



House of Commons  
Health Committee

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# 2013 accountability hearing with the Nursing and Midwifery Council

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**Fifth Report of Session 2013–14**

*Report, together with formal minutes relating  
to the report*

*Ordered by the House of Commons  
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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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<sup>1</sup> 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

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Since last year's accountability hearing, it appears that the NMC has made some improvements in its performance, and as an organisation it is now looking to future challenges, including responding to the findings of the Francis report, and introducing revalidation for nurses and midwives. However, the Committee is concerned that the progress so far remains fragile, and believes it is important that these new challenges do not become a distraction from the continuing requirement to improve its performance of its core functions.

The length of time the NMC takes to conclude its fitness to practise cases has been an enduring concern for the Committee. From 2015, the NMC proposes to toughen the target period for resolving fitness to practise cases to 15 months. We welcome this target and urge the NMC to commit themselves to delivering this objective in every case. In order to reduce the target time further, to 12 months, changes to the NMC's legislation are required – we recommend that the NMC work with the Department of Health to make these changes as a priority.

The Francis Report into the failings at Mid Staffs examined the role of regulators, including the NMC, in detail. It is crucial that in the light of this, the NMC works to raise the awareness of patients about its own work, and to raise the awareness of nurses and midwives about their professional responsibilities to raise concerns. We have recommended that the NMC develop a system to evaluate whether it is becoming easier for concerns to be raised with the NMC. While determining and monitoring staffing levels are not direct responsibilities of the NMC, health professionals who have concerns about staffing levels have a professional obligation to raise these concerns in an appropriate manner, and the NMC must make this clear to its registrants.

Public concern about the care standards within clinical professions has risen as a result of the Francis Report – the NMC needs to be able both to deliver effective and consistent regulation, and to demonstrate that ability to a more sceptical public. Transparent accountability for its own track record should be a high priority for the NMC.

The NMC has announced plans to introduce a system of revalidation by the end of 2015. Although we welcome this commitment, the NMC's plans appear to still be at an early stage, and we will therefore seek an update on progress in this specific area at the end of the first quarter of 2014. The issue of appropriate language controls for health professionals continues to cause the Committee concern. High quality care requires that staff can communicate effectively with patients, and the Department of Health must ensure that EU legislation does not prevent this from happening.



# 1 Introduction

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1. The Nursing and Midwifery Council (NMC) is the nursing and midwifery regulator for the UK. It is independent from government, and it is funded by the registration fees from the nurses and midwives on its register. It lists its functions as follows:

It is our job to protect the public by making sure that all practising nurses and midwives have the skills, knowledge, good health and good character to do their job safely and effectively. To do this, we:

- Require all nurses and midwives who practise in the UK to be registered with us.
- Set standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare consistently throughout their careers.
- Ensure that nurses and midwives keep their skills and knowledge up to date and uphold our professional standards.
- Have clear and transparent processes to investigate nurses and midwives who fall short of our standards – our fitness to practise work.<sup>2</sup>

2. We took evidence from Mark Addison CB, Chair and Jackie Smith, Chief Executive on 8 October 2013. This is the third accountability hearing we have held with the NMC in this parliament. Following last year's hearing, we published a report in March 2013, making a number of recommendations for the NMC and government, and committing to follow up on certain areas this year.<sup>3</sup> A summary of our recommendations, and areas we specifically identified for follow up, is included at Annex A.

3. In June 2013, the Professional Standards Authority for Health and Social Care (PSA), the body tasked with overseeing the work of all professional regulators in the health and social care sector, published their annual report on regulators' performance<sup>4</sup>; we discussed this with them in July, and these discussions informed our accountability hearing with the NMC.<sup>5</sup>

4. Additionally, February 2013 saw the publication of the Francis report, the recommendations of which have implications for the NMC. These are also considered in this report.

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<sup>2</sup> NMC, [Annual Fitness to Practise Report 2012 – 2013](#) (October 2013), p3

<sup>3</sup> Health Committee, Ninth Report of Session 2012 – 13, [2012 Accountability Hearing with the Nursing and Midwifery Council](#), March 2013, HC 639

<sup>4</sup> Professional Standards Authority for Health and Social Care, *Annual Report and Accounts and Performance Review Report 2012 – 2013*, HC 305-II

<sup>5</sup> Oral evidence taken on 9 July 2013, HC 528-i

## 2 Background and overview

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5. The NMC is an organisation with a recent history of poor performance, including lack of focus on its core regulatory activities, financial mismanagement and long delays in processing Fitness to Practise cases. The Council for Healthcare Regulatory Excellence (CHRE), the predecessor body to the PSA, published a highly critical review of the NMC in 2012<sup>6</sup>; since then, the NMC's Chair, Chief Executive and Council have been replaced, and the NMC has accepted a special grant of £20 million from the Department of Health, linked to delivering improved performance in its Fitness to Practise activities.

6. The PSA's 2013 performance review of the nine healthcare regulators it oversees, published in July of this year, states that "the NMC .....is not yet meeting eight of the 24 Standards of Good Regulation".<sup>7</sup> The seven unmet standards are listed below:

- Through the regulator's continuing professional development/revalidation systems, registrants maintain the standards required to stay fit to practise
- The registration process, including the management of appeals, is fair, based on the regulator's standards, efficient, transparent, secure, and continuously improving
- All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and where appropriate referred to an interim orders panel
- Fitness to practise cases are dealt with as quickly as possible taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients. Where necessary the regulator protects the public by means of interim orders
- All parties to a fitness to practise case are kept updated on the progress of their case and supported to participate effectively in the process
- All fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession
- Information about fitness to practise cases is securely retained.<sup>8</sup>

7. The eighth standard the PSA refers to is only met inconsistently.

8. The PSA points out that the NMC has not met standards (3), (6) and (7) in all Performance Reviews since 2010/11, and argues that "their continued failure to meet standards around prioritising complaints and making well-reasoned decisions illustrates, in our view, the difficulties they have in assessing and responding to the risks presented by

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<sup>6</sup> Council for Healthcare Regulatory Excellence, [Strategic Review of NMC Final Report](#) (July 2012)

<sup>7</sup> Professional Standards Authority for Health and Social Care, [Annual Report and Accounts and Performance Review Report 2012 – 2013](#), HC 305-II, para 7.4

<sup>8</sup> Professional Standards Authority ([NMC 0011](#)), para 4.1

their registrants. The inability to meet the standard around information security reflects their shortfalls in assessing and managing the risks presented by their own processes.”<sup>9</sup> In evidence to the Committee in July, Rosalyn Hayles, Director of Scrutiny and Quality at the PSA, reported that “there is definitely evidence of improvement”, but that “there are still some standards that are not being met where progress is slow, and I am sure it is slower than the NMC would want, and it is slower than we would want”.<sup>10</sup>

9. This year, the NMC has given us this assessment of their own performance:

When we last spoke to the Committee we were clear that the changes we needed to make for the NMC to become an efficient and effective regulator would take at least two years. This is also the assessment of the Professional Standards Authority. A year on, we have solid progress to report, and we feel confident that plans are in place to deliver further improvements and to meet new challenges over the year ahead.<sup>11</sup>

10. The Chair of the NMC told us that in his view, the NMC is now approaching the stage where its performance in core business areas was sufficiently improved to begin looking towards meeting new challenges.<sup>12</sup> The new challenges for the NMC include responding to the recommendations of the Francis report, and developing plans for revalidation, which it has committed to introduce by the end of 2015.

**11. Over the past year, NMC has had significant performance issues to address; the PSA evidence suggests that it believed the NMC had made progress but that more progress is required before the NMC can be regarded as an effective regulator. In the coming year the NMC will face additional challenges, both in responding to the recommendations of the Francis report, and in preparing to introduce a system of revalidation. The NMC has told us that it believes it is now able to begin to address these new challenges, but the Committee remains concerned that the progress made so far remains fragile and believes it is important that these new challenges do not become a distraction from the continuing requirement to improve its performance of its core functions. We look to the PSA to continue to closely monitor the NMC’s progress, and we shall seek evidence of continuing improvement in the delivery of its core functions at our annual accountability hearing with the NMC in 2014.**

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<sup>9</sup> Professional Standards Authority ([NMC 0011](#)), para 4.2

<sup>10</sup> Oral evidence taken on [9 July 2013](#), HC 528-i, Q70

<sup>11</sup> NMC ([NMC 0001](#)), para 39

<sup>12</sup> Q2

## 3 Fitness to Practise Procedures

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### Progress on clearing backlog of outstanding cases

12. At last year's accountability hearing, we heard that there were 572 Fitness to Practise cases still outstanding that dated from before 2011 – i.e. cases that were over two years old at the time of our report (termed by the NMC as 'historic' cases).<sup>13</sup> The NMC reported to us this year that it had met its target of concluding all these historic cases with the exception of those that were subject to delays that were outside the NMC's control.<sup>14</sup>

13. Although progress has been made in clearing the backlog of pre-2011 cases, there are now 428 pre-2012 cases which are still ongoing.<sup>15</sup>

14. We welcome the fact that the NMC has made progress in eliminating the backlog of Fitness to Practise cases dated from pre-2011 but we are disappointed that, a year on, the number of cases over two years old has only fallen from 572 to 428. It is a matter of concern to the Committee that even now the number of very old cases remains stubbornly high and we look to the NMC to demonstrate that it is able to address and resolve this issue before next year's accountability hearing.

### A total time limit for concluding cases

15. Over the past year the NMC has invested considerable energy and resources in reducing the time taken for it to conclude Fitness to Practise cases. The KPI targets by which its progress in this area is measured are broken down by stage of process. These are that by the end of 2014:

Investigation stage completed within 12 months for 90 per cent of cases

Adjudication stage completed within 6 months for 90 per cent of cases.<sup>16</sup>

16. For 2012-13, 68% of investigations were completed in under 12 months; for July 2013, this figure had improved to 88%. This year the NMC moved its investigations function in-house, and so far report that this has had a positive effect.<sup>17</sup>

17. For 2012-13, 39% of cases were adjudicated in under six months; for August this had increased to 47%. The NMC reports that this is its most challenging target, and argues that "the number is low at the moment because a high proportion of the cases going through the adjudication stage are from the backlog, and are old and complex."<sup>18</sup>

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<sup>13</sup> Health Committee, Ninth Report of Session 2012 – 13, [2012 Accountability Hearing with the Nursing and Midwifery Council](#), March 2013, HC 639, para 33

<sup>14</sup> NMC ([NMC 0016](#)), para 1

<sup>15</sup> NMC ([NMC 0016](#)), para 2

<sup>16</sup> NMC ([NMC 0016](#)), para 3

<sup>17</sup> NMC ([NMC 0001](#)), para 14

<sup>18</sup> NMC ([NMC 0001](#)), para 15

18. The Committee continues to believe that the NMC's current targets relating to the investigation and the adjudication of Fitness to Practise cases are subject to several shortcomings:

- a) They add up to a target of 18 months, which too long;
- b) They only apply to 90% of cases, which means that no individual can know whether they have received proper service because the target does not apply to each individual case.

19. We note from the end of next year, the NMC proposes to toughen the target period for resolving fitness to practise cases to 15 months.<sup>19</sup> We welcome this development and urge the NMC to commit themselves to delivering this objective in every case.

20. The Committee continues to believe that it is essential that NMC targets should clearly express the total length of time a Fitness to Practise case should take from start to finish. We therefore welcome the fact that the NMC has said that, provided it meets its targets for 2014, it will set a 'start to end' target rather than targets for individual stages from 2015 onwards.<sup>20</sup>

### Legislative change to streamline fitness to practise processes

21. During 2012/13 the NMC introduced two initiatives to enable faster resolution of cases. The initiatives are:

- **Consensual panel determinations** – parties agree a statement of facts, an admission that the registrant's fitness to practise is impaired and a proposed sanction. The agreement is then considered by a fitness to practise panel which has complete discretion about whether to accept the proposal or to require a hearing to be held.
- **Voluntary removal from the register** – a nurse or midwife who admits that their fitness to practise is impaired and who does not intend to continue practising can apply to a fitness to practise panel to authorise their removal from the register without a full public hearing of the allegations against them.<sup>21</sup>

22. The PSA reported that these changes "have the potential to significantly affect both public protection and the maintenance of public confidence". It therefore plans to look in detail at the evidence of the impact of these initiatives in next year's performance review, and to review decisions taken using these new powers.<sup>22</sup>

23. In our report last year, we recommended that the Department of Health should amend the Nursing and Midwifery Order to give the NMC the ability to review its own decisions

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<sup>19</sup> NMC ([NMC 0001](#)), para 17

<sup>20</sup> NMC ([NMC 0016](#)), para 3

<sup>21</sup> Professional Standards Authority for Health and Social Care, [Annual Report and Accounts and Performance Review Report 2012 – 2013](#), HC 305-II, pp101–102, para 17.82

<sup>22</sup> Ibid, pp 101 – 102, para 17.82

on cases<sup>23</sup>; we are pleased that in the wake of the Francis report, the Government announced that it would do this. It also announced changes to the NMC legislation which will enable it to employ case examiners from July 2014 to direct investigations and make early stage decisions.<sup>24</sup>

24. The NMC has told us that further significant reductions in the overall length of Fitness to Practise cases will only be achievable if the Law Commission's proposed reforms are enacted and provide a more flexible framework, meaning that the NMC is not legally bound to hold full hearings:

We urgently need changes to our legislation which ties us to an inefficient regulatory model ... We hope the Law Commission review of healthcare regulatory legislation will go further, particularly in giving us the ability to dispose of cases early by requiring undertakings on the part of the registrant. The General Medical Council already has this power and disposes of 65 per cent of cases at the initial assessment stage, whereas we dispose of 40 per cent.<sup>25</sup>

25. The NMC has stated that the introduction of such flexibility should allow it to reduce the overall length of its Fitness to Practise processes to 12 months. It also stated, however, that even if these changes were introduced, it did not believe it was possible to achieve this objective before 2017.<sup>26</sup>

**26. The Committee welcomes the willingness of the NMC to commit itself to a 12 month process. It recommends however that the NMC work with the Department to introduce all the necessary legislative changes no later than the end of 2014, and deliver the resulting process improvements no later than the end of 2015.**

27. Further detail about the other small, but significant legislative changes that the NMC believes would help it to streamline its fitness to practise processes are contained in its supplementary written evidence.<sup>27</sup>

28. A recent High Court ruling is also causing problems for the NMC's Fitness to Practise processes:

In February of this year, a High Court ruling established that the wording of the NMC's current legislation means that nurses or midwives cannot be struck off the register on the grounds of health or lack of competence, unless they have been suspended continuously for two years, through the issuing of a suspension order after a finding of impairment. The midwife in question had been suspended for almost four years, but through interim orders rather than a suspension order after a finding of impairment.

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<sup>23</sup> Health Committee, Ninth Report of Session 2012 – 13, [2012 Accountability Hearing with the Nursing and Midwifery Council](#), March 2013, HC 639, para 43

<sup>24</sup> NMC ([NMC 0001](#)), para 18

<sup>25</sup> NMC ([NMC 0001](#)), para 18

<sup>26</sup> NMC ([NMC 0016](#)), para 3

<sup>27</sup> Correspondence from NMC received 30 September 2013

The judge in the case made a further comment that in his view the wording of the Nursing and Midwifery Order 2001, the basis for the our powers, meant that a finding of lack of competence could never result in striking off.

The NMC's powers to strike off nurses or midwives for misconduct remain unchanged. The terms 'misconduct' and 'lack of competence' have no statutory definition, and in practise there may be a degree of overlap between the two.<sup>28</sup>

29. The NMC has told us that it is currently in discussion with the Department of Health about using a Section 60 order to change legislation to address this issue; meanwhile, the NMC has given assurances that its ability to protect the public is unaffected by this:

Meanwhile, we are dealing with the practical implications of this ruling by advising their Fitness to Practise panels not to make striking off orders on the grounds of health or lack of competence, but instead to make a suspension order. In terms of public protection this will have the same effect, removing the registrant's ability to practise, and the suspension order can be renewed indefinitely on an annual cycle.<sup>29</sup>

30. **The Committee believes that the difficulties caused to the NMC by the High Court ruling in 2013 need to be addressed as a matter of urgency. If the matter cannot be addressed by appealing against the decision, the Committee recommends that the Government should state clearly and quickly how it intends to address the issue.**

## Section 29 Appeals

31. Written evidence from the PSA to this inquiry revealed some confusion about the number of Section 29 appeals that have been made in relation to NMC cases in recent years.<sup>30</sup> The NMC originally stated that there had been no appeals since September 2010; following evidence from the PSA, the NMC has clarified this evidence by stating that there were no successful referrals of NMC decisions under Section 29 between the end of 2010 and the date of their submission to the Committee.<sup>31</sup> Since then, there has been one further appeal against an NMC decision, the outcome of which is awaited.<sup>32</sup>

32. The PSA has highlighted another further gap in the NMC's legal framework. It has told us that once a fitness to practise hearing is concluded, the registrant may 'lapse' from the NMC's register if they have not complied with the requirements for renewing their NMC registration, even if the PSA has lodged a Section 29 appeal against the fitness to practise panel's decision. In the view of the PSA, this "continues to pose a challenge to public protection".<sup>33</sup>

33. **The Committee recommends that the Department of Health work with the NMC and the PSA to close gap in the NMC's legal framework identified by the PSA.**

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<sup>28</sup> NMC ([NMC 0016](#)), para 25

<sup>29</sup> NMC ([NMC 0016](#)), para 25

<sup>30</sup> Professional Standards Authority ([NMC 0011](#)), para 5.1-5.2

<sup>31</sup> NMC ([NMC 0016](#)), para 7

<sup>32</sup> Professional Standards Authority ([NMC 0011](#)), para 5.3

<sup>33</sup> Professional Standards Authority ([NMC 0011](#)), para 5.4

## 4 Management and Governance

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### NMC Accountability

34. Following our last hearing with the NMC, we emphasised the need for leadership stability. We are pleased that there has now been a permanent appointment to the post of Chief Executive, and we note that the current Chair's appointment has been extended until the end of 2014.<sup>34</sup>

35. In May this year, the NMCs Council was reconstituted and the NMC reports that the "new Council is offering appropriate scrutiny and challenge, and demonstrating the skills and appetite for strategic leadership".<sup>35</sup> The PSA reports that "we see improvement in the quality of papers and discussions of the Council and consider that the new council demonstrates a more business-like grip".<sup>36</sup>

36. The PSA Review raised concerns about whether the NMC are monitoring their commitment to public protection:

The NMC has stated that public protection is now central to its approach and that public protection is the 'litmus test' against which all current and proposed work is now measured. However, we are concerned that the NMC has not yet been able to identify measures to assess whether or not that 'test' has been passed.<sup>37</sup>

37. The PSA re-emphasised this in their written evidence:

Whether this is the narrow test of public protection, or the broader test that we advocate, it is essential that assessment measures are swiftly identified by the NMC, if confidence in the organisation and its performance is to grow and be sustained ...in our view, the challenge for the NMC to build and sustain confidence in its regulatory performance remains.<sup>38</sup>

38. Harry Cayton, the PSA's Chief Executive, also told us that the NMC needed to concentrate on quality assurance of its own activities:

It can now do everything it needs to do well, but it cannot do it well all the time and every time. Quality assurance has become the key thing that it needs to do. I know that it has recently appointed people to help it work on quality assurance, but it is exactly the point that you are making. If you do not have good internal measurement of performance, you cannot quality assure performance.<sup>39</sup>

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<sup>34</sup> Q2

<sup>35</sup> NMC ([NMC 0001](#)), para 32

<sup>36</sup> Professional Standards Authority ([NMC 0011](#)), para 2.3

<sup>37</sup> Professional Standards Authority for Health and Social Care, [Annual Report and Accounts and Performance Review Report 2012 – 2013](#), HC 305-II, p85, para 17.4

<sup>38</sup> Professional Standards Authority ([NMC 0011](#)) para 3.3; para 9.2

<sup>39</sup> Oral evidence taken on [9 July 2013](#), HC 528-i, Q73

39. The NMC reported to us that in July of this year, its Council agreed a corporate quality assurance strategy. This sets a goal of fully implementing a performance and quality management framework across the organisation by October 2014.<sup>40</sup>

40. We questioned the NMC specifically about its plans to monitor its own impact on public protection. In response to this, the NMC agreed with the PSA that their next step should be “to be able to measure the difference we make to public protection”:

we need to know the impact of our work as a publicly accountable body and because we need to understand our impact in order to improve as a regulator. Measuring impact is a challenging area for all regulators because it is difficult to isolate the effect of regulation on patient safety from the effects of local policies, employment practises, training, and so on. But we can get better at identifying intermediate measures, such as testing what nurses and midwives understand the code to require of them on a topic, and use that learning to inform improvements.<sup>41</sup>

41. The NMC has a new Council and a permanent Chief Executive has been appointed, giving the organisation more stable leadership. However, questions remain about the NMC’s ability to provide consistent and timely regulation of key clinical professions. Public concern about care standards within these professions has risen in recent times as a result of the Francis Report and other well publicised failures of care. There is an urgent requirement for the NMC to develop both its ability to deliver effective and consistent regulation and to demonstrate that ability to a more sceptical public. Transparent accountability for its own track record should be a high priority for the NMC.

## NMC Fees

42. Last year, we recommended that the NMC should consider adopting a phased payment scheme, to enable registrants to manage the cost of the NMC registration fees more easily.<sup>42</sup> The NMC responded that administrative costs would be too high, but it did commit to reviewing this following implementation of new IT systems.<sup>43</sup> We pressed the NMC witnesses on this point during our evidence session, and they responded that they would consider this as part of their IT strategy.<sup>44</sup> **The simple option of phased payment, which is made available to the customers of most types of organisation, has the potential to make a big difference to nurses and midwives struggling to pay the NMC’s increased fees as an annual lump sum. We do not accept that “IT difficulties” should be allowed to prevent this.**

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<sup>40</sup> NMC ([NMC 0016](#)), para 22

<sup>41</sup> NMC ([NMC 0016](#)), para 6

<sup>42</sup> Health Committee, Ninth Report of Session 2012 – 13, [2012 Accountability Hearing with the Nursing and Midwifery Council](#), March 2013, HC 639, para 77

<sup>43</sup> Health Committee, Third Special Report of Session 2013-14, [Government and NMC Responses to the Committee’s Ninth Report of Session 2012-13](#), HC 581, pp11-12

<sup>44</sup> Qq 85-90

## Financial Controls

43. In our report on last year's accountability hearing, we found that long standing and fundamental flaws in the NMC's financial controls had led to serious financial problems.<sup>45</sup> This year the NMC told us that it had "worked quickly to improve financial management and controls", and that financial models and assumptions had been externally reviewed and endorsed.<sup>46</sup> It gave further detail of internal financial controls:

Directors are now required to complete detailed forecasts on a monthly basis, together with an assessment of progress towards meeting business plan objectives. The monthly management accounts are reviewed at each meeting of the Executive Board, and directors are held to account for the financial performance of their directorate. In the current financial year to date, the projection is that the full year result will be in line with budget ...

Financial resource has been strengthened, particularly in relation to Fitness to Practise which utilises the majority of NMC funds. The activity and financial forecasting for FtP has proved to be robust thus far.<sup>47</sup>

44. Particular concern was expressed in the CHRE's report in 2012 about the failure of the NMC Council to provide effective financial scrutiny. On this point, the NMC report that a detailed financial induction was provided to new Council members, and that comprehensive financial information is now supplied to the Council at their monthly meetings:

Council is provided with a comprehensive financial paper at each Council meeting ... Council members are able to question any point or aspect that they wish in each meeting.

When considering financial strategy and fee levels, Council is provided with comprehensive financial information and a range of appropriate options which detail the impact on available free reserves and therefore the NMC's financial sustainability.

Council is provided with draft budgets and financial analysis during the budget-setting process, to allow sufficient time for consideration of the final budget for approval. This is presented in conjunction with the draft business plans to ensure there is a clear correlation between proposed activity and financial impact.<sup>48</sup>

45. High staff turnover has been a major problem for the NMC, and at our accountability hearing in October 2012, it was reported to have increased to 36%.<sup>49</sup> In its written evidence this year, the NMC described a number of initiatives to manage staff turnover, including an

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<sup>45</sup> Health Committee, Ninth Report of Session 2012 – 13 , [2012 Accountability Hearing with the Nursing and Midwifery Council](#), March 2013, HC 639, paras 52-55

<sup>46</sup> NMC ([NMC 0001](#)), para 34-35

<sup>47</sup> NMC ([NMC 0016](#)), para 16

<sup>48</sup> NMC ([NMC 0016](#)), para 17

<sup>49</sup> Health Committee, Ninth Report of Session 2012 – 13 , [2012 Accountability Hearing with the Nursing and Midwifery Council](#), March 2013, HC 639, para 64

organisational pay and benefits review, investment in staff development, and management training. It states that monthly figures from July to September show a continuous reduction in staff turnover, but it remains high, at 26%.<sup>50</sup>

**46. The NMC has told us that over the past year, it has “worked quickly to improve financial management and controls”, and that the Council are now provided with detailed financial information. However, less progress has been made in improving staff turnover which, although reducing, still remains high, at 26%. We will revisit both of these issues at our next accountability hearing with the NMC.**

**47. At last year’s accountability hearing, IT was identified as a major issue of concern. We were told that as well as addressing immediate problems, the NMC planned to develop a longer term strategy for IT. The Committee understands that the ICT Strategic Plan 2013–16 was considered by the Council on Thursday 21 November. Effective IT underwrites everything the NMC does. The Committee urges the Council to agree and implement a strategy as soon as possible.**

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<sup>50</sup> NMC ([NMC 0001](#)), para 37

## 5 EU Issues

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### Language testing

48. The Committee has expressed concern on several occasions that the inability of UK professional regulators to require care staff in the UK to be able to communicate in English represented a major threat to care standards. The Committee has at the same time stated that this is not a uniquely British interest and that it is an essential requirement of high quality care in all member states that care staff can communicate with their patients in their patients' language.

49. Although the Committee welcomes the fact that this issue is addressed by amendments to the Recognition of Professional Qualifications Directive, the Committee is also concerned that NMC has stated that the amendments may not resolve the issue because the amended Directive stipulates that language controls should take place after the recognition of the professional's qualification, but before access to the profession.<sup>51</sup>

50. This poses a difficulty for the NMC, as for nursing and midwifery (unlike for the medical profession) recognition currently gives an individual immediate access to the NMC register, so they are immediately registered to practise. The NMC has explained that:

When the UK transposes the Directive it would be helpful if the new powers in the resulting UK legislation could enable us to impose language controls after the recognition of the qualification but before registration...We have begun preliminary discussions with the Department of Health on this issue and we look forward to working with them to create legislation that both meets the requirements of EU law and protects patients.<sup>52</sup>

**51. The issue of appropriate language controls for health professionals is important, and the Committee is concerned that it is not being pursued with sufficient urgency. High quality care requires that staff can communicate effectively with patients. The Department of Health must ensure that EU legislation does not prevent this from happening.**

### Other Issues

52. The NMC has supplied us with details of four other areas of concern arising from amendments to the Directive:

- EU Professional Card – concerns about cost impact, and impact on the NMC's ability to impose checks on who enters its register.
- Partial access to the register – potential for the NMC to face legal challenge from a migrant;

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<sup>51</sup> NMC ([NMC 0001](#)), para 27

<sup>52</sup> NMC ([NMC 0016](#)), para 5

- Alert mechanism – significant ICT and resource impact for the NMC associated with informing all other EU regulators of FtP decisions in a condensed timeframe;
- Temporary provision of services – nurses and midwives are able to travel to the UK and provide services on a temporary basis, and the NMC is unable to apply its full registration processes, or require professional indemnity insurance.

53. These concerns are explained more fully in the NMC’s written evidence.<sup>53</sup> The NMC has told us that it is in discussions with the Department of Health about their concerns, and hopes to clarify and mitigate issues as part of the transposition process.<sup>54</sup>

**54. The NMC has raised further concerns arising from amendments to the EU Directive on the recognition of professional qualifications. We have not examined the detail of these concerns in the limited time available to us, but the evidence presented to us by the NMC suggests that they have potentially serious implications for the NMC’s ability to protect the public, and therefore we urge the Department of Health to address these concerns as a priority.**

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<sup>53</sup> NMC ([NMC 0016](#)), para 24

<sup>54</sup> NMC ([NMC 0016](#)), para 24

## 6 The Francis report

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55. In response to a question about the implications of the Francis Report for the NMC, Jackie Smith told us:

I think there are many things that we can do better. We have to work alongside nurse directors. One of the proposals we are making is to have regional officers. We have to work better with the CQC in England, and the system regulators in the other countries too. We need to make better use of our data and we need to identify areas that represent a high risk. All those things will help us identify if there is another Mid Staffs. There is plenty the NMC can do, is doing or is working towards doing.<sup>55</sup>

### Making it easier to raise concerns with the NMC

56. Examining the role played by professional regulators in the continuing poor standards of care at Mid Staffs, Robert Francis summarised the situation as follows:

The NMC's involvement with the Trust and the fitness to practise of its nursing staff was very limited prior to the HCC report. Given what may have been widespread non-compliance with the nursing Code on the part of at least some nurses during the period under review, it is clear that cases which should have been referred to the NMC were not.<sup>56</sup>

57. Francis found deficiencies in channels of communication between the NMC and its stakeholders:

- Stafford demonstrated a lack of referrals by professionals to their regulators when they have concerns.
- The Trust failed to have a proper policy for referring clinicians to professional regulators.
- Patients are often not aware of the existence and procedure for complaining to the NMC and the GMC.<sup>57</sup>

58. Francis concluded that “the NMC has failed properly to define its role or that of its representatives in the NHS”.<sup>58</sup>

59. Francis described the public as “the prime and most valuable source of information about the conduct of nurses”. He went on to recommend that the NMC should ensure that patients and other service users are made aware at the point of service provision of the NMCs existence, role, and contact details.<sup>59</sup>

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<sup>55</sup> Q18

<sup>56</sup> [Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry](#), HC (2012-13) 898 I – III, p1040, para 12.115

<sup>57</sup> *Ibid*, p1011

<sup>58</sup> *Ibid*, p1011

<sup>59</sup> [Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry](#), HC (2012-13) 898 I – III, p1042, para 12.119

60. Helene Donnelly, the A&E nurse who eventually succeeded in raising concerns about standards of nursing care at Mid Staffs, explained to the Francis inquiry why she did not raise concerns with the NMC or other regulators:

I felt that any external bodies would have told me that it was necessary to exhaust internal mechanisms first before they would fully consider my complaint(s).<sup>60</sup>

61. The Royal College of Nursing argued in evidence to this Inquiry that “there is an urgent need for the NMC to engage much more fully with registrants, particularly front line staff, on a four country basis.”<sup>61</sup> Mark Addison reinforced this point in his oral evidence:

One of the striking things for me about Mid Staffs was the number of cases that went through our fitness to practise regime that we ourselves referred rather than them coming from the trust or colleagues there. It is an interesting and concerning point, and we are trying to place a lot more emphasis on encouraging and enabling nurses and midwives to see that part of their responsibility is to alert employers and, if necessary, us to failures of practise out there.<sup>62</sup>

62. In September, the NMC re-launched its guidance *Raising Concerns* to help nurses and midwives seeking to report patient safety incidents. The guidance reminds nurses and midwives of their professional duty to report concerns, and explains the steps to follow to raise a concern within an organisation. The guidance goes on to say that if the internal procedures do not achieve the desired result, complaints should be taken to a regulatory organisation or helpline, and lists the CQC, GMC and HCPC, but not the NMC.<sup>63</sup>

**63. The Committee was surprised by the omission of the NMC’s contact details from their own guidance on raising concerns, and we raised the matter with the NMC in our oral evidence session. We welcome the fact that the NMC has subsequently told us that they plan to amend the guidance to include their contact details. They also plan to add a statement about the different paths for raising concerns about ‘system’ issues and ‘professional’ issues, while making it clear that if a registrant is not sure what are dealing with they should raise the concern anyway.<sup>64</sup>**

64. Often, the decision to refer cases to the NMC whilst internal disciplinary proceedings are ongoing rests with the Trust Director of Nursing, and Francis identified a need for further support to those in this “important and often lonely” role. He recommended that the NMC consider a concept of employment liaison officers, similar to that of the General Medical Council, to provide support to directors of nursing.<sup>65</sup> The NMC accepted this recommendation, and report that they have already started scoping such a role, with plans to pilot “regional advisors” in 2014. These posts will perform a function similar to the GMC’s employer liaison advisers of providing support and guidance locally for employers

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<sup>60</sup> [Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry](#), HC (2012-13) 898 I - III, p1504;

<sup>61</sup> RCN ([NMC 0015](#)), para 7.1

<sup>62</sup> Q18

<sup>63</sup> NMC, [Raising Concerns – Guidance for nurses and midwives](#), NMC, September 2013, pp 20-23, accessed 7 October 2013

<sup>64</sup> NMC ([NMC 0016](#)), para 26

<sup>65</sup> [Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry](#), HC (2012-13) 898 I – III, p1042, para 12.121

and others with concerns about nurses and midwives. The NMC will also be exploring how these roles can support other regulatory functions, including revalidation.<sup>66</sup>

**65. The requirement to raise the awareness of patients about the work of the NMC as well as the awareness of registrants about their professional responsibilities lay behind several of the key recommendations of the Francis Report. The Committee welcomes the steps which the NMC has taken to address these issues, but it agrees with the Chief Executive that more work was needed in this area:**

**I do not think we are at the point where we could say that our visibility is such that members of the public would be aware of what our role is. I think we have a way to go.<sup>67</sup>**

66. We recommend that the NMC develops and introduces a system of monitoring its profile amongst patients, the public, registrants and employers, to evaluate whether it is becoming easier for concerns to be raised with NMC.

### Proactive, preventative regulation

67. Francis concluded that the regulators' role had been "largely reactive" rather than proactive, and noted that the NMC "was not set up as a proactive investigative regulator but one whose principal task was to act on information offered to it, by way of complaint or referral."<sup>68</sup> Francis is clear that in his view, a more proactive response to patient safety needs to be adopted by the professional regulators, stating that the NMC "should not have to wait until a disaster has occurred to intervene".<sup>69</sup> He acknowledges that in order to be more proactive, the NMC would need better access to information held by other regulators, as well as extra capacity, both in terms of finance, data and staffing. He therefore recommends that:

the Nursing and Midwifery Council needs to be equipped to look at systemic concerns as well as individual ones ... The Nursing and Midwifery Council needs to have its own internal capacity to assess systems and launch its own proactive investigations where it becomes aware of concerns which may give rise to nursing fitness to practise issues. It may decide to seek the cooperation of the Care Quality Commission, but as an independent regulator it must be empowered to act on its own if it considers it necessary in the public interest.<sup>70</sup>

68. In its response to Francis, the NMC has committed itself to working better with other regulators to ensure the protection of the public, but rejects the idea that it would ever proactively investigate systemic concerns:

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<sup>66</sup> NMC, [NMC response to the Francis Report](#), (July 2013) p41

<sup>67</sup> Q32

<sup>68</sup> [Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry](#), HC (2012-13) 898 I – III, p 1011; p 1041 para 12.115

<sup>69</sup> *Ibid*, p1041, para 12.116

<sup>70</sup> *Ibid*, p1041, para 12.116

We do not support the recommendation that the NMC should be tasked directly with investigating systems issues. It is important that the distinct roles of professional and systems regulators are understood by all. We do not consider that blurring of the boundaries in the way suggested is likely to lead to better public protection. We do recognise the concerns that led to this suggestion but we believe that the steps being taken by ourselves, the CQC and other regulators to work more closely together to address the most serious issues will provide a better long term solution.<sup>71</sup>

69. In its review of the NMC's performance in June 2011, the CHRE levelled particular criticism at the fact that the NMC had strayed too far from its core functions into activities that were not part of its proper role.<sup>72</sup> The Committee raised this issue with the NMC in 2012<sup>73</sup>; the NMC has since put considerable effort into re-articulating its core functions and values, and ensuring that they lie at the heart of every activity it undertakes.<sup>74</sup>

**70. Against this background the Committee supports the view of the NMC that it should be cautious about extending its role in ways which may overlap with other regulators. As the NMC put it:**

**We think broadly there is a clear distinction between our own focus on individuals and the CQC focus on systems. We have to make sure between us that there are no gaps between the two...<sup>75</sup>**

**71. However the Committee also welcomes the statement of the Chief Executive that:**

**If nurses are seeing a system operating that is impacting on patient safety, we would say that is an issue for us. We try to reflect in the guidance that there are different levels of concerns and we hope that the vast majority that a nurse or a midwife encounters can be resolved locally; where they cannot and patients are being put at risk, it is a regulatory matter.<sup>76</sup>**

## Staffing levels

72. The issue of nursing staffing levels provides a key example of this. The Francis report found that at Mid Staffs, shortage of skilled nursing staff contributed to the “completely inadequate standard of nursing” which was provided on some wards.<sup>77</sup> While stating unequivocally that it is not their role to determine safe staffing levels, the NMC was clear in its evidence to us that:

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<sup>71</sup> NMC, [NMC response to the Francis Report](#), (July 2013), p39

<sup>72</sup> Health Committee, Ninth Report of Session 2012 – 13, [2012 Accountability Hearing with the Nursing and Midwifery Council](#), March 2013, HC 639, para 22

<sup>73</sup> Health Committee, Ninth Report of Session 2012 – 13, [2012 Accountability Hearing with the Nursing and Midwifery Council](#), March 2013, HC 639, para 22 - 26

<sup>74</sup> Health Committee, Third Special Report of Session 2013-14, [Government and NMC Responses to the Committee's Ninth Report of Session 2012-13](#), HC 581, pp 4 - 5

<sup>75</sup> Q42

<sup>76</sup> Q34

<sup>77</sup> [Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive Summary](#), HC (2012-13) 947, p45, para 1.14

If staffing levels impact on public protection and patient safety, then clearly there is an issue that we need to be concerned about ... If they find there are circumstances, whatever they may be—whether they are resource driven or something else—where they cannot comply with the code, then they have an obligation to raise it.<sup>78</sup>

73. The NMC agreed that, in situations where patient safety was compromised, it would not be a valid defence “for a nurse, a doctor or any other registered professional to say, “The staffing here was inadequate,” if they knew the facts and did not raise the concern before the event”.<sup>79</sup> This is borne out by the fact that the NMC has recently issued a 5-year caution to Jan Harry, a former chief nurse at Mid Staffs, who was found guilty by a fitness to practise panel of putting patients in danger by failing to ensure there were adequate staffing levels on wards at the hospital.<sup>80</sup>

74. The Committee agrees with the NMC that determining and monitoring staffing levels are not a direct responsibility of NMC. However, the Committee also agrees with the NMC finding in a recent case that individual registrants, particularly nursing leaders, who have concerns about staffing levels at their place of work are under a professional obligation to raise these concerns in the appropriate manner. We recommend that the NMC take specific steps to ensure that the implications of the findings of this Fitness to Practise case are drawn to the attention of all registrants.

## Collaboration with other regulators

75. Francis pointed out that the NMC only found out about the Healthcare Commission’s investigation into Mid Staffs (which began in 2008) two weeks before the publication of its report.<sup>81</sup> In the section of their written evidence addressing the Francis report, the NMC state that it has revised its memorandum of understanding with the CQC and will have new protocols for information sharing and joint work by the end of 2013. It plans to extend this work to other UK regulators in 2014.<sup>82</sup> However, in oral evidence to the Committee in July, Harry Cayton of the PSA argued that memoranda of understanding between organisations were not sufficient:

The real meat of good co-operation lies at the level of case managers and staff teams. It does not matter how many memorandums of agreement are signed by chief executives; the real issue is, is the person who is looking at a Mid Staffordshire case at CQC thinking, “I must inform the NMC about that,” and is the NMC capable of acting on that information? [...] we are continuing to discuss with them how you can use what you might call soft intelligence to build a harder picture of where you need to intervene.<sup>83</sup>

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<sup>78</sup> Q49, Q52

<sup>79</sup> Q43

<sup>80</sup> [“Former Mid Staffs chief nurse given caution by NMC”](#), The Nursing Times, 8 November 2013

<sup>81</sup> [Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry](#), HC (2012-13) 898 I – III, p 1040, para 12.111

<sup>82</sup> NMC ([NMC 0001](#)), para 5.4

<sup>83</sup> Oral evidence taken on [9 July 2013](#), HC 528-i, Q40

76. In oral evidence, the NMC told us that it was now engaging far better with the CQC, including participating in joint visits to hospitals which are on the Keogh list<sup>84</sup>, and had “daily contact” with CQC staff.<sup>85</sup>

### A unique source of information

77. The information which comes to the NMC about the performance of individual registrants, and in particular about potential and actual failures of care, provides the NMC with a unique opportunity to identify common themes and patterns of behaviour which put care standards at risk.

78. When we asked Mr Addison about how the NMC planned to make use of this opportunity he responded as follows:

It is a big question for the NMC. It is a big question for all the regulators, but it is a big question for us. It is fair to say that we have lagged behind some of our fellow regulators in taking that seriously. We do have access to information and intelligence, and we can commission focused work to bolster that intelligence. We have not done a lot of that in the past.<sup>86</sup>

79. He also, however, sounded a note of caution:

We will probably go rather more carefully and modestly initially around developing proactive capability simply because we are an organisation coming out of a troubled and challenged past and we do not want to start taking on remits and setting targets we think we might not be able to meet. We have been very clear that we are only going to adopt ambitions if we are confident they can be delivered.<sup>87</sup>

**80. The Committee recommends that the NMC should develop its capacity to provide an annual commentary, drawing out themes and trends, and highlighting learning points. The intelligence the NMC gathers in the course of its work should be used not only to enhance its own processes, but also to inform policy making more widely.**

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<sup>84</sup> Q42

<sup>85</sup> Q41

<sup>86</sup> Q60

<sup>87</sup> Q42

## 7 Revalidation

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81. The Committee discussed revalidation with the NMC at last year's hearing, and expressed concern at the "little progress" that had been made since the 2011 accountability hearing, stating that "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."<sup>88</sup>

82. Robert Francis has now added his voice to those calling for nursing and midwifery revalidation, arguing that: "professional development is always vulnerable to being treated as a burdensome formality, and subject to reduction in availability through the pressure of increasingly scarce resources."<sup>89</sup> In his view, revalidation should be introduced "as a means of reinforcing the status and competence of registered nurses, as well as providing additional protection to the public."<sup>90</sup>

83. The NMC has adopted an approach to revalidation which they say can be introduced within their current legislation, within the specified timescale to December 2015, and which is affordable within their current resources.<sup>91</sup> The approach involves linking the NMC's existing system of 3-yearly renewal of registration with employers' annual appraisals. Under the revalidation model the NMC has chosen to implement:

All nurses and midwives on the register will be required to revalidate, every three years at the point of their renewal (three yearly renewal is fixed in the NMC's legislation).

The nurses and the midwives will provide a self-confirmation to the NMC at the point of their renewal that they remain fit to practise, they have reflected on the enhanced Code and standards and continue to adhere to them.

Their continuing fitness to practise will need to be confirmed by a third party. In most cases and where applicable, this third party confirmation will come from employers. Registrants will also need to provide evidence that their self declaration is supported by feedback from colleagues and patients/users.

The NMC will perform an audit which will select nurses and midwives throughout the year to assess the validity of the information provided for revalidation. The audit will be a mix of random sample and risk based sample. The risk-based selection will be informed not only by our own evidence but also on risk intelligence we have received from other regulators. Summary audit results will be made available in the public domain.

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<sup>88</sup> Health Committee, Ninth Report of Session 2012 – 13, [2012 Accountability Hearing with the Nursing and Midwifery Council](#), March 2013, HC 639, p 22, para 82

<sup>89</sup> [Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry](#), HC (2012-13) 898 I – III, p 1517, para 23.63

<sup>90</sup> [Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry](#), HC (2012-13) 898 I – III, p 1041, para 12.118

<sup>91</sup> NMC ([NMC 0001](#)), para 20

Revalidation will be based upon a reviewed and revised Code, and standards will define the criteria that nurses and midwives will be required to demonstrate in order to remain on the register.<sup>92</sup>

84. The NMC state that the total costs for the development of the revalidation system will be £4.413 million, and the annual running costs thereafter will be approximately £1 million.<sup>93</sup>

85. The Nursing Times has estimated that the running costs of the NMC's proposed revalidation system are equivalent to about £1.50 per registrant, in comparison with the General Medical Council, which spends just over £6 a year for every doctor who is subject to revalidation. They report criticism of this imbalance:

Royal College of Nursing head of policy Howard Catton told Nursing Times questions still remained over the funding of the new system. He said: "They are two different systems so we wouldn't expect the funding per head to be exactly the same, but I think this level of difference raises questions of parity." He said the RCN would be looking to see that gap closed to ensure nurses were supported in completing their continuing professional development and the profession received a fairer share of the funding available for post-registration education.

Peter Griffiths, chair of health services research at the University of Southampton, warned the potential for a nurse to be revalidated without any professional involvement undermined the principle of professional regulation. He told Nursing Times that although the requirement to get sign off was an improvement on the current system, there was a risk the new system could become a "fairly bureaucratic exercise". "There's a real danger that the resource isn't enough to do anything that's really worth doing," he said.<sup>94</sup>

86. The Royal College of Nursing also voiced its concerns about the comparatively lower levels of funding currently proposed by the NMC, arguing that "revalidation cannot impose further financial hardship on nurses."<sup>95</sup> The RCN emphasised the importance of the role of employers in revalidation, pointing out the risk involved in a model which "relies upon action by organisations and individuals over which it has no regulatory authority or remit". It also argued that "at present the quality and provision of appraisals for nurses and midwives is not consistent", and that it was therefore very important for the NMC to work closely with employers to ensure consistency.<sup>96</sup>

87. In its paper setting out options for revalidation, the NMC highlighted the following risks and issues associated with its chosen option:

Perception that the NMC model of revalidation is not robust given that it does not include Responsible Officers as the GMC.

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<sup>92</sup> Correspondence from NMC received 25 September 2013

<sup>93</sup> NMC Council papers, [Annex 2 Options Appraisal](#) (12 September 2013) para 10.10; 11.9

<sup>94</sup> "[Revalidation risks becoming 'bureaucratic burden'](#)", Nursing Times, 11 September 2013

<sup>95</sup> RCN ([NMC 0015](#)), para 5.6

<sup>96</sup> RCN ([NMC 0015](#)), para 5.8 – 5.10

Difficulty in seeking third party input from the employers (where applicable) due to lack of appraisals, inconsistent appraisal systems and lack of buy-in from employers.

Inconsistency in the quality of third party input.

Revalidation not being fit for purpose due to the great diversity of NMC register, great size and complexity in settings and scope of practise.

Cost to the wider healthcare system as a result of time taken to seek and provide confirmation.

Cost to NMC and the system as fewer nurses and midwives will be available to work if a significant number of nurses and midwives lapse as a result of the introduction of revalidation.<sup>97</sup>

88. In their written evidence to this inquiry, the PSA expressed serious concerns about the robustness of the NMC's planned approach:

We were concerned on reading the NMC's proposal that it lacks a robust evidence base in particular around risk ... we would like to see a risk profile of the register, to help readers understand how they developed the options put before their Council, and why the preferred option was seen to be most fit for purpose. It is likely that different groups on the NMC register present different types and levels of risk and it may be that a range of mechanisms, varying in the levels of assurance they provide, might enable them to focus more of their resources where the risk is greatest.

... the risks to public protection have not been identified, evaluated or quantified. Further questions arise in relation to the proposals' ability to deliver all three purposes, as we feel they do not address the following scenarios:

The registrant fails to engage with revalidation

The registrant engages but does not meet the standards

Concerns about conduct and/or competence are identified and meet the threshold for referral to the fitness to practise process.<sup>98</sup>

89. The PSA also raised the following questions:

What will be the criteria for revalidation? The content of the Code and standards and how they are applied as revalidation criteria will be crucial to the success of the scheme. As highlighted in our Performance Review, the NMC accepts that the current Prep standards are not fit for the purpose of assuring continuing fitness to practise

Will all nurses and midwives be in a position to meet the requirements for appraisals as the main method of third party confirmation of continuing fitness to practise, practically speaking, regardless of where or how they are employed?

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<sup>97</sup> NMC Council papers, [Annex 1 – Revalidation Strategy](#) (12 September 2013) para 33

<sup>98</sup> Professional Standards Authority ([NMC 0011](#)), paras 6.3 – 6.5

Why is the revalidation cycle three years when the GMC's cycle, with a profession that is arguably of higher risk, is two years longer?<sup>99</sup>

90. We discussed a number of these issues with the NMC. Jackie Smith told us that she was aware of concerns about the current quality of the appraisal process, but argued that that was not sufficient reason not to implement revalidation – indeed it made the need for revalidation more pressing:

I know that there is a view that appraisal is not consistent, that it is patchy, but that is not a reason not to do revalidation: it is a reason to do it.<sup>100</sup>

91. With regard to the costs of implementing this system, we were told that initial costs for the NMC were affordable, but that the more significant costs of revalidation would fall on employers; however the NMC was clear that additional costs associated with revalidation would not be borne by registrants.<sup>101</sup>

92. The NMC's plans for revalidation still appear to be at a relatively early stage, and we were told that different elements of them have yet to be "road tested".<sup>102</sup>

93. In their written evidence the NMC sets out the many different programmes of work which will need to feed into the revalidation system before it is introduced at the end of 2015:

An internal NMC programme board has oversight of projects that contribute to revalidation including code/standards review, revalidation communications, IT development, renewal process, audit process, evidence and evaluation. The revised code and Standards are due to be published in December 2014.<sup>103</sup>

94. Discussing the planned start date for revalidation at the end of December 2015, Mark Addison gave us his frank assessment that "there is a huge amount to do in order to get to that point".<sup>104</sup>

95. A crucial element of the NMC's revalidation proposals is the audit process that will be conducted on a sample of revalidations. It is expected that they will use a combination of random selection and targeted selection to form their audit sample. Jackie Smith told us that in deciding how to target this audit they already have many different types of information at their disposal, so they are not starting from "a zero base".<sup>105</sup> However, Mark Addison was clear that a great deal still remains to be resolved:

The bigger issues with the audit approach are, "Will we have our risk framework sufficiently developed at the point of launch? Will we have been able to invest enough in it and have we got a clear enough idea of how the sample frame should be

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<sup>99</sup> Professional Standards Authority ([NMC 0011](#)), para 6.7

<sup>100</sup> Q63

<sup>101</sup> Q76-77

<sup>102</sup> Q 72

<sup>103</sup> Correspondence from NMC received 25 September 2013

<sup>104</sup> Q74

<sup>105</sup> Q78

drawn?” Secondly, “How big a sample should it be and how much will that cost?” A lot of the cost of this exercise for us will be driven by the size of the audit sample, and the bigger the audit sample the more reliable and effective it will be. There will be a balancing act that the council has to undertake in order to determine what scale of audit to embark on.<sup>106</sup>

96. Although the Committee welcomes the commitment of the NMC to introduce revalidation for nurses and midwives from the end of 2015, it does not believe the NMC yet has a workable plan to deliver this commitment.

97. The Committee will seek further assurance on the development and delivery of the NMC’s plans for revalidation, and we recommend that the NMC publish regular updates on the timescales for different projects relating to revalidation on its website, as well as updates on lessons learned from piloting of this model. In particular, the NMC’s approach to analysing risk, and to how its audit of revalidation will be conducted, is a key element of the revalidation process which has not yet been set out in detail.

98. As part of this process of regular updates, the Committee will seek an update on progress on this project at the end of the first quarter of 2014, which it will publish.

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<sup>106</sup> Q81

# Conclusions and recommendations

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## Background and overview

1. Over the past year, NMC has had significant performance issues to address; the PSA evidence suggests that it believed the NMC had made progress but that more progress is required before the NMC can be regarded as an effective regulator. In the coming year the NMC will face additional challenges, both in responding to the recommendations of the Francis report, and in preparing to introduce a system of revalidation. The NMC has told us that it believes it is now able to begin to address these new challenges, but the Committee remains concerned that the progress made so far remains fragile and believes it is important that these new challenges do not become a distraction from the continuing requirement to improve its performance of its core functions. We look to the PSA to continue to closely monitor the NMC's progress, and we shall seek evidence of continuing improvement in the delivery of its core functions at our annual accountability hearing with the NMC in 2014. (Paragraph 11)

## Progress on clearing backlog of outstanding cases

2. We welcome the fact that the NMC has made progress in eliminating the backlog of Fitness to Practise cases dated from pre-2011 but we are disappointed that, a year on, the number of cases over two years old has only fallen from 572 to 428. It is a matter of concern to the Committee that even now the number of very old cases remains stubbornly high and we look to the NMC to demonstrate that it is able to address and resolve this issue before next year's accountability hearing. (Paragraph 14)

## A total time limit for concluding cases

3. The Committee continues to believe that the NMC's current targets relating to the investigation and the adjudication of Fitness to Practise cases are subject to several shortcomings:
  - a) They add up to a target of 18 months, which too long;
  - b) They only apply to 90% of cases, which means that no individual can know whether they have received proper service because the target does not apply to each individual case. (Paragraph 18)
4. We note from the end of next year, the NMC proposes to toughen the target period for resolving fitness to practise cases to 15 months. We welcome this development and urge the NMC to commit themselves to delivering this objective in every case. (Paragraph 19)
5. The Committee continues to believe that it is essential that NMC targets should clearly express the total length of time a Fitness to Practise case should take from start to finish. We therefore welcome the fact that the NMC has said that, provided it

meets its targets for 2014, it will set a 'start to end' target rather than targets for individual stages from 2015 onwards. (Paragraph 20)

### **Legislative change to streamline fitness to practise processes**

6. The Committee welcomes the willingness of the NMC to commit itself to a 12 month process. It recommends however that the NMC work with the Department to introduce all the necessary legislative changes no later than the end of 2014, and deliver the resulting process improvements no later than the end of 2015. (Paragraph 26)
7. The Committee believes that the difficulties caused to the NMC by the High Court ruling in 2013 need to be addressed as a matter of urgency. If the matter cannot be addressed by appealing against the decision, the Committee recommends that the Government should state clearly and quickly how it intends to address the issue. (Paragraph 30)

### **Section 29 Appeals**

8. The Committee recommends that the Department of Health work with the NMC and the PSA to close gap in the NMC's legal framework identified by the PSA. (Paragraph 33)

### **NMC Accountability**

9. The NMC has a new Council and a permanent Chief Executive has been appointed, giving the organisation more stable leadership. However, questions remain about the NMC's ability to provide consistent and timely regulation of key clinical professions. Public concern about care standards within these professions has risen in recent times as a result of the Francis Report and other well publicised failures of care. There is an urgent requirement for the NMC to develop both its ability to deliver effective and consistent regulation and to demonstrate that ability to a more sceptical public. Transparent accountability for its own track record should be a high priority for the NMC. (Paragraph 41)

### **NMC Fees**

10. The simple option of phased payment, which is made available to the customers of most types of organisation, has the potential to make a big difference to nurses and midwives struggling to pay the NMC's increased fees as an annual lump sum. We do not accept that "IT difficulties" should be allowed to prevent this. (Paragraph 42)

### **Financial Controls**

11. The NMC has told us that over the past year, it has "worked quickly to improve financial management and controls", and that the Council are now provided with detailed financial information. However, less progress has been made in improving staff turnover which, although reducing, still remains high, at 26%. We will revisit both of these issues at our next accountability hearing with the NMC. (Paragraph 46)

12. At last year's accountability hearing, IT was identified as a major issue of concern. We were told that as well as addressing immediate problems, the NMC planned to develop a longer term strategy for IT. The Committee understands that the ICT Strategic Plan 2013–16 was considered by the Council on Thursday 21 November. Effective IT underwrites everything the NMC does. The Committee urges the Council to agree and implement a strategy as soon as possible. (Paragraph 47)

### Language testing

13. The issue of appropriate language controls for health professionals is important, and the Committee is concerned that it is not being pursued with sufficient urgency. High quality care requires that staff can communicate effectively with patients. The Department of Health must ensure that EU legislation does not prevent this from happening. (Paragraph 51)

### Other Issues

14. The NMC has raised further concerns arising from amendments to the EU Directive on the recognition of professional qualifications. We have not examined the detail of these concerns in the limited time available to us, but the evidence presented to us by the NMC suggests that they have potentially serious implications for the NMC's ability to protect the public, and therefore we urge the Department of Health to address these concerns as a priority. (Paragraph 54)

### Making it easier to raise concerns with the NMC

15. The Committee was surprised by the omission of the NMC's contact details from their own guidance on raising concerns, and we raised the matter with the NMC in our oral evidence session. We welcome the fact that the NMC has subsequently told us that they plan to amend the guidance to include their contact details. They also plan to add a statement about the different paths for raising concerns about 'system' issues and 'professional issues', while making it clear that if a registrant is not sure what are dealing with they should raise the concern anyway. (Paragraph 63)
16. The requirement to raise the awareness of patients about the work of the NMC as well as the awareness of registrants about their professional responsibilities lay behind several of the key recommendations of the Francis Report. The Committee welcomes the steps which the NMC has taken to address these issues, but it agrees with the Chief Executive that more work was needed in this area:

I do not think we are at the point where we could say that our visibility is such that members of the public would be aware of what our role is. I think we have a way to go. (Paragraph 65)

17. We recommend that the NMC develops and introduces a system of monitoring its profile amongst patients, the public, registrants and employers, to evaluate whether it is becoming easier for concerns to be raised with NMC. (Paragraph 66)

## Proactive, preventative regulation

18. Against this background the Committee supports the view of the NMC that it should be cautious about extending its role in ways which may overlap with other regulators. As the NMC put it:

We think broadly there is a clear distinction between our own focus on individuals and the CQC focus on systems. We have to make sure between us that there are no gaps between the two... (Paragraph 70)

19. However the Committee also welcomes the statement of the Chief Executive that:

If nurses are seeing a system operating that is impacting on patient safety, we would say that is an issue for us. We try to reflect in the guidance that there are different levels of concerns and we hope that the vast majority that a nurse or a midwife encounters can be resolved locally; where they cannot and patients are being put at risk, it is a regulatory matter. (Paragraph 71)

## Staffing levels

20. The Committee agrees with the NMC that determining and monitoring staffing levels are not a direct responsibility of NMC. However, the Committee also agrees with the NMC finding in a recent case that individual registrants, particularly nursing leaders, who have concerns about staffing levels at their place of work are under a professional obligation to raise these concerns in the appropriate manner. We recommend that the NMC take specific steps to ensure that the implications of the findings of this Fitness to Practise case are drawn to the attention of all registrants. (Paragraph 74)

## A unique source of information

21. The Committee recommends that the NMC should develop its capacity to provide an annual commentary, drawing out themes and trends, and highlighting learning points. The intelligence the NMC gathers in the course of its work should be used not only to enhance its own processes, but also to inform policy making more widely. (Paragraph 80)

## Revalidation

22. Although the Committee welcomes the commitment of the NMC to introduce revalidation for nurses and midwives from the end of 2015, it does not believe the NMC yet has a workable plan to deliver this commitment. (Paragraph 96)
23. The Committee will seek further assurance on the development and delivery of the NMC's plans for revalidation, and we recommend that the NMC publish regular updates on the timescales for different projects relating to revalidation on its website, as well as updates on lessons learned from piloting of this model. In particular, the NMC's approach to analysing risk, and to how its audit of revalidation will be conducted, is a key element of the revalidation process which has not yet been set out in detail. (Paragraph 97)

24. As part of this process of regular updates, the Committee will seek an update on progress on this project at the end of the first quarter of 2014, which it will publish. (Paragraph 98)

## Annex A: recommendations arising from the 2012 hearing

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Following last year's hearing, the Committee published a report in March 2013.<sup>107</sup> Its key recommendations included:

- a) **Powers to review** – the Committee concluded that the NMC's inability to review its own initial decisions was a significant gap in its powers, and recommended that the Department of Health amend the Nursing and Midwifery Order to rectify this.
- b) **Leadership** – the Committee recommended that ministers should work with the Chair and Board of the NMC to ensure that the organisation benefits from a period of management consistency.
- c) **Language testing** – the Committee concluded that it was vital that the Department of Health support the NMC in developing a more immediate solution.
- d) **Fitness to practise** – the Committee recommended that:
  - the NMC work to reduce the total time it takes to investigate a complaint towards an average target of 9 months as a matter of urgency.
  - the NMC set an additional KPI determining the maximum acceptable time to determine an FTP case.
  - The NMC clear all cases which have been outstanding for more than two years by 30 June 2013.
  - 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 the timeliness of its decisions.
  - The NMC should consider introducing a phased payment system for registrants.

The Committee also decided to follow up on the following areas at this year's accountability hearing:

- The impact of the NMC's decision to bring Fitness to Practise investigations in-house;

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<sup>107</sup> Ninth Report of the Health Committee, Session 2012 – 13, 2012 *Accountability Hearing with the Nursing and Midwifery Council*, March 2013, HC 639

- The effectiveness of steps being taken to address long-standing and fundamental flaws in the NMC's financial planning;
- Whether the Council and its review groups are benefitting from the delivery of better data and are able to scrutinise and challenge management information with greater effect;
- Whether the IT systems have been stabilised, whether there is a long-term plan in place to improve the IT infrastructure, and whether existing IT systems are finally allowing staff to complete crucial tasks accurately and efficiently;
- Whether there has been a substantial improvement in workplace culture evidenced by a significant reduction in staff turnover; and
- Whether the NMC is able to provide a plan for roll-out of revalidation, detailing the timeframes involved and the high risk groups that will be targeted early in the process.

# Formal Minutes

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**Tuesday 3 December 2013**

Members present:

Mr Stephen Dorrell, in the Chair

Rosie Cooper  
Barbara Keeley  
Grahame M. Morris

Andrew Percy  
David Tredinnick

Draft Report (*2013 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 98 read and agreed to.

Annex agreed to.

Summary agreed to.

*Resolved*, That the Report be the Fifth Report of the Committee to the House.

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

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

Written evidence was ordered to be reported to the House for publishing on the Internet.

[Adjourned till Tuesday 10 December at 2.00 pm]

## Witnesses

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**Tuesday 8 October 2013**

*Question number*

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

[Qq 1–100](#)

## Published written evidence

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The following written evidence was received and can be viewed on the committee's inquiry web page at [www.parliament.uk/healthcom](http://www.parliament.uk/healthcom)

- 1 Nursing and Midwifery Council ([NMC 0001](#))
- 2 Professional Standards Authority for Health and Social Care ([NMC 0011](#))
- 3 Brenda Van Der Kooy ([NMC 0013](#))
- 4 Royal College of Nursing ([NMC 0015](#))
- 5 Nursing and Midwifery Council ([NMC 0016](#))

## Unpublished evidence

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The following written evidence has been reported to the House and copies have been placed in the House of Commons Library, where they may be inspected by Members. Other copies are in the Parliamentary Archives ([www.parliament.uk/archives](http://www.parliament.uk/archives)), and are available to the public for inspection. Requests for inspection should be addressed to The Parliamentary Archives, Houses of Parliament, London SW1A 0PW (tel. 020 7219 3074; email [archives@parliament.uk](mailto:archives@parliament.uk)). Opening hours are from 9.30 am to 5.00 pm on Mondays to Fridays.

Rebecca Reed  
Simin Shomalzadeh  
Mrs Daphne Havercroft  
Mrs Janet M Howell  
Caroline Flint  
Association of Radical Midwives  
Sarah Davies  
Clare Fisher

## List of Reports from the Committee during the current Parliament

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

### Session 2013–14

First Special Report	2012 accountability hearing with the Care Quality Commission: Government and Care Quality Commission Responses to the Committee's Seventh Report of Session 2012–13	HC 154
Second Special Report	2012 accountability hearing with Monitor: Government and Monitor Responses to the Committee's Tenth Report of Session 2012–13	HC 172
Third Special Report	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	HC 581
First Report	Post-legislative scrutiny of the Mental Health Act 2007	HC 584 (Cm 8735)
Second Report	Urgent and emergency services	HC 171 (Cm 8708)
Third Report	After Francis: making a difference	HC 657
Fourth Report	Appointment of the Chair of Monitor	HC 744

### Session 2012–13

First Report	Education, training and workforce planning	HC 6-I (Cm 8435)
Second Report	PIP breast implants: web forum on patient experiences	HC 435
Third Report	Government's Alcohol Strategy	HC 132 (Cm 8439)
Fourth Report	2012 accountability hearing with the General Medical Council	HC 566 (Cm 8520)
Fifth Report	Appointment of the Chair of the Care Quality Commission	HC 807
Sixth Report	Appointment of the Chair of the National Institute for Health and Care Excellence	HC 831
Seventh Report	2012 accountability hearing with the Care Quality Commission	HC 592
Eighth Report	National Institute for Health and Clinical Excellence	HC 782
Ninth Report	2012 accountability hearing with the Nursing and Midwifery Council	HC 639
Tenth Report	2012 accountability hearing with Monitor	HC 652
Eleventh Report	Public expenditure on health and care services	HC 651 (Cm 8624)

### Session 2010–12

First Report	Appointment of the Chair of the Care Quality Commission	HC 461-I
Second Report	Public Expenditure	HC 512 (Cm 8007)

Third Report	Commissioning	HC 513 (Cm 8009)
Fourth Report	Revalidation of Doctors	HC 557 (Cm 8028)
Fifth Report	Commissioning: further issues	HC 796 (Cm 8100)
First Special Report	Revalidation of Doctors: General Medical Council's Response to the Committee's Fourth Report of Session 2010–11	HC 1033
Sixth Report	Complaints and Litigation	HC 786 (Cm 8180)
Seventh Report	Annual accountability hearing with the Nursing and Midwifery Council	HC 1428 (HC 1699)
Eighth Report	Annual accountability hearing with the General Medical Council	HC 1429 (HC 1699)
Ninth Report	Annual accountability hearing with the Care Quality Commission	HC 1430 (HC 1699)
Tenth Report	Annual accountability hearing with Monitor	HC 1431 (HC 1699)
Eleventh Report	Appointment of the Chair of the NHS Commissioning Board	HC 1562-I
Twelfth Report	Public Health	HC 1048-I (Cm 8290)
Thirteenth Report	Public Expenditure	HC 1499 (Cm 8283)
Fourteenth Report	Social Care	HC 1583-I (Cm 8380)
Fifteenth Report	Annual accountability hearings: responses and further issues	HC 1699
Sixteenth Report	PIP Breast implants and regulation of cosmetic interventions	HC 1816 (Cm 8351)