscript{109} Q 33
\textsuperscript{110} Q 33
\textsuperscript{111} Q 33
7 Language & Competence

Language testing

83. In our 2011 report on the NMC we expressed concern that the regulator is prohibited by law from systematically testing the language competence of nurses and midwives trained in the European Economic Area and Switzerland.\(^{112}\) In response to the Committee’s recommendation in 2011 that the NMC adopt a model similar to that of the GMC’s where by a responsible officer signs off a registrants communications skills, the NMC said the responsible officer model is:

not currently applicable to the NMC. We are therefore in the process of discussing with the Department of Health other possible models that could be applied.\(^{113}\)

The Department of Health’s response to the report of our 2011 accountability hearing simply stated that the European legislation is under review,\(^{114}\) but did not address our recommendation that a tough interim measure is necessary to give patients confidence and ensure their safety.

84. The NMC’s written evidence outlined how the regulator has been working with its European peers to develop a common position on the European Union green paper on Modernising Professional Qualifications. On the domestic front the NMC has explored “the legality of requiring applicants for whom we have serious doubts as to their language proficiency to pass a test before gaining registration.”\(^{115}\) Jackie Smith noted that the NMC is working to implement reforms that would allow testing but they “need the Department’s support”.\(^{116}\)

85. Ms Smith described how communication skills could be assessed via revalidation at the point of renewal. This approach would inherently rely on assessment after a nurse or midwife has begun practising and would not represent a proactive mechanism that could prevent those nurses unable to communicate with patients from entering practice.\(^{117}\) In addition, we have already established that the roll–out of revalidation is some way off so it will not address this question at a pace acceptable to the Committee.

86. In written evidence, the Patients Association reiterated the importance of ensuring that nurses and midwives are able to communicate effectively with patients, especially in cases where patients use euphemisms or colloquialisms owing to embarrassment or habit.\(^{118}\) The NMC regards employers as being ultimately responsible for the competence of their staff and their written submission to the Committee informed us that they have written to

\(^{112}\) Health Committee, Annual Accountability Hearing with the Nursing and Midwifery Council, HC 1428, para 45

\(^{113}\) Health Committee, Fifteenth Report of session 2010–12, Annual accountability hearings: responses and further issues, HC 1699, p 19

\(^{114}\) Ibid, p 17

\(^{115}\) Ev 25

\(^{116}\) Q 84

\(^{117}\) Qq 83–84

\(^{118}\) Ev 44
employers to “remind them of their duty to ensure that their staff can communicate safely and efficiently with patients and the rest of the care team.” Jackie Smith told us simply that employers “must test language skills if you think there is a risk.”

87. We agree with the NMC’s view that employers are ultimately responsible for ensuring that staff can competently communicate with patients. We are concerned, however, that this approach transfers the assessment of risk entirely to employers and does not provide sufficient safeguards to protect the interests of patients. Employers have yet to demonstrate that their own recruitment practices ensure that staff have the ability to understand patients and make themselves understood. Progress at EU level to alter the framework of the legislation is welcome but this, ultimately, is a matter of patient safety and it is vital that the Department of Health support the NMC in developing a more immediate solution.
Conclusions and recommendations

Prioritising core functions

1. Over a number of years the NMC has failed to understand its function and properly prioritise patient safety and the new Chief Executive conceded this failure in evidence to the Committee. Ms Smith told us that the NMC’s ‘focus must now be on public protection’ and that both professionals and the public must have confidence in the NMC’s ability to deliver this. We are satisfied that as a result of the criticism it has received the NMC now understands that it must concentrate its efforts on FTP and revalidation in order to achieve its objective of delivering public protection. (Paragraph 26)

2. Given the fundamental nature of the problems at the heart of the NMC we agree with Mark Addison’s assertion that the NMC’s management has ‘no real alternative but to address the engine room’ of the organisation. We acknowledge that the NMC will have to compromise on the extent to which it can support its additional functions and accept this compromise is necessary if the NMC is to regain the trust of the public and professionals. (Paragraph 28)

Fitness to practise

3. The Committee welcomes the fact that clear KPIs have been set for the FTP process. It has reviewed the latest evidence from the NMC of progress against these indicators and welcomes the fact that the performance of the organisation is improving. In the Committee’s view, however, the KPI should focus on the total time taken to investigate a complaint and it remains concerned that it should not take 18 months to resolve an allegation of unfitness to practise. We urge the NMC to work to reduce this period towards an average target of 9 months as a matter of urgency. (Paragraph 30)

4. The Committee also urges the NMC to set an additional KPI which determines the maximum acceptable time to determine an FTP case. The Committee finds it hard to believe there can be circumstances when it is acceptable for an FTP case to take more than 12 months to resolve. (Paragraph 31)

Historic Cases

5. Although the NMC has made progress with the elimination of its backlog it is clearly very unsatisfactory that there are 572 cases which have been outstanding for more than two years. The Committee urges the NMC to clear all these cases no later than 30th June 2013. (Paragraph 33)

Current Cases

6. The Committee welcomes this evidence of progress in securing timely investigations and decisions, and note that the total average time is now within the total KPI of 18 months. As noted in Paragraphs 30 and 31, however, the Committee still regards this
process as unduly extended from the point of view of both patients and regulated professionals and urges the NMC to adopt more the demanding KPIs proposed in the earlier paragraphs. (Paragraph 35)

Section 29 Referrals

7. The Committee is pleased to note that there have been no s.29 referrals of NMC decisions since September 2010, and urges the NMC to maintain this improvement in the quality of its determinations. (Paragraph 39)

NMC powers to review cases

8. We consider that the inability of the NMC to review its own initial decisions is a significant gap in its powers. We note the forthcoming general review of regulatory powers by the Law Commission, but we recommend that the Department of Health takes action now to seek to amend the Nursing and Midwifery Order to put the NMC on a par with the GMC in these matters as soon as possible. (Paragraph 43)

External investigators

9. The Committee accepts the principle of controlling investigations in–house and modelling the structure of the investigations unit on more successful regulators. Furthermore the Committee recognises that improved control over the quality of investigations will have contributed to the improved quality of NMC determinations. The Committee is however mindful that the decision making process of the NMC remains unduly extended and questions the wisdom of dispensing with capacity when the organisation still faces a substantial backlog of work. At the next accountability hearing we shall wish to investigate whether the removal of this additional resource has reduced the NMC’s ability to shorten its decision times. (Paragraph 45)

Projections of future cases

10. While we recognise the difficulty of developing robust projections of the number of FTP cases which will be brought, it is essential that the NMC develops a business model which is sufficiently flexible to allow it to accommodate fluctuations in FTP workload without an excessive impact on either the quality or timeliness of its decisions. (Paragraph 48)

Improving Processes

11. In more recent evidence, however, the NMC has reported that it has made modest progress against KPIs which were set to encourage improved process. In particular the NMC reports that during the fourth quarter of 2012 decision letters were sent within 5 days of the decision being reached in 99% of cases and complaint letters were answered within 20 days in 86% of cases — against a KPI in both cases of 100%. Both the fact of the KPI and the performance against it reflect a welcome commitment from the NMC to deliver an improved performance. (Paragraph 51)
Financial Planning

12. Serious failures associated with financial planning over a sustained period of time eventually forced the NMC to propose a major fee increase for registrants. It is unacceptable that the NMC’s management underestimated the required budget to sustain the FTP directorate by 30%. (Paragraph 54)

13. Although the NMC’s inability to accurately project its workload and financial requirements has hamstrung the organisation, the Committee notes the fact that the NMC now recognises the seriousness of these failings. The NMC said in evidence that it is now taking steps to address the long-standing and fundamental flaws in the NMCs financial planning. The Committee will be seeking assurance at the next accountability hearing that these steps have been effective. (Paragraph 55)

14. It is fundamental to any organisation that board members should be equipped with sufficient information to challenge the decisions taken by the executive. At our next hearing with the NMC we will seek evidence that the Council and its review groups are benefiting from the delivery of better data and are able to scrutinise and challenge management information with greater effect. (Paragraph 57)

Information Technology

15. The NMC will not be able to operate its FTP processes with genuine efficiency until it invests in IT systems that communicate with one another and are less resource intensive and cumbersome to operate. We recognise the NMC’s desire to understand in detail what works well for other regulators but it needs to address this matter with utmost urgency. If the systems cannot meet the demands made of them then the NMC cannot meet the demands made of it as a regulator. (Paragraph 62)

16. Although the NMC is working towards a deadline of 2014 to deliver improvements to its existing IT infrastructure we expect the NMC to make demonstrable progress this year. At our next accountability hearing with the NMC we will seek evidence that the systems have been stabilised, that there is a long-term plan in place to improve the IT infrastructure and that the existing systems are finally allowing staff to complete crucial tasks accurately and efficiently. (Paragraph 63)

Culture and Morale

17. Staff turnover of 36% is unsustainable. The NMC will not improve its FTP performance if it continues to lose individual members of staff and collective institutional knowledge at this rate. Mark Addison believes that the “seeds of change” are in place to tackle instability and improve the NMC’s culture and he assured us of his optimism in this regard. At our next accountability hearing we will be keen to observe whether Mr Addison’s optimism has proved well founded. We expect to see a substantial improvement in the workplace culture evidenced by a significant reduction in staff turnover. (Paragraph 66)
Leadership

18. We agree that the NMC needs a period of stability in senior appointments to allow it to do its basic job better. The NMC must recognise that public concern about its role will persist until it can show marked improvement in its performance. We therefore recommend that ministers should work with the Chair and Board of the NMC to ensure that the organisation benefits from a period of management consistency. (Paragraph 69)

Additional funding

19. We accept that the failure to invest in FTP in previous years now means that the NMC requires additional resource in order to meet its obligations. We welcome the intervention made by Ministers to limit the impact of the fee rise on registrants but note that nurses and midwives will still face a 32% increase in their annual payment. The accountability hearing was held in advance of the NMC Council accepting the offer of additional funding from the department, but even then Mark Addison warned that “fees will still need to go up to deliver what we need in fitness to practise.” The Committee notes the circumstances in which the new management of the NMC have found themselves but this does not make it more palatable for the registrants who must bear the increase during a period of pay restraint within the NHS. In the light of these pressures the Committee does not believe a further increase in fees can be justified and we recommend that the NMC should consider introducing a phased payment scheme for registrants. (Paragraph 77)

Revalidation

20. As with other areas of the NMC’s work, successful implementation of revalidation depends upon access to an effective IT system. It is therefore vital that the NMC addresses this problem in order to avoid the roll-out date for revalidation slipping even further. (Paragraph 81)

21. The Committee continues to believe that the NMC should operate a proportionate but effective revalidation process; it is concerned that the NMC’s preparation for revalidation appears to be at an embryonic stage and little progress has been made since the 2011 accountability hearing. At the next accountability hearing the NMC should be able to provide us with a plan for roll-out of revalidation, detailing the timeframes involved and the high risk groups that will be targeted early in the process. (Paragraph 82)

Language testing

22. We agree with the NMC’s view that employers are ultimately responsible for ensuring that staff can competently communicate with patients. We are concerned, however, that this approach transfers the assessment of risk entirely to employers and does not provide sufficient safeguards to protect the interests of patients. Employers have yet to demonstrate that their own recruitment practices ensure that staff have the ability to understand patients and make themselves understood. Progress at EU level to alter the framework of the legislation is welcome but this,
ultimately, is a matter of patient safety and it is vital that the Department of Health support the NMC in developing a more immediate solution. (Paragraph 87)
Formal Minutes

Tuesday 26 February 2013

Members present:

Mr Stephen Dorrell, in the Chair

Rosie Cooper
Andrew George
Barbara Keeley
Grahame M. Morris

Andrew Percy
David Tredinnick
Dr Sarah Wollaston

Draft Report (2012 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 87 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Ninth 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 printed with the Report.

[Adjourned till Wednesday 27 February at 9.30 am]
Witnesses

Tuesday 16 October 2012

Mark Addison CB, Chair, and Jackie Smith, Chief Executive and Registrar, Nursing and Midwifery Council.

List of printed written evidence

1 Department of Health Ev 16
2 Nursing and Midwifery Council Ev 17
3 Nursing and Midwifery Council supplementary Ev 27
4 Council for Healthcare Regulatory Excellence Ev 34
5 Royal College of Nursing Ev 37
6 A Dignified Revolution Ev 40
7 The Patients Association Ev 42
## 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.

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Oral evidence

Taken before the Health Committee on Tuesday 16 October 2012

Members present:
Mr Stephen Dorrell (Chair)
Rosie Cooper
Andrew George
Barbara Keeley
Grahame M. Morris
Mr Virendra Sharma
David Tredinnick
Valerie Váz
Dr Sarah Wollaston

Examination of Witnesses

Witnesses: Mark Addison CB, Chair, and Jackie Smith, Chief Executive and Registrar, Nursing and Midwifery Council, gave evidence.

Q1 Chair: Good morning and welcome to this session. This is the second time we have held what we regard as an accountability hearing for the Nursing and Midwifery Council. Yours is an organisation that has had a number of issues. Let me say at the beginning that you are welcome even if, I suspect, there is going to be some fairly spirited discussions. Could I ask you briefly to introduce yourselves to the Committee?
Mark Addison: Thank you for that welcome. My name is Mark Addison. I am the Chair of the NMC. Jackie Smith: I am Jackie Smith, the Chief Executive of the NMC.
Mark Addison: Would it be helpful if we both said a few words by way of introduction, or would you like to go straight in?

Q2 Chair: Can I give you some themes to react to in doing that? It would be useful to the Committee to get the big picture and, yes, it would be helpful to have a kind of introductory view. As I was thinking about this session, there were three things I wanted to put to you at the beginning that set the scene for the challenge that you face. One is the view expressed by the CHRE that “the NMC has not understood its regulatory purpose well”, which is a pretty fundamental thing to say about a regulator. The second is the description of the culture in the organisation as “resigned resilience”, which does not feel good, to put it mildly. The third is—and I do not want to go straight into this at the beginning, but it is one thing we will want to talk about—the fact that, with a budget of £56 million, the organisation spent £73 million, an overspend of 30% against budget. Those three factors—not understanding, in the view of the CHRE, the core regulatory purpose; secondly, the organisation employing people with the “resigned resilience” culture; and, thirdly, not being able to manage its finances within a margin of 30%—I suppose are three broad brush strokes that describe the challenge that you face in turning round an organisation that has clearly not commanded public confidence in recent years. That is the challenge that is in front of us as we begin the session.
Mark Addison: Fine. Would you forgive me if, none the less, I not exactly stuck to my script but said two minutes’ worth of my initial impressions and priorities and then Jackie can do the same? Then perhaps I could say briefly a word about each of those three issues to get the conversation going. Would that be all right?
Chair: Of course.
Mark Addison: First of all, in relation to the NMC, you have our submission in front of you. It would, I think, be useful if I set the scene a little from my personal perspective. I started the role on 10 September, so I have been here for about five weeks. I should like to record that I have been extremely grateful for the help I have had from my immediate predecessor Judith Ellis, from whom I took over, and indeed from Jackie in that period. It is going to be helpful, and no doubt stimulating, for me to have a conversation with the Committee at this very early stage in my tenure of the role. I am glad it is happening now rather than later as things begin to settle down a little bit in my own mind.
Two things have been in my mind from the outset. The first is that the NMC is charged with a responsibility that is of enormous public significance at the moment. It is sensitive and difficult territory. I have a quite strong sense that there are lot of eyes on us and there is a strong focus on what we do and how we do it. The second is that the NMC has clearly, as you have said, Mr Chairman, been a troubled organisation over the last few years. It has had a number of what one might characterise as false starts.
I am very conscious of the amount of change and criticism, which you have summarised, but also sets out a programme of recommendations for action. My key overarching priority, as I see it, is to ensure that there is real follow-through and delivery on that set of recommendations.
My slightly more specific priorities in the role, very briefly, at present are as follows. One is learning about the organisation, the work it does and the context in which it works. I am new, as you may know, to the health field and to professional regulation. The second is the appointment of a substantive chief executive. I am delighted, as you may have seen, that Jackie is to
be—or is now—our chief executive on a substantive basis for at least a year. The third is understanding the financial challenges—you picked up on this point—and securing some financial stability and proper financial management in the organisation. The fourth is working with my colleagues on the Council to address the fitness to practise arrangements, which are absolutely at the centre of what we do. Perhaps I could pause there and ask Jackie to say a similarly brief few words, and then we can with come back to your three themes.

Jackie Smith: Thank you very much. I do not want to repeat what Mark said. What I want to say is what you have picked up on initially—that the NMC certainly was not clear about its regulatory purpose. It is now. We need to address the culture of resigned resilience, which I think stems from the fact that it is an organisation that has been criticised so many times in the past that the staff did not feel empowered to make changes.

Can I come back on the point about our expenditure? Our income is £52 million and we are projected to spend £73 million this year, so our focus must be on implementing the recommendations made in the CHRE review. Fitness to practise is an absolute priority for the organisation. We need to deal with the culture, but we also need to stabilise our IT systems and absolutely need to sort the basics out before we start thinking about other activity.

Q3 Chair: Thank you.
Mark Addison: Would you like me to reflect a little on those three points, as Jackie has done?
Chair: Yes, please.
Mark Addison: I will necessarily have a slightly broader and less well-informed perspective than Jackie on these points, but I certainly have some impressions and views. On the first point, I have been striking by the extent to which the focus of the organisation is now very much on patient protection and is quite clear. I would say it is a focus that is inevitably, at this point in the change programme for the NMC, quite narrow and sharp on some very specific issues, notably, as Jackie said, fitness to practise. It seems to me that, as time develops and as we implement the recommendations made in the CHRE review, we can think a little more broadly about what the full suite of activities that an excellent, serious professional regulator should be about, but at the moment, it seems to me that, one, there is very clear focus and, two, we have no real alternative but to address the engine room, if you like, and to fix the issues there before we spread our wings a little wider. I recognise that that is an uncomfortable position for some. It is not a position I would expect everybody to agree with, and there are differing views about it, but it does seem to me, from an organisational performance point of view, that it is important that we do that.

“Resigned resilience” was, I thought, an interesting phrase. I think I know what it means. I have been struck, since my arrival, by the optimism and the ambition that is just under the surface of the staff in the organisation. They have had so many changes of leadership at the top, so many stops and starts. I discovered shortly after I arrived that there have been, I think, six chairs and six chief executives in the last six years. One of the chief executives came round twice, so it is five people but six posts. It is quite hard to develop an organisation into one that feels confident about its direction, secure in the knowledge it is doing a good job and confident about the work it does, when there is that kind of instability at the top, but I do think the seeds of change are there. I am optimistic about that.

On the financial position, no doubt we will get into that in some detail, but clearly we are not in a sustainable position at the moment, and we have to put that right.

Q4 Chair: I agree that we will come back to finance when we have perhaps had a discussion about what the finances are there to deliver. Surely the key issue here, in terms of public confidence, is that there are too many stories around of failure in professional standards and professional practice in the nursing and midwifery profession. There are likely to be some more coming out, or a renewed focus on them, anyway, in the context of the Francis inquiry. The organisation responsible for regulating professional standards within the profession is itself an organisation in crisis, so there is an organisation in crisis at the centre of a profession where there are questions being asked about professional standards. That is the issue, in my mind, that is so urgent for the NMC: to re-establish a credible vision of what it means to be a professional nurse or midwife, and confidence on the part of the public that those standards are understood within the profession and are enforced by the regulator.

Jackie Smith: That is absolutely right. What is helpful about the strategic review is that it absolutely makes clear what we should focus on, which is public protection. It is an organisation that has tried, over many years, to please too many people and lost its way, but we are now clear that our focus must be on delivering public protection. It is about confidence. The public need to have confidence in us that we can do that. The professions need to have it too. Otherwise, as you say, they look at an organisation in crisis and they are not quite sure where to turn. We are absolutely on the right track, however, and I believe that we now know what we need to do to deliver public protection.

Q5 Chair: You say you are confident you are on the right track, but public confidence will come only when the public are confident that you are on the right track. How are they going to see that? What are they going to identify as being evidence that the NMC has emerged from its recent history?
Jackie Smith: I don’t think that the public or the professions will have confidence in us until we deliver—fundamentally, until we deliver on fitness to practise. That is key. We have stated publicly that we expect to clear our historical backlog of cases and achieve our KPIs by the end of 2014. That is still two years away. I know that is unacceptably long, but that is the position.
Q6 Chair: When will we hear a different view about a timetable that you would regard as acceptable? Jackie Smith: Until we achieve that timetable at the end of 2014, it is difficult to say beyond that quite where the organisation will be.

Q7 Chair: But you can understand that it is hard to build public confidence about the quality of nursing in the health care system today, tomorrow and the day after if the regulator says, “We will have our house in order by sometime a bit over two years’ time.” Jackie Smith: Yes, I am very keen that we are honest and realistic about what we can deliver. This is an organisation that has made numerous promises in the past and failed to deliver on them. I do not want to do that today in front of this Committee. We have to sort fitness to practise. That must be the priority and we cannot achieve that fundamentally until the end of 2014.

Q8 Valerie Vaz: Leading on to that, I am looking a bit confused because part of your remit is education and training, and that also seems to be an important part. Maybe it is something about this Committee—I don’t know what it is—but everyone who appears before us is always new. The people previously in post have always resigned, so we have a new set of people. We understand that you have not been part of the organisation, but we still need to ask the questions about what went wrong. It is a criticism sometimes targeted at the civil service that people move around after two years or something. It is good for people to move round, but there is such a thing as institutional memory, and it is important to keep the continuity. I want to touch on the fitness to practise element of your evidence. I assume you have seen the written evidence from the CHRE.
Jackie Smith: Yes.

Q9 Valerie Vaz: It makes for interesting reading, doesn’t it—the timeliness of the NMC’s fitness to practise case progression, the quality of the investigation? Shall I go on? Jackie Smith: I am very familiar with it.
Mark Addison: I think we know it.

Q10 Valerie Vaz: Would you like to comment on that first? Jackie Smith: I suppose I would. Part of the problem for the NMC has been its focus. It recognised in 2008, when the CHRE first reported on fitness to practise, that there was a problem, but I do not think it devoted the attention, the time and the resource to fitness to practise that was needed. The strategic review published in July said that the NMC had under-invested in fitness to practise, and that is absolutely true. No doubt we will come back to that when we talk about our financial position. Unless you devote the resources to it, it will not get any better. There have been issues with decision making, timeliness, the time it takes us to get through our caseload and the outcomes from start to finish and how long that takes. We have now agreed—

Q11 Valerie Vaz: Could I stop you there? Could you give us some times on that? How long do the cases take from start to finish? Jackie Smith: At the moment, an average investigation is taking us 11 months. In May 2011, it was 21 months. That is clear evidence of improvement. It is still a very long time, but we are clearly improving. At the moment, the NMC has 1,400 cases awaiting a hearing. We are holding 16 substantive hearings every single day, and we will increase that to 22 by next June. Our aim is to adjudicate on cases within a six-month period by the end of 2014, because that is the scale of the problem that we have to get through. What we had two years ago were about 2,500 cases at the front waiting to be screened and investigated. Now what we have is those cases at the end, but, of course, 1,400 cases is a huge amount and incredibly expensive.

Q12 Valerie Vaz: Is that what you term your “backlog”? You mentioned a backlog. It is the current live cases.
Jackie Smith: It is the cases in the queue, yes.

Q13 Valerie Vaz: How many of those end up with some sort of action being taken? I think the RCN’s criticism is that almost 80% of them do not lead anywhere. Is that right?
Jackie Smith: I think our annual report for last year indicated that we struck off about 350 registrants. I cannot be precise, but I think that was the figure, which was quite a big increase on the previous year. I know there is concern among the unions that employers are unnecessarily referring to the NMC, but the statistics—particularly the striking-off statistics—do not back that up, I am afraid.

Q14 Valerie Vaz: What sort of cases are coming through? Are you getting to the stage now where you are able to triage the more important ones and perhaps the slightly less important ones?
Jackie Smith: Yes. One of the criticisms the CHRE made of the NMC just over two years ago was that we were not able to identify and prioritise serious cases.

Q15 Valerie Vaz: Why was that?
Jackie Smith: It was because the NMC did not have a system in place for saying, “This is a particularly high-risk registrant and therefore we need to remove their right to practise while we carry out an investigation.” That is now embedded and we do that, in the vast majority of cases, within 28 days of receiving a referral. Our ability to identify and prioritise serious cases is much, much better. In terms of public protection, I think we have got that sorted. We screen out about 40% of referrals and a further 30% after they go through an investigation process. Then we end up with a number of cases in the queue waiting for a hearing, which is where we now are.

Q16 Valerie Vaz: Are you doing this in-house or has it been outsourced?
Jackie Smith: Our screening function is in-house. We have a mix of lay people, nurses and midwives who bring technical expertise into the screening function.
The investigation process was outsourced, but 80% of that, by the beginning of next year, will be done in-house so that we can reduce costs, and improve timeliness and quality as well.

Q17 Chair: What does the phrase “screening out” mean? What happens to the case that is screened out?
Jackie Smith: If it is a complaint that does not raise a question about an individual’s right to practise— it could be a very trivial complaint—we screen it out. It is a sift.

Q18 Chair: It is an early quick decision that that registrant is fit to practise.
Jackie Smith: Yes.

Q19 Valerie Vaz: Going back to the way you deal with your cases, the CHRE has said that under section 29 you have more referrals than all the other regulators put together. Do you want to make a comment about that?
Jackie Smith: The quality of our decision making has been questionable in the past. In our submission, we make it clear that we have done a lot to support panels. We have panel secretaries, we spend a great deal of time training panellists and we recruited 100 new panel chairs at the beginning of this year. We recognised that there was a problem there. The fact is that it takes time to see improvements in those areas. So, yes, we have had difficulty with our panel decisions, but I believe those will get better over time.

Q20 Valerie Vaz: Is there any mileage in you talking to the GMC to find out how it has done its set-up and maybe even use its independent tribunal?
Jackie Smith: The independent tribunal is a very interesting point. I do not think we are at that position yet. We have too much to do to be thinking about separating that function in quite the same way that the GMC has done. That is not to say it will not be on the horizon in the future. We speak to the GMC all the time about the way in which it carries out its fitness to practise function because, of course, it does it extremely well.

Q21 Valerie Vaz: How do you marry up the education point with the fitness to practise point?
Jackie Smith: Do you mean in the sense of the importance of education?
Valerie Vaz: Yes. Clearly something is going wrong at ground level, isn’t it? That is why they are being referred, for lots of reasons. We do not know. Some of the evidence is that you do not keep very good statistics, but I think that is changing now, isn’t it?
Jackie Smith: Yes. I think it is relevant to say that the number of nurses and midwives referred to us is less than 1%. It is 0.6%. There are 670,000 registrants, and we get about 4,000 referrals a year, so we are not seeing, at the moment, a significant increase in referrals. Education is very important.

Q22 Chair: That is a change, because there was a strong rising trend of fitness to practise referrals.
Jackie Smith: At the moment, we are not seeing a significant increase, but it is absolutely the case that there was a significant increase two years ago—a 48% increase. Right now, we are not seeing a big increase.

Q23 Valerie Vaz: What are you putting in place as a result of the Francis inquiry? The Francis inquiry is now delayed until January, I think. Do you have any sort of risk assessment that you have done in relation to what could come out of Francis?
Jackie Smith: We have done quite a bit of work in preparation for what could come out of the Francis inquiry. We could probably guess that Francis will say: we need to be much more proactive; we need to be working more effectively with the systems regulator in England, the Care Quality Commission; and we should not wait for something to happen before we react. All those things I think we would accept, if that is what he says, but all of those things come at a cost. What we have to do first of all is sort out the problems we have in fitness to practise, as well as making sure that we can respond to concerns in the right way at the right time.
Mark Addison: I have a couple of points to add arising from that discussion. First of all, on the learning point, I have been struck by some of the criticisms that the organisation has not learned enough or has not been open enough to external ideas. I do not detect that at present, I must say. It may have been the case in the past and people say that it was. I think there is a huge appetite to learn, not least in the fitness to practise area and around the technology and the systems that we use. One of the underlying issues that you have both touched on is the capacity of our systems to deliver the sort of data and management information that we need in order to manage those processes effectively. We are looking at that right now, but one of the things we will certainly be looking at is what systems other regulators use, and some seem to have quite good ones. That was one point. Another point I wanted to flag up is that Jackie has mentioned the number of changes, and I have been struck again by the number of changes which have been made to the processes in the fitness to practise area, particularly at the beginning of this year. They do take time to come through. There is the speed with which cases go through the system, the quality of the decisions that emerge and the clarity with which they are expressed. There is the way we deal with people, write to them and explain, and handle telephone calls and so on.
So there are three big categories in which we need to raise our game. A number of the changes that have gone in are designed to tackle exactly those things, but they will take time to come through, which is one of the reasons why we have set what looks like quite a long timetable. In practice, if you are talking about all those three issues, to say we will not get to the point where we really need to be for two years is probably about right. That would be my assessment and the CHRE has said as much.

Q24 Chair: Can I probe that a bit further? Two thoughts occur to me while listening to that. The first is that, when your predecessors came last year, we expressed concern that they did not appear to understand or have any explanation as to why there
had been a big increase in fitness to practise activity in the previous period. That has now levelled off. Query: looking forward, are you confident in your projections about likely levels of fitness to practise activity over the period between now and 2014? That must be absolutely fundamental to your delivery of the objective within that time scale.

The second is that, if you have a backlog and you share our sense that it would be nice to get the backlog clear well before the end of 2014, it is odd to me that you are reducing your use of external contractors now, rather than after you have got rid of the backlog. Because, classically, you would expect to use the external contractors to accommodate the bulging work load required to get rid of the backlog.

**Mark Addison:** May I say a word about the first of those two points, and then Jackie might pick up the second? On the assumptions—assumptions are assumptions and you can only tell whether you have got your assumptions right when you look back—the issue for us has been to—

Q25 Chair: What is the assumption you have made about demand for fitness to practise activity over the two-year period?

**Mark Addison:** The overall assumption that we have plugged into our model at the moment is an annual increase of 8% on referrals. You might say “Why choose 8%?”, but 8% felt to us—and we have looked at it quite carefully—like the best figure to take account both of the fact that we did have a very big increase, although it appears to have flattened off, and that we expect some increase, but we do not know if it will be a spike or a more chronic year-on-year increase, following the Francis inquiry report in January, as you say, which we now expect. It is very hard to predict. We are getting those assumptions externally checked.

The key decision point for all this is the Council’s meeting on the 25th, at which we will address the fee increase we need in order to achieve financial stability and fund the fitness to practise activity. To make that decision, we clearly have to make assumptions about caseload. The figure that we have plugged in is 8%, but that is being looked at and checked externally. We will be happy to publish the results of that external review. It seemed like the right figure to use.

**Jackie Smith:** Can I come back on the external contractor point? There are two points I would like to make in relation to this. Outsourcing investigations is extremely expensive. We have been criticised over a number of years for the quality of our decision making and, in some respects, for the quality of our investigation. I am not criticising any individual here at all, but what we did was think, “Is there a better model?” We spoke to the GMC and it does its investigations in-house. So we sourced the investigation unit in-house, so that we could do it ourselves and have control, reduce cost and improve quality. That is the model that we are moving to at the beginning of next year.

Q26 Chair: Yes. To come back, I see that argument. It seems odd to reduce the investigative capacity before you have dealt with the backlog.

**Jackie Smith:** The backlog, or the biggest number of cases, is now in the queue for adjudication. It is post-investigation.

**Chair:** Okay.

Q27 Dr Wollaston: I am interested in the quality of your data about the types of allegations of fitness to practise. What are the data currently telling you about how those complaints break down?

**Jackie Smith:** In our fitness to practise annual report, we break down the types of allegations, so it is dishonesty, drug errors, record keeping, cautions and convictions. I do not think it has been telling us anything new over the last few years. We have a challenge, with our IT systems, to get better data. Again, that is reflected in the strategic review. What we want to do next year is stabilise our systems to get better data so that, as a regulator, we can respond to types of allegations and also geographical areas where they arise.

Q28 Dr Wollaston: Are you confident that you will be able to make clear to nurses what the minimum standards are, or do you see that that should mostly come from, say, the professional bodies?

**Jackie Smith:** I think it should. We should publish the types of allegations—and we do for employers particularly—that come to our attention, not just as a way of reinforcing standards but also to point out the referrals that should not come to us that can be dealt with locally.

Q29 Dr Wollaston: Yes. For example, the GMC has its “Duties of a doctor”, which sets it out very clearly. How clearly do you think you give information to nurses as to what is absolutely expected of them?

**Jackie Smith:** Our code is pretty accessible. It is absolutely clear what standards we expect nurses and midwives to adhere to. There is more that we can do, and we need to be able to use our data better to get the messages across. I suppose we come back to where we started on this, which is about our priorities at the moment. I am not saying that is not a priority, but we have to invest our time and resources in clearing the problems that we have in fitness to practise. At the same time, we need to be thinking about these things so that we can respond to the Francis inquiry in particular, and so that we can be promoting what it means to be a nurse or a midwife on our register.

Q30 Dr Wollaston: So it is for prevention, really.

**Jackie Smith:** Yes.

Q31 Grahame M. Morris: May I move on a little, to revalidation? You have already touched on some of the points, but there are specific questions on which I would be interested in your responses, in relation to maintaining standards, involving other stakeholders, and the numbers that you referred to, the two thirds of a million people on the register. In particular, how are you targeting that number for revalidation in terms of the 675,000? Are you doing it in a systematic fashion? Do you have a particular plan as to how you intend to do the revalidation?
Jackie Smith: We did a post-registration education and practice portfolio audit in March this year. We took 100 registrants and audited their PREPs. That has shown us that our PREP standards are not fit for purpose. That is certainly regrettable in one area—

Q32 Chair: It is fairly important that you only needed to look at 100 out of 670,000 to draw that conclusion.

Jackie Smith: Clearly, there is a considerable amount of work that we need to do. To be absolutely honest about this, we have not made as much progress in revalidation as we should have done. There is no doubt about that, but we are also clear that the medical model of revalidation does not work for 670,000 registrants. It has to be risk-based and proportionate and it cannot add to the registration fee. We now plan to take a high-level strategy document to our Council in November, and we will focus on nurses and midwives who renew. We want to ensure that we get something out of an audit of PREP standards that is outcome-based and does actually give confidence as to continuing fitness to practise.

Q33 Grahame M. Morris: This is following on from questions from other colleagues in relation to how you are targeting that. Given that your own PREP audit, and the strategic overview by the Council for Healthcare Regulatory Excellence, discovered major deficiencies in the system, as Mr Addison mentioned, what direction is the risk analysis taking you in? Have you targeted particular groups of registrants that you want to do first?

Jackie Smith: I think that is where it will take us, but we are still fairly early on in our thinking on this, because the audit showed that the standards were not fit for purpose. We now need to think about a model that does target that. To do that, we need the systems in place to deliver it, so we have to support, stabilise and invest in our IT systems to give us the data that enable us to target revalidation.

Q34 Grahame M. Morris: Are you working with other stakeholders, and what particular suggestions are there? I know my friend and colleague Andrew George has an early-day motion, 549, on the Order Paper, concerning the RCN’s “This is nursing” Paper, concerning the RCN’s “This is nursing” initiative where it has targeted specific areas that it thinks should be addressed in terms of education, training, attitudes and so on.

Jackie Smith: We are working with all sorts of stakeholders. We intend to hold a further meeting with all the major stakeholders on revalidation. We are talking to the GMC, especially about the lessons it has learned over the last 14 years with revalidation. We cannot take 14 years to develop a model that is risk-based and proportionate.

Q35 Grahame M. Morris: I will finish on this, Chairman. On that point about the backlog, the need to focus on particular areas, and the need to improve standards and protect patient safety, how will you strike that balance between adopting a system that is so onerous and rigorous—I am not advocating light-touch regulation—and the “right-touch” to ensure patient safety?

Jackie Smith: We need to do it based on the data that we have available to us—that is the only way, I am afraid—and by working with the systems regulators and the Trust Development Authority, which is part of the Commissioning Board. They are data-rich, and if we work with them, we can target our resource, so that we are focusing on the high-risk areas.

Q36 Chair: Some of the high-risk areas are not in the NHS, are they?

Jackie Smith: No, they are not, and that is a challenge.

Q37 Chair: How are you meeting the challenge?

Jackie Smith: We will have to develop a programme where we say “We believe these are the high-risk areas.” For example, care homes could be a high-risk area, I am quite sure. It is how we get information not only from registrants working in that sort of environment but from employers. That is a challenge for us.

Q38 Chair: Is it still your objective to have a revalidation structure in place in 2014?

Jackie Smith: No, 2015 would be the earliest.

Andrew George: May I come in, as my name was mentioned?

Chair: Mentioned in dispatches.

Q39 Andrew George: In relation to regulation and revalidation, does the NMC have a view about whether the burden of regulation, including that of the absolutely correct requirements for rigorous revalidation, and other initiatives such as the hourly ward rounds and the other things that are kind of thrown at nurses—all the sort of tick-box targets and requirements—is turning nurses into two-dimensional creatures that can kind of do the tick-boxing, when in fact the most talented nurses are three-dimensional people who are very perceptive and good at observation? It is those talents we want to draw out.

Do you think we are dumbing down the talents of nurses by surrounding them with almost too much regulation, or do we have the balance right?

Jackie Smith: Thank you for that question. It is an interesting one. I am not sure that the NMC sees nurses and nursing dumbing down in any shape or form. Clearly there are local issues, and employers will have a variety of ways in which they use their workforce. We are very clear about what we expect from nurses and midwives. I do not see that there is dumbing down.

Mark Addison: I would say that the revalidation challenge, as I understand it at the moment, is to move from something that is very passive, which we have and do not think is effective enough, and which is indeed ticking boxes, to something that has some content and substance but which does that in a way that is operationally deliverable at reasonable cost but addresses the risk. That is the challenge for us. That is why the thinking is going on about how we best target that, how we use employers to make an input and how we get a richer data set in order to make
those judgments. I do not think any of us think that there is the alternative of leaving it as it is.

Q40 Chair: You have offered the date for revalidation of 2015. Is that supported by a plan to get from where we are to where we need to be? Jackie Smith: Yes.

Q41 Chair: Given that it is going to take till the end of 2014 to deal with the backlog of fitness to practise cases, and given that it has taken the GMC a completely indefensible 12 years to get revalidation in place, it strikes me as a huge undertaking for you to get fitness to practise clear right to the end of 2014, two years from now, and a full revalidation package up and running and working for 670,000 people a year after that. Are you convinced you can do it? Jackie Smith: Forgive me if I have misled the Committee, but I do not think we are going to roll out revalidation for 670,000 in one go. We have to think of the sample size. We have to think how we can identify the high-risk areas and target those initially. I am confident that we can get our systems in the right order and our standards at the right level to roll out the start of revalidation in 2015.

Mark Addison: I have a more general point—two responses to your challenge. One is that those are, I think, two quite big projects to secure within a limited time period, but that is one of the reasons why we are batting off a number of other requests, pleas and suggestions for undertaking further activity. We are trying to focus on the critical priorities. So we are being unhelpful about some of the things that we believe to be of lesser significance. They may be important in the medium to long term, but they are not priorities at the moment. The second is that I think the Council is taking a view on revalidation in November. The papers, the plans, the thinking and analysis will be available to the Committee at that point. I am very keen—and I think the Council will be very keen—to make sure that whatever plans we commit to in these troubled times, we are confident we can deliver them and they are not promises and aspirations that are not grounded in proper plans and analysis.

Chair: Thank you. That leads us neatly on to David and finance.

Q42 David Tredinnick: Thank you. I want to ask some questions about the fee increase and financial management, but before I get into the body of the questions, let me ask this. Mr Addison, at the beginning you talked about the need to fix the engine room. Shortly before that, you said you needed to stabilise the IT systems. Am I right in thinking that your IT systems are not functioning properly? Mark Addison: Jackie is the expert, but the CHRE report did flag up some significant concerns about technology and systems. In particular, it identified a mismatch between the two basic systems we use, which was a significant risk to the organisation. My overall summary is that the immediate problem has been fixed but the longer or medium-term solution of having systems that are properly integrated and allow us to look across the whole organisation and collect the information that we need is some way off.

Q43 David Tredinnick: You said “some way off”, so the problem has not been resolved. I put it to you that that means that you are unable to assess information properly, so you are getting all these inputs but you cannot process them. Jackie Smith: Can I come back on the earlier point? The CHRE said—and we agree with this—that it was not easy to extract information from the two systems. That is not to say that we have not been doing it. We have, but it is extremely resource-intensive. Staff members are keeping information from which we can make some assessments about the organisation. For example, we know how many cases we have, we know where they are in the system and we know how many registrants are on our register. The problem is that our two fundamental systems do not speak to each other. That is the stabilisation bit that we are doing at the moment, so that we do not have to have a massive amount of resource to produce the information that we need.

Q44 David Tredinnick: Ms Smith, you talk about choosing or selecting the high-risk areas, but on what criteria? Is it based on newspaper reports or are you looking at a proper computer analysis of the issues? Jackie Smith: We are looking at the two systems—WISER and the case management system—talking to each other, so that we can extract data about areas that have had a high number of referrals to the NMC and areas where there have been no referrals.

Q45 David Tredinnick: I put it to you that the financial chaos—and it is chaotic—that you are suffering is partly due to the broken engine room. You have this fundamental problem, which we have had in other Government Departments, about processing information technology properly, and this has heaped up your costs because you have too many people doing things manually that are not connected. The core problem is probably the inability of these computer systems to do the job properly. If you did that, then you could bear down on all these other costs and issues. Moving on to the questions about fee increases, is it any wonder that 99% of the Royal College of Nursing members oppose your massive proposed fee increase? Mark Addison: We no doubt will come on to the fee increase specifically and the views on that, but on the financial—

Q46 David Tredinnick: We are coming on to it as a line of questioning, but I want to ask about the fee increase and then go on to financial management, if I may. Mark Addison: On the technology point, the systems point. I agree that an integrated electronic case management system would make a huge difference, but it is not the only issue. There have been issues around the design of the process, which Jackie has been tackling. There have been issues about the way in which panel decisions are taken. There have been issues about the way we handle the people with whom
we correspond and so on. These are all issues that are not directly about the technology. The technology and the systems are important, but they are not the only problem we have.

Q47 David Tredinnick: I hear what you are saying, but I would like to go back to what the Chairman was saying earlier on. You have this huge task ahead of you—these very specific tasks—and you could do a lot of revalidation through online assessment. You could bore into this massive catchment area of people you have and do a reasonable assessment with a simple computer program. I do not hear you saying any of that. The only mention of IT we have had was in that one line, “We need to stabilise the IT systems.” My gut feeling is that, like many Government Departments, you are currently right up against it with IT and you need a lot of help there. There is a lot of new programming, a lot of things out there, which could be brought in to help your organisation. I am worried that you are not there with that, if I may say so.

Mark Addison: I agree with much of that analysis. I do not agree that we are not thinking about it hard and positively. One of the answers I think I gave earlier was around the learning that we need to do from the other regulators. We certainly know that some of the other regulators have systems that are significantly ahead of ours. We intend to pick up as much as we can from them and we are in the process of addressing it. But I agree it is a big important strategic issue for us, and we are going to get it right, but we are not going to snatch at it.

Q48 David Tredinnick: Moving on, historically your organisation has been resistant to independent audit. What independent analysis have you undertaken to verify your projections and justify imposing the substantial fee that I referred to earlier? What outside advice have you taken?

Jackie Smith: There are several things we have done. As part of putting together the fitness to practise budget, which the Council approved this year, we had KPMG audit our assumptions and make sure that we understood how much money was needed to deliver fitness to practise. KPMG is currently validating the assumptions that we have made in relation to the 8% increase in referrals and the length of our hearings, so that when Council makes a decision on 25 October about what the fee should be, it can be as assured as it can that our assumptions are reasonable. We have done a lot of work this year on our finances to make sure that the business case that we put forward was robust.

Q49 David Tredinnick: All right. What alternatives did you consider to increasing the fee paid by the registrants, and why were alternative options ruled out? There is a background to that question. I sat on the Chiropractors Bill, which became an Act, and the Osteopaths Act at the end of the 1980s and the early 1990s. One of the key issues there was getting the right price, the right payment figure, for the osteopaths and chiropractors, something that was acceptable to them. There were differences between what the chiropractors and the osteopaths were paid, the osteopaths being a much bigger organisation. It was tougher for the chiropractors at the beginning and eventually they sorted it out. I am not sure that it is reasonable to expect the nurses—and we know that 99% of them are against it—to have this extraordinary increase, and anyway aren’t we talking about two separate things here? We are talking about the broken engine room, the IT systems that do not talk to each other—the capital problem, as it were—and we are talking about revenue later on. We are talking about money coming in for keeping the process of regulation going. These are all getting muddled up.

Mark Addison: Shall I say something about our overall approach to the fee increase? Then perhaps Jackie can pick up the distinctions between capital and revenue.

Almost the first issue I had to address when I arrived was the imminent decision on fees. The consultation was still taking place—or had recently closed, I think—when I took up the post, so clearly fees have been at the front of my mind, and a lot of the questions you have raised were also in my mind as I began to consider the issue—notably, what kind of independent judgment had we had, had the models been externally checked, were the assumptions being looked at, and so on. What was the capability that we had brought to bear on the analysis of the issue, and did it really stack up against challenge, against alternative and against considering other options? That was one point in my mind.

Secondly, the issue for the NMC, and it is quite a simple issue, is that it has one source of revenue at least—or had one source of revenue until the welcome announcement yesterday of the Government’s offer of help, which the Council will be considering next week—which is fees. It has expenditure, which, as you will have seen from our annual report, breaks down into a number of categories. The fitness to practise category is the single biggest, and it is fairly stable in terms of volume, but at the moment there is a backlog, and it was growing very substantially a couple of years ago. We have to make those numbers balance.

One of the obligations on us as a result of that—partly because we are in a position to force nurses and midwives, and registrants generally, to pay this fee at a time when we recognise the timing could not be worse in a number of respects—is to make sure that we reduce our cost base as far as we possibly can. We need to make sure that we are not spending a penny more than we need to on the job that we have to do, because every penny we do spend we have to take off the pay packets of registrants. A good deal of work has been done on trying to cut cost out of our current operation. There are some figures, which Jackie will be able to give you, which relate to the reduction in the numbers of posts that we have. Savings in salaries have been undertaken, and have created a certain amount of organisational turmoil, but it is an important process to go through. The figures also relate to simplifying the systems, particularly around fitness to practise, and to reducing cost partly by—this is the point you made—bringing things in-house.
Q50 David Tredinnick: That is very helpful, but can I bring you back to the registration fee, if I may? Have you taken into account lower-paid registrants' ability to pay? One of the other issues the Committee has touched on in the past has been graduate nurses versus non-graduate nurses, and the whole issue of the level of qualification that one can say very often means the sort of level of actual wealth that they have. Some of these nurses will be much harder hit than others. Have you looked at that issue at all?

Jackie Smith: We have looked at a number of things around part-time working and graduate nurses. The fact of the matter is that it is very difficult for us to administer a system that has variable fees. We do not know where every single nurse and midwife works. We do not hold that information. We do not know how many hours they work per week, so it is enormously difficult to administer a system where we have variable fees. The fundamental problem that we have is the cost of fitness to practise. It will cost £43.5 million this year and we bring in £52 million. The rest of the organisation will cost us £30 million. So we have a shortfall. There is not an alternative way of delivering public protection. We recognise that this is a particularly difficult time even to think about increasing fees.

Q51 David Tredinnick: Have you assessed how many nurses will leave the profession, because they are obliged to register, aren't they?

Jackie Smith: Yes, they renew every three years.

Q52 David Tredinnick: How many nurses do you think you are going to lose because of this fee increase? What assessment have you made? Have you made an assessment of the numbers who will be resigning as nurses?

Jackie Smith: We have not carried out an assessment.

Q53 David Tredinnick: Don't you think you should, because it could be quite serious? This is a huge increase. It is not just 10% or 20%. It is a massive increase. I put it to you that you may be losing nurses out of the profession unnecessarily because of it.

Jackie Smith: We very much hope that that does not happen. We absolutely recognise the impact of this fee rise, but I am afraid there is no alternative to delivering public protection.

Q54 Chair: Can I ask you, for the clarity of the Committee, where you are in the fee-determination issue? Is that now a decision? Where is that process?

Jackie Smith: As you know, the Government offered the NMC a £20 million grant yesterday. That will be considered by our Council on 25 October. Essentially, it has a range of options open to it. It can keep the fee at £76, but the implications of that, I think, are pretty clear. It could accept the £20 million grant and then have a debate about where that would pitch the fee, because the reality is that even if the Council accepts the £20 million grant, fees will still need to go up to deliver what we need in fitness to practise. That is where we are. The Council will make that decision at the end of next week.

Mark Addison: It is probably worth adding that nothing we have seen—although the numbers are not finalised yet—so far suggests that the original propositions in the consultation document were way off. In other words, no number has suddenly emerged to say, “You don’t need to make an increase on anything like this scale.” There are all sorts of options, balancing the fee and the degree and the amount of activity, but the basic numbers look pretty sound.

Q55 David Tredinnick: I have only a couple of questions left. Thank you very much for that. Can I ask about your own fitness to practise, if I may—not that of the nurses, but that of your organisation? How was it possible for the executive team and the Council to underestimate the cost of fitness to practise work by over 30%, £10 million, in the last financial year? How could that have happened?

Mark Addison: My source of evidence for that is the CHRE report. It has quite a full analysis of the issues around financial management and capability in the organisation and some of the governance issues. There are a whole range of reasons why those figures were not identified earlier, but the task for us at the moment is to look ahead, to deal with the problem we have, and to set the fee at a level that gives the organisation the stability and resources it needs to do its job properly.

Q56 David Tredinnick: Okay. My last question is this. Did you, when you came to the organisation, think it was a little strange that there was not a qualified financial professional on the Council?

Mark Addison: I accepted the criticism in the CHRE report, as the organisation had already. That is one of the things we will be looking at when the Council comes up for reconstitution, of course. I should say that we have an excellent financially qualified person who joins us at Council meetings now in the form of Louise Scull, and that has been hugely helpful.

David Tredinnick: Thank you both very much.

Q57 Dr Wollaston: I have one quick question. Will you be publishing in full the report from KPMG, so that your members can see its analysis?

Jackie Smith: We will be publishing the KPMG report.

Chair: Can we move on from financing? Barbara has some questions on governance and culture.

Q58 Barbara Keeley: Your written evidence outlines some steps that you have taken to improve governance and management. Can you tell the Committee what you have been doing to encourage Council members to provide more effective scrutiny? Evidence that we had from the RCN talked about issues, which I am sure you are aware of, such as ‘lack of rigour from the NMC Council in challenging executive staff on poor performance relating to fitness to practise, a ‘drift of mission’, and poor financial management’, which we have just been discussing. How can the Council ensure that there is now attention on those key performance indicators that Jackie talked about?
Mark Addison: It is an interesting reminder of where things were. I would say that the current position is a very long way from that.

Q59 Barbara Keeley: What have you done and what are you doing?
Mark Addison: When I arrived I inherited, to be frank, a Council—a set of committees and groups—that was incredibly actively engaged on those very areas. I would not say I personally have had to intervene to secure that. The steps that had been put in place had been a response to the report when it emerged, and indeed to the interim report, which I think came out in April, so a lot had changed. By way of example, there are two particular groups that review critical areas for us. One is the finance area. We have a finance review group, which consists of Council members and members of the executive, which looks very carefully at the full range of financial management data. The other is the fitness to practise group, which I chair. I chaired the first meeting of that last week. It reviews the key performance indicators on the fitness to practise function, which are exactly as described earlier, at the heart of what we do. That is a historical statement and by no means an accuratedepiction of the approach of the Council at present.

Jackie Smith: May I add to that as well? As an organisation, the other thing we have done around governance is increase the amount of openness in Council meetings. The CHRE criticised us for holding too many confidential meetings and seminars. To be fair to Council members, they were very concerned about that too. Much more of our business is done openly. Our risk register is discussed openly. I do not think others necessarily adopt the same approach. It is not only the groups that Mark has mentioned; the way in which the Council conducts its business openly is very different.

Q60 Barbara Keeley: Clearly, you talked in your introduction about being new in your role. How do you anticipate that role differing from those of predecessors, and what do you intend to do differently from predecessors to avoid the management failings that have been highlighted?
Mark Addison: In terms of my own approach to the role, I have a fairly clear idea about its nature, and the relationships that we need to secure between the Council and the executive, and between the chair and the chief executive. That probably is the reason why some of the issues to which the report alludes arose. To summarise very briefly, the Council’s job is to set the forward direction, to set the critical targets and to hold the executive team, including the chief executive, to account for meeting them. That means there need to be the usual assurance mechanisms in the organisation in place, but the key function is setting the direction and making sure that it happens. It is not the Council’s job to do the work. It is the executive team’s job to do the work. My role, apart from being the chair of the Council, particularly at the moment, is to try to spend a lot of time outside the organisation talking to our critical partners and stakeholders out there, building relationships, explaining what we do, listening to views and feedback from them and learning, indeed, from the other professional regulators. Jackie’s job, as the chief executive, is to run the organisation and make sure it delivers. That clarity, I hope, will be helpful and address some of the issues that seem to have gone a bit off track in the past.

Q61 Barbara Keeley: Referring to the Council, do you see an enhanced willingness to challenge? Jackie, in her role, needs to be challenged, as any chief executive does. Is the Council up to that?
Mark Addison: I would say an “enhanced willingness to challenge” is probably putting it mildly.

Q62 Barbara Keeley: Looking forward—and this is obviously a question for you, Mark Addison—there was great emphasis in the CHRE’s review on recruiting senior figures with the skills to implement the set of changes that are needed. You will be looking for a chief executive in the next year, but what was done to assess candidates’ ability prior to Jackie’s appointment?
Mark Addison: As you may know, that competition did not in fact reach a final conclusion, but the process we set in hand was, I think, a thorough one. In addition to the specification that we published—the job specification—we asked candidates to go through a number of tests. We put them through a standard suite of psychometrics, which is quite common for chief executive posts. We had a meeting of the short-listed candidates with the directors of the organisation to try and get a feel for the current issues, to get a sense of what the top team looked like. We had a meeting with the staff, which was an assessed part of the process. The candidates were asked to give a short presentation on where they wanted to take the organisation, and a selected group of staff asked a range of questions, and challenged and probed them, and a judgment was made by an independent assessor of how that went. All those tests were designed to feed into the final interview assessment.

Q63 Barbara Keeley: You will be embarking on the process for a permanent chief executive next year. What qualities do you think you will be looking for at that point?
Mark Addison: That is a very interesting question. At the moment, the focus is absolutely on performance. A lot of the sorts of things we have been talking about today hinge on the organisation raising its game and doing its basic job better, and a lot of the other things will, I hope, fall into place if we get that right.

In a year’s time, the focus will still absolutely be on securing the final achievement of those key performance indicators—the clearance of the backlog and so on by December 2014—but I think we will be looking at that stage for an organisation that can take its place more properly among the rest of the professional regulators, with a clear idea of what being an excellent professional regulator looks like. We will probably be in a slightly different place in nine months’ time—I hope we will be—but without, I hope, losing that drive and relentless focus on delivering the goods.
Q64 Barbara Keeley: Do you think the gap in time in appointing a permanent chief executive is contributing to instability? You yourself talked earlier about there having been six different people in your post and five different people in the chief executive’s post. Is there still a feeling of instability around?

Mark Addison: First of all, I personally am absolutely delighted that Jackie is the new substantive chief executive. Secondly, that appointment has been extremely well received by everybody I have spoken to, and a number of press notices were put out to prove it. Thirdly, I think a period of a year is exactly what we need—it may well be longer—to have the stability we need to get through this critical phase.

Q65 Chair: Can I ask what you mean by—I am sorry, with Jackie sat beside you—“It could be longer”?

Mark Addison: I want to make no assumptions. Jackie Smith: Do you want me to leave the room?

Mark Addison: I want to make no assumptions about whether Jackie would be interested in applying for the job at that point, but of course I very much hope she would, and will test herself against the others that come forward.

Q66 Barbara Keeley: On the change management programme, clearly there have been many questions around this and a lot of comment on the need for the reforms that you are implementing. If I look back to the criticisms, they were around things like silo working, undue hierarchy, secrecy and disempowerment. What are you doing to develop the overarching plan for the NMC that will allow the Council to assess progress, moving away from that? That is a very substantial set of criticisms.

Mark Addison: It is.

Jackie Smith: We have a high-level change plan that we submit to the Council every month and commentary on progress. That plan incorporates all the recommendations by the CHRE in the final report and the ones that were in the interim report. Fundamentally, we have to change the culture, as I said at the beginning, but culture change takes a long time and I do not believe that you get staff having confidence in the organisation until we start to deliver. There are a number of things that we are doing internally to break down silos, and to get groups of staff working together on projects in relation to the change programme, so that we get more input from all staff across the organisation. I have weekly meetings with staff in the entire organisation. I go round each directorate and talk to them about what we are doing, and what the key challenges are. I met with them yesterday and talked to them about the £20 million grant and where that would leave the Council in a week’s time. They are small things but it is part of the bigger picture. It cannot be right that the organisation has that label of “resigned resilience”. Members of staff need to feel empowered to be able to make changes, to suggest changes, because they do the job. They know what works best. We do not want an organisation that is very hierarchical, and that does not listen to its staff.

Q67 Barbara Keeley: No, it is obviously not going to work. What signs could you point to that people are feeling more empowered?

Jackie Smith: We hear anecdotally, but what we are doing is a staff survey at the beginning of next year to test whether what we feel is actually the case, because unless we get that information, we are relying on anecdotes.

Q68 Barbara Keeley: Obviously, there was a damning analysis of your workplace culture, with the staff turnover at 31%. What are you doing to cut staff turnover and keep hold of your most able staff?

Jackie Smith: We have recently asked the Council to sign up to a quite ambitious HR strategy. Fundamentally, we have to invest in our staff. We need them to understand why they come to work, what part they play in delivering public protection, why it is a good organisation to work for and why they can be proud of it. I think we are a way off that. We need to improve development. We need to invest in training and induction. We need to build our youth team, as we call it, so that people stay with us for the long term, because 31%, or 36%, as it is now, is way too high. Every time someone leaves—

Q69 Barbara Keeley: It has gone up to 36%.

Jackie Smith: It is 36%. We lose money; we lose productivity. It is not good for the reputation of the NMC. We held a recruitment event in fitness to practise last week. We put a small advertisement in a newspaper. We had over 200 people attend, showing a great deal of interest in working in the NMC, which is really encouraging. What we have to do is ensure that they stay. We need to invest in them and in the culture of being a good employer.

Q70 Barbara Keeley: If the overall turnover rate is now 36%, what is it within fitness to practise?

Jackie Smith: It is 36% in fitness to practise.

Mark Addison: The numbers in fitness to practise are ramping up quite fast. That, too, creates a certain amount of turmoil in the chain.

Q71 Barbara Keeley: Are there specific things you think you can do to hang on to those people?

Jackie Smith: There are. It is about induction, training and giving them the tools to do their job properly. It is about investing in the IT systems, because if they have IT systems that do not work for them, they will become frustrated and leave.

Q72 Barbara Keeley: You have touched on IT systems quite a lot. If you think having working IT systems is a factor, when will that change? That is another big change to make, isn’t it?

Jackie Smith: There are two things that we are doing. We are investing in stabilising the two systems, and then we need to propose to the Council what the long-term vision for IT is. Very much building on what Mark said earlier, we need to talk to the other regulators and see what works for them, so that we do not spend lot of time and money investing in something that is not going to deliver for the NMC.
Q73 Barbara Keeley: Coming back to the Council, given the broad remit of the NMC across the UK, what is your view about the optimum number of Council members? Clearly you have been advised to get it to between eight and 12. I know the RCN believes it should not be less than 12, and that there should be a representative of registrants. Do you share that view?

Mark Addison: I have not spoken to my Council colleagues explicitly about this. My personal view is that 12 would be fine. There is a very strong case for equality between registrants and lay members. I do not see any reason why we should, on the face of it, be different from any of the other regulators. Most of them seem to be going for 12, and 12 would be fine. We have 14 at the moment and that, too, is fine. Once you get above that, it is hard to get a genuine collegiate sense around the table. If you have a smaller number than 12, you are beginning to lose out on the capacity, which we need, to tap into different bits—the four countries, basically, and the different registrant backgrounds, midwives and nurses—to get the right kind of diverse mix of skills and talent you need around the table. I would be happy with 12.

Q74 Barbara Keeley: How will that change from 14 to 12 occur? When do you propose to reduce—

Mark Addison: It is the Department of Health that needs to determine this. It is not in our gift. We are waiting. We expect a decision from it very shortly. At that point, the Council as a whole will come up for reconstitution to a timetable that it will determine.

Q75 Chair: Can I link the discussion we’ve just had on strategic objectives to the earlier discussion on resources? I was wondering what the terms were—and you may not know this yet—around the £20 million grant from the Department. My question is, I suppose, is this a bung to sort you out in the short term, or is this the Department buying into a recovery strategy?

Mark Addison: I very much hope it is the latter.

Q76 Chair: Indeed, but that is a much more ambitious project. I do not get the sense that you have a fully formed recovery strategy with a series of financial implications worked through. It has the sense of being work in progress. I wonder where the discussion with the Department has got to and, to put it the other way round, from the Department’s perspective, should it not, given its willingness to offer public funds to the NMC in this form, be seeking a clear strategic plan, with milestones, with a clear sense of what is going to be delivered when?

Mark Addison: Thank you. Let me try and deal with that. Jackie may want to add some points. First of all the Department’s press notice talks about strategic objectives to the earlier discussion on resources. We have 14 at the moment and that, too, is fine. Once you get above that, it is hard to get a genuine collegiate sense around the table. If you have a smaller number than 12, you are beginning to lose out on the capacity, which we need, to tap into different bits—the four countries, basically, and the different registrant backgrounds, midwives and nurses—to get the right kind of diverse mix of skills and talent you need around the table. I would be happy with 12.

Q77 Chair: That is an important part, as you stressed at the beginning, but it is not the whole of the strategic recovery plan, is it?

Mark Addison: No, but the Council has been quite keen to establish a clear connection between any offer that you have made and the delivery of a time-limited set of outcomes. We do not want to find ourselves—and the Council would not want to find itself—in the position of being in hock in some way on a continuing and permanent basis to the Government. We are an independent regulator. We prize that. We want to consider this offer against a quite specific set of deliverables and then move on. The Government and the Department will, of course, be interested in our overall recovery plan. We will make that available to them in any event. I am interested in your perspective that we do not have a fully worked-up plan. I would like to comment on that in two respects.

First, we have a very clear idea of what we need to do over the next 18 months to two years. I accept that, beyond that point—when the engine room, as I described it, is fixed, is seen to be fixed, is functioning well, and we have the capacity to think a little more broadly about the full suite of our responsibilities and opportunities as a professional regulator—there will be a rather different strategic plan in place. There will come a point at some time over the next year where we begin to need to address that, but I would push back on the suggestion that we do not have a clear plan at the moment. We have a very clear plan at the moment. While it is quite a fixed and—you might say—somewhat narrow plan, it is a recovery plan that will get us to the position we need to be.

Q78 Chair: Does the revalidation point feature in that plan? The reason I ask the question is that you said 18 months to two years, and the revalidation date is three years.

Jackie Smith: It does feature in that plan, because it is a fundamental part of what we need to be delivering.

Q79 Dr Wollaston: Can I turn to a very specific area of concern about fitness to practise? It is the ability of all clinical staff to be able to listen to and communicate with their patients, including things like euphemisms and colloquialisms. It has been raised by the Patients’ Association and more widely. The NMC has rejected the concept of having a responsible officer model. Can you set out in more detail why you have rejected that model and what you are going to put in place to have some improvement in this area?

Jackie Smith: I do not think that we took a clear decision to reject that model. If we went for the responsible officer model, there is a need for change to our legal framework. The Department was extremely helpful to us last year, after this Committee’s report—thank you for your help with that—in bringing in some changes in fitness to practise, but because of the Law Commission’s work and the consultation that it
did on all the regulators and the ability of the regulators to be able to change their own legal framework. I think the Government are saying, or the Department is saying, that unless there is a compelling case in relation to public protection, all the regulators should wait for the Law Commission work. The idea of having a responsible officer model for the NMC is probably at least four years down the track.

Q80 Dr Wollaston: Specifically, could you set out why that was possible for doctors but not for nurses, then?

Jackie Smith: It was possible for the GMC because of the length of time that it has had looking at the model for revalidation. I think it felt that revalidation could only be delivered through local clinical governance. I amstraying into territory that I probably should not comment on, but clearly that was the model it thought would work for doctors. If we are to replicate that, we would need a change in our framework, and, as I say, that is at least four years away.

Q81 Chair: Except that you did enter the caveat “unless it is required for public protection”. Well, query.

Jackie Smith: I think the Department would say, “Are there alternative models that you could explore that do not require, in a legal framework, the responsible officer?” Where we are in our thinking is that we have done the audit, our PREP standards are not fit for purpose and we need to explore something that is risk-based and proportionate, but that is short of the responsible officer model.

Q82 Dr Wollaston: For people following this debate, how is the NMC going to make sure that nurses who cannot communicate with their patients are not going to be there practising and putting patient safety at risk?

Jackie Smith: Clearly, if they cannot communicate with their patients and patient safety is at risk, we need to act on that, but we need to work with employers. Any revalidation model that we launch has to have input from employers about an individual’s practice. That is the only model that will work.

Q83 Dr Wollaston: You are going to be waiting to see if their practice is insufficient. Is there anything proactive you can do before they start work?

Jackie Smith: At the point of renewal, which is the early thinking—so when a nurse or midwife comes up for renewal of their registration—we will be seeking input not just from them on their ongoing fitness to practise, but on how they have practised over the last three years, and seeking information from employers, which is more proactive than what we are doing at the moment.

Q84 Dr Wollaston: What about before they start practising—say, if somebody is coming from abroad to work in the UK?

Jackie Smith: On the EU, which is perhaps what you are talking about here, we are working with the Department to seek changes so that we can test language, but we need the Department’s support on that.

Q85 Dr Wollaston: If somebody starts working within a hospital or a home and it is clear that they are having difficulty communicating, what is your message to employers?

Jackie Smith: We have communicated to employers this year that “You must test language skills if you think there is a risk.”

Dr Wollaston: So it is if they think there is a risk.

Jackie Smith: Yes.

Q86 Andrew George: Turning to healthcare assistants and those other workers that do not fall within your curtilage—and I am sure it is said just as a broad-brush approach—I notice in your evidence that you say that you believe that mandatory statutory regulation of healthcare assistants is “the only approach which maximises public protection.”

Obviously there is a limitation as to what you are statutorily responsible for, but you recognise that nurses and midwives are working in a sector alongside other workers. I wondered to what extent the NMC takes its own limited vision of what its responsibilities are in that sector and does not place that in context in terms of its conversations with the Department of Health. How would you describe your role in protecting patients? At the end of the day, that is what you are there to do—not only to uphold professional standards but to protect a patient’s interests.

Mark Addison: Thank you for the question about the regulation of health care support workers, essentially. Clearly this is a significant issue in the public arena at the moment. Our position on it is that that decision is one for the Government rather than for us. As you rightly say, we do not have, at present, that responsibility. The Government need to make up their mind and they are, as you may know, proceeding in a particular direction, which is short of full regulation at present.

Whatever our views might be on that question—and I know different people hold different views on it—the reality is, for all the reasons we have been discussing, for us right now, this would be a non-starter in terms of the assumption of new responsibilities. We have so much on our plate already to fix. There is no necessity for that responsibility to come in our direction in any event, but were the Government to think that was a good idea, then we would expect, obviously, to have discussions with them about it, its implications and how it would be taken forward. At the moment, we are resting on the view that it is the Government’s decision and that there is no prospect of us being able sensibly to absorb such an additional responsibility right now even if it were suggested, which is perhaps an unhelpful comment and does not address the policy question of whether it is a good or bad idea. It is about the reality of the position that we face.

1 Annex 1 of the NMC’s written submission reproduces the recommendations made in the Health Committee’s report of last year’s accountability hearing, with its updated response to the recommendations. This quote is taken from paragraph 18 of the annex and was stated by the Committee rather than the NMC.
Q87 Andrew George: If you do not mind me saying so, that is a bit of a jobsworth response. If the NMC is not there simply to work within the strict parameters but is also to see itself in the context of nursing and care standards—particularly where the boundary of what nurses do as professionals is blurred by the constant increasing role of health care support workers, for obvious budgetary reasons, both in the NHS and in the private care sector—don’t you think that you have a responsibility as an organisation at least to enter a conversation with the Government, and to recognise that, because of the blurring of those boundaries and the role that health care support workers are providing, they do compromise some of the standards that you may be seeking to uphold? Jackie Smith: That is absolutely right. We do have the responsibility to enter into that conversation, if only to restate our position at the moment, which we know is not welcomed by a number of organisations. We have supported the work on Skills for Health, which is looking at a code for health care support workers. To deal with your point about blurring boundaries, we have a responsibility to ensure that individual nurses and midwives delegate appropriately. We did start a piece of work looking at delegation standards, which I am afraid was overtaken by the events of the strategic review and the organisation refocusing. That is something that the NMC could come back to, but it is about timing. I would very much support what Mark has said. We have to wait to see what the Government say on this issue, but we do need to be part of that conversation.

Q88 Andrew George: Of course, one entirely understands that if you are suddenly, overnight, responsible for an extra 600,000 workers, you need to have the resources commensurate with that responsibility. That goes without saying. The question is one of standards in patient safety at the end of the day. Given the role of health care support workers in this particular arena, what concerns me is your initial response that it is outside your statutory duties and therefore you are not going to touch it. Shouldn’t it be the responsibility of the Council to recognise trends in the sector and make sure that it is part of a conversation you are having with the Department? Jackie Smith: Absolutely. What we are saying is that we do need to be part of that conversation. I have no doubt about that at all.

Q89 Andrew George: You have said that care needs to be taken with regard to the delegation role. Where a nurse or a midwife is delegating responsibilities, how far are you prepared to take that responsibility of delegation? If a nurse appropriately delegates a task to a health care support worker, and that work is undertaken incompetently or unsafely, to what extent is that registrant responsible, and to what extent will that reflect on their own competence to do the job? Jackie Smith: It would depend on the extent to which they have disregarded their responsibilities as a registrant under the code. We have to be careful about the regulator straying into employment issues, because it is for employers to determine how they use their work force. Where a registrant disregarded their responsibilities under the code and delegated functions inappropriately, that is something that the NMC should consider and look at.

Q90 Andrew George: The Patients Association, in its evidence to us, highlights the fact that the nurse-to-health-care-assistant ratios are slipping, with fewer nurses in relation to health care assistants. You yourself, Jackie Smith, said earlier, as far as I recollect, that the area that you were most concerned about was that of the care-home sector. I think you were saying that a moment ago. Jackie Smith: I said it is a high-risk area, yes.

Q91 Andrew George: You said it was a high-risk area. It is also an area where the ratio of health care assistants to nurses is especially high. In those circumstances, if you recognise it as a high-risk area, where the ratios are particularly high and there is pressure for those ratios to become even more compromised, what role do you think the NMC has, in terms of making contextual comments, and being part of a conversation to make sure that patient safety is protected? Jackie Smith: I think we come back to where we started, which is ensuring that nurses and midwives delegate appropriately. I do not think we should do anything other than be part of the conversation about health care support workers, but unfortunately, at the moment, we have to wait to see what the Government decide on this issue.

Q92 Andrew George: In your view, is the power of the independent safeguarding authority to bar unregulated workers, such as health care assistants, from the sector a sufficient safeguard to protect patient safety? Jackie Smith: It is one of the safeguards.

Q93 Chair: We have reached the end of the questions we had prepared. Can I conclude with a much more general question? How would you characterise the understanding within the nursing and midwifery professions of what it means to be a professional, and what do you think is the role of the NMC in supporting, addressing or changing that? Mark Addison: I do not think I can answer that, both because I do not myself know enough yet about the perspectives of the two professions themselves and, secondly—but perhaps more importantly—because in my own mind I need to work through with my Council colleagues and the executive team what the nature of the fully expanded role might be of the professional regulator, in relation to the question you asked. Jackie may have some perspectives, but I would like to say that one of the issues in my early discussions with the Royal College of Midwives, with the equivalent on the nursing side, the RCN, and the unions has been exactly about who is responsible for what here, how we work together, what the nature of professional leadership is, where it should come from and what it means. So I am in a learning period rather than a conclusions period on those huge issues, I am afraid.
Q94 Chair: Jackie Smith, do you wish to offer any comment, or do you take your chair’s lead?
Jackie Smith: I suppose the NMC is at an almost historic point at the moment. Confidence in the organisation is perhaps at an all-time low, not only from the public but from the professions, but there is a debate to be had about what it means to be a professional, and what it means to uphold standards in the code. That is an arena that the NMC needs to move into, alongside the Royal Colleges, because we cannot do this alone. We need to work with the RCN, the RCM and employers.

Mark Addison: One thing that has struck me in my recent conversations is the extent to which there is an inevitable tension between the perspectives of the Royal Colleges, the patient organisations and action groups. Jackie has frankly said that our reputation is poor at the moment. That is true. It is improving, probably, at the level of the officers, but from the perspective of people on the ground, we have a poor reputation on both sides. You might say that, if we are not satisfying the professionals or the patient groups enough, then maybe we, as a regulator, are getting it about right, but I think that is the wrong way of looking at it. I do not think our task in life is to find a way that fails to satisfy hugely important constituencies for us. I hope that, over the next few years, we can build a position where we have the respect—not necessarily the affection. I recognise, but the respect—of the professionals and the active support of the groups that represent patients, rather than having the somewhat negative perspective on the ground that we have about us at the moment, although, as I say, that is changing, at the organisational level, a little in the right direction.

Q95 Valerie Vaz: I have a final question because I am not sure if anyone has touched on this yet. The CHRE made 15 recommendations, and you know what they are. I was wondering if you have a time frame for those, and how can we measure them, so that when we see you again, we know those have been implemented?
Jackie Smith: We do. We have the high-level plan I referred to earlier, which the Council scrutinises every month. It has time scales attached to each of the recommendations, ranging from six to 24 months to three years. The CHRE said the changes would take a year to deliver. That is the time scale we are working towards.

Valerie Vaz: Thank you.

Q96 Chair: It would be helpful to the Committee to have sight of your notations against the 15 objectives.
Mark Addison: We would be happy to share that.

Chair: Thank you.

Dr Wollaston: I have a final question, returning to the issue of what it means to be a professional. The GMC set out a very clear statement that failure to raise concerns about the practice of a colleague—or indeed a visiting celebrity; that would equally apply—is a fitness to practise issue. Is that something that you would also want to make a statement about today?
Jackie Smith: We signed up to the NHS Employers launch yesterday on the “Speaking Up” charter. We were signatories to that. We absolutely do want to make a statement about how important that is, and to reinforce our “Raising and escalating concerns” guidance.

Dr Wollaston: Thank you.

Q97 Chair: The “Raising and escalating concerns” guidance is, in the context of Good Medical Practice, part of a broader definition of professional obligation for a doctor.

Valerie Vaz: Is there a difference between the GMC and the NMC?

Chair: Yes, “Duties of a doctor”.

Q98 Chair: Do you have a similar set of written-down values?
Jackie Smith: It is in our “Raising and escalating concerns” guidance, but it is not called—

Q100 Chair: “Duties of a doctor”.
Jackie Smith: Yes.

Q101 Chair: Exactly. There is a difference between having a document which sets out duties of a nurse and duties of a midwife, and a document that says what you do when you want to raise concerns.

Jackie Smith: Absolutely. We do not have a similar document, no.

Chair: I accept this is not one of the immediate issues that have to be dealt with in the short term, but would it be part of the medium-term objectives of the NMC to develop such a document for the nursing and midwifery professions?

Jackie Smith: I think it has to be, based on your final question to us, which is, “What does it mean to be a professional and what does professionalism mean?” That is part of the conversation, yes.

Q103 Chair: I am asking what a classical scholar would call a norme question, a question to which you expect the answer “yes”, but is that right?
Jackie Smith: Yes.

Mark Addison: Yes.

Chair: Thank you very much.
Written evidence

Written evidence from the Department of Health (NMC 01)

This memorandum has been prepared by the Department of Health in England in response to the House of Commons Health Committee’s call for evidence for its planned accountability hearing with the Nursing and Midwifery Council (NMC) on Tuesday 16 October 2012.

The Department acts in an advisory capacity to the Privy Council on policy and legal matters arising from the activities of the health professional regulatory bodies. The Department also has an interest in the regulators’ performance in terms of public safety and protection. The Department welcomes scrutiny of the NMC by the Committee through its annual accountability hearing and is grateful for the opportunity to contribute to this process.

In September 2011, the Department provided a response to the Health Select Committee’s recommendations from its 2011 annual accountability hearing for the NMC. The Committee published this on 7 March 2012.

BACKGROUND

1. The NMC is accountable to Parliament through the Privy Council. Provisions in the Nursing and Midwifery Order 2001 require the NMC to report to the Privy Council on a number of matters relating to its performance. These include matters in respect of its financial performance, how it complies with its duties as a public body in terms of equality and diversity matters, and its strategic plan for future years. This material should be submitted to the Privy Council and laid before Parliament.

2. In its annual accountability meeting with the NMC in July 2011, the Committee found that, while significant work needed to be done to allow the NMC to become an effective regulator: “the NMC is leaving behind its previous organisational and financial instability, and is improving in many areas of its work.” However, since that time, it has become clear that the NMC faces significant challenges in terms of its performance, leadership and financial management. The magnitude of these problems was not clear from the evidence the NMC gave to the Health Select Committee last year. This is disappointing and requires urgent redress.

PERFORMANCE BY THE NMC OF ITS STATUTORY DUTIES

3. The CHRE published its Audit of the Nursing and Midwifery Council’s initial stages fitness to practise process in November 2011, which found continuing areas of significant weaknesses in its handling of cases at the initial stages of the fitness to practise process. The CHRE concluded that “these weaknesses create risks for public protection and public/professional confidence in the regulatory process.”

4. In light of these concerns, the Department, acting on behalf of the Privy Council, took steps to ensure that the NMC continued to meet its statutory duties effectively and that it was able to protect the public. On 26 January 2012, the Parliamentary Under Secretary of State for Public Health announced, via a Written Ministerial Statement, that a strategic review of the NMC would be undertaken by the Council for Healthcare Regulatory Excellence (CHRE).

5. The Department commissioned the strategic review to look at the NMC’s organisational structure, resource allocation and operational management. It aimed to establish what further action was needed to ensure that the NMC was effectively carrying out its statutory duties to promote high standards of conduct and practice for its registrants in order to protect the public.

6. The review (published 3 July 2012) found that the NMC fulfilled its basic safeguarding duties. However, the review also raised concerns that longstanding problems with poor leadership had resulted in performance at the NMC that was below the standard that both the public as well as registered nurses and midwives have the right to expect. Specific concerns were raised around financial management and fitness to practise.

7. The Government is clear that improvements must be made and the NMC must take the necessary steps to ensure it is able to safeguard care to patients to an appropriately high standard.

8. The NMC has committed to taking forward the CHRE’s recommendations, and work is underway. The Department welcomes this approach from the NMC and expects CHRE to continue to work with the NMC to ensure that the recommendations are taken forward, and that progress on key indicators continues to be monitored.

NMC LEADERSHIP

9. In the first quarter of 2012, both the NMC Chair and Chief Executive resigned. Interim arrangements were put in place and Ministers sought and received assurances that focus would be maintained on improving fitness to practise performance during the interim period.

10. The Appointments Commission, with support from the NMC, commenced a recruitment exercise for a new Chair. However, on 11 July 2012, the Appointments Commission decided to cease its campaign to recruit
a new Chair for the NMC. The decision was made on the basis that CHRE Strategic Review’s focus on leadership meant that it was appropriate to look again at the person specification and selection criteria for the post.

11. In light of the Appointment Commission’s decision, the Privy Council, acting on advice from the Department, determined that it would be appropriate for it to exercise its powers directly and to make this important appointment. This was to ensure that an appointment was made in a timely manner, both ensuring stability for the NMC and providing the leadership position to make the necessary improvements in its performance. The Department assisted the Privy Council with the recruitment. The importance of taking decisive action on leadership was given weight by CHRE’s recommendations in the strategic review. Future appointments will be made through the usual appointments procedures.

12. On 31 July 2012, Mark Addison was announced as Chair of the NMC, and he took up post on 10 September 2012. The Department considers his appointment to be an important milestone in delivering longer-term improvements at the NMC. We understand that a recruitment process to recruit a permanent Chief Executive is now in hand.

Registration Fee

13. On 1 June 2012, the NMC began a twelve-week public consultation on proposals to increase the annual registrant fee and on whether future fees ought to be linked to inflation. The consultation concluded on 24 August 2012. The NMC has stated that the need for the rise is to enable the organisation to fulfil its statutory duties.

14. The Government’s position on health professions regulatory bodies was set out in the command paper Enabling Excellence: Government would not expect registration fees to increase beyond their current levels, unless there is a clear and robust business case that any increase is essential to ensure the exercise of statutory duties.

15. Ministers have been clear about the need for the NMC to be absolutely sure that the case around their fees rise is robust, and that any impact on registrants is minimised as far as possible. To this end, Ministers wrote to the NMC seeking further external assurances about the validity of assumptions in the NMC’s business case for the fee increase. The NMC considers that its justification for a fee rise of the order of magnitude proposed is robust. However, we understand that the NMC will consider external assurance on the options for Council consideration. The Department would welcome such a move. We understand that the NMC’s Council will be discussing this issue at its meeting on 25 October 2012.

September 2012

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

Introduction

1. The NMC is the regulator of nurses and midwives in the United Kingdom. We were established by Parliament under the Nursing and Midwifery Order 2001.

2. Our main objective is to safeguard the health and wellbeing of people using or needing the services of nurses and midwives. We do this by:
   a. Registering all nurses and midwives and ensuring that they are properly qualified and competent to work in the UK. There are currently just under 670,000 registered nurses and midwives on the register.
   b. Setting standards of education, training, conduct and performance for nurses and midwives.
   c. Ensuring that nurses and midwives maintain those standards.
   d. Ensuring that midwives are safe to practice by setting rules for their practice and supervision.
   e. Maintaining fair processes for investigation of allegations made against registered nurses and midwives.

3. A great deal has happened since our last appearance before the Health Committee. At the request of the former Parliamentary Under Secretary of State for Public Health, the Council for Healthcare Regulatory Excellence (CHRE) conducted a strategic review of the NMC; the final report of which was published in July 2012. The CHRE also produced its annual review of the NMC’s performance in June 2012. These two documents provide the basis for a comprehensive improvement agenda for the NMC.

4. The criticisms of the NMC are serious and wide-ranging. We are sorry that we have fallen below expected standards for a regulator. We accept that patients and the public, and all of our stakeholders, have a right to expect that we will improve our performance and work hard to address identified failings.

5. We welcomed the CHRE review and worked closely with their team to help them scrutinise our practice. We have accepted CHRE’s recommendations in full and have developed a comprehensive change programme...
to tackle these. We have restructured the organisation to focus on our core regulatory business, we are strengthening our governance, and we are encouraging a culture of openness and reflection. We are determined to ensure that the NMC has a sharp focus on its impact on patients and the public.

6. The CHRE is clear that the NMC is protecting the public, but not to the standard that stakeholders have a right to expect.

7. The CHRE recognises that it will take at least two years for us to address their recommendations.

8. We look forward to this year’s accountability engagement with the Health Committee. CHRE’s strategic review will be of benefit to the Committee as it provides a very comprehensive picture of the NMC’s current performance. As the Committee might expect, our efforts are currently focused on ensuring that we have in place appropriate plans to address the recommendations and by 2013 we would expect to be able to provide evidence to the Committee that those plans are proving effective at delivering the change required by the CHRE.

9. We found the Health Committee’s 2011 recommendations helpful. As agreed with the Committee Chair, a commentary detailing our response to those recommendations is annexed to this submission. The main body of the submission comprises sections on the NMC’s capacity to be an effective regulator, and an update on the delivery of our core regulatory functions.

**Enhancing our Capacity to Protect the Public**

*Ensuring clarity of purpose and a consistent focus on the NMC’s regulatory functions*

10. In January 2012, we reviewed all programmes and prioritised those essential to public protection. Our 2012—2015 corporate plan now focuses efforts and resources on the delivery of our four statutory functions.

11. Staff workshops in the autumn will seek to ensure all staff understand the role of a regulator, the NMC’s values and its expectations about behaviour, and our corporate priorities over the next two years.

**Strengthening leadership and culture**

12. The CHRE made it clear that the appointment of a substantive Chair and Chief Executive were critical to leading the necessary change and restoring public confidence in the NMC. A new Chair, Mark Addison, took up post on 10 September 2012, and we hope to appoint a substantive Chief Executive in October 2012.

13. The Department of Health consulted earlier this year on the NMC constitution and reducing the size of Council to between eight and twelve members. We await the outcome of the consultation and any resulting changes to our legislative framework.

14. Our change programme includes action to embed new ways of working, addressing criticisms from the CHRE about silo working, undue hierarchy, secrecy and disempowerment. We are adopting more open and transparent communications about decision-making and are seeking to improve staff engagement.

**Engaging more effectively with stakeholders and the public**

15. We are revitalising our relationships with key stakeholders to communicate our plans for improvement and build a constructive dialogue based on clear understanding of respective roles and responsibilities which will allow us to concentrate on our core regulatory functions. A new stakeholder engagement strategy will place particular emphasis on seeking and responding to the views of the public, patients and service users. We are committed to adhering to good practice in public consultations and enhancing the transparency of our processes and the evidence that informs our regulatory model.

**Improving governance**

16. We recognise the need to strengthen governance and put this at the heart of our work. We adopted a revised governance framework in March 2012 and approved plans to further strengthen our governance assurance arrangements in September. We have developed a fuller suite of management information and key performance indicators to help interrogate and challenge performance and this will be subject to ongoing development.

17. We have implemented the CHRE’s recommendation that the Audit Committee should be chaired by a Council member.

18. We will implement the recommendation that there should be a Council member with financial expertise as soon as a non-registrant vacancy arises. In the meantime an independent member of the Audit Committee with this expertise attends Council in an advisory capacity.

**Improving financial competence and management**

19. The strategic review identified weaknesses in financial capability and in financial planning and reporting. CHRE pointed to the need for significant investment in our ICT infrastructure, although it recommended that
this should not take place before the appointment of a substantive chief executive. We are developing financial and ICT strategies to address the weaknesses identified by CHRE. We also recognise the need to demonstrate that we are making the most effective use of our resources. We have and are continuing to significantly improve our financial modeling and have established an efficiency programme, which includes identifying the scope for further efficiencies.

Fee increase

20. In May 2012 Council approved a public consultation on raising the annual registration fee from £76 to £120. The last fee rise, to the current £76, was in 2007 and provides an annual income of £53 million. We do not take a decision to seek a fee rise lightly, particularly in the current economic climate. However, even after the introduction of efficiency savings, the overall expenditure of the NMC is around £73 million per year: £43 million on direct costs in fitness to practise, and £30 million on other regulatory activity and indirect costs. We have a very large fitness to practise caseload—there are approximately 4,500 cases at various stages in our system. If we scale back our fitness to practise work we put public protection at risk. It is therefore clear that we need to raise the fee or identify an alternative source of funding if we are to continue to protect the public. We note the Health Committee’s recommendation that we should avoid a fee rise; if we could protect the public without recourse to a fee rise, we would do so.

21. Fitness to practise represents 59 percent of spending in the current financial year, and it is just one of four statutory regulatory functions. We have scaled back expenditure on the other functions and will continue to look for more cost effective means of achieving public protection, but there is a limit to how much we can reallocate without failing to fulfil our whole statutory remit. The fee rise is necessary to meet the significant demands of our fitness to practise hearings schedule—by June 2013 we are planning to hold twenty-two substantive hearings every working day.

22. We have considered a range of options for the scale of the fee rise, factoring in considerations including forecast increases in referral rates, which may be exacerbated by the fallout of the Francis Inquiry into Mid Staffordshire NHS Foundation Trust. In common with other health regulators we also need to meet the costs of introducing revalidation.

23. The public consultation on the fee increase closed on 24 August. As we anticipated, there is opposition to the proposals from the majority of nurses and midwives who responded to the consultation. We have listened to and reflected on the feedback we have received, and to our other stakeholders, and Council will take a decision in October 2012.

REGULATORY DELIVERY

The regulatory role in upholding standards of nursing and midwifery care

24. Public interest in standards of nursing and midwifery practice continues to be high. Professional regulators play an important role in assuring practice standards. There are a number of ways in which the NMC seeks to influence dignity in care:

24.1 Our code sets out the responsibilities of nurses and midwives, including putting the needs of patients and services users first, communicating with patients and carers, raising concerns and maintaining responsibility for the quality of care when delegating tasks to others. Among our best received standards and guidance are those concerned with escalating concerns and the care of older people.

24.2 The professional education we approve requires providers to assure themselves of the good character of those they admit to train as a nurse or midwife, as well as those that graduate from programmes, and the introduction of revalidation will provide an opportunity to check continued suitability to remain on the register post-qualification.

24.3 We ensure service users are involved in the development of standards, and the quality assurance of education programmes and local supervising authorities for midwives.

24.4 We hold nurses and midwives to account when failings in standards of care or conduct are alleged through fitness to practise procedures.

25. However, the professional regulator is at a distance from the delivery of care, and there are limits to the impact it can have on the quality of care.1 Failures of care are most effectively dealt with close to practice, unless the practitioners concerned pose a greater risk to the public which requires the attention of the regulator. The first responsibility for safe, effective and compassionate nursing rests with registered professionals. Nurses and midwives are trained to provide care of quality, and with dignity, and when they register they commit to putting patients first. It is their responsibility to put those skills and values into practice, and to raise concerns if a good standard of nursing care is impeded.

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1 Midwifery supervision can provide some limited self-regulatory intervention in healthcare settings. Although the NMC has oversight of the midwifery supervision function, through setting standards for local supervising authorities and monitoring their activities, practically we cannot exert influence over midwifery practice at a local level on a day-to-day basis.
26. Thereafter, employers and commissioners have a duty and an opportunity to shape the quality of care through setting priorities, monitoring standards and allocating resources. Leadership teams are also responsible for the culture they establish, with particular regard to the priority attached to patient experience and to openness about concerns and errors. We are continuing to work with employers to ensure that we receive appropriate referrals and that other concerns about practice are dealt with effectively in settings. We also plan to strengthen our work with public and patient groups to ensure that service users know about the various channels for raising concerns, including referral to the NMC.

Setting standards

27. We have initiated a comprehensive review of our approach to the regulatory function of setting standards. We will evaluate how our standards serve our other regulatory functions. We also want to know more about how useful they are for patients and the public, as well as registrants.

28. We want to be sure that our standards address public concerns about the quality of care that may fall “below the radar” of fitness to practice. They need not only to inform our wider regulatory work (education, fitness to practise) but to be practically useful for patients and staff in their pursuit of quality care. Revalidation standards will provide our next opportunity to enhance public protection through standards setting.

Education

29. We set standards for nurse and midwifery education and approve and monitor programmes of education that meet these standards, ensuring that students spend 50 percent of their time in practice settings. We require approved providers to demonstrate that they involve patients and service users in programme development and act on their feedback.

30. We will be revising the management of our education quality assurance function from September 2013. We now have better data on each of our 79 providers which enables us to take a more risk-based approach in future. We will be tailoring our approach in the light of the CHRE’s steer to enhance proportionality, and having looked at the approaches taken by other regulators to this function. We will also focus on reductions in cost and bureaucracy that are consistent with public protection.

Acting on concerns

31. A key focus of the Mid Staffordshire NHS Foundation Trust Inquiry chaired by Robert Francis QC has been communication within and between regulators around settings causing concern. We have identified the need to strengthen our capacity in this respect through two workstreams: improving the quality and use of our own data; and working with other regulators where settings cause concern.

32. We have identified the following components to the effective use of data to highlight and manage risks to public protection:

32.1 Assure the quality of the data generated by each of our regulatory functions.
32.2 Establish and use effective systems for triangulating data across our functions.
32.3 Establish and use effective procedures for sharing intelligence with others as relevant.

33. We are working to strengthen each of these components and this work is achieving positive results. For example, we undertook a joint visit with CQC to the University Hospitals of Morecambe Bay NHS Foundation Trust in July 2011 that demonstrated the value of sharing and evaluating evidence collaboratively. The review has subsequently driven closer working relationships between ourselves and other regulators and provides confidence that collaborative working is effective for us, less onerous for providers, and ultimately provides better protection for the public.

34. In response to the concerns aired by the Francis Inquiry about timely awareness of concerns, we are working with system regulators to use the learning from our recent experiences of joint activity to capture and implement operating procedures so that all NMC staff know what to do with intelligence that may be of use to another regulator.

35. We have also sharpened our focus in nurse and midwife education on placement settings within a risk-based model of quality assurance. We have increased the responsibility on providers to notify us by exception of any changes in practice settings, via a self assessment monitoring report.

36. We set out priorities in our other regulatory functions, registration and fitness to practice, in subsequent sections.

Integrity of the register

37. The register is at the heart of our public protection work. It is the means by which members of the public and employers can confirm that nurses and midwives are qualified and registered to practise. Behind the public register there is a more detailed body of data on registrants. All registration data needs to be accurate. For example, the register needs to reflect fitness to practice decisions. In May 2012 we initiated a project to identify and tackle any discrepancies between our fitness to practise and registration databases. Hearings and
registrations staff are responsible for the systemic review of the updates. This is a good example of improvements to cross-functional working within the organisation.

38. In 2010, CHRE recommended that all regulators provide information through their registers about registrants who have been suspended or struck off so that the public can identify health practitioners who are currently not able to practice.

39. Council approved changes to the fitness to practise disclosure policy in principle earlier this year and we subsequently engaged with stakeholders about the new policy. At its September meeting, Council made the decision that information about nurses or midwives who have been struck off the register should be made available on line indefinitely. This will be implemented in early 2013.

Revalidation

40. Revalidation provides healthcare regulators with a real opportunity to enhance public protection, by focusing more closely on current and continuing fitness to practise. The challenge of revalidation is finding a meaningful and measureable basis on which to make a judgment about continuing fitness to practise which is proportionate, encourages good practice and complements the responsibilities of the employer and nurse or midwife.

41. The NMC’s plans for revalidation are progressing, but we recognise there is significant work still to be done. Since we last met the Committee we have undertaken an extensive programme of stakeholder engagement on the subject. We convened 90 meetings on revalidation, meeting approximately 1,700 stakeholders representing around 1,000 organisations. We are liaising closely with other regulators to learn from their approaches and we continue to seek their critical scrutiny of our own proposals.

42. In 2011 the Health Committee recommended that the NMC conducted an audit of registrants’ portfolios demonstrating that they have met the Prep standards. The audit we conducted earlier this year highlighted weaknesses in our current Prep standards, and drew attention to the need for third party evidence, particularly from employers, to gain assurance of a nurse or midwife’s continuing fitness to practise.

43. We also conducted a literature review of evidence about how professional competence and development can be meaningfully measured and validated. This will inform how we gather evidence as part of our proposed revalidation model.

44. Strengthened revalidation standards will be put before Council for approval later this year. We anticipate that they will include assurance of delivery of safe and effective care over the preceding three year period, including third party verification. For midwives, our role in statutory supervision provides another possible source of verification in addition to employers. Registrants will also be required to demonstrate that their professional learning over the period has contributed to improvements in patient care. The proposed standards will be the subject of a public consultation in early 2013 and we will begin auditing registrants against the revalidation standards on a sample basis each month, as they apply for renewal, in spring 2014.

45. The size of the NMC register makes it impractical to implement comprehensive revalidation. Our likely approach will be to combine random sampling—so that all registrants know they have to be ready to demonstrate they meet the revalidation standards—with targeted sampling—so that we can look more closely at specific groups of registrants. In the latter category we may target groups that feature disproportionately in fitness to practise cases, or conversely, those that are under-represented, if we want to be sure that low case numbers are a reliable indicator of public concern in a field or setting.

Fitness to Practise

46. Improving fitness to practise remains our most significant challenge. As CHRE’s strategic review recognised, the difficulties experienced in fitness to practise need to be seen in the context of a sharp increase in the volume of cases and past underinvestment in fitness to practise compared with other health regulators.

47. Following the Committee’s recommendation last year, we are pleased to report that, with help from the Department of Health, we introduced changes to our rules which enabled us to streamline some of our fitness to practise processes. These came into effect in February 2012.

48. We took account of the Health Committee’s concerns and those of other stakeholders and looked particularly carefully at the issue of voluntary removal. Following public consultation, we are now in the process of making changes to the rules governing our registrations processes to allow voluntary removal for those subject to fitness to practise investigations in limited circumstances. The amendment rules were made by our Council in September 2012 and are now awaiting Privy Council approval. We hope they will come into force on 1 January 2013.

49. We also recently consulted on the introduction of wider case management powers and consensual disposal of cases by means of an agreement between the parties being approved at a hearing or meeting. The consultation period has now closed and we are reviewing the responses with a view to progressing with some of our proposals over the coming months.
50. In parallel, we have intensified our improvement efforts on three key areas: the speed of case progression, the quality and consistency of decisions and the standards of customer service provided to those involved in fitness to practise cases. CHRE’s strategic review noted the progress being made and commended the energy and commitment of our staff.

51. However, we recognise the scale of the challenge still ahead and the dependence on adequate funding being available. We are developing an improvement strategy to pull together all the initiatives and projects underway and which will be embedded in our wider change management programme. Key elements include:

51.1 Significant investment to strengthen our capacity including further recruitment of case managers, panelists and chairs, increases to our daily capacity for hearings (from 10 to 22 per day), and action on the number of adjournments and part-heard cases, including by increasing the costed length of hearings from 2.8 to 3.5 days to reflect the growing complexity of cases. We have set challenging but realistic targets to ensure:

51.1.1 All cases received prior to January 2011 (“historic cases”) will have begun adjudication by April 2013.

51.1.2 If future funding is assured, by the end of 2014, all cases received after January 2011 will complete investigations within 12 months and progress to the first day of final hearing within 6 months, in line with our key performance indicators.

51.2 Ongoing work to review the threshold at which cases are sent for investigation to ensure that our approach is proportionate, reflects modern regulatory standards and focuses resources on those cases where action is needed to protect the public or maintain public confidence in the profession.

51.3 Bringing investigation of cases in-house on an incremental basis to improve the speed and management of the investigation process.

51.4 Further section 60 Order changes to modernise our processes, together with a lean programme to ensure that we are as efficient as possible, which will deliver further improvements.

51.5 More rigorous modeling of our fitness to practise activity and improving the quality of our management information to enable Council to scrutinise and challenge performance more robustly. This includes work to analyse and make more effective use of our data including equality and diversity data to ensure that our processes are fair and non-discriminatory.

September 2012

Annex 1

UPDATE ON THE COMMITTEE’S RECOMMENDATIONS OF 2011

This annex sets out the Committee’s recommendations to the NMC in 2011, along with an updated response.

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)

1.1 Following on from the Committee’s recommendation we were able to make amendments to our rules to improve the efficiency and effectiveness of our fitness to practise processes. The amended rules came into effect on 6 February 2012 and we are now beginning to see an impact on performance.

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)

2.1 For the reasons described in our submission, we are not currently in a position to consider holding or reducing our registration fees. We held a public consultation on a proposal to increase our registration fee from £76 to £120 between 1 June and 24 August 2012, which is dealt with in our submission. We expect that Council will discuss the findings of the consultation and make a decision on the proposed level of future fees at its meeting of 25 October 2012.

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)

3.1 CHRE’s strategic and annual performance review reports make clear the internal issues we need to address in order to be an effective regulator. We have accepted CHRE’s recommendations—all but one of which we will be able to take forward ourselves; we are
developing a change programme, as discussed in paragraph 6 of our submission, in order to do this.

3.2 Our response to the report is detailed in our submission.

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)

4.1 In light of the CHRE’s recent strategic review and annual performance review, it is clear that our priority must be to address the issues and failings that they have identified. In focusing on the core business of regulation as identified by the Committee—fitness to practise, revalidation, education and training and proactive regulation—we have, with the support of CHRE, restructured the organisation around our core regulatory functions. We have also undertaken a robust and exacting recruitment process for directors and assistant directors to be assured they have the required high level operational competence and leadership values and behaviours to take the NMC forward.

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)

5.1 The NMC experienced a significant spike in referrals two years ago which has not been repeated. We reviewed research into referrals undertaken by other regulators in order to understand the combination of factors in play but as there seemed to be no single or simple reason for this pronounced increase, we took the view that the our priority should be to focus on ensuring that we are receiving the right referrals and handling them effectively. We are working with employers and patient/public groups to ensure that there is clarity about how to raise concerns and that it is preferable for concerns to be raised first in settings unless public protection demands regulatory action from the outset. We are investing in improvements to screening so that our resources are better focused on the cases that require our action. Work on thresholds for referrals, consensual disposals and voluntary removal from the register has the potential to reduce the volume of hearings while upholding public protection.

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)

6.1 For the first time our annual fitness to practise report for 2011–2012 includes equality and diversity data at each stage of the process covering five of the nine protected characteristics. We recognise that further work is needed to analyse what the data can tell us about the impact of our work. We have also published equality and diversity data relating to the NMC register on our website. We are continuing to encourage registrants to return equality monitoring forms so as to increase the data we hold.

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.

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. (Paragraphs 17 and 18)

7.1 Council has approved an overarching review of NMC standards and guidance. The review will look closely at the way that standards and guidance for practice have been developed in the past and consider how this might be done more effectively and efficiently in the future. We acknowledge the particular public concern around care for older people and the review of our Guidance for the care of older people will be addressed as a matter of priority as part of the overarching review described in paragraphs 26 and 27 of our submission.
8. 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)

8.1 We continue to promote our Raising and escalating concerns guidance and the tools developed around it. In August we, along with five other health professions regulators—the GDC, GMC, GOC, GPhC and HCPC—endorsed the NHS Employers Whistleblowing Charter, committing ourselves to continue to remind healthcare professionals of their duty to raise concerns.

8.2 We are also currently working closely with CQC, GMC, the Royal College of Nursing and the British Medical Association on the development of a statement setting principles of understanding on whistle blowing and joint working, a piece of work that developed from the Committee’s hearing on the professional duty of health professionals in December 2011. The Committee was updated on this work through a joint letter in July 2012.

9. 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.

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. (Paragraphs 22 and 23)

9.1 We supported this principle in our response to the Law Commission’s consultation which can be found on our website. However, as these proposals are not expected to be implemented until 2017, we are still seeking to make further urgent improvements to our legislative framework by means of a section 60 order. We have been working with CHRE and the Department of Health in drafting proposals for the section 60 order. This work is ongoing but we are hoping to have these changes implemented in 2014–2015.

10. 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)

10.1 Following our public consultation in 2011, Council approved in principle further changes to our rules to allow voluntary removal for those subject to fitness to practise investigations in limited circumstances. Discussions were held with CHRE and the Department of Health to ensure that appropriate checks and balances were in place to address their concerns. The amendment rules were made by our Council in September 2012 and are now awaiting Privy Council approval.

REVALIDATION OF NURSES

11. 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.

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. (Paragraphs 31 and 32)

11.1 Following the Committee’s recommendation we undertook an audit of 100 Prep portfolios as a pilot in March. Assessment of the audit confirmed that our standards are inadequate in providing assurance of continuing fitness to practise. Implementing a regular auditing process against these standards would provide a limited public protection value.

11.2 Testing the Prep standards through this pilot has been a valuable exercise as it will inform the development and implementation of our revalidation standards.

12. The Committee will monitor progress against the 2014 deadline for the introduction of revalidation by the NMC at subsequent accountability hearings. (Paragraph 33)

12.1 We are still on track for introduction of the standards in 2014, further detail is contained within our submission.
13. 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)

13.1 We have no further update from our response of October 2011.

14. 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)

14.1 The NMC register is monitored constantly in respect of leavers and recipients of conditions of practice orders, and will do so when revalidation is implemented.

15. 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)

15.1 We understand that the National Quality Board is discussing this issue and we look forward to hearing the outcome.

16. 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.

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.

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.

(Paragraphs 45, 46 and 47)

16.1 We have continued to work with partners on this issue, we convened a meeting of EU competent authorities for nurses in February this year to develop common position on EU green paper and hosted meeting of the Network of European Midwifery Regulators in March to prepare common position on EU proposals. We also participated in the conference of Healthcare Professional Crossing Borders (HPCB) in March to engage with MEPs.

16.2 The next stage will be the adoption of legislative amendments to the European Commission’s proposal by the European Parliament in the beginning of next year.

16.3 As we noted in our October 2011 response, we strongly agree with the Committee that measures must be taken to mitigate the risk under the existing legislation. We have welcomed the Government’s introduction of powers for “responsible officers” to have a mandatory duty to check all non-UK doctors that apply to work in the UK have sufficient English language skills. However, this model cannot be applied to nursing or midwifery.

16.4 We are working with the Department of Health to find a solution for nurses and midwives. We are exploring the legality of requiring applicants for whom we have serious doubts as to their language proficiency to pass a test before gaining registration.

16.5 We have written directly to employers of nurses and midwives to highlight their duty under the code to escalate concerns they may have regarding the communication competencies of registrants they interview for prospective employment. We have also communicated to all employers our limitations under the current legislation to test the language proficiency of EU nurses and midwives and remind them of their duty to ensure that their staff can communicate safely and efficiently with patients and the rest of the care team.

PROACTIVE REGULATION

17. 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.

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.

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. (Paragraphs 50, 55 and 56)

17.1 We continue to exercise our existing powers to open investigations into registrants without a formal referral from an employer, a member of the public or another professional where we consider this appropriate.

17.2 We remain committed to working alongside other healthcare regulators to strengthen public protection. A good example of this has been in the management of issues at University Hospitals Morecambe Bay NHS Foundation Trust, as mentioned in paragraph 32 of our submission. Following a number of concerns and complaints which had been raised to the NMC, we undertook an unannounced three day visit jointly with the Care Quality Commission in July 2011. We continue to monitor progress at the trust against our action plan and are working closely with colleagues at CQC and Monitor, who are both also involved with intervention work at the trust.

THE FUTURE OF REGULATION

18. 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.

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. (Paragraphs 63 and 64)

18.1 During the passage of the Health and Social Care Bill (now Act), the Government responded to public concern about assuring standards of practice on the part of health and social care support workers. It was not persuaded of the need for mandatory regulation but has given a new power to the CHRE to accredit voluntary registers maintained by organisations that meet specified criteria. It has also commissioned work from Skills for Health and Skills for Care to develop a code of conduct and training standards for health and social care support workers. The NMC has welcomed and contributed to this initiative. We also welcome the government’s commitment to revisiting the issue if measures short of mandatory regulation prove not to offer adequate public protection. The NMC will continue to use its statutory duties to make set out, in our code, the responsibilities of nurses and midwives for the tasks or care they delegate to others.

Supplementary written evidence from the Nursing and Midwifery Council (NMC 02A)
### Summary of recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Status (December 2012)</th>
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<tbody>
<tr>
<td>1 Winning back the confidence of the public and the professions through improved performance</td>
<td>Early performance improvements noted, Work ongoing</td>
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<tr>
<td>2 Explaining plans for improvement clearly to all stakeholders</td>
<td>Completed and monitoring</td>
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<tr>
<td>3 Developing a constructive dialogue with external stakeholders</td>
<td>Engagement Strategy developed</td>
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<tr>
<td>4 External stakeholders taking responsibility for their roles</td>
<td>Constructive dialogue established and on-going</td>
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<tr>
<td>5 Defining clear behavioural values and demonstrate them in practice</td>
<td>Behaviour competencies and framework developed to be launched at staff conference in December</td>
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<tr>
<td>6 Challenging the culture of resigned resilience</td>
<td>HR Strategy and new behaviours agreed</td>
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<tr>
<td>7 Appointing a Chair and Chief Executive</td>
<td>Both roles appointed to</td>
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<tr>
<td>8 Consolidating all change activities</td>
<td>Change Management Portfolio Board established</td>
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<tr>
<td>9 Council defining strategic aims and holding the executive to account</td>
<td>Strategic aims for 2013–16 agreed</td>
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<tr>
<td>10 Reviewing the roles and reporting lines of committees</td>
<td>Governance review underway</td>
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<tr>
<td>11 Establishing a stronger link between activities and costs</td>
<td>Strengthened corporate planning and budget framework being introduced</td>
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<tr>
<td>12 Given greater profile to financial management and reporting</td>
<td>Monthly financial reporting to Council</td>
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<tr>
<td>13 Subject to the appointment of the Chief Executive, investing in IT systems</td>
<td>Short term stabilisation strategy being implemented</td>
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<td>Delivery of long term strategy being scoped</td>
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<tr>
<td>14 Focusing on meaningful management information</td>
<td>Balanced Scorecard introduced and reported monthly to Council</td>
</tr>
<tr>
<td>15 Sustaining clear oversight of operations</td>
<td>Fitness to Practise and Registrations strategies developed</td>
</tr>
<tr>
<td>No</td>
<td>Recommendation</td>
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<tr>
<td>1</td>
<td>The NMC will best win back the confidence of the public and the professions by being an effective and efficient regulator. We recommend it concentrates its strategy, business planning and resources on improving effectiveness, efficiency and customer service</td>
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<td>2</td>
<td>We recommend that the NMC explains its plans for improvement clearly to all stakeholders and then concentrates on delivering the changes that are needed</td>
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<td>3</td>
<td>We recommend that the NMC develops a constructive dialogue with external stakeholders and concentrates its communications to those that relate directly to its core functions. It should also ensure that it follows best practice in all public consultations</td>
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<tr>
<td>4</td>
<td>We recommend that external stakeholders, especially the nursing and midwifery organisations take responsibility for their roles in improving quality and in the development of policy in their respective fields. They should allow the NMC to concentrate on its regulatory tasks and give it time and space to address its problems and to improve</td>
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<td>Recommendation</td>
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<td>5</td>
<td>The leadership of the NMC must behave and act in the way they expect others to do. We recommend that they define clear behavioural values and demonstrate them in practice and in their relationships with others. We have developed new ways of working, which includes embedding new behaviours and values to all staff within the organisation. There are plans in place to make this happen. As part of the restructure of the organisation, directors, assistant directors and the level below needed to go through a selective process which tested the evidence of new behaviours, competencies and ways of working.</td>
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<td>6</td>
<td>We recommend that the NMC challenges the internal culture of resigned resilience by reducing hierarchy, encouraging openness, listening to staff, enabling management to take responsibility and make decisions and by valuing quality and customer service. We consulted with staff during the restructure of the organisation through the Staff Consultation Group. We ensured staff feedback is taken into account where appropriate in decided the best structure for the organisation to deliver its core regulatory function. We have reduced directorates from seven to four to reduce unnecessary management overhead and provide clearer lines of accountability and communication. We have introduced monthly staff forums which are led by our Chief Executive. The sessions provide staff with an opportunity to contribute in shaping the organisation through their ideas. We have introduced weekly staff briefings that are run by the directors in their directorates. This allows the directors to communicate directly with staff and engage them in a two way conversation on how to improve our operations. Our Chief Executive provides weekly updates to the staff by way of walk around the buildings and use of our staff intranet. We publish agendas for Directors’ Group and the Change Management Portfolio Board in advance of the meeting to allow staff to ask questions of their line managers or the director and publish the minutes of these meetings. We have developed a new set of behaviours and competencies which include taking accountability for actions. We have developed our customer service principles as part of our engagement strategy which we will adapt in all parts of the organisation through embedding those principles in the local business plans.</td>
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<td>7</td>
<td>The appointments of the new Chair and Chief Executive are crucial to both public protection and public confidence in the NMC. We recommend that due diligence is exercised in the appointment of the Chair and the Chief Executive to ensure that the individuals appointed to these roles have the personal credibility, leadership behaviours, competencies and communication skills necessary to implement the changes set out in this strategic review.</td>
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<tr>
<td>8</td>
<td>The NMC should consolidate all of the change activities taking place across the organisation to enable the Council to have a clear understanding of the totality of planned changes so that they can determine if the speed and extent of change is achievable and appropriate.</td>
</tr>
<tr>
<td>9</td>
<td>Good governance will be central to the success of the NMC in addressing its problems. We recommend that the Chair and Council define the NMC’s strategic aims, objectives and values, scrutinise the business plan and hold the executive to account for its implementation and take responsibility for the overall performance of the NMC.</td>
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<tr>
<td>10</td>
<td>The Council needs to review the roles and reporting lines of all committees and groups to reduce duplication while ensuring that oversight and levels of scrutiny and challenge are appropriate.</td>
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<td>11</td>
<td>The NMC must establish a stronger link between its activity levels and the impact of those activities on costs. Key activity levels need to be clearly stated as part of any performance reporting. When presenting financial information for review and decision the NMC needs to provide much greater clarity over the assumptions that are being used so that the Council has a clear view of the impact of its decisions.</td>
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<td>No</td>
<td>Recommendation</td>
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<td>12</td>
<td>We recommend that financial management and reporting is given a greater profile within the NMC and the finance team should take greater responsibility for review and challenging of budgets and holding the respective directors to account.</td>
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<td>13</td>
<td>It is clear that the ICT systems at the NMC require significant new investment and development to be able to support an efficient organisation and to be able to supply management with the information it needs to effectively manage the organisation. We recommend that before further investment is made the NMC ensures it understands the capabilities of the systems it has and how these can be accommodated in a sustainable ICT strategy. We also recommend that the decision on further investment in the ICT infrastructure should not be made until the new Chief Executive is appointed and a revised ICT strategy completed.</td>
</tr>
<tr>
<td>14</td>
<td>We recommend that the NMC reviews its collection of management information to ensure it is focussed on meaningful and useful data, that it provides informative comparisons and trends and that it is proportionate to the purpose for which it is collected. We recommend that management data is reported accurately and consistently, is interrogated by Council and its committees and is used as the basis for sound decisions.</td>
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<tr>
<td>15</td>
<td>The NMC executive must provide and sustain clear direction and oversight of operations including a fitness to practise improvement strategy within an overall operations plan. We recommend that theyCouncil agreed a new set of KPIs for the organisation earlier in the year. Reports against these are made at each Council meeting in the form of the balanced scorecard. These were developed to allow the Council to hold the Executive to account for the delivery of its key functions. More detailed performance measures and management information is considered by the Director’s Group monthly and each director has a package of detailed management information to monitor the performance of their teams.</td>
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Health Committee: Evidence
<table>
<thead>
<tr>
<th>No</th>
<th>Recommendation</th>
<th>Progress to date</th>
<th>Next steps</th>
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<tbody>
<tr>
<td></td>
<td>address the skill and capacity issues identified here, achieving our KPIs by 2014</td>
<td>scrutinised at executive senior meetings</td>
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<td></td>
<td>strengthening business planning and oversight, quality assurance and operational management</td>
<td>We have developed our Registrations and Standards strategy which outlines the improvement we will make to the function over the next two years</td>
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<th>Key</th>
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<tr>
<td>Priority and risk</td>
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<tr>
<td>High risk, high priority</td>
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<tr>
<td>Medium risk, work scoped or to be scoped</td>
</tr>
<tr>
<td>Achieved and maintaining</td>
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10 December 2012
Change management portfolio delivery

Council - Set strategic direction and hold the executive to account in delivery of public protection

Directors Group - Lead delivery of public protection effectively, efficiently and economically

**Governance**
- Putting robust systems, procedures and decision-making at the heart of everything we do
- Corporate Goals 1, 2 & 3
- Owner: Director Corporate Governance

**Leadership**
- Changing the culture
- Corporate goals 1, 2 & 3
- Owners: Directors Group

**Delivery**
- Delivering world class regulatory functions
- Corporate goal 1
  - Owners: Directors of Fitness to Pratice, Registrations & Standards
- Corporate goal 3
  - Owner: Director Corporate Services

**Enabling**
- Strengthening our capability and capacity
- Corporate goal 3
  - Owner: Director Corporate Services

**Key Priority and risk**
- High risk, high priority
- Medium risk, work scoped or to be scoped
- Achieved and maintaining progress
- No progress or significant issues
- On track, some issues
- On track, milestones met
- No action yet

**Vision and strategic aims**

**Delivery Portfolio**
- Delivery 6 months (February 2013)
  - Appointment of CEO
  - Management of risk
  - KPIs & performance measurement
  - Engagement strategy

- Delivery 12 months (June 2013)
  - Quality Assurance framework
  - Preparing for new Council

- Delivery 24 months (July 2014)
  - Key priority and risk
    - High risk, high priority
    - Medium risk, work scoped or to be scoped
    - Achieved and maintaining progress
    - No progress or significant issues
    - On track, some issues
    - On track, milestones met
    - No action yet

- FIP improvement plan
  - Phase I
  - Voluntary removal and public register changes

- Data quality & integrity
- New Ways of Working

- Quality assurance of Education and LSA

- ICT strategy delivery

- Financial strategy

- HR strategy
Change Management Portfolio Delivery framework

- Strategic delivery and monitoring
  For: CEO, directors
  Reporting to: Council

- Delivery plan management
  For: CEO, directors
  Reporting to: Change Management Portfolio Board

- Detailed actions, delivery and monitoring
  For: action owners
  Reporting to: directors

- Sub-level action plans
  For: individual action deliverer
  Reporting to: action owners

Top level outline of change management action plan, key milestones and progress, RAG rated. Used by CEO and directors to keep strategic level track on overall progress. Forms basis of monitoring report to Council.

Shows underlying key actions to be addressed, timeframes and accountabilities.

Used by CEO and directors as accountable officers to track progress. Progress reporting by directors to CMPB.

Detailed delivery programme with all actions listed, accountable officers and action owners (i.e. those driving day-to-day activities), timeframes for each individual activity.

Used by action owners to track and monitor progress for reporting to accountable directors.

Individually detailed actions with individual deliverer.

Used by action owners to keep track of day-to-day progress and reporting.

Introduction

1. CHRE is pleased to submit written evidence to the Committee ahead of the accountability meeting in October 2012. Our annual performance review report was published on 28 June 2012, and our strategic review was published on 3 July 2012.

2. We set out below a brief summary of our recent findings about the NMC’s performance.

CHRE, 2012

Strategic Review of the Nursing and Midwifery Council Final Report July 2012
Key finding

3. The Nursing and Midwifery Council has continued to carry out its public protection duties, although not as well as it should. It failed to meet six of the 24 Standards of Good Regulation and demonstrated weaknesses in its performance against two others.

CHRE Strategic Review 2012

4. In January 2012 CHRE was asked by the Parliamentary Under Secretary of State for Health, Anne Milton MP to examine what changes need to be made to ensure that the NMC (at strategic leadership, management, organisational, and resource allocation levels) is focused on delivering against its statutory duties, and is able to build capacity to deliver its core functions in a more efficient and effective manner.

5. Our report highlighted several problems with the NMC, including lack of clarity about its regulatory purpose, unbalanced working relationships, weak governance, and inadequate business systems. We recommended changes in leadership, culture, finance and operational management. Since our report a new Chair has been appointed to the NMC and the NMC is recruiting a permanent Chief Executive.

CHRE Performance Review 2011–2012

6. Under our legislative framework, CHRE reviews the performance of nine UK health professional regulators on an annual basis and reports to Parliament. The performance review has two important outcomes:
   — It enables improvement in the work of the regulators as we identify areas of strengths and areas of weakness in their performance and recommend changes.
   — It reports publicly on how well the regulators are protecting the public and promoting confidence in health professionals and the system of regulation.

7. By also commenting on what the regulators have done well, the performance review also allows regulators to learn from good practice demonstrated elsewhere to help address any areas for improvement identified in our review.

8. Our performance review considers how effective the regulators, including the Nursing and Midwifery Council, have been in protecting the public and promoting confidence in health professionals and regulation. We assess the regulators’ performance across their four regulatory functions using our Standards of Good Regulation. The four functions are:
   — Guidance and standards.
   — Education and training.
   — Registration.
   — Fitness to practise.

9. The Standards of Good Regulation are outcome-focused and describe what the public should expect the regulators to do, rather than being prescriptive about how they should do it.

10. In 2011–2012, our overall assessment of the NMC is that it had not met six of the 24 Standards of Good Regulation and that it had demonstrated weaknesses in its performance against two other Standards of Good Regulation. This is a significantly worse performance than the other nine regulators.

11. Our concerns related to the NMC’s performance in its education, registration and fitness to practise functions and specifically to:
   — The integrity of the NMC’s online register of registered nurses and midwives.
   — The effective management of the NMC’s registration workload.
   — The NMC’s ability to prioritise, progress, and effectively monitor its fitness to practise caseload, particularly in relation to those cases that were initiated prior to January 2011.
   — The timeliness of the NMC’s fitness to practise case progression.
   — The quality of the NMC’s investigation of fitness to practise cases.
   — The quality of the decisions made and recorded by the NMC’s Investigating Committee and fitness to practise committees.
   — The consistency of the ongoing monitoring of risk in fitness to practise cases.
   — The ability of the NMC to keep its fitness to practise information secure.
   — The quality of customer service in the fitness to practise department.
   — The quality of record-keeping in the fitness to practise department.
   — The processes that the NMC has in place in its fitness to practise department to enable it to learn from errors, such as its serious event review process.
   — The slow progress being made on introducing a scheme which will enable the NMC to assure itself of its registrants’ continuing fitness to practise.
   — The quality of the NMC’s management of information.
12. We also reported our disappointment that the NMC had failed to follow good practice in relation to public consultations that it undertook. Our concerns related to:

— The short timeframes set for each consultation.
— The lack of notification to key stakeholders about the consultations commencing.
— Indications given in either the consultation documents or papers that were considered by the NMC’s Council prior to the closing of the consultations that the NMC’s plans were already well-developed and unlikely to be changed in the light of the feedback gathered through the consultation process.
— Its failure to recognise that it would need to publicly consult on its revised Indicative Sanctions Guidance.

13. The full review of the Nursing and Midwifery Council can be found on pages 728–8 of the Performance Review report.3

Findings from our review of final fitness to practise determinations (January 2012 to 21 August 2012)

14. In accordance with our legislative framework, we review all final decisions made by the regulators’ fitness to practise committees. We can refer those decisions to court if we consider they are unduly lenient and do not protect the public. We only refer decisions to court if there is no other effective means of protecting the public. Referring a decision to court may mean that the decision is overturned and therefore the public is better protected from that particular individual. But the main value of our review of final decisions is to improve the overall quality of the regulators’ processes and the decisions made by their committees.

15. We promote good practice by the regulators in a number of ways, including sharing with them the “learning points” that we identify from all the decisions that we review. We believe that the reduction in the number of decisions that we have referred to court over the past three years shows that the quality of the decisions made by the regulators’ fitness to practise committees has improved, as a result of the shared learning from our work in this area.

— Since January 2012 we have considered seven NMC cases at six case meetings. We have also issued a high number of learning points in relation to other cases we have considered. There are no outstanding Court referrals involving NMC cases.
— We are still referring more NMC cases to formal section 29 case meetings than cases of all the other regulators put together, due to the poor quality of their fitness to practice panel decisions (sometimes combined with poor quality investigation by the NMC). We are aware that the learning points we send to the NMC cover very similar issues as those previously sent to the NMC (which we consider may indicate a failure to implement learning successfully) such as the quality of decision reasoning but we have not conducted any formal analysis of the learning points to confirm this.

16. We also carry out an annual programme of audits of the regulators’ decisions in relation to complaints that are not referred for a formal hearing in front of a fitness to practise committee. We audit a random sample of these complaints and assess whether the interests of users of health and care services and the public were properly considered by the regulator before the regulator made its decision not to refer the complaint for a formal hearing. The audit of the NMC’s early fitness to practise decisions is being carried out. We will send a copy of our audit report to the Committee when it is published.

Other feedback that we have received about the NMC

17. Twenty-five individuals have raised concerns with us about the performance of the NMC under the “Raising Concerns about regulators” policy (this compares to 12 for the GMC, eight for the HCPC and six for the GDC). These concerns relate to:

(a) Decisions made at the initial fitness to practise process (including quality of decision letter).
(b) Delays/Customer Service/Handling of organisational complaint.
(c) Unduly harsh decision made by a final fitness to practise committee.
(d) Handling of a fitness to practise case.

Conclusion

18. The Nursing and Midwifery Council is still not performing as a fully effective regulator, albeit it is not failing in its basic statutory duties. We identified numerous areas for improvement during our strategic review. In our most recent review of its performance we found it was not meeting a quarter of our Standards of Good Regulation.

19. We would be happy to meet with the Committee and discuss our evidence further, if that would be helpful to your inquiries.

September 2012

Written evidence from the Royal College of Nursing (NMC 04)

1. INTRODUCTION

1.1 With a membership of more than 410,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the UK Governments, the UK Parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

1.2 The RCN welcomes this opportunity to make a submission to the Health Select Committee in advance of the Nursing and Midwifery Council (NMC) annual accountability hearing.

2. EXECUTIVE SUMMARY

2.1 The RCN broadly agrees with the recent report by the Council for Healthcare Regulatory Excellence (CHRE) which criticised the NMC’s performance as a professional regulator.

2.2 The NMC is currently in a period of instability due to uncertainty surrounding its financial mismanagement and questions over its ability to process fitness to practice cases. The RCN acknowledges that the NMC is attempting to reverse the current situation, and that a new Chair has been appointed. The RCN also notes that the NMC is in the process of appointing a new Chief Executive.

2.3 The RCN has recently submitted to the NMC consultation on proposals to increase registration fees by 58%, from £76 to £120 per annum. As part of our submission process 85,720 RCN members responded to a recent survey on the fee increase with 99.3% of those responding declaring their opposition to the proposed fee hike.

2.4 RCN members are angry at the proposal that they may face an increased annual registration fee because of the NMC’s mismanagement of its finances.

2.5 The RCN welcomed the letter (6 August 2012) to the NMC from the then Secretary of State, Rt Hon Andrew Lansley MP, which called for the NMC to look at all possible options to avoid a fee increase and commission an independent audit of the reasons behind the NMC’s proposals.

2.6 The RCN does acknowledge that the new Chair and acting Chief Executive have taken into account the findings of the CHRE report and are taking steps to instigate change.

2.7 Any changes to the NMC’s functions or realignment of its priorities must look to the long term and not be short sighted.

2.8 Plans to reduce the NMC’s governing Council must not render it ineffectual and it must retain a position for registrant representation.

3. FINANCIAL MANAGEMENT

3.1 The RCN broadly concurs with the issues and concerns highlighted by the CHRE in its root and branch investigation of the NMC earlier in 2012. The CHRE highlighted a catalogue of organisational and financial mismanagement resulting in a confusion of purpose and poor performance in the NMC’s core functions, particularly in regulating fitness to practise.

3.2 A key concern for the RCN is the failure by the NMC to manage its finances. The NMC is fortunate that compared to many organisations, it has a reliable, fixed income through mandatory registration fees. The fact that the NMC is now consulting to increase annual fees by 58%, from £76 to £120, demonstrates how poorly the organisation has managed its finances. This proposal is entirely inappropriate.

3.3 The RCN has consulted with members in order to inform our submission on the NMC’s proposal. A total of 85,720 responses were received to an RCN survey on the proposal and the overwhelming majority, 99.3%, disagreed with the move to raise the fee.

3.4 The NMC must demonstrate that it has made all possible efficiencies before seeking to increase income at registrants’ expense. A 58% fee rise during the current climate of financial austerity faced by registrants is wholly unacceptable.

3.5 The NMC has stated that public protection is at risk if their fitness to practise activities are not increased and improved. The NMC claims that this can only be achieved through increasing the registration fee. The
RCN feels it is necessary to seek independent assurance that the NMC’s current assumptions around fitness to practise costings and caseloads are accurate and sound.

3.6 The CHRE has also accused the NMC of failing to accurately cost activities. We therefore call for an independent audit of the NMC’s financial plans and welcome the recent letter by the then Secretary of State for Health, the Rt Hon Andrew Lansley MP, calling for the NMC to provide independent analysis for their proposals.

3.7 RCN members also demonstrated a desire to look again at the model for funding the NMC. When asked if it was time that government contributed to the funding of the NMC 87.3% agreed that it was.

3.8 The RCN asked members if they supported the £800,000 payment the NMC is required to make towards the funding of the CHRE. As nursing is the largest regulated profession it contributes significantly more to the running costs of the CHRE than any other profession. The vast majority of members surveyed (79.6%) did not support this level of payment. Whilst the RCN acknowledges that there is an important role for the CHRE in overseeing the various professional regulators, our members do not believe they (via their regulator) should be contributing such a large amount to financially support the CHRE.

4. WELCOME CHANGES

4.1 The RCN acknowledges that since the publication of the CHRE report, the NMC, under the Chair of Council and acting Chief Executive, have taken a number of steps to instigate change in the organisation. For example, in order to make financial savings and re-commit to core regulatory functions, the organisation is undergoing a process to realign its executive and staffing structure.

4.2 The RCN has also noted that the organisation appears to be becoming more transparent. For example, in open council sessions there is now an opportunity for the public to raise questions and air comments, and the quality of information and paperwork available has improved. There now appears to be a greater presumption that more Council business should take place in the public rather than the private sessions. For example, an up to date organisational risk register is now made available as well as plans setting out how the NMC is implementing its change management process.

5. CORE ACTIVITIES

5.1 The RCN supports the need for the NMC to focus resources on its core regulatory remit. However, the NMC must find the right balance in order to deliver the necessary package of work required for a professional regulator to be truly fit for purpose, now and in the future. For example, whilst the RCN agrees that fitness to practise procedures must be dramatically improved, we are clear that the development of education standards and revalidation to ensure ongoing fitness to practise are absolutely critical. These activities must be seen as core preventative business of the NMC. If done effectively they will help to avoid future fitness to practise cases.

5.2 The NMC must first address substantial challenges around improving fitness to practise processes, the provision of education standards and setting up a proportionate but effective system for revalidation. The organisation must look to ensure that it will be able to meet future core activities, based on the requirements of a nursing profession which is constantly evolving and developing. For example, the RCN has repeatedly stated the necessity of extending regulation from registered nurses and midwives to currently unregulated health care assistants (HCAs).

5.3 During the passage of the Health and Social Care Act 2012 the RCN worked hard to attempt to amend the Bill to include a section which would mandate HCA regulation instead of the proposed voluntary model. HCAs are an increasingly important and integral part of the nursing workforce and carry out an ever increasing number and complexity of tasks. It is vital to ensure that this workforce is adequately trained and is deployed appropriately. Mandatory regulation of these workers, by a professional regulator is therefore necessary and should be explored by the NMC. The need to regulate assistant practitioners alongside those HCAs carrying out patient care is a matter of public protection.

5.4 The RCN has concerns about a number of decisions the NMC has made in reducing activities, including the cessation of a number of work streams or scoping projects which we believe will help to underpin public protection.

5.5 The NMC has now ceased the student indexing project. The RCN is disappointed that this work is no longer going forward. We believe student registration will provide an important public protection function. It will help ensure that education providers do not enrol students who have been removed from other courses due to concerns about their conduct.

5.6 There have also been practical problems associated with the cessation of work, such as the NMC’s decision to stop providing a professional advice service. This service was useful for registrants. However, beyond the principle of whether this service ought to be provided by the NMC, there were some problems associated with this decision. Not only did the NMC withdraw the support offered by its telephone service all of the associated professional advice information on the NMC website also suddenly disappeared.
6. Governance

6.1 In the course of 2012, the RCN responded to a Department of Health consultation on proposals to reduce the size of the NMC’s governing Council. The consultation document proposed that the Council be reduced from the current size of fourteen to between eight and twelve, with a preference for eight members. The RCN’s response made it clear that we believe the Council must not be smaller than twelve members.4

6.2 The NMC’s remit covers the four countries of the UK as well as the full range of nursing and midwifery practice. The council is also required to be comprised of 50% of lay and registrant members. This ratio must be retained. The RCN believes therefore that the NMC would struggle to constitute a board with the range of skills and experience required with less than twelve members.

6.3 In order to inform our response to this consultation, the RCN consulted with our members. RCN members stated the NMC council should not be reduced significantly. The majority of RCN members responding felt that the NMC Council would not have the breadth of knowledge and experience required to effectively lead the NMC if the size of the Council was reduced too much. Furthermore, a majority (69%) disagreed that the council should be reduced as low as eight members.

6.4 The RCN is committed to a number of high level principles guaranteeing a role for registrants within the NMC. We believe that public protection will be best served by ensuring that registrants continue to play a role in setting the future strategy of the organisation and holding to account executive staff members. We believe it is essential to ensure that registrant members continue to account for at least half of the Council.

6.5 We note that in the past there has been a lack of rigour from the NMC Council in challenging executive staff on poor performance relating to fitness to practise, a “drift of mission”, and poor financial management. We do accept that Council members now sit on standalone committees, for example, overseeing the organisation’s plans to improve fitness to practise plans, and feed back to the Council. We believe it is key that the Council, under the new Chair, continue to pay close attention to the NMC executive staff’s delivery of key performance indicators.

7. Future Priorities

7.1 The RCN is concerned that the turbulence of recent times coupled with the huge scale of the work now taking place to make the organisation fit for purpose in the future could de-rail other key priorities for action. One of these is revalidation. The RCN is clear that revalidation is absolutely the core business of the NMC and we must see swift progress on this. The fact that the NMC is still not in a position to effectively monitor the completion of continuing professional development (CPD) by checking post-registration education and practice (PREP) portfolios is deeply concerning.

7.2 The RCN is aware that nurses do not always receive CPD and we work hard to encourage employing organisations to protect the time and resources necessary for nurses to access this. We are concerned that in the current economic climate there is an increased risk that a greater number of nurses will not be able to access CPD. This represents a real risk to public protection. We believe that ensuring nurses receive CPD will help to limit future fitness to practice cases. The RCN would like to see the NMC develop a revalidation system that is effective and proportionate as soon as possible.

8. Looking to the Future

8.1 As set out above, the RCN believes that the coming months and years contain major challenges for the NMC. It must get to grips with the fitness to practise caseload backlog and implement efficient and effective procedures for the future. It must regain the confidence of registrants in its ability to be financially responsible and it must do so under a new Chair and Chief Executive, who must quickly establish the organisation’s short, medium and long term strategy.

8.2 We note also that the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC, is expected imminently. This may contain further challenges for all organisations and bodies involved in professional and system regulation. It may have specific challenges for the NMC and its vital public protection role, for example around healthcare support worker regulation, whistle blowing and the escalation of concerns.

September 2012

4 RCN response to Department of Health consultation on NMC constitution http://www.rcn.org.uk/__data/assets/pdf_file/0007/466648/38.12_NMC_constitution_amendment.pdf
Written evidence from A Dignified Revolution (NMC 05)

A Dignified Revolution is submitting the following evidence for consideration at the Health Select Committees annual review with the Nursing and Midwifery Council (NMC). It is being submitted because of recent concerns concerning the NMC’s annual accounts and the circulation of consultation documents on Fitness to Practise and the rise in registrant fees. These are issues that we have recently raised with the NMC in written correspondence.

Consultation on the Fee Increase

This document states that:

The annual income is approximately £53 million. Our current expenditure exceeds this amount and we are having to spend money from reserves. Total NMC expenditure was £61 million and total income was £53 million, creating a deficit of £8 million which was funded by our reserves.

However, according to the 2010–2011 annual accounts, which were provided by the NMC, there was a surplus of £7 million in 2011 and £60 million in the bank at 31 March 2011.

Direct expenditure on fitness to practice in 2011–2012 was £31 million, a 50% increase on the previous year. To deal with our Fitness to Practise caseload in 2012–2013 we forecast that our expenditure would be £43 million.

The 2010–2011 annual accounts show that £26 million was spent on Fitness to Practise. The difference between £26 million and £31 million does not, therefore, constitute a 50% increase?

The increase over the last two years has been £5 million. On what evidence therefore, has the NMC based the increased figure of £43 million?

Had we increased annual registration fee in line with inflation it would now be £86.

Why then has the new fee been set at £120, as this is above inflation?

The proposed increase in registration fees will mean that the NMC would have over £50 million to spend on fitness to practise ie twice the amount that it currently spends.

The document states that NMC is experiencing a significant increase in fitness to practise referrals. There has been a 48% increase in referrals since 2009–2010 and cases have become more complex.

It would be helpful to explain why cases have become more complex and to use the cases to explore how the NMC might be able to avoid such cases coming to its attention in the future, thereby reducing the number of Fitness to Practise cases.

A Dignified Revolution is concerned about how the NMC manages its finances. An example is the current consultation survey, which we believe to be poorly developed and a wasteful use of financial resource. The survey asks two questions, both of which will provide very little useful feedback, and the rest is consultation and diversity monitoring data, which is inappropriate in such a document. If NMC believes that such a survey is necessary it could have easily carried it out using, other means. For example, Survey Monkey is free of charge.

The NMC has a duty to ensure that it spends finances appropriately, and is accountable to its registrants. In view of the fact that NMC has been reviewed on a number of occasions for poor governance within the organisation it might be more appropriate to reflect on internal functions to see how it can improve its performance before it increases registration fees.

Annual Accounts 2011–2012

1. We are concerned that the significance of the overspend that has occurred during the last financial year is not emphasised at the outset in the report.

2. There is a commitment to make efficiency improvements thereby saving £8.5 million on Fitness to Practise. We would like to know if this has been taken into account when forecasting Fitness to Practise expenditure for 2012—2013 ie £43 million?

3. The report states that “our fitness to practise cases involve only a very small number of nurses and midwives: 0.6% of those on our register with less than 0.1% on our register receiving a sanction last year.”

We do not consider 0.6% of cases to be “a very small number”. Your report states that at 31 March 2012 there were 671,668 nurses and midwives on the register. 0.6% therefore equates to over 4,000 individuals who are trained to be professionals of a caring profession.

4. The report monitors the rise in Fitness to Practise referrals over recent years and is forecasting how much extra finance is likely to be needed in the future to deal with the increased referrals. However, it does not explain whether, if any, analysis of the increase is being undertaken to determine how it might help improve practice and reduce referrals in future years.
Whilst we are aware that there is a commitment within the report to make improvements it has to be acknowledged that many of the issues raised are ones that have been raised on a number of occasions in the past. For example, in 2008 the Council for Health Regulatory Excellence (CHRE), on behalf of the Government, carried out an annual performance review. It showed 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.

CHRE has just published its 2011–2012 performance review of the nine UK regulators.

It once again reports concerns related to the NMC’s education, registration and fitness to practise functions, and specifically to:

— the slow progress being made on introducing a scheme which will enable the NMC to assure itself of its registrants’ continuing fitness to practise;
— the integrity of the NMC’s online register of registered nurses and midwives;
— the effective management of the NMC’s registration workload;
— the NMC’s ability to prioritise, progress, and effectively monitor its caseload, particularly in relation to those cases that were initiated prior to January 2011;
— the timeliness of the NMC’s fitness to practise case progression;
— the quality of the NMC’s management information;
— the quality of the decisions made and recorded by the NMC’s Investigating Committee and fitness to practise committees;
— the quality of customer service in the fitness to practise department;
— the quality of record-keeping in the fitness to practise department;
— the processes that the NMC has in place to enable it to learn from errors, such as its serious event review process;
— the consistency of the ongoing monitoring of risk in fitness to practise cases;
— the quality of the NMC’s investigation of fitness to practise cases; and
— the ability of the NMC to keep its fitness to practise information secure.

These longstanding issues are not likely to leave the general public feeling confident that the NMC is capable of transforming itself into a credible regulator. Nor, does it leave the registrant confident that increased fees will be managed efficiently.

As many of the Council will have been associated with the failings that have occurred the public and registrants would probably be interested in hearing whether there are any plans to bring in new members?

Consultation on Fitness to Practise

We wonder why the NMC is seeking the views of the public on this issue when there are a numerous court challenges to regulatory rules and the fairness of them.

The expectation of the public should be that a responsible body in drafting its rules would determine what is acceptable on the basis of good quality legal advice, so that the rules they have are robust, fair and free from the risk of court challenge. The expectation of the public should be that Counsel’s advice is sought and the NMC approves, and subsequently adopts the rules. It should not, in our view, be the source of wider public debate.

We believe that it is in the public interest for the rules to allow for the speedy disposal of cases. However, it is also in the public interest that the rules are lawful and that their implementation is impossible to challenge, so that nurses are able to avoid a hearing on the grounds of a technicality.

A Dignified Revolution is particularly concerned to learn from the consultation document that nurses are able to avoid co-operating with the process until the last minute. It is unacceptable that this situation has been allowed to continue for so long.

The apparent uncertainty expressed in the documentation as to the various options gives A Dignified Revolution cause for concern. Surely, rather than going through this public consultation, the NMC would be better placed to seek advice from a Leading Counsel on how the rules can be changed to secure fairness, but to assure the public that each case will be handled with expedition and secure the objective of making sure that nurses who are not fit to practice should be either taken off the register, or subject to appropriate conditions to secure a change in their practice.

We believe that robust and firm rules are a matter for legal advice at the highest level and not for consultation from an uninformed public on the legal viability of any change.

We are concerned:

— that nurses who are unfit for the role, continue to practice;
— those who have the courage to speak out about poor practice risk being struck off the register;
— that the timescales for getting a case to hearing are extremely long and unacceptable;
— members of the public who complain are not being treated fairly. For example, we have experience of complainants being told there are no nursing issues to investigate, when they are clearly documented;
— NMC is not working in collaboration with the police regarding cases that are passed from the Coroner’s office. We have experience of this through past correspondence with the NMC; and
— NMC is failing to be proactive in protecting the interests of the public, and subsequently failing to protect the reputation of the nursing profession.

September 2012

Written evidence from the Patients Association (NMC 06)
— The NMC is facing significant challenges and must be given the resources it need to meet them.
— The Patients Association continues to hear case of appallingly poor quality care, robbing patients of their dignity and causing misery for many, which involve poor nursing care.
— We know there are good, caring and conscientious nurses, but the ones practising poorly are not only causing pain but also damaging patient trust in the profession.
— There remains a perception amongst some patients that the NMC is out to protect nurses rather than dealing equitably with those that breach standards.
— The NMC needs to address this perception as a matter of urgency.
— The NMC must take a more active stance in tackling the issue of poor nursing, for example pursuing revalidation of nurses.
— There are also issues surrounding the lack of a regulatory framework for healthcare assistants. We believe the NMC should be given responsibility for regulating these new essential members of the health workforce.
— Language and communication skills, particularly amongst nurses and midwives from the EU, remain an issue. The EU is considering changing the Professional Qualifications Directive but in the meantime the NMC must seek ways to address the problem.

1. For the past three years, the Patients Association has published reports detailing the very worst care that we have heard about through our Helpline. Our most recent report, “We have been Listening, Have you been Learning” included examples of extremely poor care such as:
   (a) Jessie Thayer, whose daughters despaired at the failure of nurses to attend to her basic hygiene needs whilst she was a patient at Frimley Park Hospital.
   (b) Helena Grimwood, who whilst being treated at Southend Hospital was often left “desperately thirsty” according to her daughter, who also said nurses neglected her toileting needs.
   (c) Brian Smith, whose wife alleges that she had to run out into the corridor screaming for help as her husband lay dying in his bed, because nobody answered the call buzzer.
   (d) Barry Woodward, who had to wait seven hours for an ambulance and was then not given any pain relief on arrival at hospital.5

2. At the same time as publishing that report we launched our Care Campaign to try and improve the quality of care in UK hospitals. We are calling on all healthcare providers to ensure that, as a minimum, all patients should get assistance when they call for help, encouragement to eat and drink, assistance with going to the toilet, and have their need for pain relief addressed.

3. However, we must ask why such a campaign is necessary in the first place. Why in the 21st Century, are there four patients a day dying because of malnutrition and dehydration?6 The Office for National Statistics reported in January 2012 that 218 people died as a result of bedsores and around 25,343 people died from another condition but were suffering from pressure sores at the time of their death.7 These are entirely preventable conditions and problems yet reports about these types of failings continue to be published.

4. The Patients Association, as part of the Care Campaign, has gathered cases of best practice from Trusts from across the country. These were published is our report, Practices in CARE Review, which we released earlier this month. Best practice is out there and national bodies, including the NMC, should take every opportunity to spread it to ensure that all patients receive the highest quality care possible.

5. As the regulator for nursing, the Nursing and Midwifery Council (NMC) is in a pivotal position to improve nursing care in this country. While there are of course many very committed and conscientious nurses, the poorly performing ones are contributing to patient suffering. The NMC should be taking much greater steps in trying to prevent poorly performing nurses from being able to continue practising, or at the very least prevent

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5 Patients Association, We have been Listening, Have you been Learning, 2011, London
6 Office for National Statistics
7 Office for National Statistics
them from causing any more harm through additional training or conditions on their practice. We appreciate
that it has a massive job to do and hundreds of thousands of professionals to regulate, but the NMC must not
allow such issues to prevent it from fulfilling its duties to patients and the public. However in recent years it
has become clear that it is, as an organisation, the NMC is finding it difficult to achieve its core objectives.

6. The main outcomes that the NMC should be focused on achieving should be:
   (a) protecting patients from poor nursing raising the standards of nursing and midwifery practice;
   (b) Maintaining patient and public confidence in the nursing and midwifery professions.

7. All processes, procedures and structures must be grounded on these twin paramount duties. If processes,
   procedures and structures employed by the NMC are not solely aimed at ultimately furthering these two
   principles either directly or indirectly, they should be discarded and replaced with mechanisms that do reflect
   these aims. We note that the Law Commission recommended that similar paramount duties be placed on all
   regulators in its proposals for a single legislative framework for health and social care regulation.

8. We also believe the NMC should be much more proactive and decisive in its actions to protect patients
   from poorly performing nurses and in ensuring that its guidance is understood and followed.

9. This should include looking at instituting the system, currently under development for doctors, of regular
   revalidation of registered nurses to ensure that they continue to have the right skills, abilities and attitudes for
   nursing throughout their careers. We understand that there are moves to introduce such a system in due course.

10. We appreciate that the NMC already regulates the most number of professionals compared to other
    healthcare regulators, but we believe that it should be given adequate resources at all times to fulfil its role,
    including any additional support it may need to bring about changes, such as revalidation, which will ultimately
    result in higher quality services for patients. Indeed, as the regulator of the largest part of the healthcare
    workforce, it would seem all the more desirable to ensure that nurses and midwives continue to be able to
    perform at a high standard throughout their careers through regular appraisal and revalidation.

11. There is also a question around patient information about the NMC and satisfaction with its decisions.
    Most of the patients who contact our Helpline are largely unaware of the NMC and its role and function.
    However, amongst those patients that have heard of the NMC here is a perception that it works to protect
    professionals rather than hold them to account for poor quality care. This perception has a detrimental impact
    not only on the NMC, but also the nursing profession as a whole. Unfounded or otherwise, this perception
    must be tackled as a matter of urgency.

12. 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.
    Furthermore, the NMC should be more proactive about removing educational status when they have evidence
    of poor care.

13. There are two issues which are not strictly speaking within the purview of the NMC but we believe need
    urgent discussion as they have had and will continue to have a significant impact on the twin fundamental
    outcomes we have identified for the NMC.

14. The first is the role of healthcare assistants. There are thousands of healthcare assistants working within
    the NHS. In June 2011 it was estimated that 125,000 were working in the NHS and in September 2011 it was
    estimated that 600,000 were working across the UK in various care settings. The Royal College of Nursing
    has set the staffing ratio for nurses to healthcare assistants for good quality care 65:35, yet it has found that
    the real ratio is closer to 50:50. We are concerned that as healthcare assistants are cheaper to recruit and pay,
    many Trusts and hospitals are becoming increasingly reliant on them to bring up staff numbers of the ward.
    However, they lack even basic regulation and have minimal training. Many, it is reported, pick up skills (and
    indeed bad habits) as they go along rather than undergoing any rigorous training. Despite this, we are
    increasingly hearing that healthcare assistants are undertaking tasks which should only be performed under
    supervision from a nurse. Indeed, even some more complex tasks like taking blood have been reported to have
    been performed by healthcare assistants. We have heard from many patients who struggle with distinguishing
    between different nursing roles and healthcare assistants. We look forward to recommendations on how this
    matter will be addressed.

15. 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.

16. “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.”

17. “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’.”
18. We believe that it will be impossible to provide high quality care and for nurses to perform their duties to highest professional standards unless healthcare assistants are also regulated, given codes of practice and minimum qualifications. The body which is in the strongest position to undertake this regulation is the NMC, but we do understand their concerns about almost potentially doubling the number of professionals they are responsible for. We note that plans are in place to introduce a voluntary register from 2013, but this is not sufficient to ensure that all healthcare assistants are practicing to an adequate standard. There should be mandatory regulation of these professionals to ensure they are held accountable for their actions and have clear guidance on the minimum standards expected of them.

19. The other issue is the registration of nurses from the European Union which remains an issue. We understand that the former Chair of NMC, Dickon Weir-Hughes, has also expressed his concern on this issue during an investigation by a committee in the House of Lords. There are two specific issues at play here—English language skills and understanding of modern practice.

20. Communication is key to effective healthcare and if nurses struggle to communicate with patients and vice versa, mistakes will be made. However, there are regular reports that healthcare staff from other countries are not proficient enough in the English language. We know, for example, that the use of euphemisms to describe bodily functions is a perennial problem. We appreciate that under EU law, member states and national organisation are prohibited from introducing systematic testing of language skills or qualifications that would interfere with the free movement of persons. While this may be acceptable in some industries, in healthcare it simply does not make sense.

21. The European Commission’s Green Paper on Modernising the Professional Qualifications Directive looked in detail this issue. The Patients Association has made its views clear to the Commission in our response to this Green Paper, which is available in full on our website. We also note that the Secretary of State for Health has recently announced plans to devolve the testing of language skills for doctors to local authorities in order to avoid conflicting with EU Law. We would appreciate more information on the CHRE’s views on a similar procedure being applied to nurses. We are uneasy about such a compromise as it relies on local authorities to undertake the responsibility without national oversight. While not directly applicable to nursing, the case of Dr Ubani is pertinent. He was originally blocked from working for one PCT “out of hours” service due to his lack of English language skills, so he simply kept applying until one PCT allowed him to work for them.

22. It is also essential that nurses from other countries not only understand how the NHS operates, but also are up to speed with current practice. The NMC have already said that they have to operate a two tier system to accommodate EU rules on free movement of persons. This included having to allow the registration of nurses and midwives who had no professional experience for 20 years despite concerns about their understanding of modern nursing practices. We believe that this puts patients at risk and is unreasonable.

23. The structure and process of the NMC must be capable of delivering these outcomes and addressing these issues. Good governance is integral to any successful regulatory body and without it any other response will prove pointless. The NMC has faced some instability in recent months and this has hampered its ability to perform its duties. The governance of the NMC must be stable and effective, with clear lines of responsibility and accountability throughout both the Council and the Executive.

24. We would also welcome more information on what key performance indicators will be in place to guide the work of both the executive and board of the NMC.

25. Lay membership of the Council is also vital to ensure that the patient voice is at the heart of the strategic leadership of the NMC. We would like to see high ratio of lay members to professional members on the Council so that the Council is always cognizant of the needs of patients when designing and leading strategy.

26. We would also appreciate further information on how the independence and impartiality of lay members will be ensured.

September 2012

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

The Health Committee has requested further information on the NMC’s Fitness to Practise (FiP) caseload.

Total Caseload

As of January 2013 there are 4,401 cases in our system. Of these there are 825 at screening stage, 1,862 at investigation stage and 1,714 awaiting adjudication.

During our evidence session we told the Committee that we had around 1,400 cases awaiting adjudication. This figure has increased to 1,714 cases since October 2012 as we have increased activity at the investigations stage. These 1,714 cases are either part-heard, listed for a hearing or actively being scheduled for a hearing.
HISTORIC CASES

The NMC commenced its FtP improvement plan in January 2011. As this was the time when screening process started, the FtP action plan group (now FtP committee) took the decision that all cases received prior to this date should be called historic cases.

There are currently 572 historic cases open, of these 236 have interim suspension or conditions of practice orders in place.

FITNESS TO PRACTISE DATA JANUARY 2013

Last year, in order to improve performance in FtP we agreed to focus on three particular areas; timeliness in case management, quality of decision making and customer service. We have reported our progress under these main headings on a monthly basis since. We are now asked to provide any further information that evidences progress for the purposes of the PSA report to DH on 29 January 2013.

We note that it is not necessary to repeat any information given to you during the recent audit process and we have assumed that this also applies to the FtP information we have recently provided through the performance reporting process.

Set out below in table and graph format are the key data that demonstrate improved performance since January 2011.

Timeliness

— The average case investigation is now taking just over 10 months compared to more than 22 months two years ago.
— The average time at the adjudication stage has reduced by more than six weeks since January 2011.
— The combined average time for investigation and adjudication is now 18 months down from 31.5 months in the first quarter in 2011.

Areas for improvement:
— We continue to work on reducing the number of cases that go part-heard.
— The increase in hearing activity, which by June will mean we will hold 22 substantive hearing events a day and new case management processes being introduced this month, will ensure that we meet the adjudication KPI by the end of 2014.

Customer service

— Decisions have been communicated more quickly as shown by our record of dispatch of decision letters.

Areas for improvement:
— Increase in staffing levels across all areas of FtP will continue to reduce caseloads which should lead to an improved level of service to customers.
— We are beginning to collect and analyse customer feedback, which will in due course be a useful measure of performance.

Decision making

— There is objective evidence of good decision making from two recent High Court judgements, which we have referred to in our performance report.
— There have been no S.29 referrals by the CHRE/PSA of NMC determinations since September 2010. During that time period the NMC has made more than 2500 final decisions.

Areas for improvement:
— A decision review group meets regularly to identify poor performance and learning points which are fed back to staff and panel members.
— We continue to invest heavily in improving the quality of decision making at all stages, through training of panellists and staff and by offering an enhanced level of legal input and other staff resource at all stages.
**FTP IMPROVEMENT PLAN PERFORMANCE TABLE 1**

<table>
<thead>
<tr>
<th>Performance indicator</th>
<th>Jan - Mar 2011 (Quarter 1)</th>
<th>Apr - Jun 2011 (Quarter 2)</th>
<th>Jul - Sep 2011 (Quarter 3)</th>
<th>Oct - Dec 2011 (Quarter 4)</th>
<th>Jan - March 2012 (Quarter 5)</th>
<th>Apr - Jun 2012 (Quarter 6)</th>
<th>Jul - Sep 2012 (Quarter 7)</th>
<th>Oct - Dec 2012 (Quarter 8)</th>
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<tbody>
<tr>
<td><strong>Investigation time</strong></td>
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<tr>
<td>KPI = 12 months</td>
<td>22.6</td>
<td>19.7</td>
<td>15.3</td>
<td>16</td>
<td>16.4</td>
<td>13.8</td>
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<td>10.6</td>
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<td><strong>Adjudication time</strong></td>
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<td>KPI = 6 months</td>
<td>8.9</td>
<td>8.7</td>
<td>9.2</td>
<td>9.8</td>
<td>9.6</td>
<td>8.6</td>
<td>8.7</td>
<td>7.4</td>
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<tr>
<td>KPI = 18 months</td>
<td>31.5</td>
<td>28.4</td>
<td>24.5</td>
<td>25.8</td>
<td>26</td>
<td>22.4</td>
<td>20.5</td>
<td>18</td>
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<td><strong>Interim orders</strong></td>
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<td>KPI = 28 days</td>
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<td>66</td>
<td>52</td>
<td>38</td>
<td>37</td>
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<tr>
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<td>1991</td>
<td>1636</td>
<td>1589</td>
<td>1303</td>
<td>967</td>
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* Historic cases are all cases received prior to January 2011

**FTP IMPROVEMENT PLAN PERFORMANCE TABLE 2**

<table>
<thead>
<tr>
<th>Performance indicator</th>
<th>Jan 12</th>
<th>Feb 12</th>
<th>Mar 12</th>
<th>Apr 12</th>
<th>May 12</th>
<th>Jun 12</th>
<th>Jul 12</th>
<th>Aug 12</th>
<th>Sep 12</th>
<th>Oct 12</th>
<th>Nov 12</th>
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<tbody>
<tr>
<td>Decision letters sent</td>
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<tr>
<td>KPI = 100% sent in 5 days (% met each month)</td>
<td>81%</td>
<td>93%</td>
<td>88%</td>
<td>83%</td>
<td>80%</td>
<td>54%</td>
<td>33%</td>
<td>70%</td>
<td>98%</td>
<td>99%</td>
<td>99%</td>
<td>100%</td>
</tr>
</tbody>
</table>

| Complaints letters answered |        |        |        |        |        |        |        |        |        |        |        |        |
| KPI = 100% answered in 20 days (% met each month) | 100%   | 100%   | 89%    | 89%    | 100%   | 96%    | 89%    | 93%    | 90%    | 89%    | 86%    | 86%    |
FTP IMPROVEMENT PLAN PERFORMANCE GRAPHS

**Graph 1**
Performance against investigation KPI

- Investigation time
- KPI = 12 months

**Graph 2**
Performance against adjudication KPI

- Adjudication time
- KPI = 6 months
**Graph 3**
Performance against combined investigation and adjudication KPI

- --- Investigation and Adjudication time combined
- KPI = 18 months

**Graph 4**
Performance against interim order KPI

- --- Interim orders
- KPI = 28 days
Graph 5
Historic case progression

Graph 6
Decision letters sent in 5 days

KPI = 100 %