House of Commons
Health Committee

2012 accountability hearing with the Nursing and Midwifery Council: Government and Nursing and Midwifery Council Responses to the Committee’s Ninth Report of Session 2012–13

Third Special Report of Session 2013–14

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The Health Committee

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

Membership

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The Reports of the Committee, the formal minutes relating to that report, oral evidence taken and some or all written evidence are available in printed volume(s).

Additional written evidence may be published on the internet only.

Committee staff

The staff of the Committee are David Lloyd (Clerk), Martyn Atkins (Second Clerk), Stephen Aldhouse (Committee Specialist), Frances Allingham (Senior Committee Assistant), and Ronnie Jefferson (Committee Assistant).

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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).
Third Special Report

On 9 January 2013 the Health Committee published its Ninth Report of Session 2012–13, 2012 accountability hearing with the Nursing and Midwifery Council. The Government Response to the Report was received by this Committee on 30 April 2013 and is published as Appendix 1 to this Report. The Nursing and Midwifery Council’s Response was received on 8 July 2013 and is published as Appendix 2 to this Report.

The Committee will be taking evidence from the NMC again in the autumn of 2013 as part of its function of holding medical regulators accountable on behalf of Parliament.

Appendix 1 – Government Response

Introduction

On 6 March 2013, the House of Commons Health Committee (the Committee) published the report: 2012 accountability hearing with the Nursing and Midwifery Council (NMC).

The Department strongly believes that these hearings are of great value in strengthening the accountability of the professional regulatory bodies to Parliament and the wider public.

The Department is committed to continuing to work with the NMC, Devolved Administrations and other stakeholders in developing policy affecting regulation of UK health professionals.

Departmental response

We welcome this report and have carefully considered the Committee’s recommendations and the issues it raises.

The majority of the report’s recommendations are for the NMC. This memorandum provides the Government’s response to the three recommendations directed to the Department of Health.

We note the Committee’s ongoing interest in a system to provide assurance of continuing fitness to practise for nurses and midwives. The Department supports the NMC in developing such a model in a way that delivers enhanced public protection. The Department will work with the NMC and partners to consider how such a model could be proportionate and appropriate and work within the evolving healthcare framework.

NMC powers to review cases

Recommendation: 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.

The Department believes that patients should receive the highest possible standards of care and any complaints made against clinical staff must be thoroughly investigated as quickly and efficiently as possible, whilst ensuring fairness.

In light of this recommendation, and broader legislative changes recommended by the Francis Report, the Department is working with the NMC and other health regulators to ensure that the structures and safeguards that are in place fully protect patients. Consideration is being given to the most appropriate way for this work to be taken forward. The Law Commission proposals, amongst other things, will consider legislation on the investigation and adjudication of fitness to practise cases. The Department has written to the Law Commission, in light of the Francis report, for its advice as to measures that may be included in its proposals which will enable the modernisation of the NMC’s decision-making processes. The Department will seek to legislate at the earliest possible opportunity to overhaul existing, complex legislation into a single Act that will enable faster and more proactive action on individual professional failings.

In parallel, we are exploring with the NMC the scope of legislation required within a Section 60 Order that will enable the NMC to review the decisions of its Investigation Committees.

Leadership

Recommendation: 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.

The Department agrees that the NMC must focus and provide continuity of purpose as the organisation makes significant changes and improvements in the delivery of its core functions. However, fundamentally issues of appointments are a matter for the NMC itself.

Following consultation on proposals, the Department is working with the NMC to reconstitute its council to reduce its size, with a view to further strengthening the NMC’s leadership and governance. This is in line with a recommendation made by the Professional Standards Authority (formerly the Council for Healthcare Regulatory Excellence).

Language testing

Recommendation: 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.

The Department has been considering how to strengthen the system of checking language knowledge for nurses, midwives and the other regulated healthcare professionals, following the policy proposals in relation to doctors. Whilst it is for employers and those contracting with health care workers to verify the language knowledge of any person they appoint, we consider that there should be a role for the professional regulators.

The Directive on the Mutual Recognition of Professional Qualifications (2005/36/EC) and related case law prevents the systematic checking of language for health professionals during registration. Any language checking therefore currently has to be necessary and proportionate and can only be applied following recognition of the qualification.

However, the Directive is under review, and the European Commission’s current proposals will, if introduced, expressly permit competent authorities (regulators) to undertake language controls on all health professionals following recognition, but before there is access to the profession. It is envisaged that agreement on the proposed Directive text should be reached from mid 2013. If the present proposal is accepted, a system of language checks for all health professions would be permissible and we would then move to implementation into domestic law as part of the transposition of the Directive, a process that is likely to take around two years.

The Department considers that due to the progress of the Directive review, the most appropriate vehicle for introducing these changes for nurses and other regulated health professions would be the transposition of the new Directive. Once the text has been finalised we will be clearer on the changes that can be introduced. However, as stated we are already discussing with the NMC how best this could be introduced for nurses and midwives. In developing any policy, we will also need to consider views from the other UK countries.

Appendix 2 – Nursing and Midwifery Council Response

Introduction

The Nursing and Midwifery Council (NMC) is the UK regulator for nurses and midwives. Our primary purpose is to protect patients and the public in the UK through effective and proportionate regulation of nurses and midwives. We set standards of education and practice, maintain a register of those who meet these standards and take action when a nurse or midwife’s fitness to practise is called into question. By doing this well we promote public confidence in nurses and midwives, and in regulation.
The NMC welcomes the Health Committee’s scrutiny of its work, and the proposal to formalise the Committee’s role in our accountability advanced by the Law Commission in its review of the legislative framework for healthcare regulation.

Shortly before our 2012 appearance before the Health Committee the NMC was subject to a strategic review by the Professional Standards Authority. As a result we have a challenging set of improvements to implement over the next 18 months to two years that will allow us to demonstrate that we are an effective regulator. The consequences of not meeting these objectives would be serious for the NMC and we appreciate the Committee’s recognition that our capacity for additional new initiatives was constrained. By focusing on our ‘core business’ we have been able to reflect on and improve work already in train.

Since we appeared before the Committee we have been taking stock of the highly significant second report of Robert Francis QC into serious failings at Mid Staffordshire NHS Foundation Trust. The Committee has taken a keen interest in how the sector responds to the Francis recommendations and we look forward to the opportunity to share what we are doing to reduce the risk of serious failings of care in future. The Francis Report challenges all regulators to be effective in their own roles and in the work they do together to protect the public. We will publish our initial response to the Francis recommendations for the NMC in July 2013.

Responses to 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.

2. Given the fundamental nature of the problems at the heart of the NMC we agree with Mark Addison’s assertion that the NMC 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.

It is heartening to hear that the Committee recognises that the NMC’s Council and executive understand what is required of them in order to keep the public safe and deliver confidence in regulation. We are focused on our core statutory functions, with FTP a clear priority. We are now making progress with plans for revalidation, mindful of the need for improvements to the registration and IT to support this development.

We believe it would be short-sighted to stint on some of our other statutory functions, such as setting and monitoring education standards, because these are the functions that contribute to reducing failures of competence and conduct in nursing and midwifery. But
we have maintained the discipline of our 2012 review of all projects and we have not strayed into initiatives which are not central to our purpose or remit.

We have a co-ordinated programme of improvement plans in place relating to our regulatory and support functions, with scrutiny from a Change Management Portfolio Board to manage interdependencies and ensure delivery.

Our Council members have been selected for their strategic governance and scrutiny skills. Their comprehensive induction programme was well received and they took decisive action to agree a revised governance framework that will enable them to focus and to challenge effectively across the business.

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.

The Committee is right to urge the NMC not to be satisfied with an 18 month KPI for resolution of FTP cases, and with historic cases cleared and a reformed legislative framework we would look to set a more challenging target. It would be irresponsible for us to pretend such a step would be achievable at this stage. We note that no other regulator is achieving a 9 month completion time – the General Osteopathic Council comes closest at 45 weeks but its FTP panels considered 9 cases in 2012–13 and the comparable figure for the NMC is 1,535. Our response to recommendation 9 also touches on improvement to date with the speed of the investigations stage of cases (the first stage on receipt of a complaint).

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 in which it is acceptable for an FTP case to take more than 12 months to resolve.

It is in everyone’s interest that cases are completed promptly, and we are working hard to reduce the time it takes us to dispose of cases, and measuring our performance against a wide range of KPIs in order to understand where we can affect speed without compromising quality. However there will always be cases that take a long time because of factors beyond our control and that is why we have not set a maximum acceptable time. Our target for the average time taken to dispose of cases should be set in accordance with what we believe is realistic, challenging and achievable. At the moment that KPI is 18 months because of the volume of cases in the system. Although we are not proud of our record on the cases that take a long time to complete, we note that in 2012–13 despite our historic cases we are in the middle of the healthcare regulators judged by longest time taken for cases to be completed. Over time if we invest, improve business processes, reform thresholds and achieve legislative change we would be pleased to consider more
challenging KPI. We will endeavour to set out for the Committee what we believe is possible with and without legislative change before our next accountability hearing.

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 30 June 2013.

We agree with the Committee’s assertion that progressing historic cases is a priority and that is why we are working towards a very challenging target already. We have reviewed that target and cannot realistically bring it forward. Since we were before the Committee we have reduced the number of historic cases in the system to 189, 162 of which are now scheduled for hearing. Among the 27 not yet scheduled will be a number with which we cannot proceed for reasons beyond our control such as cases that are the subject of ongoing criminal proceedings. Such cases aside, we are on track to meet our KPI of listing historical cases for hearing by the end of September 2013.

Current cases

6. The Committee welcomes this evidence of progress in securing timely investigations and decisions, and notes 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.

Please see our responses to recommendations 3 and 4 above.

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.

We welcome the Committee’s recognition of this achievement, which speaks to the quality of decision–making – another important aspect of fitness to practise performance.

NMC powers to review cases

8. We consider 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.

We are grateful to the Committee for having brought its influence to bear on the issue of changes to the NMC’s fitness to practise legislation. In February 2013 the Prime Minister announced an opportunity to look at some reforms to our legislation in his response to the
publication of the Francis Report into failings at Mid Staffordshire NHS Foundation Trust. Work on some urgent s.60 changes has recently been initiated by the Department of Health and we are now working with DH lawyers on the scope of this work, which will include powers to review fitness to practise panel decisions and to appoint case examiners. We hope to have these changes made by July 2014. We will continue to seek further important legislation changes via the Law Commission or a further s. 60 order.

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.

The decision to bring more investigations in–house was taken on the grounds of quality and overall efficiency but the Committee is right that it must have no detrimental impact on speed. We have continued to improve the speed of investigations while conducting more investigations in house. We have reduced the length of the investigations stage from an average of 22.6 months in 2011 to 8.4 months by March 2013. As our investigations performance improves, the pressure moves through to adjudications as more cases are coming through for hearing, but we do maintain contracts with external suppliers in order that we can respond flexibly to any increase in demand.

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.

We have done as the Committee recommended and invested in a system that in time will allow us to project fitness to practise cases and therefore to model and plan for the impact on business needs as referrals fluctuate. Our Council scrutinised some of those projections in June 2013 as part of its induction into the challenges of the NMC’s extensive FTP caseload. We need to take this work further.

Improving processes

11. 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 per cent of cases and complaint letters were answered within 20 days in 86 per cent of cases – against a KPI in both cases of 100 per cent. Both the fact of the KPI
and the performance against it reflect a welcome commitment from the NMC to deliver an improved performance.

We are pleased that the Committee recognises the NMC’s commitment to improve the customer service aspects of FTP. We continue to perform at or around our KPIs in these areas. In May 2013 96 per cent of decision letters were sent within five days and 100 percent of complaints were answered in 20 days.

We draw the Committee’s attention to another significant KPI – the length of time taken to impose an interim order where it is deemed necessary to limit or prevent a registrant’s work while their fitness to practise is under investigation. The average time taken for the NMC to impose an interim order where needed in 2012–13 was 4 weeks, while other regulators took between 6 and 23 weeks to do so.

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 per cent.

Our work to avoid such failings in future is described in response to recommendations 13 and 14 below. Our ability to project fitness to practise activity levels is key to our ability to predict our financial requirements. We recognise the seriousness of this historical failure and have addressed the under-investment: FTP represented 58 per cent of our expenditure in 2010–11, 67 per cent in 2012–13 and 77 per cent in 2013–14.

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 NMC’s financial planning. The Committee will be seeking assurance at the next accountability hearing that these steps have been effective.

We will be happy to provide that assurance to the Committee. In October 2012 in conjunction with the fee decision, the strategic financial model was rebuilt and the financial assumptions were reviewed by KPMG and considered to be reasonable. Monthly forecasting is now carried out with all directorates and the strategic model is updated on a monthly basis following each forecast. Financial training has been delivered to cost centre managers. FTP and finance teams have worked to strengthen the read-across between FTP activity levels and costs.

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.

Our new Council members were selected for their strong Board level experience and in particular, financial expertise. In addition to monitoring a set of key performance
indicators at every meeting, members are taking a close look in turn at every aspect of
business that features in the risk register. Monthly financial reporting packs and papers
have been redesigned to provide more detailed, accurate and consistent information to
Council on a timely basis. We are working on a corporate data strategy and we see
enhancing the quality and use of data as critical to our effectiveness and our capacity to
work well with other regulators.

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.

Our longer term IT plans are predicated on the need for one source of reliable NMC data,
but we are continuing to effect improvements to what we have. We are making
investments in Autumn 2013 in the FTP case management system to improve functionality
and workflow. Reports linking CMS and the Register to ensure consistency between
systems are now in place. Data flows between CMS, the register and the website are being
analysed to determine where automation can be introduced before the end of 2013–2014.

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.

Key upgrades to core systems such as document management, reporting, telephone
systems, email and our office computers are on track to complete by the end of 2013.
Further improvements to systems availability and performance will be completed by the

Although we do not plan to make the significant changes to our main register database
until 2014–2015 we are planning some significant improvement over the next 12 months:

• online capabilities for registrants in 2014
• further enhancements to data reporting capabilities focused on quality and
  forecasting
• an initial prototype of the new register based on industry standard software
• a technical roadmap to support revalidation.

Enhancements to the governance of IT will ensure that NMC systems are funded and
aligned with business needs. The strategy for ICT for 2013–2016 detailing the road map for
all ICT improvements will be agreed with Council in October 2013.
Culture and morale

17. Staff turnover of 36 per cent 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.

The NMC takes this recommendation very seriously. We know it speaks not only to whether we are a good employer, but also whether we are an effective regulator. There are stark lessons from Mid Staffordshire about listening to staff and empowering them to drive quality. The new Council has set and monitors a KPI for the reduction of staff turnover from 32.7 per cent to 26.4 per cent per year by March 2014.

On culture, we have introduced a behaviours framework and we are implementing organisation wide training about what it means for our work. We have used this framework as a point of reference in recruitment since the 2012 restructure and we are using it as part of future performance management discussions.

We are implementing a number of HR reviews and strategies including a learning strategy to build organisational capability and capacity in both leadership and the wider workforce.

We have conducted a staff survey and all staff are been involved in developing the action plan arising from the findings. We have committed to repeating the process and checking against delivery of that plan.

When we next appear before you we will be able to report on the work we are doing to reduce turnover and improve culture.

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.

When we last appeared before the Committee, the role of chief executive was filled by Jackie Smith who had been appointed for a year pending the resumption of the recruitment exercise for a substantive Chief Executive. In June 2013 our Chair Mark Addison was pleased to announce that Jackie had been appointed to the permanent position and this has given us continuity at an important time for the organisation. We also have a full complement of permanent directors and following a governance review by KPMG in early 2013 the director group will function in future as a more formally constituted Executive Board. We are delivering a leadership development programme to enhance the skills and behaviours of individual directors and the director group.
We have also appointed and inducted Council members to our new reconstituted Council of twelve and we were pleased to attract a strong field for the Council positions. Our new members are already providing the organisation with the right degree of scrutiny and challenge, and demonstrated the skills we sought at this time of change for the NMC.

We hope our stakeholders have greater confidence in our leadership and management, and can see we are clear about the respective roles of Council and the executive.

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.

Council never takes a decision to raise the fee lightly, particularly when we are aware of the adverse impact of recession on the finances of nurses and midwives. In 2012 it was necessary to raise the fee from £76 to £100. The fee rise was predicated on the need – pointed out by this Committee – for FTP investment due to the increasing number and complexity of cases.

We do not suggest that this is a desirable situation. Our legislation binds us to a very costly model of fitness to practise and we have taken steps to reduce those costs within our legislation and without undermining the public interest in regulation. We have urged Ministers to allow us to make changes to our Order and Rules that would enable us to streamline the disposal of cases without compromising fairness or public protection. The Committee has supported us in this matter. We are therefore pleased that the Prime Minister announced in February 2013 that he was authorising some changes to our legislation which will enable us to be a more effective and cost effective regulator, although more are needed and we are happy to set these out for the Committee.

A grant of £20 million provided by the DH with conditions based on achieving our adjudication KPI for FTP made it possible to avoid a bigger increase. In response to the understandable sensitivity associated with fee rises Council has instituted an annual review of both the fee level and the reserves level. The first review was in March 2013 and the Council opted to leave the fee at £100 for the year 2014–15. The next review will be March 2014.

In March 2013 Council also acted on the Committee’s recommendation that it considered a phased payment scheme. It did not judge the time right to implement such a scheme.
Until our IT systems can support online transactions the administrative costs of such a scheme may be prohibitive but Council agreed to keep this under review as the IT strategy is rolled out. Options in the frame include monthly direct debit and differentiated fee categories.

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.

Council recognises that under-investment in IT has inhibited our regulatory delivery. Our IT strategy includes improvements to systems so that registrants can register and renew online. Since revalidation will be aligned with the existing three year renewal process, the improvements to these systems will benefit the implementation of revalidation. There has been close work between IT and revalidation teams to ensure that the technological requirements of revalidation are understood and delivered. Most of the IT work required for revalidation will be completed in 2014, allowing for full testing before revalidation begins in earnest by the end of 2015.

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.

We have made significant progress on revalidation since we appeared before the Health Committee, although there is of course still a great deal to do if we are to launch a scheme before the end of 2015, which is the ambitious target we have set ourselves. There is no immediate prospect of changes to our legislation (beyond the limited FTP-related s.60 changes) so phase 1 of revalidation will work within our existing legislation. Evidence from this phase will inform any legislative changes we may seek for the next phase of revalidation.

We have recruited a revalidation team and it has started work, overseen by a revalidation programme board. We have established stakeholder groups to give key players including employers, nurse leaders from the four UK jurisdictions, and unions and professional bodies the chance to shape our model from the outset, and we have engaged service users and their representatives on our Patient and Public Engagement Forum. We have delivered a series of four nation engagement events which has enriched our understanding of priorities and aspirations in England, Northern Ireland, Scotland and Wales. This work all feeds in to a proposed model for revalidation which will go to Council for approval in September 2013, and which we look forward to sharing with the Committee thereafter. This paper will include timeframes and we also hope to be in a position to set out how our assessment of risk will inform the roll out of revalidation. We will consult on Council’s preferred model towards the end of 2013.
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.

We welcome the Committee’s continued interest in and support for the power for regulators to ensure that applicants to healthcare registers have the requisite language skills to practise in the UK. The NMC has worked with other regulators to press for this in the context of the review of the Recognition of Professional Qualifications Directive. We recognise the need to strike a balance between the labour mobility rights of EU applicants and patient safety. We encourage the Committee to make its views felt to the Department of Health as it considers how to embed the revised Directive in domestic law.

Concluding remarks

The Committee is aware that the NMC has been given until the end of 2014 to demonstrate improvements in performance. This timescale reflects the challenge in turning around an organisation which requires improvement on a number of fronts simultaneously. When we next appear before the Committee we recognise that it will want to see more ‘green shoots’ and measurable progress towards our key targets. We also hope that our stakeholders will be able to confirm that the direction of travel is positive. By the end of 2014 we need to meet the targets set in the 2012 strategic review and begin to demonstrate our capacity for further improvement, ‘beyond competence’. The scrutiny we receive from the Health Committee provides us with essential challenge and support for our next phase of improvement.