

Meeting of the Council

To be held from 09:30am on Wednesday 25 July 2018
at 23 Portland Place, London, W1B 1PZ

Agenda

Philip Graf
Chair

Fionnuala Gill
Secretary

- | | | | |
|----------|--|-----------|--------------|
| 1 | Welcome and Chair's opening remarks | NMC/18/50 | 09:30 |
| 2 | Apologies for absence | NMC/18/51 | |
| 3 | Declarations of interest | NMC/18/52 | |
| 4 | Minutes of the previous meeting | NMC/18/53 | |
| | Chair | | |
| 5 | Summary of actions | NMC/18/54 | |
| | Secretary | | |
| 6 | Chief Executive's report | NMC/18/55 | 09:40 |

Matters for decision

- | | | | |
|----------|--|-----------|-------|
| 7 | Lessons Learned - report back | NMC/18/56 | 09:50 |
| | Director of Registration and Revalidation | | |
| 8 | Gosport Independent Panel report | NMC/18/57 | 10:25 |
| | Director of Registration and Revalidation | | |
| 9 | A new strategic direction for fitness to practise | NMC/18/58 | 10:40 |
| | Director of Fitness to Practise | | |

10	Education	NMC/18/59	11:10
	10a. Review of Return to Practice standards		
	10b. Standards for Medicines Management		
	Director of Education and Standards		
	Coffee		11:30–11:45
Matters for discussion			
11	Overseas review update	NMC/18/60	11:45
	Director of Registration and Revalidation		
12	Update on the consultation on registration fees for nursing associates	NMC/18/61	12:00
	Director of Education and Standards		
13	Midwifery update	NMC/18/62	12:15
	Director of Education and Standards		
14	PSA's Annual Performance Report 2016–2017	NMC/18/63	12:25
	Director of Registration and Revalidation		
15	Questions from observers	NMC/18/64	12:40
	Chair of the Council	(Oral)	
	Lunch		12:55–13:35
16	Audit Committee Annual Report 2017–2018	NMC/18/65	13:35
	Chair of Audit Committee		
17	Annual Report and Accounts 2017–2018	NMC/18/66	13:45
	AD Governance/Interim Director of Resources	(see separate pack)	
18	Annual Fitness to Practise Report 2017–2018	NMC/18/67	14:00
	Director of Fitness to Practise	(see separate pack)	

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| 19 | Annual Revalidation Report 2017–2018 | NMC/18/68 | 14:30 |
| | Director of Registration and Revalidation | | |
| 20 | Appointments Board Annual Report 2017–2018 | NMC/18/69 | 14:50 |
| | Chair of the Appointments Board | | |

Corporate reporting

- | | | | |
|-----------|---|-----------|-------|
| 21 | Performance, risk and financial report | NMC/18/70 | 15:00 |
| | Interim Director of Resources | | |

Matters for information

Matters for information will normally be taken without discussion. Members should notify the Chair or the Secretary to the Council in advance of the meeting should they wish for any item to be opened for discussion.

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| 22 | Chair’s action taken since the last meeting | NMC/18/71 | |
| | Chair of the Council | | |
| 23 | Questions from observers | NMC/18/72 | 15:25 |
| | Chair of the Council | (Oral) | |

Meeting of the Council
Held on 6 June 2018 at 23 Portland Place, London, W1B 1PZ

Minutes

Present

Members:

Philip Graf	Chair
Sir Hugh Bayley	Member
Robert Parry	Member
Marta Phillips	Member
Stephen Thornton	Member
Lorna Tinsley	Member
Ruth Walker	Member
Anne Wright	Member

NMC Officers:

Jackie Smith	Chief Executive and Registrar
Emma Broadbent	Director of Registration and Revalidation
Sarah Daniels	Director of People and Organisational Development
Matthew McClelland	Director of Fitness to Practise
Gary Walker	Interim Director of Resources
Geraldine Walters	Director of Education and Standards
Edward Welsh	Director of External Affairs
Clare Padley	General Counsel
Alison Neyle	Strategic Adviser
Fionnuala Gill	Secretary to the Council
Pernilla White	Governance and Committee Manager

Minutes

NMC/18/39 Welcome and Chair's opening remarks

1. At the start of the meeting, the Chair apologised unreservedly on behalf of the Council and staff to the families affected by the NMC's failings. Everyone at the NMC deeply regretted the traumatic impact and distress caused to the families by what the NMC had done and what it had failed to do.
2. The Chair welcomed all attendees, including Edward Welsh, Director of External Affairs, attending his first meeting. Anne Wright, Vice-Chair, welcomed the Chair to his first meeting on behalf of Council members.

NMC/18/40 Apologies for absence

1. Apologies had been received from Karen Cox; Maura Devlin; and Derek Pretty.

NMC/18/41 Declarations of interest

1. There were no declarations of interest.

NMC/18/42 Minutes of the previous meeting

1. The minutes of the meeting on 28 March 2018 were agreed as an accurate record, subject to substituting 'standards of proficiency' for 'pre-registration standards' in relation to midwives (NMC/18/25 2c).

NMC/18/43 Summary of actions

1. The Council noted progress on actions from the previous meetings.

NMC/18/44 PSA Lessons Learned Review

1. The Chair reiterated the Council's unreserved apologies to the families for their experiences of the NMC. The Council fully accepted all the report's findings and recommendations and was absolutely committed to learning the lessons and putting things right.
2. The Chief Executive expressed her apologies and said how sorry she was that the NMC had made a tragic situation worse, adding to the families' distress by not listening to them and not treating their views with respect. She paid tribute to the families for taking part in the PSA review, given how very difficult it must have been to relive these experiences yet again. Significant changes needed to be made to the way we work in the following priority areas:

- a) Treating everyone who comes into contact with the NMC with respect.
- b) Improving the approach to transparency and making sure the organisation is open with people when things go wrong.
- c) Embedding a culture of openness and learning throughout the organisation.

3. A review of the cases in 2014 had focused on progressing the cases as quickly as possible, rather than being honest with the families about what had already gone wrong at that point. Mistakes could never be completely eliminated but it was important to ensure that in future we are open and honest about what has gone wrong at the time.

4. Each of the Council members expressed their deep personal regret at the way in which the NMC had repeatedly failed the families by not listening to them; not valuing their input; and not treating them with respect. The PSA findings were deeply shocking and Council members reflected on their own failure to have been aware of the issues and how the families had been treated. Points made included that:

- Council members had been given very clear instructions that they should not get involved in the detail of Fitness to Practise (FTP) work and had allowed this to constrain the extent to which FTP activity was questioned and challenged. A thorough review of FTP governance was needed.
- The Council's focus had been on timeliness and meeting the KPIs and targets agreed with the Department of Health in return for the £20m grant: it had lost sight of the people involved in these cases and their lived experiences and was truly sorry for this.
- There had been a complete lack of recognition of the human dimension. No support had been given to the families and their voices had not been heard. Every aspect of how we deal with, listen to and engage with people needed to be reviewed and addressed. The constraints of our legal framework should not compromise how we deal with people.
- The failure of the NMC to be open with families about what had gone wrong was deeply concerning.
- The offensive emails had added further distress and were completely unacceptable. Behaviours needed to change.
- There were missed opportunities and repeated mistakes in day to day work not just a long time ago but until quite recently. This should be recognised and the Council needed assurance that this would not happen again.
- People must be at the centre of everything we do in future.
- The Council needed to ensure that it was in touch with prevailing societal values and that it fully understood the expectations of patients and the public.
- Staff were also likely to have been shocked and dismayed by the

PSA's findings. Staff were central to delivering the improvements and it would be important to support them to do this. In addition to hearing from public and patients there was also a need for the Council to hear from and listen to registrants and the NMC's own staff.

- The organisation had been unreasonably secretive, bureaucratic and legalistic. A much more transparent approach was required. This extended to the information discussed by the Council at open meetings to ensure public accountability.

5. The PSA report should not have been necessary but it was now clear that it had been. The Council welcomed the report and was determined that the lessons would be learnt. All members were committed to ensuring that matters were put right. The Council would want to see clear and demonstrable improvements and assurance that such mistakes and failures could not happen again.
6. The Director of Fitness to Practise expressed his apologies for the distress caused to the families. Significant mistakes had been made; the NMC's engagement with the families was poor - they were not listened to and information they provided was not acted on. FTP was adversarial, legalistic and process driven: the proposed new FTP strategic direction was an opportunity to change this. The handling of the Subject Access Request by one family member had not taken account of what they wanted, so the information provided was not helpful and added further distress.
7. The Council asked about the chronology provided by one family, as highlighted in the report. This was shocking and the failure to value evidence provided by families was unforgivable. The Director of Fitness to Practise said that he understood the significance of this issue to the family. The PSA had looked into this in detail. There was a record of the chronology in 2010 but the NMC was unable to account for it after that. When the family member had again provided a copy during a hearing in 2016, consideration had been given to whether to put this before the Panel but it was decided not to do so. The failure to value the family's evidence was compounded by the way in which the NMC had described what had happened. This had created the perception that we were less than transparent.
8. The Council expressed concern about the apparent hierarchy of evidence – attaching more weight and value to the views of institutions/professionals than to the information supplied by patients and the public. The Council would expect the same seriousness and value to be attached to information provided by families and witnesses and this must be a critically important principle going forward. It was noted that the 'hierarchy of evidence' was an issue for all regulators and a key lesson for the NMC to learn and share with others. Changing the way we engage with families and others involved in FTP processes so

that we are open and transparent is where most improvement is needed. The new Public Support Service (PSS) would be key to this and expert support is being obtained to help guide development of the Service, along with input from members of the public. In particular, it was very much hoped that the families affected would be willing to engage with this.

9. The Director of Registration and Revalidation added that whilst some improvements had been made to handling complaints about the NMC's work, it was recognised that there was much more to do. There was also a need to look at how themes and learning from complaints and all other forms of feedback were captured and shared with the Council.
10. The PSA found that the documents it saw generally demonstrated a professional approach, however there were a very small number of disrespectful emails between internal staff. The Executive was clear that one such email was one too many. The staff concerned had been spoken to and it had been made clear to all staff that this behaviour was unacceptable. Changes would be made to induction and training and measures put in place to ensure staff were continuously reminded of the behaviours expected. The Chief Executive of the PSA had agreed to discuss the report's findings on cultural and behavioural issues with the Executive team and would also meet with the Council.
11. Whilst much had been done or was being put in place to address issues identified in the review, it was recognised that this was the start and there was no complacency about the significant changes still needed. Each of the issues identified in the PSA report from which lessons needed to be learned were discussed.
12. *a. Recordkeeping*
The PSA recognised that there had been significant improvements in this area and the NMC had met this PSA standard of good regulation over the last few years. Quality assurance systems were in place to help maintain and drive continuous improvements to ensure full audit trails of the issues and decisions on cases were maintained. The Council would want to understand the improvements that had been made and would want assurance that effective systems and processes were in place to ensure that high standards of recordkeeping were sustained.
13. A separate but related challenge arises from records being still largely paper based, so there is no room for complacency. Implementation of planned technology improvements should assist in the medium term. There was scope to learn from the approach adopted by the Crown Prosecution Service.
14. *b. Identification of the Issues*
Access to clinical advice and expertise had already been reviewed in the light of the PSA findings. Clinical advice was available to staff at all

stages of a case, including at the start. Further action was being taken to help staff identify and understand better when clinical advice should be sought. Further action would also take account of any recommendations arising from Professor Sir Norman Williams' review which was expected shortly. The Council would require assurance that there were effective arrangements for access to clinical and legal advice and that effective use was made of such expertise when appropriate.

c. Working with third party investigators

15. Clear guidance was now in place about the approach to be taken when cases were under investigation by other parties, such as the police. The PSA review recognised this and that the NMC was now in a significantly better position to reach appropriate decisions than it had been in 2012. The Council would wish to have assurance that the guidance was being applied and that appropriate decisions were being made.

d. Looking beyond individual cases

16. The PSA report had recognised that the Employer Link Service (ELS) and Regulatory Intelligence Unit (RIU) should in principle address the problems identified. It had stressed the importance of these teams being fully integrated into the organisation. The work of the ELS had been very positively received by employers in its first year and a report on the second year of operations would be coming to the Council in September 2018. The RIU was still at a very early stage of development but was able to draw information from across the whole of the organisation as well as externally from system regulators across the four countries and other sources.

e. Working with others

17. Better relationships and information sharing arrangements were now in place. The PSA's recognition that strong steps had already been taken which addressed this recommendation was welcome. As previously indicated, consideration would be given to whether any changes were needed to the work of the ELS in the light of the review's findings to ensure it was operating to maximum effect.

18. The NMC had powers to require employers and others to provide documents but could not require employers to undertake investigations or mandate action. The question of legislative change was a matter for the government and the suggestions made by the PSA would be considered.

f. The treatment of the families

19. The new PSS was building on the work of the Witness Liaison Team to ensure patients and families were listened to and supported better. It was hoped that the families affected by the failings at Furness General Hospital, as well as patients and members of the public more generally, would share their experience and views to help shape the PSS.

20. The skills required of staff in the PSS needed careful consideration. The PSS could not be an 'add-on'; it should be a 'centre of excellence' within the organisation. There would be a need to address staff skills across the whole of the organisation.
21. Further comments made included that:
- The FTP process was difficult for anyone outside to understand and access. In addition to improving the information available to the public, consideration should be given to whether the PSS should encompass providing 'advocacy assistance' by helping those they were supporting to understand, articulate and frame what it was they were seeking or wanted to get across.
 - As changes were made, it would be important to hear from families, patients, service users, registrants and other witnesses involved about their experiences and feelings about going through the FTP process, to test out whether these were working or having an impact.
 - The principle of 'continuity of support' for the families was critical and should be a key element of the service provided by the PSS.
 - Consideration could be given to seeking feedback at the end of every case from all those involved. There may be a benefit in using a third party for this feedback process, so that respondents could give frank and unvarnished views.
 - Consideration should be given to the scope for learning from the significant changes implemented in the criminal justice system in recent years in terms of looking after witnesses and minimising the distressing aspects of adversarial processes as much as possible for those involved.
22. The Council was already due to receive a progress report on the setting up of the PSS in September 2018. This report would also reflect any adjustments planned to the PSS in the light of learning from the review. This should also include action being taken to address the 'hierarchy of evidence' issues discussed earlier.
23. More generally, the Council would want further information about how all the various teams such as the ELS, RIU, high profile team and other initiatives already in place were working, together with assurance that we had looked again at each of these to see if any changes were needed in light of the review.
24. There was also a need to ensure that the lessons were learnt across the organisation more widely including:
- A wider review of customer service across the organisation was needed to address how we treat everyone who comes into contact with the NMC. Complaints should be seen as a gift and an opportunity for learning. The review should encompass all the information and feedback provided to the Council.

- The cultural and behavioural issues needed to be addressed. The People Strategy should be revisited to prioritise this and ensure that treating people honestly and with decency and respect were core expectations of everyone working at the NMC. Consideration would need to be given by the Executive to how this could be measured and tangible improvements demonstrated.
- Consideration should be given to how learning from the report around listening to the patient and public voice, could be shared and taken forward with other regulators.

g. Openness and transparency

25. A root and branch review of the approach to transparency was needed, including the information brought to the Council in open meetings. This should include looking at our approach to all requests for information with the aim of being as open and transparent as possible. There should be a 'presumption of transparency' and this should be defined so that everyone was clear what this meant in practice.
26. A new data sharing policy had been introduced, prompted by General Data Protection Regulation (GDPR). This sought to encourage a new approach to being open and sharing information, so that people did not need to resort to legal routes such as Subject Access Requests. It also sought to take account of the three lessons identified in the PSA report (*paragraph 4.127*); making further efforts to contact anyone submitting a request to understand the information they really want; obtaining a clear understanding of whether they are content to waive their rights under the Data Protection Act; and considering more fully the extent to which more information can be provided without breaching other people's rights.
27. As previously indicated, being open with people when mistakes were made was a key lesson that needed to be taken very seriously. The Council would want assurance that this was being addressed.
28. A review of the complaints policies and processes would also be undertaken in the light of the review. This would also look at improvements in how complaints are analysed to identify themes, flag up issues, and address any learning including ensuring openness, honesty and transparency. Staff would need to be better supported to ensure that the key values of transparency, fairness and valuing people were integral to everyday work.
- h. Flaws in the FTP system*
29. As the PSA report recognised the features of current FTP systems, whether at the NMC or elsewhere, are not conducive to addressing concerns early or to encouraging an open culture. The proposed new strategic direction for FTP sought to address some of these issues but would not completely eliminate the need for hearings and an adversarial

approach. The consultation period had been extended so that those who wished to respond in the light of the PSA report could do so. In addition, some of these issues would be picked up in the qualitative research which was being undertaken. As indicated, learning from improvements in the criminal justice system would be sought including in relation to vulnerable witnesses.

30.

The Council would consider the outcomes of the consultation on the new strategic direction for FTP in July 2018. The report to the Council should make clear how the Lessons Learned recommendations had been taken into account in revising and shaping the final proposals.

31.

In addition, the Council stressed the importance of ensuring that the wider issues and lessons from the review be addressed. For example it was important that trends and learning from FTP informed how educational and other standards were developed, so that wider improvements could be made to registrants' practice and patient safety.

32.

i. Governance of FTP

In the light of the PSA report, there was a need for a root and branch review of the governance of FTP to ensure that the Council was able to exercise effective oversight and scrutiny and obtain assurance about the way operations were run. This should include looking at the information provided to the Council on specific FTP cases, the quality of decision making and the support given to all those involved in FTP processes.

33.

The Council needed to have the information required to ask questions and challenge. Information was now provided in confidential session about high profile cases. Consideration needed to be given to how some of this could be brought into the public domain for discussion, recognising that this would not always be straightforward. This would be a good test of the 'presumption of transparency'.

Comments and questions from Observers

35.

The Chair invited questions from observers. The following comments were made:

- a) The openness of the Council's discussion had been very positive and represented a potentially significant turning point for the organisation in terms of transparency. It would be important to extend this approach to registrants; educational institutions and others.
- b) When developing/implementing the new FTP strategy, it was important that the NMC took account of the impact on mental health of all parties going through an FTP process.
- c) Public access to FTP hearings should be improved including making hearing lists available. At present, it was difficult for the public to find out what was going on and to participate.

- d) The NMC should consider the principle of 'open justice' (Toulon, Court of Appeal) and making all evidence put before a hearing available in the public domain. There was also a need to consider full disclosure and ensure that where there is 'non-disclosure of evidence' there is a fair hearing which produces outcomes that prevent failings in the future.
- e) A reporter from Channel 4 asked whether inaction by the NMC following information provided by Cumbria police in 2012 meant that lives continued to be put at risk. The Chief Executive said that this had been covered in some detail in the PSA report. We were absolutely clear that the cases took too long. When it was suggested that we had failed to protect the public in respect of one of the midwives, we had commissioned an independent review – the Kark Opinion – which had been disclosed. This confirmed that a risk assessment had been carried out at every opportunity and the PSA report was clear on this point.
- f) A question was asked about whether electronic records may resolve the issues of errors with recordkeeping and how the NMC would engage with members of the public and registrants going forward. The Director of Fitness to Practise noted that a much better case management system was now in place. In terms of engagement with the public and registrants this was one of the NMC's key priorities to address but he would discuss further with the observer who raised the question outside the meeting.
- g) A registrant and former staff member suggested that the NMC should also apologise to registrants for the distress caused by the overly long time taken to resolve FTP cases. She also noted the importance of team working and stability in the workforce and asked how the NMC was addressing its high turnover of staff. The Chair commented that, whilst today was rightly focussed on the families, it was recognised that the process took too long for everyone involved: the proposed new FTP approach was seeking to address this. The Director of People and Organisational Development confirmed that the People Strategy had been developed to focus on all staff related matters. Whilst turnover was down, there was a lot more needed to be done including better support to staff to improve team working.
- h) An observer suggested that the NMC might consider safety summits and 'Rapid reviews' of events used elsewhere in the health service. She also asked for assurance to registrants that recordkeeping and information gathering processes were reliable. The Director of Fitness of Practise said that the FTP consultation was looking at the early stages of cases and ways where concerns could be reviewed early. He also noted that the NMC was in a much better position in relation to recordkeeping but that as indicated earlier there was more work to do and further assurance would be brought back to the Council.
- i) An observer noted that she had seen significant changes at the NMC, although this report was disappointing. She asked how registrants could further support the work around engagement in the

new FTP approach once the consultation had closed. The Director of Fitness of Practise confirmed that there would be opportunities for further engagement in development of the new approach.

36. The Chair thanked all those who had contributed.

Next steps

37. Summing up, the Chair said this had been a hugely important and significant session. There was deep sadness and regret at what the PSA report had revealed. The Council fully accepted the PSA findings and conclusions and was absolutely determined and committed to delivering the recommendations.

38. There was a desire to move forward changes at pace, whilst also ensuring that the views and input of the families affected and others were taken into account in shaping our response to the recommendations.

39. A comprehensive response was needed: the Executive should report back in July 2018 setting out a programme of work for the next six to twelve months. This should also capture interdependencies such as the work on the midwifery standards. Given the significant and central focus this work needed, the Council would want to understand the resources allocated and the impact on other commitments and priorities. There should be regular review of whether the actions being taken were having the desired effect including seeking views of families, patients and the public. The Council would require a report at every future meeting.

40. The NMC had been invited to give evidence to the Health Select Committee in July 2018. The PSA had confirmed that it would be monitoring the NMC's progress in implementing the recommendations through its annual performance review.

41. The Council had a responsibility to ensure that that the families were aware of its discussions. The Chair had written to all the families and spoken to some of them. He would write personally to share a summary of the Council's discussions and to assure them of the seriousness with which the Council was addressing the review's recommendations and its determination to put matters right.

Action:	Report back with a comprehensive programme of work taking account of the expectations set by the Council.
For:	All Directors
By:	25 July 2018

NMC/18/45 Chief Executive's report

1. The Council considered a report from the Chief Executive and Registrar on key external developments since the previous Council meeting. The following points were noted in discussion:
 - a) The consultation into how the NMC proposed to regulate nursing associate was closing on 2 July 2018. Everyone was encouraged to respond.
 - b) The launch of the Future Nurse Standards at the House of Commons had been very positive. It was important that similar launches were held in Scotland, Wales and Northern Ireland and dates for these were being fixed.
 - c) Important and critical work had begun on a review of the entire overseas registration process.
 - d) The NMC was engaging with the Regional Chief Nurse, NHS England to explore ways to protect the title of a registered nurse: this was welcomed.

NMC/18/46 Performance and Risk report

1. The Council considered the performance and risk report. This also now included the financial monitoring information previously provided as a separate report. The interim Director of Resources introduced the paper and noted the following key updates:
 - a) The report included the out-turn financial monitoring report for 2017–2018, which had been break-even overall due to various factors although there had been slippage on some projects. The approach to forecasting and planning during 2018–2019 would be improved.
 - b) Eight of the 12 corporate plan commitments for 2017–2018 had been delivered; two had been partially delivered and two had been closed due to a refocus and managing risks.
 - c) The corporate risk register reflected changes from the discussion with Council in March 2018 and did not yet reflect recent developments.
2. In discussion, the following points were noted:
 - a) Corporate priorities and risks would need to be reviewed in the light of the Lessons Learned report and the departure of the Chief Executive and Registrar, particularly risks 3 and 8. In July 2018, the Council would need to have a frank discussion about priorities and commitments for 2018–2019 and what could not be done or would need to be deferred so that the Lessons Learned work could be prioritised.
 - b) Overall staff turnover had improved due to a range of initiatives including creation of a specialist recruitment team; a strengthened induction process; and the roll out of a leadership development

programme. However, a turnover rate of 25% staff within six months was extraordinary: it was not good for the individuals concerned or the NMC and was a waste of effort and investment. The reasons for this needed to be clearly understood and should be brought back to the next meeting.

- c) As discussed previously, the People Strategy would now be revisited in light of the Lessons Learned Review.
- d) It was important for staff to have the ability to speak up in the organisation and for the Council to hear the voice of the staff. The employee forum provided such an opportunity for staff.
- e) The year-end progress against the corporate plan commitments for 2017–2018 for nursing and midwifery education quality assurance had an amber status due to a number of interdependencies, including IT.
- f) The inter-dependency with IT of critical work in FTP, Registrations and Education was striking. It was important for the Council to understand whether the IT strategy would deliver at the necessary pace. The interim Director of Resources confirmed that the work was proceeding as fast as it could but could not proceed more quickly safely. Replacement of the register had been prioritised and other work to ensure security and modernise the infrastructure was essential. The Council would welcome clarity about whether sufficient resource and support was available and whether the Executive had the equipment needed.

Action: Review corporate priorities and risks, particularly risks 3 and 8 in light of the Lessons Learned Review findings and departure of the Chief Executive and Registrar.

For: Interim Director of Resources
By: 25 July 2018

Action: Provide clear information to enable the Council to understand the reasons for the high number of staff leaving within the first six months.

For: Director of People and Organisational Development
By: 25 July 2018

Action: Update the Council on progress of implementation of the IT strategy and whether sufficient resource and support is available.

For: Interim Director of Resources
By: 25 July 2018

NMC/18/47 Audit Committee Report

1. The Chair of the Audit Committee introduced the report. Key points highlighted included:

- a) New internal auditors (RSM) had been appointed and there had been a successful transition from the previous providers. Areas for

- improvement identified in the annual review of Internal Audit effectiveness would be taken forward with the new Internal Auditors.
- b) The internal audit work programme for 2018–2019 had been approved and work had been spread evenly throughout the year. The Committee would consider at its next meeting whether any adjustments would be needed in light of the Lessons Learned Review.
 - c) The Committee had reviewed the preparations for the year end accounts and was satisfied with progress.
 - d) The Audit Committee would continue to monitor the technology issues on the risk register, including compliance with the GDPR and the replacement of IT systems.

2. It was agreed that consideration be given to including more detail in future Audit Committee reports on themes and issues arising from serious event reviews, taking into account the commitment to increased openness and transparency agreed as part of the Lessons Learned Review.

Action: Review the scope for more detailed information to be included in future Audit Committee reports on themes from serious event reviews.

For: Chair of the Audit Committee/Secretary

By: 25 July 2018

NMC/18/48 Chair's action taken since the last meeting

1. There were no Chair's actions to report.

NMC/18/49 Questions from observers

1. The Chair invited questions and comments. The following points were raised and discussed:
 - a) In relation to the 25% turnover rate of staff within six months, a former member of staff offered to share her resignation letter which set out her personal experience of working at the NMC.
 - b) An observer made a number of comments and raised a number of questions:
 - The Council may want to consider discussing as much business as possible in the Open meetings to ensure openness and transparency with only really confidential items in private session. This may include splitting reports, if necessary. This may encourage more feedback from the public.
 - The risk rating approach used by the Council was outdated; high impact risk could hit at any time. The interim Director of Resources advised that the new internal auditors were reviewing the NMC's risk management processes.

- The Council may wish to look critically at the issue of diversity both in relation to the Council and staff, as this would ensure that more diverse views were being heard.
 - The need for Freedom to speak up was, in effect, the result of a failure to listen. Was the NMC listening well enough? Could the NMC be more willing to accept change and encourage Freedom to speak up? The interim Director of Resources noted the importance of promoting the freedom to speak up within the NMC.
 - As there had been two years to get ready for GDPR it was unclear why any organisation would not have had sufficient time to ensure it was ready. Did this suggest a need to improve processes in future? The interim Director of Resources confirmed that the NMC had met all essentials for GDPR compliance by 25 May 2018 but recognised that there was still scope for improvements in some areas.
- c) In response to a question about financial forecasting, the Interim Director of Resources confirmed that steps were being taken to improve the forecasting process, including staff training.

The next meeting of the Council in public will be held on Wednesday 25 July 2018 at the NMC, 23 Portland Place.

Confirmed by the Council as a correct record and signed by the Chair:

SIGNATURE:

DATE:

Council

Summary of actions

Action:	For information.
Issue:	Summarises progress on completing actions from previous Council meetings.
Core regulatory function:	Supporting functions.
Strategic priority:	Strategic priority 4: An effective organisation.
Decision required:	None.
Annexes:	None.
Further information:	If you require clarification about any point in the paper or would like further information please contact the author below.

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Summary of outstanding actions arising from the Council meeting on 6 June 2018

Minute	Action	Action owner	Report back to: Date:	Progress to date
NMC/18/44	PSA Lessons Learned Review Report back with a comprehensive programme of work taking account of the expectations set by the Council.	All Directors	25 July 2018	See agenda item 7.
NMC/18/46	Performance and Risk report Review corporate priorities and risks, particularly risks 3 and 8 in light of the Lessons Learned Review findings and departure of the Chief Executive and Registrar.	Interim Director of Resources	25 July 2018	This has been completed and information has been included in the performance and risk report on the agenda.
NMC/18/46	Performance and Risk report Provide clear information to enable the Council to understand the reasons for the high number of staff leaving within the first six months.	Director of People and Organisational Development	25 July 2018	This information has been included in the performance and risk report. A separate presentation will come back to Council in September 2018.
NMC/18/46	Performance and Risk report Update the Council on progress of implementation of the IT strategy and whether sufficient	Interim Director of Resources	25 July 2018	Further information is included in the IT business case on the confidential agenda.

Minute	Action	Action owner	Report back to: Date:	Progress to date
	resource and support is available.			
NMC/18/47	Audit Committee Report Review the scope for more detailed information to be included in future Audit Committee reports on themes from serious event reviews.	Chair of the Audit Committee/Secretary	25 July 2018	More information on themes will be included in the Audit Committee's reports in the future.

Summary of outstanding actions arising from the Council meeting on 28 March 2018

Minute	Action	Action owner	Report back to: Date:	Progress to date
NMC/18/25	Education 7a. Standards of proficiency for registered nurses and standards for education and training Consider i. how and when to undertake a stocktake review of the effects and benefits of the new Standards; ii. how to monitor and	Director of Education and Standards	6 June 2018	i. The task of evaluating our new standards will be considered in the 2019–2020 budget setting process, and options will be presented to the Council by March 2019. ii. Our new QA Framework is a means by which changes in education provision can be tracked on an ongoing basis. The new QA Framework will be published by 25 July 2018.

Minute	Action	Action owner	Report back to: Date:	Progress to date
	provide assurance on a) appropriate use of simulation and b) practice placement quality through QA reports.			
NMC/18/25	<p>7b. Standards for prescribing and medicines management</p> <p>Provide an update for Council on</p> <ul style="list-style-type: none"> i. further collaborative work on prescribing practice; ii. development of cross-professional guidance on medicines management. 	Director of Education and Standards	25 July 2018	This is addressed in a separate agenda item.
NMC/18/26	<p>Education quality assurance framework</p> <p>Update the Council on the final QA framework, including</p> <ul style="list-style-type: none"> i. the differences between major and minor modifications; ii. further work on enhanced scrutiny arrangements; and iii. the criteria and process for withdrawing approvals. 	Director of Education and Standards	25 July 2018	<p>The new QA Framework has been developed to align with our new standards. The Council will receive a copy of the new QA Framework by 24 July 2018 which is prior to its publication on 25 July 2018. A briefing paper will accompany the framework and will explain the main changes.</p> <p>The QA Framework includes information on major modifications, with a link to the QA handbook which details further the differences between major and minor</p>

Minute	Action	Action owner	Report back to: Date:	Progress to date
				modifications. The QA Framework also includes information on enhanced scrutiny and the NMC's process for withdrawing approval.
NMC/18/31 NMC/18/15	Performance and Risk report Focus further information on customer service on those highly dissatisfied.	Director of Registration and Revalidation	25 July 2018	Information will be provided at the September 2018 Council meeting in the context of the Lessons Learned update and the work we are doing to review our approach to customer feedback and how it is shared with Council.
NMC/18/33	Ensuring patient safety, enabling professionalism: a new strategic direction for fitness to practise Report further to Council on the Public Support Service.	Director of Fitness to Practise	26 September 2018	This is on the agenda for the September 2018 meeting.
NMC/18/34	Draft Corporate Plan and budget 2018–2021 Review the scope for more stretching key performance indicators after six months.	Interim Director of Resources/all Directors	28 November 2018	Not yet due.
NMC/18/34	Draft Corporate Plan and budget 2018–2021	Interim Director of Resources	6 June 2018 Deferred to September 2018	Deferred to September 2018 Council meeting.

Minute	Action	Action owner	Report back to: Date:	Progress to date
	Bring investment options to Council.			

Summary of outstanding actions arising from the Council meeting on 31 January 2018

Minute	Action	Action owner	Report back to: Date:	Progress to date
NMC/18/10	Review of Council allowances 2017 Develop proposals for a 'remuneration philosophy' for consideration by the Council	Secretary/Chair of the Remuneration Committee	28 November 2018	Not yet due.

Summary of outstanding actions arising from the Council meeting on 29 November 2017

Minute	Action	Action owner	Report back to: Date:	Progress to date
NMC/17/100	Education Quality Assurance Annual Report 2016–2017 Include trend data and information around public protection in future annual reports	Director of Education, Standards and Policy	28 November 2018	Not yet due.

Minute	Action	Action owner	Report back to: Date:	Progress to date
NMC/17/101	People Strategy Provide more information on the key outcomes being sought; the priorities for action and the key indicators/measurements which will be used to measure progress against the key outcomes	Director of People and Organisational Development	31 January 2018 Deferred to 25 July 2018 Deferred to 26 September 2018	This item has been deferred to September 2018 given the need to reprioritise the People Strategy as part of the Lessons Learned work programme.
NMC/17/103	Annual equality, diversity and inclusion report 2016–2017 and strategic action plan Provide more analysis of data in future reports and planned action to address findings	Director of Registration and Revalidations	26 September 2018	Not yet due.

Summary of outstanding actions arising from the Council meeting on 27 September 2017

Minute	Action	Action owner	Report back to: Date:	Progress to date
NMC/17/86	Employer Link Service report one year on Take account of the Council's comments in future reports.	Director of Fitness to Practise	26 September 2018	Not yet due.

Council

Chief Executive's report

Action: For information.

Issue: The Council is invited to consider the Chief Executive's report on (a) key developments in the external environment and (b) key strategic engagement activity.

Core regulatory function: This paper covers all of our core regulatory functions.

Strategic priorities: Strategic priority 3: Collaboration and communication.

Decision required: None.

Annexes: None.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

Author: Peter Pinto de Sa
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Chief Executive: Jackie Smith
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Context: 1 This is a standing item on the Council agenda and reports on (a) key developments in the external environment; and (b) key strategic engagement activity.

Discussion: Nursing associates

2 The changes to our legislation to give us the powers to regulate nursing associates (NAs) were approved in the House of Lords on 25 June 2018 and in the House of Commons on 27 June 2018. Privy Council approval was given on 11 July 2018 and the Statutory Instrument was laid on 18 July 2018.

Department of Health and Social Care (DHSC)

3 We continue to engage with senior officials at the DHSC on a range of issues. The Chair held an introductory meeting with the Permanent Secretary at the Department of Health and Social Care on 6 July 2018. The Chair also met the Director General for Acute Care and Workforce on 27 June 2018.

Chief Nursing Officers

4 The Chair and the Chief Executive met with the CNOs for England and Wales in Cardiff on 25 June 2018 to discuss a range of issues relating to four-country engagement.

Engagement with Parliamentarians

5 We have held discussions with the following Parliamentarians:

5.1 Rosie Cooper MP (5 June 2018)

5.2 Martin Vickers MP (19 June 2018)

5.3 Ben Bradshaw MP (20 June 2018)

5.4 Lord Willis of Knaresborough (28 June 2018)

5.5 Baroness Watkins of Tavistock (2 July 2018)

6 On 13 June 2018, the General Counsel and the Director of Fitness to Practise gave oral evidence to the Joint Committee on the Draft Health Service Safety Investigations Bill. Following this session, we sent a letter to the Committee with further points of clarification, as requested during the session, on 28 June 2018.

7 Ahead of the debates in the House of Commons and House of Lords on the proposed changes to our legislation to give us the powers to regulate NAs, we sent a briefing to MPs on 19 June 2018 and Lords on 22 June 2018 setting out why we need their support on legislative change.

- 8 Ahead of the Education Select Committee's second oral evidence session as part of its nursing degree apprenticeship inquiry which commenced in June 2018, we sent the Committee a briefing on our role in nursing apprenticeships on 11 July 2018.
- 9 On 17 July 2018, the Chair, Chief Executive and Director of Fitness to Practise gave evidence to the Health and Social Care Select Committee on the Professional Standards Authority's (PSA's) Lesson Learned Review.

Education

- 10 Following the future nurse and education standards publication launch event in Westminster in May 2018, we are planning further events in Scotland, Wales and Northern Ireland in October 2018.
- 11 We are currently developing stakeholder engagement and communications activity for the implementation phase of the project which will start fully in September 2018. This will include: a number of workshops in the four countries; interactive webinars; supporting information provided on the website (some of which will be published in July 2018); social media; and possible videos and animations to support implementation of the new standards. This engagement will also include updating relevant stakeholders on our Quality Assurance (QA) plans.
- 12 We are continuing the second phase of early engagement for the future midwife project, which is feeding into the first draft of the new proficiencies. To date we have spoken with over 300 people, and aim to speak to approximately 500 around the UK before this phase finishes.
- 13 We held a highly successful webinar on Return to Practice on 4 July 2018 with a wide range of stakeholders including educators and commissioners. A webinar with practitioners who have returned to practice is scheduled for 24 July 2018. A roundtable event, principally with employers, is planned for August 2018.
- 14 The Chief Executive chaired her final meeting of the midwifery panel on 19 July 2018. A new chair of the panel is being sought.
- 15 On 2 July 2018, the Chief Executive met Professor Mary Renfrew, who is leading the work on the development of new midwifery standards to discuss progress.

Visit by Nottingham nursing students

- 16 On 18 June 2018, we hosted a visit by a group of nurses from Nottingham. They visited our fitness to practise facilities, sitting in briefly on a hearing. They heard about our approach to using evidence and research to inform the development of our policies and concluded their visit with a question and answer session with the

Chief Executive.

NHS 70 celebration

- 17 On 6 July 2018, we marked the NHS 70th anniversary with social media activity celebrating the contribution of nurses and midwives. The Chief Executive attended the celebration events at Westminster Abbey and the NHS Scotland event at the National Museum of Scotland. She also attended Walthamstow School for Girls to talk about the NHS 70 celebration as part of the 'speakers for schools' initiative.

Visit to Ashford and St Peter's county hospital

- 18 The Chief Executive visited Ashford and St Peter's county hospital on 19 June 2018. While there, she spoke about the introduction of the NA role and some of the wider challenges in the healthcare regulatory sector.

Collaboration

- 19 On 19 June 2018, we held a briefing session on regulatory reform in the House of Lords with the General Medical Council (GMC). This event was hosted by Baroness Finlay of Llandaff. The event was attended by the Chair and Chief Executive of the NMC and the GMC.
- 20 The Chief Executive continues to engage regularly with the GMC's Chief Executive; their latest meeting took place on 17 July 2018.

Media activity

- 21 The PSA's Lessons Learned Review was discussed at our June 2018 Council meeting. The meeting was reported in the national media including, the Times and Daily Mail, a large number of regional media including BBC North West and North West Evening Mail and the trade media including Health Service Journal, Nursing Standards and Nursing Times.
- 22 We welcomed the PSA's Annual review of performance, which was published on 4 June 2018. We issued a statement in response which was reported in Nursing in Practice.
- 23 Following a four year independent investigation into concerns relating to Gosport War Memorial Hospital the 'Report of the Gosport Independent Panel' was published. All of the national print and broadcast media covered the report including, BBC, ITV, the Guardian, Daily Mail, Telegraph, Independent etc. In all of the coverage we were referenced, however, the majority of the coverage focused on the doctor involved.

Public protection implications:	24	No direct public protection implications.
Resource implications:	25	No direct resource implications.
Equality and diversity implications:	26	No direct equality and diversity implications.
Stakeholder engagement:	27	Stakeholder engagement is detailed in the body of this report.
Risk implications:	28	No direct risk implications.
Legal implications:	29	No direct legal implications.

Council

Lessons Learned review: Putting patients and the public at the heart of what we do

Action: For decision.

Issue: This paper sets out our proposals for learning lessons from our handling of fitness to practise concerns about midwives at Furness General Hospital. It also takes into account the key learning we have identified from the Gosport Independent Inquiry.

Core regulatory function: All regulatory functions.

Strategic priority: All strategic priorities.

Decision required: **Recommendation: the Council is invited to discuss and approve our proposed approach and our programme of work (paragraph 23).**

Annexes: The following annexe is attached to this paper:

- Annexe 1: Programme of work

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

Director: Emma Broadbent
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- Context:**
- 1 On 6 June 2018, the Council fully considered and discussed the Professional Standards Authority's (PSA) Lessons Learned Review of the NMC's handling of concerns about midwives' fitness to practise at Furness General Hospital, during which the Council apologised unreservedly to the families for not listening to them; not acting on credible evidence and for the multiple missed opportunities. Our failures to act and subsequent delays meant some midwives continued to practise who may not have been safe to do so and mothers and babies may have been at risk during this period.
 - 2 Since the Council's last meeting, the Gosport Independent Inquiry Report was published on 20 June 2018. We have reviewed that report to consider what action is necessary. Themes in the report resonate with the Lessons Learned review, particularly around our engagement with families and relatives. We have written to the families involved and hope to work with them as we take forward next steps.
- Four country factors:**
- 3 Not applicable for this paper.
- Discussion:**
- 4 Since the publication of the lessons learned review, we have written to all the families affected by the tragic events and said sorry for the way in which we treated them. We have offered to meet with all of them either as a group or individually, and some meetings have taken place. Hearing from the families and asking them to share their experiences with us is the first and most important stage in helping us shape our future strategy of putting patients and families at the heart of what we do.
 - 5 At pace, we are committed to a wide ranging programme of work to move forward in response to the lessons identified in the review.
 - 6 Our immediate activity has focused on the two key priorities identified in the lessons learned review, that of improving how we engage with and listen to patients and the public day to day, specifically in the context of fitness to practise, and being open and transparent.
 - 7 Underpinning this work we are:
 - 7.1 Taking a person-centered approach through our new Fitness to Practice strategy, and by setting up the Public Support Service.
 - 7.2 Putting a presumption of transparency at the heart of our corporate values and developing new approaches to ensure we are open and honest when things go wrong.

- 7.3 Putting a renewed and reinvigorated emphasis on the importance of living our values and behaviours.
 - 7.4 Engaging systematically with patients and public groups to inform our work going forward across all areas of the NMC.
 - 7.5 Scoping a programme of work to engage with stakeholders about the value of patient and public voices in regulation.
 - 7.6 Committing to maintaining and continually reviewing areas which were identified in the PSA report as having improved.
- 8 As part of our approach to being as transparent as possible we will be reporting to the Council on an ongoing basis as we deliver our programme of work. We will have clear plans for each of our specific proposals setting out how they will be achieved, the timelines involved, how we will measure success and who will be responsible for delivery. The Council will wish to update and share progress with the PSA.

Putting patients, families and those who raise concerns at the heart of what we do

A new strategic direction for Fitness to Practice

- 9 Our proposals for a new strategic direction for fitness to practise are on the agenda for the July Council meeting. We have undertaken a full public consultation, completed qualitative research with members of the public and other stakeholders, and have considered carefully the learning from the Lessons Learned Review. Our proposals will protect the public by:
- Putting individual patients and families at the centre of how we work.
 - Contributing to a just culture in health and social care.
 - Supporting nurses and midwives to practise safely and professionally.

The Public Support Service

- 10 We have set up a Public Support Service (PSS) which will lead our work to embed a person-centered approach in the organisation to:
- 10.1 Put patients, families, carers and the public at the heart of the way we operate and the support we offer.
 - 10.2 Support people who are involved in our cases to make sure they are protected, valued, cared for, respected and held as important partners throughout the fitness to practise process.
- 11 In the lessons learned review, this service was seen as integral to us being able to show that we have genuinely learned from these

events. To achieve this, the Council will want to be assured of the aims and objectives and how they are being measured. We have scheduled a discussion with the Council on the Public Support Service for September 2018. The steps we are taking to set up the service include:

- 11.1 Having appointed a Head of the PSS, we are now recruiting the core public support team. We expect to have completed this by September 2018.
- 11.2 Setting up a steering group including patient groups and experts to guide set up and delivery of the service.
- 11.3 Training fitness to practise colleagues to identify vulnerable people and to support them appropriately.
- 11.4 Improving the information we provide for patients, families, and the public. Improved information will be published on our website by the end of July 2018. We are also producing a film for witnesses which we expect to publish on our website in August 2018.
- 11.5 We have developed a tailored needs assessment for individual members of the public who make referrals to us. The needs assessment will ensure that we are listening to and addressing each individual person's needs and concerns and it will drive improved communication throughout the case lifecycle. We will start to introduce this, together with an introductory telephone call from the case officer at the point we receive a referral, from August 2018.
- 11.6 Designing a pilot programme offering meetings at the start and end of the investigation with members of the public who have made a referral. We expect the pilot to begin in October 2018 and to last for 12 months. We will review the outcomes of the pilot before deciding whether to implement in full.

Improving the way we communicate with people every day

- 12 We are only as good as our last letter, phone call, contact and face to face meeting. In the lessons learned review, our letters to the bereaved families were cold and unhelpful. In many cases, it was difficult for the person on the receiving end to know what was going to happen and by when. The language we used was bureaucratic and legalistic. At pace, we will review all our correspondence and letters to make sure they are clear, empathetic and offer the right level of support. We have begun work on a new "tone of voice" which will help shape all our communication across the NMC.

Improving our approach to transparency

Being open, approachable and helpful

- 13 A strong theme emerging from the lessons learned review was that we failed to be open with the families when things went wrong. We had opportunities which we failed to seize upon when we knew things had gone off track. We must make sure that in the future we are open with people when things go wrong.
- 14 As such, we are now putting at the heart of our corporate values a presumption of transparency. This means that when people ask us for information or make a complaint about something we have done, our starting point must be that we will be as transparent as we possibly can be. This applies to all aspects of our work including, especially, handling corporate complaints from which we can learn many lessons about us and our procedures and how we can do better.
- 15 At pace, we will implement a new approach to handling enquiries, information requests and corporate complaints with a focus on effective triage, first line resolution, mediation, quality investigations and customer focused responses. We want to support people to gain access to the information they need before they need to put in a formal request or raise a complaint. We will also explore options for an independent third party to review our handling of corporate complaints at the end of the process.

Values and Behaviours

- 16 What the lessons learned review showed us was that we failed to engage with and listen to those who come into contact with us. There was very clear evidence that we were either dismissive or we ignored concerns from bereaved and distressed families. Never again should we find ourselves in the position where we are ignoring those who most need our help in a time of need. This clearly demonstrates that we have an urgent need to work with our employees to discuss the findings of the review in detail and what changes we need to make together so that we demonstrate empathy and understanding for those we are working with and supporting.
- 17 Ensuring we treat individuals with respect every day goes to the very heart of our values. Our work in this area will start with a reprioritisation of our People Strategy so that our immediate focus is a programme of events across the organisation to work with our teams to embed our values and behaviours in our work.

Other priorities

Giving the Council more assurance and oversight of fitness to practise

- 18 One of the questions the Council debated at the meeting in June 2018 is how to gain greater assurance in the work of fitness to practise. In other words: how could the Council assure itself that these events will never happen again.
- 19 As part of the development of the new strategic direction for fitness to practise, we have consulted on the key principles that will guide our approach, as well as a programme of work for fitness to practise. We have reflected on the Lessons Learned Review in developing our final proposals for Council's approval elsewhere on the agenda.
- 20 There is scope for greater independent assurance of the fitness to practise process to be available to management and to the Council. We are developing a plan for the Audit Committee to approve in October 2018 aimed at ensuring there is the right level of independent assurance over our performance against learning from the Lessons Learned Review and the PSA Standards of Good Regulation.

Considering the lessons learned in everything we do

- 21 **Annexe 1** summarises the key things we are doing now to incorporate the lessons across our work.
- 22 The learnings from what happened at Morecambe Bay will also inform the work we are doing to reshape the future of midwifery education in the UK. The learning will be part of the evidence base that informs the development of the new midwifery proficiency standards.
- 23 **Recommendation: the Council is invited to discuss and approve our proposed approach and our programme of work.**

Public protection implications:

- 24 The issues identified in the report clearly posed a risk to public protection. At this point, our assessment is that there are no immediate public protection concerns. We recognise that we must work hard to ensure that we maintain public confidence in us as a regulator.

Resource implications:

- 25 The new activity we are proposing and the re-prioritisation of other activity will have resource and capacity implications. These will be discussed with the Council separately.

Equality and

- 26 We recognise we need to engage on our future plans as widely as

- diversity implications:** possible to ensure all sections of our workforce and the wider community have the opportunity to contribute. Working across diverse groups will be built into our detailed plans.
- Stakeholder engagement:** 27 We hope to continue to engage with the families as we take forward our programme of work, which also commits us to a wider programme of public and patient involvement as we develop our plans.
- Risk implications:** 28 The issues identified in the report are relevant to corporate risk 2: the risk that we may fail to take appropriate action to address a regulatory concern. It is clear that such failures did occur in our handling of concerns about midwives at Furness General Hospital. Our assessment is that it is right that the risk remains amber at present, given the improvements to our process that we have made since 2014. As we take forward the action plan, we will reflect any new controls in our assessment of the risk.
- Legal implications:** 29 All changes we make will be discussed with our legal team to ensure they remain in line with our statutory obligations.

Lessons Learned: Proposed Programme of Work

What we are doing now

Lessons learned	How we are responding	What does success look like?	When we will report back
<p>Putting patients, families and those who raise concerns at the heart of what we do</p>	<ul style="list-style-type: none"> • We are taking a person-centred approach to fitness to practise. • We are setting up a Public Support Service. We have appointed an experienced lead who is already supporting fitness to practise colleagues to engage better with individual members of the public. Recruitment of the core public support team is expected to be complete by September 2018. • We are setting up a steering group, including patient groups and experts, to guide set up and delivery of the service. The first meeting of this group will take place in September 2018. • We established a network of 55 public support champions in the fitness to practise directorate in July 2018. They will receive full training on our approach in August 2018. • We are engaging with fitness to practise 	<p>Taking a person-centred approach to fitness to practise will help us to properly understand what has happened, to make sure concerns raised by patients and families are properly listened to and addressed, and to explain to them what action we can take and why.</p>	<p>Full report to Council in September 2018</p>

	<p>colleagues and panel members in July 2018 to seek their input and ideas for change and improvement.</p> <ul style="list-style-type: none">• All fitness to practise employees will receive training from September and this will be built into our standard induction and development going forward.• We have reviewed the information about fitness to practise we provide for members of the public. Improved information will be published on our website by the end of July 2018.• We are producing a film for witnesses which we expect to publish on our website in August 2018.• We have developed a tailored needs assessment for individual members of the public who make referrals to us. The needs assessment will ensure that we are listening to and addressing each individual person's needs and concerns and it will drive improved communication throughout the case lifecycle. We will start to introduce this, together with an introductory telephone call from the case officer at the point we receive a referral, from August 2018.• We are designing a pilot programme offering meetings at the start and end of the investigation with members of the public who have made a referral. We expect the pilot to begin in October		
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	2018 and to last for 12 months. We will review the outcomes of the pilot before deciding whether to implement in full.		
Improving the way we communicate with people every day	<ul style="list-style-type: none"> We are reviewing all our correspondence and communication to make sure it is clear, helpful and easy to understand. We have increased the pace of this programme of work, which includes providing guidelines, training and a network of champions to help colleagues improve how they communicate with all those who come into contact with us. 	<p>We will adopt a consistent, empathetic and clear approach in all our communications that reflects what it means to be a modern regulator:</p> <ul style="list-style-type: none"> We are approachable We show empathy We are helpful 	We will report to the Council on progress in November 2018
Being open, approachable and helpful	<ul style="list-style-type: none"> Being open and honest when things go wrong by putting a presumption of transparency at the heart of our corporate values. Implementing a new approach to handling corporate complaints with a focus on: <ul style="list-style-type: none"> Effective triage First line resolution Mediation Quality investigations Exploring options for an independent third party to review our corporate complaints at the end of the process if the complainant does not feel we have addressed the issue. 	<p>A new process for capturing and analysing customer feedback from across the organisation.</p> <p>We will have greater transparency and understanding of the information people want from us and the reasons they complain.</p> <p>We will be sharing more information on our website, informed by what our customers want to know.</p>	<p>Interim improvements bringing key work into one team during August 2018</p> <p>First changes to our approach to requests for information in August 2018</p> <p>Full proposals for change to Council in September</p>

		We will have fewer complaints and greater levels of customer satisfaction.	2018.
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Strategic next steps

Lessons learned	How we are responding	What does success look like?	When we will report back
Values and behaviours	<ul style="list-style-type: none"> • Renewing our commitment to treat everyone who comes into contact with us with respect, compassion and empathy by firstly revising approach to our People Strategy. • We will reprioritise the People Strategy focusing on: <ul style="list-style-type: none"> ○ delivery of a programme of events across the NMC to work with employees on embedding our values and behaviours. ○ A refreshed approach to recruitment and induction with a greater emphasis on our values and behaviours. 	<p>Our employees and the people we recruit will respect and empathise with everyone we engage with.</p> <p>All staff will have discussed the Lessons Learned Review and input into next steps.</p> <p>On annual employee appraisals will assess whether people have demonstrated the values and behaviours we expect.</p>	<p>Employee event programme will be developed in August and September 2018</p> <p>Programme launch October 2018</p> <p>All employee Conference November 2018</p> <p>New recruitment and induction in place October 2018</p>
Strategic engagement with	<ul style="list-style-type: none"> • We are developing a programme to listen to 	The voices of patients,	We will discuss

patients, families, and members of the public	<p>patients, families, and public groups to inform our work going forward across all areas of the NMC.</p> <ul style="list-style-type: none"> We will work with other regulators, representative groups and individuals to develop our approach to valuing patient and family voices in regulation. 	<p>families, and the public will shape what we do.</p> <p>The patient safety community working with us to change and improve regulation.</p>	our plans with the Council in September 2018
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How we will maintain and improve

Lessons learned	How we are responding	What does success look like?	When we will report back
Governance	<ul style="list-style-type: none"> We have consulted on the key principles that will guide our approach and a programme of work for a new approach to fitness to practise. We are developing a plan for greater independent assurance for the executive and the Council regarding our performance in fitness to practice against the lessons learned and the PSA Standards of Good Regulation. 	Council has greater assurance and oversight of the way we do fitness to practise.	<p>Fitness to Practise Strategy to Council July 2018</p> <p>For Audit Committee approval – October 2018</p>
Record-keeping	<ul style="list-style-type: none"> We have introduced a common objective for fitness to practise teams to ensure that decisions and rationales are clearly recorded. We will monitor this through our quality management framework. Our new ICT strategy places greater emphasis on 	We continue to improve our record keeping.	<p>Reporting through standing Council reports.</p> <p>Council will consider the IT</p>

	<p>the quality and accuracy of the data that we hold. This will enable better record keeping and quicker reporting.</p>		<p>Business Case at its July 2018 meeting</p>
<p>Identification of the issues</p>	<ul style="list-style-type: none"> • We are recruiting dedicated clinical advisers and are creating a toolkit for colleagues so they can recognise when clinical advice is required and can access it appropriately. • We will evaluate the progress of the complex and high profile cases team and decide whether any changes need to be made as part of the business planning process for next financial year. • We are retendering for investigation services. We have updated the invitation to tender so that it includes a requirement for firms to adopt a patient/family centred approach. 	<p>Colleagues have access to clinical advice and other specialist input they need to help them identify regulatory concerns and manage cases effectively.</p>	<p>Clinical advice: September 2018.</p> <p>Complex and high profile cases team: as part of business planning cycle.</p> <p>Investigations tender: September 2018.</p>
<p>Working with third party investigators</p>	<ul style="list-style-type: none"> • We have reminded staff about the criteria for putting cases on hold and are undertaking additional management checks. • We will undertake an internal quality assurance review on managing cases subject to third party investigations in Q2 2018–2019. 	<p>Our proceedings go ahead without delay.</p> <p>Cases are only put on hold where there are clear and compelling reasons to do so.</p>	<p>Exception reporting through standing Council reports.</p>

Looking beyond individual cases	<ul style="list-style-type: none"> • The Employer Link Service was established in 2016 and the Regulatory Intelligence Unit was established in 2017. • The annual report on the Employer Link Service and Regulatory Intelligence Unit will enable the Council to have assurance over activities in 2017–2-18 and plans for 2018–2019. • To expand our network, we have recruited two new Regulation Advisers who will join the Employer Link Service on 20 August 2018. 	We share intelligence internally and with other regulators to make sure that patient safety concerns are identified and dealt with effectively.	The Council will discuss the annual report on the Employer Link and Regulatory Intelligence Service in September 2018.
Working with others	<ul style="list-style-type: none"> • We have memoranda of understanding in place with a range of different organisations so that we can better share information. • We will report on our work with other regulators as part of the Employer Link Service and Regulatory Intelligence Unit annual report. 	Closer working with others in the health and care system to address concerns about patient safety.	The Council will discuss the annual report on the Employer Link and Regulatory Intelligence Service in September 2018.

Council

The Gosport Independent Panel Report

Action: For discussion.

Issue: To discuss the Gosport Independent Panel's report into concerns raised by families over a number of years into the care their relatives received at Gosport War Memorial Hospital and the subsequent investigations into their deaths.

Core regulatory function: All regulatory functions.

Strategic priority: All strategic priorities.

Decision required: The Council is invited to discuss the Gosport Independent Panel Report and note the next steps being taken (paragraph 24).

Annexes: The following annexe is attached to this paper:

Annexe 1: The Gosport Independent Panel Report excerpts:

- Forward
- Chapter 7: The Nursing and Midwifery Council
- Chapter 12: Summary and conclusions

A full copy of the report can be found [here](#).

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

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- Context:**
- 1 The Gosport Independent Panel was set up in 2013 to address concerns raised by families over a number of years about the care of their relatives in Gosport War Memorial Hospital and the subsequent investigations into their deaths. The report was published on 20 June 2018 (Annexe 1) and identifies a number of lessons for organisations and authorities across the health and care sector, including our role as the regulator of nurses and midwives.
 - 2 It is clear from the report that we and others badly let down the families who lost loved ones at Gosport War Memorial Hospital. We are extremely sorry for the role that we played and want to pay tribute to the families who have fought for 20 years to understand what happened during that time.
 - 3 We are committed to learning lessons from past mistakes and will be considering the report in detail to see what further action we may need to take and what lessons we can learn as an organisation.
- Four country factors:**
- 4 The report and its lessons apply to all of our work across all four countries.

Discussion: Gosport Independent Panel

- 5 Since 1998, the families who lost loved ones being cared for at Gosport War Memorial hospital between 1989 and 2000 have raised many concerns about the circumstances surrounding the death of their relatives and the care they received.
- 6 A number of investigations into the events surrounding the deaths were carried out, including three police investigations, a Commission for Health Improvement investigation; a General Medical Council (GMC) inquiry; the Council for Healthcare Regulatory Excellence (now the PSA) review; inquests into 11 deaths at the hospital, a review by the Crown Prosecution Service (CPS) in 2010, as well as our own investigations of the nurses involved between 2001 and 2010.
- 7 In 2013, the Department of Health published a clinical audit of care which found that there was evidence to suggest the almost routine practice of prescribing opiates to patients before death and that this had most certainly shortened the lives of some patients.
- 8 For the families, there were many unanswered questions arising from these investigations, including the care their relatives received, the circumstances surrounding their treatment and death and the speed at which investigations were undertaken.
- 9 In light of this, the Gosport Independent Panel was established to look at the care of people and the subsequent investigations into

their deaths.

- 10 As part of the review, the Panel spoke with and listened to individuals and families who lost loved ones to ensure that their views and evidence were taken into account from the outset. The Panel requested documentary evidence from all relevant organisations, including the health service, the police and regulators. We provided the Panel with all our files relating to concerns raised about nurses at the Gosport War Memorial Hospital from 2001 to 2010.

Report findings

- 11 Following its review of all documentary evidence, the Panel found that despite nurses raising concerns about drugs being prescribed without medical justification, the lives of more than 450 people were shortened as a direct result of a pattern of prescribing and administering opioids which had become common practice at the hospital, and that there was evidence to suggest that potentially another 200 patients were similarly affected.
- 12 The Panel concluded that at Gosport War Memorial Hospital between 1989 and 2000:
 - 12.1 There was a disregard for human life and a culture of shortening the lives of a large number of patients.
 - 12.2 There was an institutionalised regime of prescribing and administering “dangerous doses” of a hazardous combination of medication not clinically indicated or justified, with patients and relatives powerless in their relationship with professional staff.
 - 12.3 When the relatives complained about the safety of patients and the suitability of their care, they were consistently let down by those in authority – both individuals and institutions.
 - 12.4 Organisations from across the health service, the police and regulators failed to act in ways that would have better protected patients and relatives.
- 13 In reviewing our approach to the cases, the Panel found that during our investigations we:
 - 13.1 Dismissed material supplied by the police as not warranting action, and did not provide a rationale for this decision.
 - 13.2 Failed to communicate with the families of those affected appropriately between 2002 and 2010.
 - 13.3 Held up cases whilst waiting for third party action and relied on investigations carried out by others which in turn caused

greater distress for those involved.

- 14 It's clear from this review and the recent PSA report that we still have much more work to do to improve how we communicate with families, however, we are in many other areas a very different organisation to the one which considered these cases. Our approach to fitness to practise cases has changed significantly and we have many more mechanisms at our disposal to ensure that we are able to better protect the public, including:
- 14.1 The Regulatory Intelligence Unit which has started to collate, analyse and disseminate intelligence related to any potential risks to public and patient safety.
 - 14.2 The Employee Liaison Service which provides support to employers who may have a fitness to practise concern about a nurse or midwife.
 - 14.3 Established information sharing protocols and memorandums of understanding with a number of organisations, including the Care Quality Commission (CQC).
 - 14.4 Reviewing and formulating a clear action plan upon receipt of information from the police.
 - 14.5 Third Party Investigation Guidance and protocols for recording rationales should we decide not to proceed with an investigation pending third party investigation.
 - 14.6 In house clinical advice which we use to help us determine the level of risks, the seriousness of allegations and potential areas to explore through our investigations.
- 15 Over this period we have also improved the time in which it take us to investigate cases, which has been recognised by the Professional Standards Authority (PSA) as party of its annual review of our performance.
- 16 More broadly, the duty of candour and supporting guidance as well as the National Guardian's Office encourage all healthcare professionals to be open and honest when things go wrong. The introduction of clinical governance also ensures that employers are held to account for continuously improving the quality of their services.

Next Steps

- 17 The Panel's report and its findings are a testament to the courage and determination of the families of those who fought for 20 years to understand what happened to their loved ones at Gosport. It is clear that the families have been let down by the entire system and there

is much more that needs to be done in the future to improve.

- 18 We are currently reviewing the report carefully to understand if any further regulatory action is required. We will provide an update to Council on the progress of this work in September 2018.
- 19 We are also going through the entirety of the report to understand what lessons we need to learn as an organisation.
- 20 What we do know at this stage is that our communications with some of the families raising concerns about the treatment and subsequent deaths of relatives in Gosport War Memorial Hospital were extremely poor. For some who had lost loved ones there is no doubt that the way we handled the cases added to their distress. We made mistakes, did not admit these quickly enough and we did not do enough to put them right at the time.
- 21 We recognise that a number of nurses raised concerns early on and that these were not acted upon. It is important that we and others support health care professionals so that they feel they are able to speak up when they have concerns or when things go wrong.
- 22 In our response to the PSA's Lessons Learned Review, published on 16 May 2018, we committed to making changes to the way we work with all of those who come into contacts with us, including:
- 22.1 Improving the way we listen to and engage with people
- 22.2 Embedding a culture of openness and learning throughout the organisation.
- 23 There are many parallels with this report and we are therefore committed to ensuring that the lessons identified in the Gosport report are reflected and taken forward in our work to improve our approach to communication with patients, families and the public. Our associated programme of work is detailed elsewhere in the papers (Item 7).
- 24 **Recommendation: The Council is invited to discuss the Gosport Independent Panel Report and note the next steps being taken.**
- Public protection implications:** 25 The issues identified in the report clearly posed a risk to public protection at the time. We are currently reviewing the report to determine whether we may need to take any further action with regard to cases or new evidence.

Resource implications:

- 26 There are no resource implications at this stage.

Equality and diversity implications:	27	None.
Stakeholder engagement:	28	We are committed to engaging effectively with patients and members of the public as we take forward actions arising from this and the PSA's Lessons Learned Review.
	29	As part of this, a full programme of work that focuses on engagement with stakeholders, including patients, families and public groups will be developed as part of our response.
Risk implications:	30	We are currently reviewing the report to determine whether there is any further action required which will inform the level of risk posed.
Legal implications:	31	None.

Item 8: **Annexe 1**
NMC/18/57
25 July 2018

Gosport War Memorial Hospital The Report of the Gosport Independent Panel

Gosport War Memorial Hospital

The Report of the Gosport Independent Panel

June 2018

Return to an Address of the Honourable
the House of Commons
dated 20 June 2018 for

Gosport War Memorial Hospital: The Report of the Gosport Independent Panel

Ordered by the House of Commons to be printed on 20 June 2018



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Foreword by The Right Reverend James Jones KBE

Foreword by The Right Reverend James Jones KBE

When I first came to Gosport and met those who had historical concerns about how their loved ones had been treated in the town's War Memorial Hospital, there were eight families. Once the Independent Panel had been set up, we were soon in touch with over 100 families. The shocking outcome of the Panel's work is that we have now been able to conclude that the lives of over 450 patients were shortened while in the hospital, and to demonstrate that those first families were right to persist in asking questions about how their loved ones had been treated.

Over the many years during which the families have sought answers to their legitimate questions and concerns, they have been repeatedly frustrated by senior figures. In this Report, we seek to understand how and why this has happened. The obfuscation by those in authority has often made the relatives of those who died angry and disillusioned. The Panel itself felt some of that frustration directed towards ourselves at the beginning of our work. The families had already been let down so often that they saw no reason why they should trust a Panel set up by the Government, albeit an independent one.

Some of the family members are the first to acknowledge that their quest for truth and accountability has had an adverse effect on their own lives. They know that the frustration and anger that they feel has sometimes consumed them. This in turn has no doubt made those in authority less inclined to build a bridge towards them and to investigate their concerns thoroughly. But what has to be recognised by those who head up our public institutions is how difficult it is for ordinary people to challenge the closing of ranks of those who hold power.

It is a lonely place, seeking answers to questions that others wish you were not asking. That loneliness is heightened when you're made to feel even by those close to you that it's time to get over it and to move on. But it is impossible to move on if you feel that you have let down someone you love, and that you might have done more to protect them from the way they died. Many of the families to whom the Panel has listened feel a measure of guilt, albeit misplaced.

The anger is also fuelled by a sense of betrayal. Handing over a loved one to a hospital, to doctors and nurses, is an act of trust and you take for granted that they will always do that which is best for the one you love. It represents a major crisis when you begin to doubt that the treatment they are being given is in their best interests. It further shatters your confidence when you summon up the courage to complain and then sense that you are being treated as some sort of 'troublemaker'.

Many of the family members from Gosport have a background in the services. They were brought up to believe that those in authority are there to serve and to protect the community. The relatives did not find it easy to question those in senior positions. It says something about the scale of the problem that, in the end, in spite of the culture of respecting authority, the families, as it were, broke ranks and challenged what they were being told about how their loved ones were treated and how they died.

The Report of the Gosport Independent Panel

This Report is a vindication of their tenacious refusal to be dismissed. It shows how they were failed by the professional bodies and by others in authority charged with responsibility for regulating the practice of professionals in the interests of patient safety.

The documents that the Panel has found reveal that, as demonstrated in Table 1 at the end of the Report, during a certain period at Gosport War Memorial Hospital, there was a disregard for human life and a culture of shortening the lives of a large number of patients by prescribing and administering “dangerous doses” of a hazardous combination of medication not clinically indicated or justified. They show too that, whereas a large number of patients and their relatives understood that their admission to the hospital was for either rehabilitation or respite care, they were, in effect, put on a terminal care pathway. They show that, when relatives complained about the safety of patients and the appropriateness of their care, they were consistently let down by those in authority – both individuals and institutions. These included the senior management of the hospital, healthcare organisations, Hampshire Constabulary, local politicians, the coronial system, the Crown Prosecution Service, the General Medical Council and the Nursing and Midwifery Council. All failed to act in ways that would have better protected patients and relatives, whose interests some subordinated to the reputation of the hospital and the professions involved.

In the relationship with these powerful public bodies, the families have felt powerless. The Panel’s Report gives voice to their historical concerns and substantiates them.

The Panel – in submitting the Report to the Secretary of State for Health and Social Care in order for it to be laid before Parliament on Wednesday 20 June 2018 – expects the relevant individuals and authorities from whom documents were sought to address these historical concerns that the families have carried for over 20 years.



The Right Reverend James Jones KBE

Chair, Gosport Independent Panel

June 2018

Chapter 7: The Nursing and Midwifery Council

Introduction

7.1 In 2002, the Nursing and Midwifery Council (NMC) replaced the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) as the statutory regulator for nurses and midwives in the UK. As with its predecessor, the central functions of the NMC are described as being, *“to establish standards of education, training, conduct and performance for nurses and midwives and to ensure the maintenance of those standards”*.

7.2 The NMC’s main objective is to safeguard the health and well-being of persons using or needing the services of its registrants. As with the UKCC before it, the NMC is responsible for dealing with cases of alleged misconduct by nurses and midwives.

7.3 The Royal College of Nursing is a membership organisation and trade union which represents nurses and nursing. It has an in-house legal team and acts for its members when the NMC brings disciplinary proceedings against them.

7.4 The documents show that no referral was made to the UKCC, as it was then called. This chapter explains what the NMC did from the point at which it succeeded the UKCC in September 2000 up until its Preliminary Proceedings Committee (PPC) considered allegations against seven nurses. The chapter concludes by looking at a further complaint and communication with families.

How the Nursing and Midwifery Council became involved

7.5 As part of the second police investigation described in Chapter 5, Lesley Lack and Gillian Mackenzie, daughters of Gladys Richards, provided witness statements to the police which were critical of the care provided to Mrs Richards and also referred to the nursing staff. Mrs Lack gave her statement on 31 January 2000 (FAM003525). Mrs Mackenzie provided a witness statement to the police on 6 March 2000 in which she was critical of the actions of the nurse involved (BLC003731).

7.6 The documents show that Hampshire Constabulary did not make the UKCC aware of these criticisms at the time. On 18 September 2000, Detective Chief Inspector (Det Ch Insp) Raymond Burt wrote to the UKCC informing it that an investigation had begun into whether a woman had been unlawfully killed at the Gosport War Memorial Hospital in 1998. Det Ch Insp Burt asked *“whether there are any matters recorded which might be relevant to our investigation in terms of [the nurse’s] Professional competence”* (HCO000941, p2).

7.7 The UKCC appears to have treated Det Ch Insp Burt’s enquiry as a request for information sharing rather than a complaint. The Panel has not seen evidence of any further contact

between the UKCC and the police until May 2001 when the UKCC contacted Det Ch Insp Burt to let him know that, having been prompted by the Department of Health, it had reviewed its position in respect of the nurse and was seeking a meeting with the police (HCO000635).

7.8 The UKCC met with Hampshire Constabulary on 15 May 2001. A confidential briefing was provided by the police about the investigation into the nurse but no formal disclosure was made (HCO000635). Later that day, Liz McNulty, Director of Professional Conduct at the UKCC, wrote to Mike Woodford, the Force Solicitor for Hampshire Constabulary, explaining that the UKCC had not interpreted Det Ch Insp Burt's letter from September 2000 as being a complaint against the nurse. She asked whether Hampshire Constabulary *"believe that [the nurse's] conduct should be investigated by the UKCC, and whether your investigations so far have revealed any information about [the nurse's] conduct which may warrant his interim suspension from the register"* (HCO003123, p2).

7.9 The police disclosed material to the UKCC about those nurses who, on the advice of Professor Brian Livesley, a consultant physician at Chelsea and Westminster Hospital, might have had a degree of criminal culpability in relation to the treatment of Mrs Richards. The material disclosed to the NMC was limited to what had already been disclosed to the individuals when interviewed by the police and comprised the witness statements prepared by Mrs Mackenzie and Mrs Lack as well as the hospital notes for Mrs Richards (HCO000635, p148; HCO000913).

7.10 Det Ch Insp Burt wrote to the UKCC on 18 May 2001 stating that Professor Livesley had expressed a view that the two relevant staff nurses might have a measure of criminal culpability in respect of the treatment of Mrs Richards and enquiring whether either had been the subject of complaint or investigation by the UKCC (HCO000861). In response, the UKCC sought clarification as to whether the police were making a complaint against the two relevant nurses, as *"the UKCC can only investigate allegations against registrants in response to a complaint ... the situation is that if you are making a complaint against the three nurses, we are obliged to investigate"* (HCO005416, p3).

7.11 On 21 May, Hampshire Constabulary wrote to the UKCC stating that Det Ch Insp Burt's letter to the UKCC in September 2000 was not considered to constitute a complaint against one of the nurses because the police had no authority to make a complaint against him (HCO000914).

7.12 On 29 May, the UKCC informed the police that it had decided to open a file for the cases of the three relevant nurses (HCO000911).

The Nursing and Midwifery Council investigation: before Operation Rochester

7.13 On 21 June 2001, the Fareham and Gosport Primary Care Trust (PCT) responded to a letter from the UKCC. It described the circumstances of Mrs Richards' admission to the hospital, the complaint that the family had made to the PCT and the investigation that the PCT subsequently undertook (DOH700267). On 27 July, the PCT provided the UKCC with the material generated as a result of the complaint made to the PCT by Mrs Lack (DOH102868). This included the letter from Mrs Lack as well as the PCT's investigation report, which found no evidence of wrongdoing by any of the nurses (NMC100090, p222).

7.14 On 14 August, Hampshire Constabulary informed the UKCC that, following advice from the Crown Prosecution Service, no criminal prosecutions would be brought against the three relevant nurses (HCO003876).

7.15 On 18 September, the PPC of the UKCC convened to consider the cases of these nurses in relation to the treatment of Mrs Richards at the hospital. The PPC represented the first of a two-stage process which applied at the time (NMC100090).

7.16 The PPC carried out the following functions:

- investigations into cases of alleged misconduct
- determination of whether or not to refer a case of alleged misconduct to the Professional Conduct Committee with a view to removing practitioners from the register
- determination of whether or not to refer a case of alleged misconduct to professional screeners for consideration of a practitioner's fitness to practise
- determination of whether a practitioner was guilty of misconduct and, if so, whether it was appropriate to issue a caution as to their future conduct.

7.17 The PPC noted that the referral had been made by Hampshire Constabulary as part of the criminal investigation into the circumstances of Mrs Richards' death. It was noted that the family's main concerns were as follows:

- “1. On 12 August when first admitted to Gosport her agitation was put down to dementia when in fact it could have been simply that she wanted the toilet. She could have been treated with a milder form of pain relief.
2. When she suffered her fall a doctor should have been called before she was moved back to her chair.
3. On 13 August, it took a long time for staff to identify that she had suffered a fall. Her distress was continually put down to her dementia and she was not admitted to Haslar A and E until 24 hours after the fall.
4. On 17 August when she was returned to Haslar Hospital she was obviously in extreme pain from being positioned wrongly. Why was nothing done about this until Mrs lack arrived and assisted the nurse to move her.
5. When Mrs Richards developed a haematoma why was a decision made to do nothing other than to keep her pain free.” (NMC100090, p8)

7.18 The UKCC report noted that no specific allegations had been made against the three practitioners but identified concerns raised by Mrs Richards' family in respect of the conduct of each nurse. The UKCC report proposed that, for the following reasons, no action should be taken against the nurses:

- “1. The police are not proceeding with any criminal prosecution of any practitioner.
2. The Trust's findings do not support any allegations of misconduct.
3. The family's complaints are mainly about the medical treatment received by Mrs Richards, although they have identified some mistakes and delays in the system their evidence does not provide proof to the required standard of professional misconduct by any practitioner.” (NMC100090, p9)

7.19 Under the process in place at the time, when the UKCC had investigated a case and considered that it might lead to the removal of a practitioner from the register, it would write to the practitioner involved and then consider referral to the Professional Conduct Committee. In this case, the UKCC decided to take no further action.

7.20 The Panel notes that the PPC relied upon the Trust's findings and upon the decision not to take criminal proceedings rather than conducting its own enquiries. Mrs Richards' family were not informed of the decision of the PPC because they were not considered to be the complainants (NMC100090, p6).

7.21 On 6 February 2002, Hampshire Constabulary disclosed to the UKCC expert reports prepared by Professor Livesley, Dr Keith Mundy, a consultant geriatrician, and Professor Gary Ford, a medical professor at Newcastle University (HCO003853). At the same time, the reports were disclosed to the Hampshire and Isle of Wight Strategic Health Authority (HCO501408). On 11 February, Liz McAnulty responded for the UKCC, noting that as the police were not going to conduct any further inquiries, and given that the UKCC had to apply a similar standard of proof to matters of fact, it would not be progressing matters any further (HCO003121).

7.22 Liz McAnulty's letter prompted Detective Superintendent (Det Supt) Jonathon (John) James to respond on 21 February setting out the terms of the police inquiry. He highlighted the fact that the police investigation concerned the criminal offence of gross negligence manslaughter and said: *"this seems to me to be very different from determining, to the same standard of proof, that nursing or medical staff have failed to deliver care to the appropriate professionally recognised standards"*. Det Supt James went on to say:

"The reports previously forwarded to you were only a small part of the information gathered during the course of our investigations. In order to enable UKCC to discharge its functions as a regulatory body I have authority to share all information with you in addition to the material already supplied. I would stress that our enquiries have focused upon the potential criminal liability of individuals. I nor any other member of the enquiry team, have not, and could not, have come to an informed conclusion about the standard of care delivered by individual doctors or nurses against any recognised professional benchmark. Nevertheless, it appears that there is a prima facie case for enquiries to be commenced to establish whether or not individuals concerned in the care of patients described in the reports of Ford, Livesley and Mundy have failed to meet professional standards of care." (HCO501396, pp1–2)

7.23 On 13 February, Det Supt James wrote to family members who had made complaints about the treatment of their loved ones while in the hospital. While stating that there would be no further criminal investigation into the deaths, Det Supt James informed family members that the reports commissioned as part of the investigation had been forwarded on to the regulatory authorities, including the UKCC, which could *"Initiate further enquiries or act upon the reports as they deem appropriate"*. (See, for example, HCO003912.)

7.24 The documents show that the UKCC asked the Trust for comments on Professor Ford's report but took no other action. The Trust responded on 15 May, indicating that it would take no disciplinary action against any of the nurses named (NMC100012, p2).

7.25 Family members contacted the NMC (which had succeeded the UKCC) in 2002, expressing their concerns about the hospital:

- On 17 May, Bernard (Barney) Page made a formal written complaint about the treatment of his late mother, Eva Page, by the nurses involved. He considered that there were “*several areas of grave concern*” (NMC100338, p11).
- On 1 June, Marilyn Jackson made a formal complaint to the NMC about the “*appalling level of care*” given to her mother, Alice Wilkie, prior to her death at the hospital in August 1998. The complaint referred to the nursing staff generally and to a nurse by name (IMI000178).
- On 6 June, Ann Reeves wrote to the NMC lodging a formal complaint against the nurses involved in respect of the treatment of Mrs Reeves’s mother, Elsie Devine. Mrs Reeves stated that her mother had received treatment that was tantamount to “*abuse*” and that “*those involved in our Mother’s care are inhumane and a poor representation of the medical profession*” (NMC100338, pp7–8).
- On 19 June, Marjorie Bulbeck wrote to the NMC to register a formal complaint about the nursing care provided to her mother, Dulcie Middleton. The complaint referred to the conduct of individual nurses (albeit unnamed) and the poor standard of nursing care generally, stating that “*some nurses were uncaring and had an unprofessional attitude to vulnerable helpless patients*” and “*lacked humanity*” (NHE000584, p4). Mrs Bulbeck later wrote to the NMC naming a nurse as being responsible for the “*appalling care my Mother received whilst at the Gosport War Memorial Hospital*” (NMC100325, p358).
- On 22 August, Rita Carby wrote to the NMC lodging a formal complaint against the nursing staff alleging “*complete negligence*” on the part of the relevant nurses in the treatment of her husband, Stanley Carby (NMC100325, p372).

7.26 The NMC passed Mrs Bulbeck’s complaint on to the Trust (NHE000586, p2). The PCT referred the NMC to the report of an investigation carried out by Jane Williams, Nurse Consultant in Stroke Care. The report of the investigation, prepared by Fiona Cameron, Operational Director at the PCT, noted that the nursing documentation was inadequate and found certain concerns in relation to the treatment of Mrs Middleton but did not find evidence of any misconduct by a named nurse (NMC100325, pp363–5).

7.27 The NMC also referred the complaint from Mrs Carby to the Trust, which commissioned Professor Jean Hooper to prepare a report (DOH800992). Professor Hooper’s report concluded that, while there were discrepancies in the nursing records in terms of dates and times, she was “*unable to find any specific reason through review of the notes to indicate that the nurses were negligent in their care and management of Mr Carby*” (NMC100325, p377).

The Nursing and Midwifery Council investigation: during Operation Rochester

7.28 The complaints from Mrs Jackson, Mrs Reeves and Mr Page were referred to the PPC which, on 24 September 2002, considered the cases against four relevant nurses (NMC100323). Shortly before the PPC convened to consider these cases, Hampshire Constabulary reopened the investigation into the deaths at the hospital and initiated Operation Rochester to consider the circumstances surrounding the deaths of 90 patients. The PPC therefore decided to adjourn its own consideration of these cases pending the outcome of the further police investigation. The family members who had brought the complaints were informed of this decision on 27 September (NMC100268, NMC100269, NMC100272). Similar letters were sent to Mrs Bulbeck and to Mrs Mackenzie (NMC100267, NMC100270).

7.29 While it had the power to suspend the registration of any of the nurses pending the outcome of the police investigation, the PPC chose not to do so. The documents show no record of the reasons for this decision (NMC100327).

7.30 In October 2004, Hampshire Constabulary met with Liz McAnulty to brief her about Operation Rochester and to discuss the basis on which the information held by the police, and in particular the findings of the Key Clinical Team (KCT), could be disclosed to the NMC (HCO000641, p32). The briefing highlighted how the KCT had divided the cases into three categories: Category 1 (acceptable treatment), Category 2 (suboptimal care but no evidence of unlawful criminal activity) and Category 3 (warranting further detailed investigation to determine whether unlawful activity could be identified). The Category 3 cases were the subject of continued investigation by the police (NMC100012, p3).

7.31 As of 12 October, 19 of the Category 2 cases had been provided to the General Medical Council (GMC) and it was proposed that they would also be provided to the NMC. The police were keen to ensure that the material was provided on the basis that it would be used in private PPC hearings and that there would be no adverse publicity prior to the conclusion of any criminal investigation and proceedings that might follow (HCO001599).

7.32 The documents show that the police's request that matters be heard in private and without publicity created difficulty for the NMC. Complaints against some nurses had already been considered by the PPC, and had been adjourned pending the outcome of the police investigation. This was an important distinction. Where an allegation was received by the NMC before 1 August 2004 but proceedings had not commenced by that date, the matter would be dealt with under the procedures previously in place. Subsequent complaints, or other cases referred to the NMC, would be dealt with under the new procedures (the New Rules). In respect of all cases, however, in preliminary hearings the NMC would be required to disclose material to the registrant, expert witnesses, complainants or third parties.

7.33 The procedures for allegations received by the NMC on or after 1 August 2004 were governed by the New Rules. These provided a process whereby the Investigating Committee could make interim suspension orders or impose conditions on a practitioner's registration while an investigation was ongoing or where a matter had been referred by the Investigating Committee to the Conduct and Competence Committee but no final hearing had taken place. The Investigating Committee could make such an order if it was satisfied that it was necessary for the protection of members of the public or was otherwise in the public interest, or was in the interests of the person concerned. If the Investigating Committee considered that there was a case to answer, it refers the case to the Conduct and Competence Committee.

7.34 Under the New Rules, the NMC's Investigating Committee had the power to make interim orders. However, these hearings ordinarily took place in public, unless it was considered to be in the interests of a third party or in the public interest for the hearings to be held in private. Any interim order imposed on a practitioner had to be made public under the New Rules. In this case, the NMC was therefore unable to give categorical reassurance that there would be no publicity relating to hearings before the Investigating Committee if an interim order was considered necessary; nevertheless, the NMC would make representations that the hearing should take place in private. The NMC also confirmed that, ordinarily, no substantive hearing would take place before the conclusion of a criminal investigation (HCO007108).

7.35 It was agreed between the NMC and Hampshire Constabulary that before any material was released into the public domain by the NMC, the police would be given the opportunity to discuss their position with the NMC (HCO002261).

7.36 On 9 November, the NMC received files for 19 of the Category 2 cases containing the following material generated by the KCT:

- nursing expert report from Irene Waters (a summary of the significant information from patient records)
- relevant extracts from the report of Dr Robin Ferner (expert in pharmacology)
- relevant extracts from the report of Dr Peter Lawson (geriatrician)
- relevant extract from the report of Dr Anne Naysmith (palliative care)
- case review by Matthew Lohn, solicitor and partner at Field Fisher Waterhouse (NMC100086, p91).

7.37 The police also provided the NMC with the medical records for each patient. Clare Strickland, the in-house lawyer at the NMC, considered the papers that had been received but accepted that *“without further assistance [she] lacked the medical/practical expertise to be able to identify any evidence of misconduct”* (NMC100086, p91). She expressed the view that the NMC may have required an expert to consider the cases and identified Irene Waters – who had actually been a member of the KCT (p91). Irene Waters formed part of a five-person team charged with the duty of screening each case according to whether the overall care received was negligent, sub-optimal or optimal and whether the death had been natural or not. The team had not been instructed to identify specific issues of nursing care (see paragraph 7.30).

7.38 Clare Strickland began to review the files herself and formed the view that:

- the evidence in the case of the treatment of Mrs Page was insufficient to proceed against two relevant nurses
- in respect of the treatment of Mr Carby, it would be possible to prove that the nurse had failed to record the time of her nursing notes entries on 27 April 2004, but this alone would not be sufficient evidence of misconduct
- there was also no evidence of misconduct by the two nurses in respect of the treatment of Mr Carby (NMC100086, pp88–9).

7.39 Hampshire Constabulary continued to deliver files related to the Category 2 cases throughout December (NMC100086, p131) and by January 2005 had delivered 47 cases (p130). On 12 January 2005, the NMC told the police that it was unlikely to take any immediate further action in respect of the Category 2 cases which had been served on it and that any action it might take in the future would have to follow the conclusion of criminal proceedings (p127). Further boxes of files were sent to the NMC by the police in September and November 2005 (p120). The police continued to investigate the Category 3 cases and it was not until December 2006 that it was announced that there would be no criminal prosecution in relation to any of the deaths at the hospital.

The period following Operation Rochester

7.40 By February 2007, two months after the Crown Prosecution Service’s decision that there would be no criminal prosecutions, the NMC still had not received disclosure in respect of the ten Category 3 cases (NMC100086, p100). The NMC had received complaints about the treatment of five patients: Mrs Page, Mr Carby, Mrs Wilkie, Mrs Devine and Mrs Middleton. Clare Strickland had carried out a review of two of those cases (Mrs Page and Mr Carby) and considered that there was no case to answer in respect of any of the nurses named. The other three cases had not been reviewed.

7.41 Clare Strickland had reviewed the police reports, expert reports and case summaries prepared by Mr Lohn for the 76 cases provided to the police as part of Operation Rochester. She noted that there was “*no direct criticism of any named nurse in any of the expert reports*”, although there were examples of named nurses being criticised by family members (NMC100086, p69).

7.42 The ten Category 3 cases were provided to the NMC in March 2007 (NMC100086, p42). Clare Strickland reviewed them and concluded that the only files in which family members had expressed criticism of individual nurses were those of Arthur Cunningham and Mrs Devine. Of the 80 Category 1 and Category 2 cases only five contained material in which there had been expressions of dissatisfaction with named nurses (Mr Carby, Margaret Queree, Mrs Wilkie, Mrs Richards and Mrs Middleton). In respect of Mrs Richards, the case had been closed by the PPC (NMC100010). The lawyer acknowledged that she did not review every document provided:

“This is partly because I lack the clinical expertise to review medical records, but also because to review these files fully would be a full-time job lasting weeks and I do not have this sort of time available at present.” (NMC100012, p4)

7.43 Three years later she felt able to reassure the police, if asked, that:

“... every single case they passed to us was reviewed. I read all of the material provided, with the exception of the medical records, although I did refer to them when there was anything in the other material that led me to them. None of the expert reports contained any criticism of any named nurse. None of the police summaries of their contacts with the relatives contained anything amounting to an allegation against a named nurse or nurses.” (NMC100097, p4)

It is important to note that none of the experts engaged by Hampshire Constabulary had been asked to consider the position of the standard of nursing conduct in any case. Nor did any of the experts, asked to provide full reports, have the requisite expertise to deal with these issues.

7.44 The documents provided to the Panel show the NMC’s dismissal of the material supplied by the police as not warranting action but do not provide evidence of the basis on which the assessment was made. In respect of the five cases subject to complaint, Clare Strickland was of the view that there was insufficient evidence of misconduct on the part of any of the nurses referred to in the papers, save for the possibility of the failure of certain nurses to challenge the inappropriate prescribing administered by Dr Jane Barton in the cases of Mrs Wilkie and Mrs Devine. However, Clare Strickland did not appear to consider it necessary to obtain expert evidence on this matter, or on any other matter, despite her own acknowledgement that she did not have the medical/practical expertise to identify evidence of misconduct.

7.45 On 20 April 2007, Clare Strickland suggested that the next stage of the process would be to seek a meeting with the GMC in order to obtain information about the progress of its proceedings (NMC100012, p19).

7.46 The meeting with the GMC took place over a year later, in May 2008. By that time the GMC investigation was at an advanced stage. The Coroner had opened inquests into the ten Category 3 deaths and the GMC took the view that the disciplinary proceedings against Dr Barton should not take place until the conclusion of those inquests (PCO000279, NMC100039). The GMC considered that the NMC should not do anything that would discourage nurses from giving evidence at any GMC hearing to determine Dr Barton’s fitness

to practise. Clare Strickland was of the view that any proceedings that the NMC brought against the nurses should wait until the outcome of the GMC proceedings had been determined (NMC100086, pp34–6).

7.47 As Chapter 8 shows, the inquests into the ten deaths began in March 2009 and concluded in April 2009. In the interim, the NMC instructed Leading Counsel who, in February 2009, provided advice as to how the NMC should proceed (NMC100034). Counsel was not provided with all the paperwork but relied on the summary prepared by Clare Strickland. On this basis, Counsel concurred with her view that there was insufficient evidence to proceed with an allegation of misconduct against any nurse in the cases of Mrs Page, Mr Carby and Mrs Middleton. Counsel also took the view that there was no case to answer in respect of some of the allegations that had been made against the nursing staff in the cases of Mrs Wilkie and Mrs Devine. However, Counsel was of the opinion that there was “*a possible case of failure to challenge/report inappropriate prescribing*” (p12) in the cases of Mrs Wilkie and Mrs Devine.

7.48 Counsel had not been provided with any of the papers in relation to any of the remaining cases. She was therefore unable to advise on whether there was any prospect of establishing misconduct in those cases. However, Counsel was able to advise that these additional cases would fall to be determined under the new (and more flexible) rules that had been in force since 2004 (NMC100034). Counsel also expressed her opinion that the NMC had “*acted entirely properly in postponing disciplinary proceedings pending the outcome of investigations by the police and the subsequent inquests and the GMC proceedings*” (NMC100034, p12). However, Counsel also said that the cases adjourned by the PPC in September 2002 and the additional two complaints made in 2002 should be placed before the PPC as soon as possible. The PPC could decide to adjourn all the cases until the conclusion of the inquests and the GMC hearings or could deal with them immediately. The result would be that the cases involving Mrs Page, Mr Carby and Mrs Middleton would be closed immediately and the cases of Mrs Wilkie and Mrs Devine would be closed as well or postponed until the conclusion of the GMC proceedings.

7.49 The NMC was unable to arrange a meeting of the PPC before the inquest was due to start in March 2009. Clare Strickland took the view that it would be “*undesirable to arrange for the PPC meeting to take place whilst the inquest is ongoing*” and that, in any event, “*the PPC is unlikely to adopt any course other than adjourn pending the outcome of the inquest*” (NMC100105).

7.50 Following the conclusion of the inquests in April 2009, the NMC decided that the hearing before the PPC would not take place until the conclusion of the GMC hearing, which was scheduled for August 2009 (NMC100086, p5). It was envisaged that the hearing before the PPC would take place in early October 2009 (NMC100069).

7.51 On 21 August 2009, the findings of fact stage of the GMC hearing concluded. The Disciplinary Panel said that there was insufficient time to determine if Dr Barton’s actions amounted to misconduct or to decide whether or not a sanction should be imposed. The case was relisted for a sanction hearing in January 2010 (NMC100077).

7.52 Clare Strickland was of the view that while the GMC’s findings “*were not determinative... [they were] a relevant factor for the PPC to take into account. The key issue is whether the GMC finds that the doctor’s actions amount to serious professional misconduct*” (NMC100079). The decision was therefore taken to once again postpone the PPC hearing until the GMC hearings had concluded (NMC100114). The GMC proceedings concluded on 29 January 2010.

7.53 In November 2009, Christopher Green, solicitor at the Royal College of Nursing, emailed a Senior Case Officer in the Fitness to Practise Division of the NMC. Mr Green informed the Senior Case Officer that he was representing seven nurses who had been referred to the NMC and requested information in relation to the allegations that had been made. In January 2010, the NMC responded, giving the background to the referrals and a brief outline of the complaints, and proposing that the matter should be put before the PPC in late March/early April 2010 (NMC100122, p3).

7.54 On 17 March 2010, the Senior Case Officer wrote to the following nurses informing them that a complaint had been made against them:

- The nurse in respect of the treatment of Mr Carby (NMC100209)
- The nurse in respect of the treatment of Mrs Devine (NMC100220)
- The nurse in respect of the treatment of Mrs Devine (NMC100221)
- The staff nurse in respect of the treatment of Mrs Page and Mrs Devine (NMC100222)
- The sister in respect of the treatment of Mrs Devine and Mrs Page (NMC100224)
- The nurse in respect of the treatment of Mr Carby (NMC100229)
- The nurse in respect of the treatment of Mrs Wilkie, Mrs Middleton and Mr Carby (NMC100240).

Their cases were being referred to the PPC and would be considered together at a two-day hearing to be held on 11 and 12 April.

The Preliminary Proceedings Committee hearing into the five complaints

7.55 The PPC members were provided with a bundle of documents prepared on behalf of the NMC: Professor Ford's report; the CHI report; an investigation overview provided by Hampshire Constabulary; relevant transcripts from the inquests and the GMC hearing, as well as copies of the letters of complaint; and clinical notes and drug charts and nursing notes (where available) in respect of each of the five patients whose cases were being considered (NMC100325, p33). The PPC members were provided with responses prepared on behalf of each of the nurses (NMC100191).

7.56 The PPC members were also provided with a copy of a report prepared by Clare Strickland setting out the background to the referrals, the history of complaints at Gosport War Memorial Hospital and the police investigations, as well as the inquests and GMC proceedings (NMC100325, pp11–32). The report set out the evidence on misconduct and the conclusions on whether there was a case to answer.

7.57 The nurses faced the following allegations.

The relevant nurse

“In respect of Patient A (Alice Wilkie):

- Failed to maintain accurate patient records:
 - (i) On 17 August 1998, by writing a note suggesting that her daughter, Mrs Jackson, had agreed to a syringe driver for Patient A and that active treatment was not appropriate;

- (ii) On 21 August 1998, wrote in Patient A's clinical notes that her family had been present when she had died when they had not been;
- On 20 August 1998, failed to ascertain the level of pain Patient A was in;
- On 21 August 1998, failed to monitor Patient A appropriately and keep her family informed of her condition;
- On 21 August 1998, failed to monitor Patient A appropriately and keep her family informed of her condition." (NMC100325, p7)

"In respect of Patient B (Dulcie Middleton):

- Failed to ensure that meals were provided within her reach and on an occasion on an unknown date, without cutlery;
- Failed to ensure that her alarm bell was within her reach so that she could call for assistance;
- Failed to ensure that Patient B was kept warm;
- Failed to ensure that Patient B received basic nursing care or was treated with dignity." (NMC100325, p7)

"In respect of Patient C (Stanley Carby)

- Was negligent in the care provided to Patient C." (NMC100325, p7)

The relevant sister on the ward

"In respect of Patient D (Eva Page)

- Failed to act in the interests of Patient D." (NMC100325, p8)

"In respect of Patient E (Elsie Devine)

- Failed to act in the interests of Patient E by failing to remove a fentanyl patch from her until three hours after the morphine syringe driver has started;
- Failed to provide accurate information to Patient E's family when you telephoned that morning, in that you said that while she was confused you denied there was any urgency in family members attending;
- Returned clothes provided by Patient E's family by saying that they were 'too good' for a hospital stay (as they were dry clean only);
- Failed to ensure accurate patient notes were maintained for Patient E in that there was an incorrect statement in the notes on 3 November 1999 that she could not climb stairs. A kidney infection was diagnosed and antibiotics started, but this was not written up in the notes.

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At a subsequent independent review meeting relating to the care provided to Patient E:

- Suggested that she was agitated on the morning of 19 November 1999, but none of the family had ever seen her agitated.
- Made an unprofessional comment about tension between Mrs Reeves and her sister-in-law." (NMC100325, p9)

The relevant staff nurse

"In respect of Patient D (Eva Page)

- Failed to act in the interests of Eva Page." (NMC100325, p9).

"In respect of Patient E (Elsie Devine)

- Failed to provide the family of Patient E with any explanation about her medication.
- Failed to adequately account to Patient E's family for her sudden deterioration." (NMC100325, p9)

The relevant nurse

"In respect of Patient C (Stanley Carby)

- Failed to maintain accurate patient records in respect of Patient C, in that you failed to record the time in entries on the contact record.
- Was negligent in the care provided to Patient C." (NMC100325, p9)

The relevant nurse

"In respect of Patient C (Stanley Carby)

- Was negligent in the care provided to Patient C." (NMC100325, p9)

The relevant nurses

"Named as part of Anne Reeves' complaint against the nursing care provided to her mother, Elsie Devine." (NMC100325, p10)

7.58 In respect of all the allegations against each of the nurses concerned, the PPC declined to proceed (NMC100150). In respect of certain allegations, the PPC found that even if the facts were proven, it would not lead to the removal of the nurse from the register. In respect of other allegations, the PPC considered that the alleged behaviour was "*not capable of amounting to misconduct*".

7.59 In addition to the matters set out in the list of allegations, the PPC also considered certain nurses' actions in commencing patients on syringe drivers. The PPC found that, in respect of each of these allegations, the conduct of the nurses was not capable of amounting to misconduct and, therefore, declined to proceed with the matter (NMC100150).

7.60 On 1 June 2010, the Senior Case Officer wrote to the various complainants (NMC100207, NMC100208, NMC100233, NMC100234, NMC100235) and nurses (NMC100144, NMC100156,

NMC100177, NMC100186, NMC100189, NMC100151, NMC100147) informing them of the decision reached by the PPC not to proceed with any of the allegations and of the reasons given by the PPC in support of its decision.

A further complaint: Mr Cunningham

7.61 In June 2009, Charles Stewart-Farthing gave evidence at the GMC proceedings involving Dr Barton regarding the treatment of his stepfather, Mr Cunningham. On 24 June 2009, Mr Stewart-Farthing wrote to the NMC suggesting that the relevant sister and nurses “*all had a hand in [Mr Cunningham’s] demise*” (FAM102585).

7.62 The NMC responded by stating that the case would undergo an initial screening assessment and then requested further information (NMC100304, NMC100302). In October 2009, Mr Stewart-Farthing completed a consent form that allowed the NMC to disclose to the nurses concerned the information that a complaint had been made against them (NMC100295).

7.63 Five months later, on 30 March 2010, the NMC again wrote to Mr Stewart-Farthing requesting evidence specifying what the relevant nurses had done wrong. The NMC specifically asked for Mr Stewart-Farthing’s stepfather’s “*medical notes, or anything else (e.g. witness statements) which depicts the actual actions of the nurses with regards to the treatment of your step-father*” (NMC100301).

7.64 On 18 May, the NMC wrote to Mr Stewart-Farthing in these terms:

“As no response was received from you and due to the lack of direct evidence, the decision has been made to close this case. This is because without specific evidence regarding each nurse, the case is ‘not in the form required’ to enable progression to our panel.” (NMC100294)

7.65 In dismissing Mr Stewart-Farthing’s complaints about the role played by nurses in the death of his stepfather Mr Cunningham, the records show no evidence that the NMC investigated his complaint. The Panel is surprised by the NMC’s approach to the complaint raised by Mr Stewart-Farthing. Requests were made of Mr Stewart-Farthing for evidence upon which potential allegations could be made. However, the matters that were being raised by Mr Stewart-Farthing related to events that took place nearly a decade earlier. Furthermore, Clare Strickland had received evidence in relation to Mr Cunningham from the police and had, in March 2007, been able to identify criticisms of individual nurses made by Mr Cunningham’s family.

Communication with families

7.66 This chapter shows that no referral was made to the UKCC, as it then was, until September 2000. The documents reveal what the NMC did or did not do from that point to the decision of its PPC in April 2010 to decline to proceed in respect of all the allegations against each of the seven nurses concerned (NMC100150). The documents also reveal the almost complete lack of communication between the NMC and the families between August 2002 and June 2010 when they were told of the outcome. By its own admission, the NMC had been dedicated in that period to maintaining contact with the official bodies involved.

7.67 The documents show particular problems in the NMC’s communications with the family of Mrs Richards. The PPC decided in September 2001 not to proceed with the allegations but neither Mrs Mackenzie nor Mrs Lack, Mrs Richards’ daughters, were informed. A year later, the

NMC wrote to both Mrs Mackenzie and Mrs Lack wrongly suggesting that the investigation into the circumstances of their mother's death had been adjourned. The NMC was aware that it had made a mistake in this matter by, at the latest, May 2008 (NMC100086, p36). The records show that no attempt was made to communicate with the family for nearly two years (NMC100226, NMC100231).

7.68 The NMC recognised that its level of communication with the complainants had been poor. In a file note prepared by the Senior Case Officer, he noted that:

“... while the NMC had been dedicated to maintaining contact with Hampshire Constabulary, the coroner's office, the Trust, the GMC and its agents, on review it is recognised that better work should have been done at the time about engaging with those members of the public that have made complaints directly to the NMC.” (NMC100176, p4)

7.69 The documents show that Norman Lamb MP, then the Liberal Democrat Health spokesman, had written to the NMC's Chief Executive in November 2009 (NMC100357, NMC100356). In reply, Professor Dickon Weir-Hughes acknowledged:

“I accept that we could have been more pro-active in our engagement with those members of the public who had raised this issue with us. Notwithstanding some of the limitations about what we could have said about progress at various stages, I acknowledge that we could – and should - have kept patients, relatives and others with a key interest in the case better informed about developments and I would like to assure you that we will seek to improve on this aspect.” (NMC100343)

Conclusion: what is added to public understanding

- On 29 May 2001, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting informed Hampshire Constabulary that it had decided to open a file for the cases of three relevant nurses.
- The Panel notes that the Preliminary Proceedings Committee in effect relied upon Portsmouth HealthCare NHS Trust's findings and upon the decision not to take criminal proceedings rather than conducting its own enquiries. The family of Gladys Richards were not informed of the Preliminary Proceedings Committee's decision not to proceed with the allegations because they were not considered to be the complainants.
- The documents show the Nursing and Midwifery Council's dismissal of the material supplied by the police as not warranting action, but they do not provide evidence of the basis upon which their assessment was made. In respect of the five cases subject to complaint, Clare Strickland, the in-house lawyer for the Nursing and Midwifery Council, was of the view that there was insufficient evidence of misconduct in respect of any of the nurses referred to in the papers, save for the possibility of the failure of certain nurses to challenge the inappropriate prescribing administered by Dr Jane Barton in the cases of Alice Wilkie and Elsie Devine. However, the lawyer did not consider it necessary to obtain expert evidence in this matter, or in respect of any other matter, despite her own acknowledgement that she did not have the medical/practical expertise or the time to identify evidence of misconduct.

- The Nursing and Midwifery Council was extremely cautious in seeking not to undermine or in any way prejudice any of the other investigations. The length of the police investigation, the time spent before the inquests took place and then the subsequent time taken in the General Medical Council proceedings all meant that the delay before the Preliminary Proceedings Committee hearing took place was excessive.
- The documents also reveal the almost complete lack of communication between August 2002 and June 2010 when the families were told the outcome. By its own admission, the Nursing and Midwifery Council in that period had been dedicated to maintaining contact with the official bodies involved.

Part IV

How the Report adds to public understanding

Chapter 12: Summary and conclusions

Introduction and key conclusions

12.1 In waiting patiently for the Panel's Report, the families of those who died at Gosport War Memorial Hospital ('the hospital') will be asking: "Have you listened and heard our concerns, and has the validity of those concerns been demonstrated?"

12.2 It is over 27 years since nurses at the hospital first voiced their concerns. It is at least 20 years since the families sought answers through proper investigation. In that time, the families have pleaded that "*the truth must now come out*". They have witnessed from the outside many investigative processes. Some they have come to regard as "*farce*" or "*cover-up*". Sometimes they have discovered that experts who had found reason for concern had been ignored or disparaged. Sometimes long-awaited reports were not published.

12.3 The Panel has now completed its work. It has listened and heard the families' concerns and interrogated documents and personal medical records – including over one million pages of documents – which in their entirety had not previously been independently reviewed.

12.4 Having looked at documents covering the whole period since 1987, the Panel can say: "Yes, we have listened and yes, you, the families, were right. Your concerns are shown to be valid." Indeed, as this Report shows, the practice of anticipatory prescribing and administering opioids in high doses affected many patients and families – not only those who have led the way in pressing for the truth, but also very many other families.

12.5 Opioids are powerful drugs that bring significant benefits when used appropriately, but they carry commensurate risks. The Panel's analysis demonstrates that the lives of very many people were shortened as a direct result of the pattern of prescribing and administering opioids that had become the norm at the hospital.

12.6 For the initial group of 163 patients drawn to the attention of the Panel (**the Initial Group**), clinical records or key parts of them were not available in 58 cases. For the remaining 105 patients, the Panel found that in 71 cases there was evidence that opioids were used without appropriate clinical indication.

12.7 The starkness of this finding raised immediate concern that other patients, of whom we were not initially aware, might also have been affected. The Panel therefore sought all the clinical records for the 2,024 patients whom it was aware had died in the hospital between 1987 and 2001. The Panel found hospital records for 1,564 of these patients, and examined them for evidence of opioid use without appropriate clinical indication. In 1,043 of these patients (**the Wider Group**), there was sufficient information available for the Panel.

12.8 In 385 of the Wider Group of patients, the Panel found evidence of opioid use without appropriate clinical indication.

12.9 In summary, the Panel found evidence of opioid use without appropriate clinical indication in 456 patients. The Panel concludes that, taking into account the missing records, there were probably at least another 200 patients similarly affected but whose clinical notes were not found.

12.10 The Panel's analysis therefore demonstrates that the lives of over 450 people were shortened as a direct result of the pattern of prescribing and administering opioids that had become the norm at the hospital, and that probably at least another 200 patients were similarly affected.

12.11 In short, during the period between 1989 and 2000 at Gosport War Memorial Hospital, which appears to cover the start and end of the pattern of opioid prescribing of concern, the disclosed documents reveal that:

- There was a disregard for human life and a culture of shortening the lives of a large number of patients.
- There was an institutionalised regime of prescribing and administering “*dangerous doses*” of a hazardous combination of medication not clinically indicated or justified, with patients and relatives powerless in their relationship with professional staff.
- When the relatives complained about the safety of patients and the appropriateness of their care, they were consistently let down by those in authority – both individuals and institutions.
- The senior management of the hospital, healthcare organisations, Hampshire Constabulary, local politicians, the coronial system, the Crown Prosecution Service, the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) all failed to act in ways that would have better protected patients and relatives, whose interests some subordinated to the reputation of the hospital and the professions involved.

12.12 Relatives of patients at the hospital could have hoped that those responsible for healthcare would have identified what had happened, or that the various investigations conducted since they sounded the alarm would have done so. This Report has described how many experts were called upon to offer their opinion. However, none of them had access to the full range of medical records.

12.13 The families, and indeed the nation as a whole, are entitled to ask how these events could have happened; how the hospital dismissed the nurses' concerns and subsequently took no action; how the healthcare organisations failed to intervene; how the professional regulators allowed matters to continue; how the police failed to get to the bottom of what had happened; and whether what happened is to be explained as a conspiracy or in some other way.

12.14 From the documents it has examined, the Panel has been able to answer many of these questions as set out in this chapter. The Panel's Terms of Reference did not extend to any hospital other than Gosport War Memorial Hospital, then or now. So the Panel cannot speculate on whether anything similar to what happened at Gosport War Memorial Hospital also happened elsewhere.

12.15 It is not the Panel's role to ascribe criminal or civil liability. The Secretary of State for Health and Social Care and the relevant public authorities will want to consider the action that now needs to be taken to further investigate what happened at the hospital. The Secretary of

State will want to ensure that families who believe they were affected by events at the hospital have the support they deserve going forward, and also to consider wider lessons.

Summary of the chapters

12.16 The Terms of Reference require the Panel to explain how the documents it has considered add to public understanding of what happened at the hospital. Each of the chapters in this Report concludes by identifying those points of public understanding that can now be seen clearly and for the first time.

12.17 The Panel has interrogated the documents. Each chapter of this Report describes what the documents say about what happened at the hospital and how the responsible authorities chose to respond. The chapters explain what is added to public understanding in the case of the hospital and each of those authorities.

12.18 Chapter 1 shows that, following concerns first raised by Anita Tubbritt (a staff nurse working on Redclyffe Annexe), Sylvia Giffin, a fellow staff nurse, wrote to their manager in February 1991 expressing concern over the prescribing and use of drugs with syringe drivers.

12.19 The documents the Panel has reviewed show that between then and January 1992, a number of nurses raised concerns about the prescribing specifically of diamorphine. In doing so, the nurses involved, supported by their Royal College of Nursing branch convenor, put the hospital in a position from which it could have rectified the practice. In choosing not to do so, the opportunity was lost, deaths resulted and 22 years later it became necessary to establish this Panel in order to discover the truth of what happened. The documents therefore tell a story of missed opportunity and warnings unheeded.

12.20 Chapter 2 describes the drugs that were prescribed, including diamorphine, and the pattern of anticipatory prescribing that became the norm at the hospital. The occurrence of opioid use without appropriate clinical indication followed a clear pattern over time. We found no instances of this in 1987 or 1988, but from 1989 the number of cases rose markedly and then reached a plateau between 1994 and 1998. This was followed by an equally striking decline over 1999 and 2000, with no instances in 2001. Within the period 1989 to 2000, lives were shortened to the extent described in Chapter 2, see Figure 2, and earlier in this chapter.

12.21 Chapter 3 uses case studies to illustrate the experience of patients and relatives at the hospital. As well as confirming the pattern of prescribing and administration of drugs, Chapter 3 demonstrates the sub-optimal care and lack of diligence by nursing staff in executing their professional accountability for the care delivered. Patients and relatives were marginalised and their interests became subordinate to those of the professional staff.

12.22 Chapter 4 shows how the relevant healthcare organisations failed to recognise what was happening at the hospital and failed to act to put it right.

12.23 Chapter 5 sets out how Hampshire Constabulary dealt with the allegations made by the families, the shortcomings of the investigations, and the cases that were presented to the Crown Prosecution Service. The chapter explains that, although the investigations were protracted, they were limited in their depth and in the range of possible offences pursued. The documents show the involvement of senior officers including at chief officer level. The chapter also describes the response of the CPS, including the limitations in considering the possibility of corporate liability and health and safety offences.

12.24 The GMC's primary purpose is to protect patients. Chapter 6 shows that concerns about the hospital were brought to the attention of the GMC in 2000. It also describes the circumstances that meant there was a ten-year delay before the GMC's Fitness to Practise Panel considered sanctions against Dr Jane Barton, clinical assistant at the hospital.

12.25 The NMC's main objective is to safeguard the health and well-being of people using or needing the services of its registrants. Chapter 7 demonstrates a similar pattern with the NMC as the statutory regulator for nurses. From the point of referral to its predecessor body, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, in 2000, it would take ten years for the Preliminary Proceedings Committee to decline to proceed in respect of all the allegations against the nurses concerned.

12.26 Chapter 8 shows how the Coroner and Assistant Deputy Coroner proceeded with inquests nearly two years after the Crown Prosecution Service had decided not to prosecute.

12.27 Chapter 9 describes how the local and national media covered concerns about the hospital from April 2001 onwards. This was over two and a half years after Gillian Mackenzie and others contacted Hampshire Constabulary, thereby setting in motion the police investigation. The documents illustrate the sometimes close relationship between the police and the media, and how the police and healthcare organisations made contact with each other when the media raised questions.

12.28 Chapter 10 describes how Sir Peter Viggers, the local MP, questioned the need for repeated inquiries into what had happened at the hospital.

12.29 Chapter 11 describes the work of the Panel in delivering its Terms of Reference, and sets out the Panel's concerns about standards of record keeping and missing material.

Wider conclusions

12.30 In reviewing the documents for the respective chapters, the Panel has been able to draw upon the specialist expertise of Panel members relating to the prescribing and administering of drugs, medicine for the elderly, nursing skills and care for older people, the healthcare and regulatory systems, the police and prosecutions, the coronial system, government and the media. The chapters of this Report explain how the documents reviewed add to public understanding. In this final chapter, the Panel has been able to piece together the picture that has emerged, to look across the material as a whole and to answer the questions that have arisen.

12.31 The practice of anticipatory prescribing, and of administering certain drugs in circumstances and doses beyond what would have been indicated or justified clinically, involved the consultants, the clinical assistant, the nurses and the pharmacists. It was a practice that built up and continued over many years, and lives were shortened before the pattern changed significantly from 2000. Some nurses had questioned the practice in 1991, but it continued, becoming a culture and a norm for the wards involved. It became institutionalised on the wards.

12.32 One of the most difficult things to understand about these events is why so many people were prescribed and administered drugs that were not clinically indicated, in quantities sufficient to shorten their lives. The documents indicate two striking features. First, anticipatory prescribing was used on the basis that medication might become necessary at a time when the doctor covering a ward was unable or unwilling to attend in order to prescribe it. The documents show that inappropriate use of opioids not clinically justified became more and more common

over the years up to 1994, and persisted until 1998. This created a situation where powerful and potentially lethal medication was available for a large number of patients, and was expected to be used at some point.

12.33 The second feature of note is a pattern of clinical judgements being made that patients were close to death, regardless of the purpose of their admission or the plan in place. The documents show that these judgements were often not justified clinically and did not take into account patients' or families' views.

12.34 It may be tempting to view what happened at the hospital in the context of public debate over end of life care, what a 'good death' is, and assisted dying. That would be a mistake. What happened at the hospital cannot be seen, still less justified, in that context. The patients involved were not admitted for end of life care but often for rehabilitation or respite care. The pattern of prescribing and administering drugs was excessive and inappropriate in the ways explained in this Report.

The failure to act on the nurses' concerns: what is revealed as to how no one at the hospital listened to those concerns and intervened

12.35 The documents show that some nurses raised concerns in 1991. Their warnings went unheeded. The Panel has considered what the documents reveal about why those in authority at the hospital did not listen effectively.

12.36 It is clear from the documents disclosed that others in the hospital had knowledge of the way that powerful medications were used and the consequential shortening of lives. Most obviously, there was the attempt by some of the nurses to raise concerns, but other individuals should also have been aware of what was happening, including consultants, other doctors, nurses and managers. Yet a striking feature of the documents is that no one attempted even to challenge these behaviours.

12.37 The documents point to an explanation in a further aspect of the culture at the hospital. Part of that culture was a legacy of the concept of 'clinical freedom'. This held that medical decisions could not be questioned by other clinicians and managers, because they were based solely on individual professional judgement. In theory, this should have been entirely supplanted by evidence-based practice, but in many places this was slow to happen, and the documents suggest that it did not happen in the hospital in the period in question. While there should have been an accepted practice of challenge, for example from the nurses (beyond those who challenged in 1991), that was not the prevailing culture. Indeed, in accepting the medical judgement made most often by the clinical assistant, the consultants effectively supported rather than challenged the practice of prescribing and the nurses were themselves involved.

12.38 Towards the end of the 1990s, the culture of challenge should have been reinforced by the advent of clinical governance, which made clinicians and managers accountable for the quality of clinical care, crucially including patient safety. Again, this was slower to take effect in some places than others, and the disclosed documents show that this was the case in the hospital. The failure of the executive directors, including the medical director, to respond effectively to concerns about opioid prescribing raised by an external consultant physician who provided an independent report in 1999 is instructive in illustrating the rudimentary state of clinical governance at the hospital.

12.39 The disclosed material makes it clear that, notwithstanding the explanations of persistent notions of ‘clinical freedom’ and ineffective clinical governance, there were ample signs of problems that were serious enough to have overridden any concerns over professional boundaries.

12.40 Seen from this perspective, the events surrounding the nurses’ concerns of 1991 can be put into the correct context. Raising the concerns in the first place was a brave act given the culture at the hospital. There is evidence in the documents that the nurses felt ostracised as a result. After an unsatisfactory meeting at which the nurses were faced with an intimidating array of other staff, including doctors, the documents show that the nurses were dismissively told to take any future concerns up directly with the doctor whose practice they had reason to challenge. This placed the nurses in a position where the only means of pursuing their reservations was to confront, unsupported, an individual in a professionally dominant position.

12.41 The documents show that the nurses raised clear concerns in 1991, but these were ignored. From the perspective of 2018, it is hard to understand how such serious matters could be so easily discounted.

12.42 Those who raise concerns about the conduct and practice of colleagues are now widely known as ‘whistle-blowers’. To put it into context, it is generally agreed that the NHS has not been good at protecting people who take such a difficult step; as the documents make clear, the events of 1991 were no exception. Nor should the consequences for whistle-blowers be underestimated: these commonly included disciplinary action and undermining of professional credibility.

12.43 There is a wider point. The documents relating to the hospital correspond with evidence elsewhere in the health system and indeed in other sectors: organisations simply do not listen to what their frontline staff have to say. This is despite the fact that those members of staff see what is happening very clearly and can gauge its impact in practice, not least from engaging with members of the public, in this case patients and relatives.

12.44 If those responsible for the hospital had listened properly to what their own nurses said in 1991, and acted, the Panel is clear that the events described in this Report would not have followed the path they did. This should serve as a challenge to all those in positions of authority.

The response of individuals and organisations: what is revealed about healthcare organisations and their interaction with the police and regulatory organisations

12.45 The failure to heed the nurses’ warnings meant that, for many years, there was no effective challenge to what was happening at the hospital. When that challenge did come from the families, the documents reveal a pattern of response that even then did not focus on their concerns or effectively address them.

12.46 The documents show that, following a complaint to the Trust in 1998 and the police investigation, it should have become clear to local NHS organisations that there was a serious problem with services at the hospital. Although the successive police investigations undoubtedly complicated the NHS response, it is nevertheless remarkable that at no stage was there a public admission of failure or any public apology. Nor was there a proportionate clinical investigation into what had happened. On the contrary, the documents show numerous instances of defensiveness and denial – to families, to the public and the media, and to health service and other organisations.

12.47 In the years following the re-emergence of serious concerns about the hospital, beginning in 1998, many NHS organisations had knowledge of at least part of the picture: Health Authorities, Primary Care Groups and Trusts, the regional office of the NHS Executive, the Commission for Healthcare Improvement and the Department of Health. Despite this, the documents make clear that no external organisation was able to intervene effectively to find out what had happened, to ensure that corrective action was taken, and to give the answers that the families and the public should have had many years ago.

12.48 As this Report has shown, many disparate organisations were involved from 1998, and especially from 2000, spanning the health and justice systems. Between them, as is now clear from the documents, they failed to identify the nature of the underlying problem or to deal with it effectively. It is understandable that the families in particular have sought explanations as to why this was the case. There are two broad possibilities.

12.49 First, each organisation may have acted in its own interests and those of its leaders, motivated by reputation management, career self-preservation and taking the path of least resistance. This coincidence of interests would itself lead to identical responses across organisations, without there being a conspiracy between the organisations.

12.50 The second possibility is that there was collusion – a conspiracy between organisations to ensure that the views of the families were consistently frustrated. It is not clear what the underlying motivation would be for such a course, but it is understandable that the almost uniform consistency with which all concerns were dismissed and families were rebuffed might lead to suspicions of collusion or conspiracy between organisations.

12.51 The documents the Panel has reviewed do not contain evidence in support of such collusion or conspiracy. They show that the underlying explanation is the tendency of individuals in organisations, when faced with serious allegations, to handle them in a way that limits the impact on the organisation and its perceived reputation. This does not diminish the importance or the impact of organisations acting similarly and prioritising compliance with their own processes. Too readily opting for what is convenient within an organisational setting is the enemy of recognising the real significance of concerns and allegations.

12.52 The Panel is able to say in this case that there was a coincidence of interests across organisations; and that this may well have been sufficient to explain their conduct, including at times their dismissive treatment of the families.

12.53 Instead of listening to the families objectively, the documents speak of a tendency to dismiss them as troublemakers. For example, as Chapter 5 demonstrates, within a week of meeting two relatives, a detective constable wrote: *“I have no idea why these 2 sisters are so out to stir up trouble”*.

The response of individuals and organisations: what is revealed about focusing on an individual ‘rogue doctor’ following Shipman

12.54 A perception rapidly took root with both the police and NHS bodies external to the Trust that Dr Barton might be a ‘rogue doctor’ or ‘lone wolf’, operating surreptitiously and without authorisation. It is impossible to miss the significance of the relatively recent conclusion to the Harold Shipman case at the time, and there are several references, direct and oblique, to the Shipman case in documents briefing Ministers. It is notable that the Chief Medical Officer selected Professor Richard Baker to carry out the external audit of deaths in significant part because he had carried out a similar audit in connection with the Shipman investigation.

12.55 This perception, that the events might be due to ‘another Shipman’, cast a long shadow. Hence, even in 2007 when the final police investigation concluded, the obvious next step seemed to be to resume the GMC professional regulatory process against Dr Barton. The culmination of that process clearly dissatisfied many, including the GMC’s Chief Executive. However, the outcome was at least in part due to the exclusive focus on one individual when there were significant systemic problems – as the proceedings began to reveal – as well as the length of time that had elapsed by then.

12.56 It is clear from the documents that awareness of the Shipman case cast a shadow over how concerns at the hospital were viewed. Shipman was first arrested in September 1998. Whether for that reason or for some other reason, the police focused on the allegation that Dr Barton was guilty of unlawful killing, rather than pursuing a wider investigation. Hampshire Constabulary approached Dr Barton’s managers, including the then Chief Executive at the Trust, and Dr Althea Lord, the responsible consultant, in a way that ignored the possibility that they too might have been subject to investigation.

The response of the police: what is revealed about their approach and priorities

12.57 Chapter 5 reveals the approach taken by Hampshire Constabulary throughout its three investigations. It is no surprise to the Panel that the police approach failed to satisfy the families from the start. The documents show that the quality of the police investigations was consistently poor.

12.58 From the start, the mindset was one of seeing the family members who complained as stirring up trouble, and seeing the hospital, by contrast, as the natural place to go for guidance and assurance. As such, the police did not attempt to conduct enquiries in the same way as they would have done in a different setting; that is, one not involving medical decisions and treatment given in a hospital. The documents show that the police viewed the allegations as matters for the Trust and the regulatory bodies.

12.59 In reviewing the documents, the Panel has been mindful of how police forces set their priorities for investigation and for resources. In particular, in the period covered by this Report, both national and local targets informed that process of prioritisation. There are no documents referring to any decisions within Hampshire Constabulary to place less emphasis on their investigations into the hospital than on other activities that would have scored against any such targets. However, the Panel notes that organisations tend to favour acting in ways that are relevant to how they are measured or judged.

12.60 More generally, the evidence in this case suggests that, faced with concerns amounting to allegations of unlawful killing in a hospital setting, there are clear difficulties for police investigation. It is not clear to the Panel how the police can best take forward such investigations, and how they are to know whose advice to seek from within the health service without compromising their enquiries. This is particularly significant if the problem concerns the practice on a ward where more than one member of a clinical team is involved. It is a need that calls for action across different authorities, rather than a matter for the police service in isolation.

The response of individuals and organisations: what is revealed about wrongly relying on professional regulatory bodies

12.61 This exclusively individual focus by the police led to a continuation of the bar on investigating or sharing results pending completion of the regulatory process, in order to prevent the case being jeopardised. It also reinforced the perception that there were no systemic

issues to be addressed locally and thus no further reason to investigate. This, however, reflects a prevalent but incorrect view of the function of professional regulators like the GMC. Their function is neither to investigate systemic health service failures nor to punish errant doctors; rather, it is to protect the public by regulating the current fitness to practise of registered medical practitioners. Hence, even though the GMC found that there had been impairments to Dr Barton's fitness to practise, strictly speaking it was entitled to find that she was not a danger to patients by the time the hearing had been completed. The distress caused to families by the outcome of the GMC proceedings arose in part from the exclusive reliance of NHS bodies on the GMC, when it was not in fact an appropriate sole mechanism.

The response of individuals and organisations: what is revealed about suspending effective action pending police investigation

12.62 The documents illustrate the effect of the police investigations on all the external health service organisations. All concerned assumed not only that the police investigations took priority, but that they prevented any other investigations from proceeding. There were only two exceptions: the management investigation into the actions of managers who had failed to admit knowledge of the nurses' dossier (which was halted after its initial phase because another police investigation was under way) and the Baker Report (which was entirely records-based and could be carried out without requiring wider knowledge of the findings). Otherwise, not only were no investigations commissioned, but it appears (from their responses) that most NHS organisations were reluctant even to mention the problem.

12.63 This has been a common occurrence when police investigations into NHS services take place, and there are valid concerns. If interviewees are asked about events, if they talk to others and if they see or hear potential findings, their evidence would be regarded as contaminated by prior knowledge if a case came to court. The documents in this case make clear that at several points the police communicated this view and its attendant warning widely to national and regional health service bodies. It is clear that none wanted to risk any possible subsequent case being thrown out because they had failed to observe this precaution.

12.64 When the police investigations subsequently concluded without prosecutions, this bar was removed. It is notable, however, that there was still no effective NHS action. There are some obvious reasons for this, although none fully explains the failure to grasp a problem of this magnitude and significance.

The response of individuals and organisations: what is revealed about the use of experts

12.65 As noted earlier in this chapter, and in Chapters 4 to 8, a number of experts were engaged, including by the police, the NHS, the Chief Medical Officer and the Coroner. The documents show that none of these experts had access to the full range of medical records to which the Panel has had access, and they are therefore not responsible for the failure of the full picture to appear clearly until now. A more detailed review of the use of the experts is available at the Expert Overview on the Gosport Independent Panel website (<https://gosportpanel.independent.gov.uk/expert>).

12.66 The documents reveal weaknesses in how the experts were commissioned: there was sometimes no clarity on their remit and insufficient focus on the relevant specialist expertise required.

12.67 At times, the documents reveal a misuse, not just of the experts' opinions, given in good faith, but of the experts themselves. This, along with the poor standards in commissioning experts and making use of their contribution, points to a need for a more professional framework for the use of experts.

Completion of the Panel's Terms of Reference

12.68 The Panel understands the further deep anger and frustration of the families that none of the investigations effectively revealed the truth of what had happened. The Panel has listened to the families and the documents now disclosed enable that truth to emerge.

12.69 Nothing in this Report can restore to the families their loved ones whose lives were shortened. With this Report and an online archive of documentation, the Panel has completed its Terms of Reference. The Panel now calls upon the Secretary of State for Health and Social Care and the relevant investigative authorities to recognise the significance of what is revealed by the documentation in this Report and to act accordingly.

June 2018

Council

Ensuring patient safety, enabling professionalism: a new strategic direction for fitness to practise

Action: For decision.

Issue: Sets out a new strategic direction for fitness to practise, taking into account the consultation and research findings and the PSA lessons learned review.

Core regulatory function: Fitness to Practise.

Strategic priority: Strategic priority 1: Effective regulation.
Strategic priority 2: Use of intelligence.
Strategic priority 3: Collaboration and communication.
Strategic priority 4: An effective organisation.

Decision required: The Council is invited to consider our analysis of the key issues arising from the consultation, the research, and the Lessons Learned Review, and to approve the new strategic direction set out in Annexe 1 (paragraph 34).

Annexes: The following annexes are attached to this paper:

- Annexe 1: Ensuring patient safety, enabling professionalism: a new strategic direction for fitness to practise.
- Annexe 2: Consultation and research response.

Further information: If you require clarification about any point in the paper or would like further information please contact the authors or the director named below.

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- Context:**
- 1 Since April 2018, we have consulted on our proposed new strategic direction for fitness to practise, and completed qualitative research with external stakeholders on our proposals. We have also considered carefully the learning arising from the PSA Lessons Learned Review.
 - 2 As a result, we intend to proceed with our proposals with the following modifications to policy principles:
 - 2.1 Introducing a new strategic policy principle to reflect a person-centred approach to fitness to practise and the importance of engaging effectively with patients and families.
 - 2.2 Clarifying when we will take action to maintain public confidence or uphold standards.
 - 2.3 No longer suggesting that deliberately covering up when things go wrong will result in automatic removal from the register; we now say this conduct is likely to result in restrictive regulatory action.

- Four country factors:**
- 3 We intend our proposals to apply across the UK. Through our initial engagement work, consultation and research analysis, we recognise that there were no variations in the feedback from across the four nations. However, we are aware that there are significant differences in the healthcare economies across the four nations and will continue to engage across each as we roll out the strategy.

Discussion: Background to our proposals

- 4 In March 2018, the Council authorised us to consult on a proposed new strategic direction for fitness to practise. At that point, we set out proposals consisting of:
 - 4.1 Two regulatory outcomes.
 - 4.2 Ten strategic policy principles.
 - 4.3 Changes and improvements to achieve the outcomes and give effect to the policy principles.
- 5 Our proposals were made in line with the commitments in the NMC 2015-2020 strategy: ‘dynamic regulation for a changing world’:
 - 5.1 Striking the right balance between the public interest and proportionate use of resources by making appropriate use of alternative means of disposal, in place of full hearings.
 - 5.2 Engaging with employers to ensure our referral thresholds are understood and matters better handled locally do not result in

referrals.

- 5.3 Exploring the benefits of other approaches to adjudication.
- 6 We also recognised a pressing need to change our approach to fitness to practise for the following reasons:
 - 6.1 A growing body of evidence suggests that an unintended consequence of regulators' current fitness to practise model is a culture of blame and denial. That runs contrary to the values of openness and learning that are central to a patient safety culture.
 - 6.2 We know from our own research that black and minority ethnic nurses and midwives are more likely to be referred to us by employers. That disproportionality creates a perception of unfairness which, again, runs contrary to patient safety.
 - 6.3 Learning from the way in which we have handled cases in the past highlights the need for us to be much better at helping members of the public to engage with our processes.
 - 6.4 Our process is cumbersome, lengthy, and adversarial and, as a result, has a significant impact on all parties who engage with it.
- 7 In the longer term, we believe that legislative change is required to fundamentally reform the system of professional regulation. We wish to start the process of reform now, by setting a new strategic direction for fitness to practise, working for the time being within our existing legislation.

Public consultation and research

- 8 Between 4 April and 8 June 2018, we carried out a public consultation on our proposals to ensure that we understood the views of patients and members of the public, nursing and midwifery professionals, and other key stakeholders.
- 9 We had originally intended to close the consultation on 30 May 2018. After discussion with one of the family members affected by the events at Morecambe Bay, we extended the deadline to allow people an opportunity to consider their responses in light of the PSA Lessons Learned Review.
- 10 There were 892 responses to the consultation, with a large majority expressing support for our proposals. The responses were analysed independently by a third party and the full analysis has been published on the consultation page of our website:

www.nmc.org.uk/about-us/consultations/past-consultations/2018-

[consultations/ensuring-patient-safety-enabling-professionalism/](#)

- 11 At the same time, we commissioned a third party to complete a significant programme of targeted qualitative research with 206 people, including patients and service users, employers, and registrants. The research findings also indicated broad support for our planned strategic changes. The full research report has also been published on the consultation page our website (as above).
- 12 We received a full response to our consultation from the PSA and subsequently met with senior staff from the PSA to get further input. The full PSA response is available on their website:

www.professionalstandards.org.uk/publications/consultation-responses

- 13 We are very grateful to everyone who responded to the consultation and participated in the research.

Key issues arising from the consultation and research

- 14 We have considered very carefully the responses to the consultation, the research findings, and the learning from the PSA Lessons Learned Review. A consultation and research report, which sets out our analysis of the issues and what we intend to do as a result, is attached at Annexe 2.
- 15 A summary of the key issues relating to the proposed regulatory outcomes and strategic policy principles is set out below.

Regulatory outcomes

- 16 There was very significant support for our two proposed regulatory outcomes:
- 16.1 *A professional culture that values equality, diversity, and inclusion, and prioritises openness and learning in the interests of patient safety.*
- 16.2 *Registrants who are fit to practise safely and effectively.*
- 17 In their response, the PSA expressed concern that the first outcome (paragraph 16.1 above) may conflict with our statutory objective to protect the public, and that overrepresentation of certain minority ethnic groups in fitness to practise cases should not be a reason to raise the threshold for fitness to practise referrals. We do not share these concerns. As well as our statutory objective to protect the public, we have responsibilities under the Equality Act 2010 to promote equality and eliminate discrimination. We are not proposing to change the threshold for regulatory action on the basis of equality considerations: we are aiming to promote fairness in the way

professional concerns are handled in the sector.

- 18 We propose to adopt the two regulatory outcomes without modification.

Strategic policy principles

- 19 There was significant support for our proposed strategic policy principles. Based on the feedback, we propose to modify the strategic policy principles in the following ways:

- 20 A key finding from the Lessons Learned Review is that we must do much more to engage with patients and their families and take a person-centred approach to fitness to practise. The consultation responses and research findings supported that view. For that reason, we propose to add the following policy principle :

20.1 *Taking a person-centred approach to fitness to practise helps us to properly understand what happened, to make sure concerns raised by patients and families are properly addressed, and to explain to them what action we can take and why.*

- 21 One of the principles we consulted on was:

21.1 *We will only take regulatory action to uphold public confidence if the regulatory concern is so serious that otherwise the public would be discouraged from using the services of registrants.*

- 22 Overall, a large majority of consultation responses were supportive of this proposal. However, the research suggested that further clarity around ‘public confidence’ was required. Also, the PSA expressed concern about linking public confidence to whether misconduct would have a material impact on the likelihood of a member of the public using the services of registrants. In their view, it risks undermining the focus we should place on all three of the limbs of public protection (patient safety; public confidence; and upholding standards).

- 23 Based on the feedback we have received, we believe it is right to seek to clarify the thresholds for regulatory action. It is not our intention to focus on one of the three limbs of public protection at the expense of the others. We do wish to clarify when we believe regulatory action will be required on the basis of public confidence or upholding standards. We propose to substitute the following two new policy principles:

23.1 *In cases about clinical practice, taking action solely to maintain public confidence or uphold standards is only likely to be needed if the regulatory concern can't be remedied.*

- 23.2 *In cases that aren't about clinical practice, taking action to maintain public confidence or uphold standards is only likely to be needed if the concerns raise fundamental questions about the trustworthiness of a registrant as a professional.*
- 24 Two of the policy principles we consulted on were:
- 24.1 *Deliberately covering up when things go wrong seriously undermines patient safety and damages public trust in the professions. A registrant who does so should be removed from the register.*
- 24.2 *Some regulatory concerns, particularly if they raise fundamental concerns about the registrant's professionalism, can't be remedied and require removal from the register.*
- 25 There was very significant agreement about the seriousness of this type of conduct. However, a significant minority – including the PSA – disagreed that such conduct should automatically result in removal from the register. Respondents cited the need to consider context and mitigating factors. We agree with that feedback and we propose to amend the policy principles as follows:
- 25.1 *Deliberately covering up when things go wrong seriously undermines patient safety and damages public trust in the professions. Restrictive regulatory action is likely to be required in such cases.*
- 25.2 *Some regulatory concerns, particularly if they raise fundamental concerns about the registrant's professionalism, can't be remedied and require restrictive regulatory action.*
- 26 There was very significant support for our proposal to focus hearings on resolving central aspects of the case that are in dispute. The PSA expressed concerns that our proposal may not be consistent with our legislation and case law. We do not agree with their concerns. We have not identified any case law which conflicts with our position and we already have the power in our legislation to deal with cases at meetings. Meetings are hearings on the papers. Only the panel, a legal assessor and a panel secretary attend. The NMC is not represented and the nurse or midwife is not present, and witnesses are not called. A registrant always has the right to a full hearing if they request one.
- 27 We intend to proceed with this proposal. However, it is clear from the consultation responses and the research findings that we need to communicate our approach clearly to all concerned.
- 28 There was significant support for the remaining policy principles and we propose to proceed with them without modification.

Other feedback

- 29 The Lessons Learned Review, the consultation responses, and the research findings contain very rich commentary about ways in which we can improve what we do. We are prioritising the feedback, alongside an internal process mapping exercise to identify opportunities for continuous improvement projects. Our initial areas of focus are:

29.1 Reviewing our correspondence to improve our ‘tone of voice’.

29.2 Preparing for and completing hearings.

29.3 Managing cases involving third party investigations.

29.4 Managing correspondence, documents, and evidence.

Recommendation and next steps

- 30 Annexe 1 sets out our proposed new strategic direction for fitness to practise, *Ensuring patient safety, enabling professionalism*. It describes:

30.1 Why we’re going in a new direction.

30.2 What we want fitness to practise to look like (including the regulatory outcomes and the strategic policy principles).

30.3 How we plan to make changes to get there.

- 31 The new strategic direction is intended to set an ambitious direction for fitness to practise that will endure at least until the end of the current strategic planning cycle in 2020. Overall, we expect it to deliver the following benefits:

31.1 Improved professional culture.

31.2 Earlier resolution of cases.

31.3 Improved customer experience.

31.4 Increased confidence in the NMC as a regulator.

31.5 Reduced cost and improved efficiency.

- 32 Subject to the Council approving the new strategic direction we will start to implement it. The main deliverables in 2018–2019 are:

32.1 Updating our decision-making guidance to reflect the strategic policy principles and training colleagues so that they are able to use them.

32.2 Implementing a person-centred strategy, fully establishing the

public support service, and upskilling our people to engage better with patients and families.

32.3 Piloting a new approach to handling referrals from members of the public.

32.4 Developing new referral guidance and an online referral system for employers.

32.5 Piloting a new tool for assessing the context in which patient safety incidents occur.

32.6 Piloting a new approach to early and tailored remediation.

32.7 Piloting a consensual approach to hearings.

32.8 Starting to deliver continuous improvements projects.

33 We will report to the Council on progress through the performance and risk report during the remainder of 2018–2019. We will plan the next phase of implementation as part of the business planning cycle for 2019–2020, including the realisation of benefits.

34 **Recommendation: the Council is invited to consider our analysis of the key issues arising from the consultation, the research, and the Lessons Learned Review, and to approve the new strategic direction set out in Annexe 1.**

Public protection implications:

35 The proposed new strategic direction is intended to ensure that we continue to deliver our overarching objective to protect the public.

Resource implications:

36 We have made provision in the 2018–2019 budget for c. £870,000, for which we received approval in March 2018. The budget reflected the cost of consultation, implementation work planned for 2018–2019, and programme management. Currently after Q1, we are progressing well with our actual spend matching against forecast and budget. Cost reductions as a result of strategic change will be budgeted from 2019–2020. The strategic investment case (which was in the Council’s confidential papers in March 2018) contained more information about internal and external costs in the budget.

Equality and diversity implications:

37 Research tells us that our current fitness to practise processes do not contribute to a healthcare culture that values diversity, equality and inclusion. In particular, there is an overrepresentation of registrants from outside the EU and from black and minority ethnic (BME) backgrounds in fitness to practise proceedings. Therefore, one of the proposed regulatory outcomes was to create a professional culture that values equality, diversity and inclusion, and as such EDI is at the heart of the strategy. EDI has been considered

in the strategy from the planning stage.

- 38 We ensured our qualitative research was held with diverse groups, and the consultation included several questions on the EDI implications of the strategy. We took steps to ensure that a proportional number of people with key protected characteristics relevant to the fitness to practise process participated in the qualitative research, and with this in mind applied quotas for the recruitment of registrants to get views from people with diverse backgrounds.
- 39 An EQIA has been drafted and will be updated post consultation. We intend to do further work to ensure diverse views are captured as part of our ongoing engagement and implementation.
- Stakeholder engagement:** 40 Before and during the consultation period we undertook stakeholder engagement, including strategy briefings with NHS and independent employers, representative bodies (who are keen to be involved in co-creation activities in relation to regulatory theme deliverables), other regulators, patient groups and equality groups, and staff from across the NMC.
- 41 Consultation responses totaled 892 with 809 individual responses and 83 responses from organisations. 48 responses were from people who identified as a 'member of the public, service user or carer'.
- 42 206 participants took part in the qualitative research. The sample for this exercise was recruited from across the UK and included representation from England, Scotland, Wales and Northern Ireland.
- 43 113 registrant participants took part in the research and included representation from each of the four primary fields of practice for nurses (adult, children, mental health and learning disabilities) and midwives from a range of work settings, including non-NHS. It also included registrants who work in rural and urban locations, registrants who are early career and established registrants (defined as individuals with under or over three years on the register) and registrants from a range of religions/beliefs and sexual orientations.
- 44 41 employer participants (38 of whom were also registrants) took part in the research from a wide range of organisations and work settings including adult, children, corporate nursing, GP practices, learning disabilities, mental health, midwifery and private/non-NHS. They were also from varied levels of authority and included Directors of Nursing and Midwifery, ward managers and specialist managers.
- 45 49 members of the public participated in the research. 'Member of the public' was defined as any individual who has engaged with a service that employs registrants within the past six months. This was

to ensure that those involved in the study had recent experiences that they could reflect on during the discussions and to include those individuals most likely to interact with the services of registrants.

- 46 Three members of the public who have been involved with fitness to practise participated in the research. These individuals were included to ensure that members of the public who have interacted previously with the fitness to practise process were consulted as part of this research.
- 47 The sample size for the qualitative research was determined by the objectives of the study and whether or not new information related to the study objectives was likely to be found by adding additional participants. The point at which no new themes arise is known as the point of conceptual saturation. Based on the research provider's experience of conducting qualitative research, the conceptual saturation point was reached for each of the stakeholder groups during the research exercise.
- 48 Our engagement and communications plan sets out the main activities we will use to engage and co-create with stakeholders across the UK during the design, delivery, and evaluation of pilots. We have started planning a programme of engagement to support the full implementation of the strategy in the next financial year.
- 49 There is a continued focus on staff engagement. Monthly strategy progress reports to fitness to practise staff include short surveys providing a channel to feedback on progress. In addition staff participate in regular strategy activity workshops, regular staff engagement sessions and specific events such as the fitness to practise staff away day which took place on 6 July 2018 and focused on the strategy. NMC-wide staff are kept informed of progress at quarterly Community of Interest meetings which provides an opportunity for us to update colleagues across the NMC and capture their views.
- Risk implications:** 50 Over the course of the consultation and research, we received widespread support from key stakeholder groups for the strategy. The risk to programme success due to lack of external stakeholder engagement is lower at this point. However it remains a risk, and as we move into the pilot phase of the programme and subsequently the full implementation in 2019–2020, the risk is to the delivery of the strategic objectives and the realisation of benefits. This will be mitigated through ongoing stakeholder engagement and the co-creation approach that we are taking specifically with employers and representative bodies. In addition we will continue to seek feedback and views from registrants, patient groups and members of the public as we roll out strategic changes.
- 51 Secondly, a change in corporate priorities that would divert

resources away from the programme, remains to be a key risk to delivery. The use of pilots to trial the initiatives, and the resourcing of these pilots from within the BAU team helps to mitigate this risk.

**Legal
implications:**

- 52 Our proposals will be delivered within our existing legislative framework. In its response to our consultation, the PSA said that it believed there were some legal barriers to our proposed approach. We have since discussed this with the PSA and reviewed the case law. We are satisfied that there is no outstanding legal concern.

Ensuring public safety, enabling professionalism

New strategic direction

[INSERT FOREWORD FROM CHAIR]

This sets out:

- why we're going in a new direction
- what we want fitness to practise to look like
- how we're making changes to get there.

Why are we going in a new direction?

Our '*Dynamic regulation for a changing world*' strategy (2015–2020) encouraged us to:

- 'Strike the right balance between the public interest and proportionate use of resources by making appropriate use of alternative means of disposal, in place of full hearings'
- 'Engage with employers to ensure our referral thresholds are understood and matters better handled locally do not result in referrals'
- 'Explore the benefits of other approaches to adjudication.'

We've made significant progress in each of these areas since 2015 and have improved our ability to protect the public. However, our processes remain complex, and we continue to spend a large part of our resources on resolving cases at hearings which are adversarial in nature and consequently have a negative impact on the people involved. We know that some patients and

members of the public have felt distress at the length of time our process can take and how complex and impersonal it can seem.

We recognise that, in the continued absence of the wide-ranging regulatory reform which is required in fitness to practise, we have a responsibility to make sure that our fitness to practise function remains relevant and fit for purpose.

This new strategic direction is the product of our thinking in this area.

A number of key sources of information have helped us to get to this point:

- the responses to our consultation on a proposed future direction for fitness to practise, which ran between April and June 2018
- qualitative research on public attitudes towards fitness to practise, undertaken by ICE Creates between April and June 2018
- a literature review on how fitness to practise processes and healthcare investigations promote professionalism and patient safety
- the Professional Standards Authority's *Lessons Learned* report into our handling of the cases relating to the Morecambe Bay maternity deaths, published in May 2018
- the findings of the report into patient deaths at Gosport Memorial Hospital, published in June 2018
- the Williams review into gross negligence manslaughter, published in June 2018.

What do we want fitness to practise to look like?

In short, we believe that two key factors apply:

- *ensuring patient safety*: using our regulatory powers to encourage fairness, openness and learning; taking regulatory action where it's needed; and avoiding punishing nursing and midwifery professionals for mistakes
- *enabling professionalism*: supporting nursing and midwifery professionals to address concerns about their practice, so that members of the public can

continue to have confidence in the professions and confidence in us to promote and uphold high standards.

In order to properly explain this we need to set out our revised understanding of public protection, our desired regulatory outcomes and the policy principles that underpin them.

Public protection

Article 3(4) of the Nursing and Midwifery Order 2001 states:

‘The over-arching objective of the Council in exercising its functions is the protection of the public.’

Article 3(4A) states:

‘The pursuit by the Council of its over-arching objective involves the pursuit of the following objectives—

- (a) to protect, promote and maintain the health, safety and wellbeing of the public;
- (b) to promote and maintain public confidence in the professions regulated under this Order; and
- (c) to promote and maintain proper professional standards and conduct for members of those professions.

We’re required by law to make sure that public protection is at the forefront of our minds when we exercise any of our statutory functions. Within our fitness to practise process we’re committed to identifying, investigating and, if necessary, restricting the practice of those individuals who pose an ongoing and serious risk.

We know that protecting the public means more than managing and mitigating immediate patient safety risks. It goes further than that. We need to play our part in making sure that people have confidence in using the services of nurses and midwives generally. This can involve taking regulatory action to maintain public confidence or uphold standards of the profession, even if the registrant in question doesn’t pose a patient safety risk.

However, we recognise that taking regulatory action in these circumstances can have profound implications both for the individual registrant and the wider healthcare

environment. Each and every time someone is seen to be ‘punished’ for their actions through the intervention of the regulator, there is the risk that this contributes to a culture where it becomes more – not less – likely that the actions will happen again. The potential for registrants to focus on avoiding blame rather than acknowledging errors or weaknesses in their practice is increased.

This contribution to an anti-learning culture is clearly an acceptable trade-off in situations where there is an ongoing and serious risk posed by an individual or the concern about their fitness to practise is of such severity that not taking regulatory action against them would be untenable. It has considerably less justification in cases where the nurse or midwife has already addressed the concern, or where it’s of a less serious nature. Indeed, pursuing a case in such situations on the basis that it’s necessary to maintain public confidence or uphold standards has the potential to conflict with our patient safety responsibilities, if by so doing we undermine a culture of openness and learning.

In light of the above, we recognise that there is a need for us to be clear as to when we will take action under each part of our overarching objective and why. We have set out our thresholds for taking action later in this document.

Regulatory outcomes

Historically, fitness to practise has been viewed primarily as a vehicle for restricting the practice of registrants. We think this assumption needs to be challenged given that the nature and context of nursing and midwifery practice are shifting rapidly. We consider that effective and proportionate fitness to practise actually means putting patient safety first, and that an open, transparent and learning culture will best achieve this. We’re not alone¹ in thinking that a culture of blame and punishment is

¹ See, for example, Berwick, D. (2013). A promise to learn—a commitment to act: improving the safety of patients in England. London: Department of Health, 6, Francis, R. (2013). Report of the Mid Staffordshire NHS Foundation Trust public inquiry: executive summary (Vol. 947). The Stationery Office. The Francis Report itself cited Professor Ian Kennedy’s report into Bristol Royal Infirmary (Inquiry, B. R. I., & Kennedy, I. (2001). The report of the public inquiry into children’s heart surgery at the Bristol Royal Infirmary 1984-1995. Stationery Office.) and Professor Sir Liam Donaldson’s An organisation with a memory (Donaldson, L. (2002). *Clinical Medicine*, 2(5), 452-457) as reports well

likely to encourage cover-up, fear and disengagement, and we know that some people affected by things going wrong in the care of those close to them might expect that it's our role to discipline registrants for such incidents. We want registrants to engage with the fitness to practise process in a positive way and see it as an opportunity to learn and reflect on their practice, while increasing patient safety, and we want to better support the people who make complaints about care by explaining to them clearly that our purpose is to protect the public.

As the largest healthcare professional regulator in the world, we think we have a particular responsibility to lead in this area and that we need to be clear on what we want to come out of the fitness to practise process. We're calling these our regulatory outcomes.

A professional culture that values equality, diversity and inclusion and prioritises openness and learning in the interests of patient safety

We recognise that if people perceive there to be a culture of punishment in the profession, this could prevent an open, learning culture. It can lead to denial and cover-up and doesn't put patient safety first.

Academic studies² about how fitness to practise affects professionals have found that if people think their regulator is punitive or focused on blame, they're more likely to be anxious or even preoccupied about how their regulator might see their practice. This can lead to them being more likely to hide incidents that could affect patient safety. Recent work³ has found that cultures of blame are 'pervasive' in healthcare.

Research also tells us that our current fitness to practise processes don't contribute to a healthcare culture that values diversity, equality and inclusion. Registrants from outside the EU and from black, Asian and minority ethnic (BME) backgrounds are

over a decade ago that called for a move away from a culture of blame, and which the evidence suggested healthcare has yet to achieve.

² McGivern, Gerry, and Michael Fischer. Medical regulation, spectacular transparency and the blame business. *Journal of health organization and management* 24.6 (2010): 597-610.

McGivern, Gerry, et al. Exploring and explaining the dynamics of osteopathic regulation, professionalism and compliance with standards in practice. (2015).

³ Armstrong, N., Brewster, L., Tarrant, C., Dixon, R., Willars, J., Power, M., & Dixon-Woods, M. (2018). Taking the heat or taking the temperature? A qualitative study of a large-scale exercise in seeking to measure for improvement, not blame. *Social Science & Medicine*.

overrepresented in fitness to practise proceedings, driven by disproportionate referrals from employers⁴. This is a concern in other parts of the regulatory sector. General Medical Council research found that BAME and non-UK doctors are overrepresented in investigations⁵, while five years of General Dental Council hearings data reviewed by the British Dental Journal in 2009 showed that dentists trained outside the UK made up 42 percent of registrants charged⁶.

We're aware of these problems, and we want the way we regulate to help solve them. This is why we have identified a professional culture as our first desired regulatory outcome.

Registrants who are fit to practise safely and professionally

Now, more than ever, we need a healthcare workforce which is able to respond to the complex and changing needs of an expanding population. The nurses and midwives on our register play a vital part in this. We think that our fitness to practise operation needs to support the maintenance and development of a skilled, safe and professional workforce and not hinder it.

With this in mind, we want fitness to practise to deliver improvements to the safe practice and professionalism of those who enter the process and not to curtail or restrict practice unnecessarily. We recognise that there will be situations where restrictions on or removal from practice are inevitable but we don't think that these cases are the norm. Most registrants who have difficulties in their practice are willing and able to remediate the problem. We want to break down the barriers that stop them from doing so as early as possible.

Policy principles

We've developed a number of key principles for fitness to practise. We want these to inform the expectations of those who are involved in the process, whether these are registrants, patients, members of the public, employers or decision-makers. We are

⁴ West, Elizabeth, and Shoba Nayar. A Review of the Literature on the Experiences of Black, Minority and Internationally Recruited Nurses and Midwives in the UK Healthcare system. (2016).

⁵ General Medical Council: 'The state of medical education and practice in the UK 2015' www.gmc-uk.org/SOMEPEP_2015.pdf 63501874.pdf (pp. 58- 83)

⁶ Singh et al 'A five-year review of cases appearing before the General Dental Council's Professional Conduct Committee' British Dental Journal vol 206 no. 4 Feb 28 2009

happy to be judged by how well we keep to these principles and will be incorporating them into our own quality frameworks.

While these principles accord with our legislation and case law, they are also consistent with our underlying vision of a fitness to practise process that delivers our desired regulatory outcomes.

1. Taking a person-centred approach to fitness to practise helps us to properly understand what happened, to make sure concerns raised by patients and families are properly addressed, and to explain to them what action we can take and why.

What patients, their families and loved ones tell us about their experiences helps us understand the regulatory concerns about registrants. Sometimes, they provide vital information that shows we need to scrutinise the conclusions others have reached. Some patients and members of the public haven't felt supported or listened to in our fitness to practise proceedings. Putting patients and members of the public at the heart of what we do helps us to make sure we are in the best placed to protect the public.

2. Fitness to practise is about managing the risk that a registrant poses to patients or members of the public in the future. It isn't about punishing people for past events.

If professionals see us as being punitive, those professionals are more likely to hide things going wrong or act defensively. This will make it difficult to achieve the kind of open and learning culture that's most likely to keep patients and members of the public safe. If we are seen by the people affected by unsafe care as being there to discipline the registrants involved, those people may be distressed if we don't take action against registrants who are no longer a risk.

3. We can best protect patients and members of the public by making final fitness to practise decisions swiftly and publishing the reasons openly.

Transparency is crucial to an effective fitness to practise process. All the people involved in a case, including patients, members of the public and registrants, expect fitness to practise processes to be efficient and joined up. They need to understand clearly and as quickly as possible what we have done about the concerns, and the reasons for our decisions. Those reasons may help others in similar situations make decisions that will help keep patients and members of the public safe.

- 4. Employers should act first to deal with concerns about a registrant's practice, unless the risk to patients or the public is so serious that we need to take immediate action.**

Employers are closer to the sources of risk to patients and members of the public, and better able to recognise and manage them. If they need to, they can intervene directly and quickly in a registrant's practice, and do so in a targeted way dealing specifically with the risks. We are further away from the sources of possible harm, and have a more limited range of options to prevent it. We only need to become involved early on if the registrant poses a risk of harm to patients or the public that the employer can't manage effectively (perhaps because the registrant has left), meaning the registrant's right to practise needs to be withdrawn or restricted immediately.

- 5. We always take regulatory action when there is a risk to patient safety that is not being effectively managed by an employer.**

In the small number of cases where employers can't put the right controls in place to keep patients and members of the public safe, then we will need to become involved. This can often happen when the registrant practises in more than one setting, or doesn't have an employer, although these aren't the only examples. We may need to consider putting conditions on the registrant's ability to practise, or remove it.

- 6. We take account of the context in which the registrant was practising when deciding whether there is a risk to patient safety that requires us to take regulatory action.**

When incidents of poor practice actually happen because of underlying system failures, taking regulatory action against a registrant may not stop similar incidents happening again in the future. Regulatory action against an individual registrant may give false assurance, direct focus away from a wider problem and cause a future public protection gap.

- 7. We may not need to take regulatory action for a clinical mistake, even where there has been serious harm to a patient or service-user, if there is no longer a risk to patient safety and the registrant has been open about what went wrong and can demonstrate that they have learned from it.**

Encouraging registrants to learn from mistakes, including mistakes with serious consequences, is more likely to promote a learning culture that keeps patients and members of the public safe than taking regulatory action to 'mark'

the seriousness of the consequences. Negative stories about regulation have a harmful effect on registrants. We want to assure registrants that they won't be punished if they admit to, and show they have learned from, past mistakes because this will support them in positively engaging with their professional duty of candour and help promote, rather than discourage, the kind of professional culture that's been shown to keep people safe.

8. Deliberately covering up when things go wrong seriously undermines patient safety and damages public trust in the professions. Restrictive regulatory action is likely to be required in such cases.

The duty of candour requires registrants to be open and honest when things go wrong. It stops them from trying to prevent colleagues or former colleagues from raising concerns. We know that if professionals don't speak up when things go wrong, significant numbers of people can suffer harm, and have done in the past. Registrants who try to cover up problems in their own practice deny patients and members of the public the honest explanation and apology they deserve when they have been put at risk of harm. It can also put other people at risk of suffering harm if organisations are prevented from investigating wider problems.

9. In cases about clinical practice, taking action solely to maintain public confidence or uphold standards is only likely to be needed if the regulatory concern can't be remedied.

If the registrant has fully remedied the problem in their practice that led to the incident, and already poses no risk to patients, the case is unlikely to be serious enough to need us to take action to uphold public confidence in all registrants, or to declare standards for them. As our role is not to punish people for past events, only those cases that can't be remedied are likely to be serious enough for us to need to take regulatory action to promote public confidence or uphold standards.

10. In cases that aren't about clinical practice, taking action to maintain public confidence or uphold standards is only likely to be needed if the concerns raise fundamental questions about the trustworthiness of a registrant as a professional.

We know that the public take concerns which affect the trustworthiness of registrants particularly seriously. Our research told us that these cases are likely seen by the public as serious breaches of professional standards. Conduct that could affect trust in registrants and require action to uphold

standards or public confidence include, where related to professional practice, dishonesty, bullying and harassment. Within a registrant's private life, convictions that relate to specified offences or result in custodial sentences are also likely to require regulatory action for the same reason.

11. Some regulatory concerns, particularly if they raise fundamental concerns about the registrant's professionalism, can't be remedied and require restrictive regulatory action.

Conduct that calls into question the basics of someone's professionalism raises concerns about whether they are a suitable person to remain on a register of professionals. It's more difficult for registrants to be able to remedy concerns of this kind, and where they cannot, it will be difficult to justify them keeping their registered status.

12. Hearings best protect patients and members of the public by resolving central aspects of a case that we and the registrant don't agree on.

Full public hearings are not always required to reach a decision that protects the public. Their adversarial nature often has a negative impact on people, and they are slow and resource intensive.

How are we making changes to get there?

The changes and improvements we intend to deliver in 2018/19 and 2019/20 are:

A person-centred approach

We will:

- launch a person-centred strategy
- complete the set-up of our Public Support Service, including:
 - holding meetings with patients and family as part of the fitness to practise process
 - delivering training to fitness to practise staff.
- explain better how our process works and set expectations more effectively
- improve how we engage members of the public
- explain key decisions to members of the public who have an interest in the case and seek their input where it is appropriate to do so.

Applying our policy principles to how we make decisions

Our decision-maker guidance will be updated in September 2018 to incorporate the 12 policy principles.

Prioritising effective local action by employers

In order to prioritise effective local action by employers we will:

- produce new referrals guidance and an online referrals system for employers
- introduce a new approach to handling referrals from members of the public.

Taking account of the context in which safety incidents occur

To make sure that we take context into account across our processes we will:

- introduce guidance that sets out why context is relevant and how we will take it into account when we make decisions
- introduce a tool to standardise the way we assess context, and build this into our decision-making.

Enabling remediation

To help registrants to remediate regulatory concerns at the earliest opportunity, we will:

- engage more with the registrant at the beginning of the process
- provide a more tailored approach to remediation in respect of easily remediable cases.

Only holding full hearings to resolve material disputes

To make sure that we're only holding full hearings when there is a material dispute, we will:

- update our criteria for when a case needs to be heard at a hearing
- introduce a process for the use of statements of case in meetings.

Working effectively with regulators and other key stakeholders within clearly defined boundaries

We will:

- define more clearly the routine interactions we expect to have, and the information we expect to share, with other organisations in the interests of public protection
- refer concerns to other organisations where they are better placed to deal with them than we are
- explore opportunities for joint working where they're in the interests of public protection.

Continuous improvement

We will improve the way we operate by embedding continuous improvement in our culture.

Following an initial review of our processes, we will start to make changes and improvements in the following areas:

- preparing for and completing hearings
- managing cases involving third party investigations
- managing correspondence, documents, and evidence.

We will fundamentally review our processes more fundamentally in line with the plan to replace our case management system.

Consultation report: Ensuring patient safety, enabling professionalism

Introduction

1. From 4 April to 8 June 2018 we consulted on changes to our fitness to practise function. We proposed reforming fitness to practice with a new strategy: *Ensuring patient safety, enabling professionalism*.
 - **ensuring patient safety**: using our regulatory powers to encourage fairness, openness and learning, taking regulatory action where it's warranted, and avoiding punishing nursing and midwifery professionals for mistakes
 - **enabling professionalism**: supporting nursing and midwifery professionals to address concerns about their practice, so that members of the public can continue to have confidence in the professions and confidence in us to promote and defend high standards.
2. We proposed ten strategic policy principles for fitness to practise, to inform the expectations of those who are involved in the process. We revisit those principles in this report.
3. We received a significant number of responses to our consultation: 892 responses, of which 809 were from individuals and 83 from organisations. Of the 747 respondents who told us more about themselves, 48 identified as being a 'member of the public, service user or carer' and 573 said they were a UK registered nurse or midwife.
4. The number of responses compares very favourably to other consultations concerning fitness to practise. We thank everyone who took the opportunity to respond and in doing so has helped shape our strategy.
5. During the same period we commissioned ICE¹ to carry out qualitative research with key stakeholders including employers, registrants, members of the public and members of the public who have been involved in the fitness to practise process. This was to understand current perceptions of fitness to practise and the acceptability of our proposed strategy.
6. ICE conducted the research² across the four UK countries and engaged with a diverse sample of participants. The final sample of 206 included:
 - 49 members of the public who had used the service of registrants in the last six months and 3 members of the public who had been involved in fitness to practise in the last three months. This included representation from male and females and a wide range of age groups. 14% were from black and minority ethnic groups (BME)

¹ ICE Creates Ltd, www.icecreates.com.

² We have published this on our consultation webpage at www.nmc.org.uk/about-us/consultations/past-consultations/2018-consultations/ensuring-patient-safety-enabling-professionalism/

- 113 registrants from a range of practise areas and work settings, and who were representative of the ethnicity and gender of the registrants who interact with fitness to practise
- 41 employers from a range of work settings including private and NHS, and from varied levels of authority.

7. This document sets out a summary of the responses we received to the consultation and research analysis. You can find further detailed analysis on how organisations and individuals responded to our consultation and our full qualitative research report on the consultation page of our website at: www.nmc.org.uk/about-us/consultations/past-consultations/2018-consultations/ensuring-patient-safety-enabling-professionalism/

The changes we are making

8. We have used the responses and research to inform the changes we have made to our strategy. The main changes are:
- Introducing a new strategic policy principle to reflect a person-centred approach to fitness to practise and the importance of engaging effectively with patients and families.
 - Clarifying when we will take action to maintain public confidence or uphold standards.
 - No longer suggesting that deliberately covering up when things go wrong will result in automatic removal from the register; we now say this conduct is likely to result in restrictive regulatory action.
9. We deal with these changes in more detail throughout the relevant sections of our report.

Background

10. We've made several improvements to our processes in recent years. We made some of these through legislative change, such as the introduction of case examiners. Other reforms involved changes to how we operate, such as supporting employers and improving the quality of referrals with the Employer Link Service.
11. In January 2017 the General Dental Council (GDC) published *Shifting the balance: a better, fairer system of dental regulation*. This discussion document set out the GDC's views on reforming dental regulation without relying upon legislative change. For fitness to practise, it outlined a refocus: being clear about the serious nature of 'impaired fitness to practise' and taking action to ensure that anything short of that is dealt with using alternative tools with the right touch, and providing support to patients to find the best mechanism for resolving their issue.
12. In October 2017, the Department of Health published *Promoting professionalism, reforming regulation, a paper for consultation*. This consultation recognised that regulation needs to change. From the perspective of patients and the public, the current system of regulation can be confusing, inconsistent and slow, and the adversarial nature of fitness to practise proceedings does not support the early identification and resolution of concerns. To meet the challenge of changing healthcare systems, it proposed that regulators should be given greater autonomy to innovate, without having to wait for legislation, and while working with other groups to better support professionalism.
13. In November 2017 the Professional Standards Authority for Health and Social Care (the PSA) published a report, *Right-touch reform: A new framework for assurance of professions*. This report proposed a number of guiding principles for reform. For fitness to practise, it proposed only using fitness to practise measures when necessary and seeking early resolution and remediation where appropriate. The report also proposed 'a more radical principle' of only using formal adjudication when a registrant disputes the case.³
14. The common theme in all these publications is that the current model of regulation needs to change. The fitness to practise model needs to be flexible and proportionate, and foster professionalism. Regulators have a key role to play in this.
15. It's against this backdrop that we commissioned research, engaged with stakeholders and developed our proposed strategy for reforming fitness to practise that puts patient safety first, and supports an open, transparent and learning culture that values equality, diversity and inclusion.

The evidence base for our strategy

16. In developing our strategy we reviewed the literature, reviews of fitness to practise and healthcare, and research already undertaken by other regulators and the PSA. It's clear that a culture of blame and punishment is likely to encourage cover-up, fear

³ The PSA deemed this as radical in light of what case law suggests. However, in the PSA's view there would be value in re-evaluating this assertion. [Right Touch Reform](#), paragraph 3.216

and disengagement.⁴ From our review, we found that if people think that their regulator is punitive or focused on blame, they're more likely to be anxious or even preoccupied about how their regulator might see their practice. This can lead to them being more likely to hide incidents that could affect patient safety.

Research

17. In January 2017, we commissioned research into the *Progress and Outcomes of Black and Minority Ethnic (BME) Nurses and Midwives through the Nursing and Midwifery Council's Fitness to Practise*.⁵ The research tells us that individuals in the black and unknown ethnic categories are referred to us with greater frequency than would be expected given their numbers in the population of registrants.
18. Males are referred to us at around twice the rate than would be expected given the number of male nurses and midwives registered with us. So, male registrants from a BME background may experience a double disadvantage in that they are a minority in society by virtue of their ethnicity and a minority in the profession by virtue of their gender.
19. Employers and members of the public are the most frequent sources of referrals. Employers refer more BME registrants than we would expect given the proportion of BME registrants on our register. Conversely, members of the public refer mainly white registrants and are less likely to refer any of the other ethnic groups.
20. However, when we hold final hearings, BME registrants are the least likely to receive a penalty that prevents them from working. This suggests that the fitness to practise process does not discriminate against BME registrants, but that there is some evidence of discrimination in terms of the disproportionate number of referrals by employers.
21. This identifies support for gearing our regulatory processes towards supporting a professional culture that values equality, diversity and inclusion.

Just Culture

22. Organisations across the healthcare sector have recently been working to embed a just culture approach to investigations for a number of years. A just culture involves

⁴ See, for example, Berwick, D. (2013). *A promise to learn—a commitment to act: improving the safety of patients in England*. London: Department of Health, 6, Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust public inquiry: executive summary* (Vol. 947). The Stationery Office. The Francis Report itself cited Professor Ian Kennedy's report into Bristol Royal Infirmary (Inquiry, B. R. I., & Kennedy, I. (2001). *the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995*. Stationery Office.) and Professor Sir Liam Donaldson's *An organisation with a memory* (Donaldson, L. (2002). *Clinical Medicine*, 2(5), 452-457) as reports well over a decade ago that called for a move away from a culture of blame, and which the evidence suggested healthcare has yet to achieve.

⁵ West et al (2017), [The Progress and Outcomes of Black and Minority Ethnic \(BME\) Nurses and Midwives through the Nursing and Midwifery Council's Fitness to Practise Process](#); Ice Creates Ltd research (2018), NMC: *Fitness to Practise Insight* [Published at <https://www.nmc.org.uk/about-us/governance/the-council/council-meetings/council-meeting-25-july-2018/>]

avoiding blame and punishment when things go wrong, if a reasonable professional would have acted similarly in the circumstances. Above all it focuses on learning from mistakes to make systems safer. Some of the more recent developments in this direction include:

- the establishment of a Just Culture Taskforce for England by the Department of Health in January 2017
- Healthcare Safety Investigation Branch (HSIB) becoming operational as an independent investigation body for serious safety incidents in the NHS in England in April 2017
- publication of the Health Service Safety Investigations Bill, establishing the Health Service Safety Investigations Body (HSSIB) to build on the work done by HSIB in September 2017
- NHS Improvement adopting a Just Culture tool for the NHS in England at the end of March 2018.

23. We welcomed these developments. HSSIB is part of an ambition to create a more open, learning culture across the NHS and represents, ‘a landmark moment for patient safety across our NHS, and is a historic opportunity to achieve widespread cultural change in learning from mistakes’.⁶

24. We think that changing our approach to fitness to practise gives us the chance to be part of the solution; we have engaged with the organisations at the forefront of this approach and think that our role can help to underline that a just culture approach is the one most likely to keep patients and the public safe.

Stakeholder engagement

25. During our consultation we communicated with our stakeholders, setting out our proposed strategy, listening to their views and encouraging them to respond to our consultation. Our stakeholder base spanned the four nations and sought to include all the groups we interact with. It included registrants, employers, healthcare bodies and charities, people with first hand experiences of fitness to practise, such as patients and patient organisations, and registrants who had been referred to us and who had gone through the fitness to practise process.

26. As well as email and telephone conversations, we held roundtable events and webinars. We spoke with panel members and our staff. After our consultation closed, we continued to speak with interested people and organisations.

⁶ Secretary of State for Health, Jeremy Hunt, <https://www.gov.uk/government/news/new-bill-to-improve-patient-safety>

Lessons learned review

27. During our consultation period the PSA published the *Lessons Learned Review*.⁷ The review considered our handling of concerns about midwives at the University Hospitals of Morecambe Bay NHS Foundation Trust.
28. We welcomed the review and agree with its recommendations. Our approach to the Morecambe Bay cases, in particular the way we engaged with the families, was unacceptable. We missed opportunities to deal with concerns sooner and this put the public at higher risk. We are sorry for this. We take the findings of the review extremely seriously and we're committed to change and improvement.
29. Our strategy recognises this and is part of the significant changes we have made to the way we work. The views of families and patients are central to everything we do and this is now encapsulated in our policy principles, which set out the aims of our strategy and the approach we will take. Our principles state that taking a person-centred approach to fitness to practise can help us to properly understand what went wrong, and make sure concerns raised by patients and families are properly addressed. It helps us to make sure they understand what is happening in our process.
30. We haven't always appreciated that what patients, their families and loved ones tell us about their experiences helps us understand the regulatory concerns about registrants. But we are learning from our mistakes. Our full Public Support Service will be up and running by autumn 2018. It will provide tailored support to make sure patients, families and the public are protected, valued and respected, specifically when we consider whether a nurse or midwife is fit to practise.
31. We won't stop there. We know we have a lot more to do. In the past, we haven't been open with people when things went wrong. We are improving our approach to transparency through the training we give to staff and the information we make available. This is also a key feature of improving [how we operate](#), outlined in our strategy.
32. We revisit these lessons throughout this report.

The consultation

33. Our consultation was set out over six parts. Parts one to four set out our strategy.
34. Part one introduced our regulatory outcomes:
- a professional culture that values equality, diversity and inclusion and prioritises openness and learning in the interests of patient safety
 - registrants who are fit to practise safely and professionally

⁷ PSA, May 2018, [Lessons Learned Review: The Nursing and Midwifery Council's handling of concerns about midwives' fitness to practise at the Furness General Hospital](#)

35. We also asked what the public expected from us as a regulator, in terms of public protection and the wider public interest. The aim was to identify a threshold for when we should take cases forward purely to uphold public confidence or proper professional standards, and to gather evidence, through the questions we asked, as to when the public think we should take action.
36. Part two discussed how we regulate. We identified four different ways in which we can achieve our regulatory outcomes using our current regulatory powers: prioritising effective local action by employers; taking the context into account; enabling registrants to remediate regulatory concerns at the earliest opportunity; and holding full hearings only in exceptional circumstances.
37. Part three focused on how we operate. We identified three areas where we can improve how we operate. Area one dealt with managing public expectations and supporting vulnerable stakeholders better. This is an important focus for us and part of our commitment to ensuring that the views of families and patients are central to everything we do. Area two outlined how we will continue to work with regulators and other key stakeholders and share information in the interests of public protection. Area three explained how we will continuously improve how we operate by using and embedding a consistent quality improvement methodology.
38. In part four we asked specific questions about equality, diversity and inclusion. Our first regulatory outcome identifies that we aim to achieve a professional culture that values equality, diversity and inclusion. We envisage that a fitness to practise process that does value equality, diversity and inclusion and supports employers to incorporate these principles, could result in fairer outcomes.

Policy principles

39. To achieve the aims of our strategy we know that we need to take a consistent and proportionate approach to fitness to practise. By identifying ten policy principles in our consultation, we sought to identify our aims and inform the expectations of people involved in our fitness to practise process. We've considered them further in light of our research and the responses we've received to the consultation.
40. The responses to principle seven told us that automatic removal from the register in cases such as deliberately covering up when things go wrong is considered too restrictive. On reflection, we agree that other factors and context may mean that automatic removal won't always be the right result. We've amended this principle to reflect this.
41. We have added a further two principles, which incorporate our approach to patients and members of the public, and clarify our position on when we will take action to uphold public confidence in the professions. We set out our revised principles at the [end of this report](#).

Qualitative research

42. The overall objective of the separate qualitative research was to gain feedback from stakeholders on our proposed changes. However, we also wanted to understand the current perceptions and expectations of fitness to practise.
43. We asked ICE to:
- understand stakeholders' expectations of us with respect to fitness to practise
 - understand perceptions of the current fitness to practise process
 - understand the acceptability of the potential change to our regulatory focus
 - understand the acceptability of the four different ways in which we propose that we can achieve our regulatory outcomes
 - explore stakeholders' perceptions regarding the potential benefits and challenges associated with the proposed changes – including whether or not the proposed changes would be expected to improve processes and outcomes in fitness to practise.
44. The research methods included workshops, face-to-face interviews and telephone interviews. A quarter of the participants were members of the public who had used a registrant's service in the last six months. Our strategy takes a person-centred approach to fitness to practise. The voice of patients, families and members of the public help us understand the fitness to practise concerns about registrants. So it was important for us to understand what members of the public expect from the fitness to practise process, and what they expect from us.

A summary of responses

Consultation

45. In our consultation we asked 19 questions about the changes arising out of our proposed strategy. The questions fell into six categories:
1. Public protection
 2. Public confidence in the regulatory process
 3. Our regulatory outcomes
 4. Achieving our regulatory outcomes
 5. How we operate
 6. Impact on equality, diversity and inclusion
46. We asked respondents whether they agreed or disagreed with each question. They had the option of stating 'don't know'. All respondents had the option to provide additional commentary in relation to the proposals. Respondents were able to reply through our online survey platform or in writing.
47. A total of 892 respondents answered some or all of the questions in the full consultation document. These included 83 organisations and 809 individuals. Of organisations, the strongest support for our proposals came from NHS employers of doctors, nurses and midwives.

48. We had a low number of responses from ethnic minorities, who made up 5% of responses. This is significantly below the number we'd expect given ethnic minority nurses and midwives make up 22% of our register, and 13% of the general population in the UK. Therefore, the responses of this consultation may not reflect the wider views of diverse communities, and more engagement is required to understand the equality, diversity and inclusion impacts of the strategy on minority groups.
49. The detailed analysis of responses to each question can be found on the consultation pages of our website at <https://www.nmc.org.uk/about-us/consultations/past-consultations/2018-consultations/ensuring-patient-safety-enabling-professionalism/> . It does not include an analysis of responses received outside of the consultation period. However, we have taken them into account in preparing this response.

Research

50. Our qualitative research findings focus on seven sections:
1. Stakeholders' expectations of the NMC regarding the FtP process
 2. Stakeholders' perceptions of the current FtP process
 3. Feedback on public confidence policy statement
 4. Prioritising effective local action by employers
 5. Taking context into account
 6. Enabling registrants to remediate regulatory concerns at the earliest opportunity
 7. Holding full hearings only in exceptional circumstances
51. The key findings of the research for sections one and two identified that people expect us, through fitness to practise, to protect patients and the public and uphold the standards of the professions.
52. We asked researchers to make sure that the groups in our qualitative research were diverse. Although we know the groups were made up of people with a range of protected characteristics, we don't have an analysis of the research by protected characteristic which would give us insight into the impact of the strategy on specific groups and individuals.

Expectations

53. Across all stakeholder groups, participants said that they would expect us to uphold standards and make judgements on registrants' practice by applying standards and policies in a consistent manner. There was also an expectation for fair, proportionate regulatory action based on the severity of the concern regarding a registrant's fitness to practise in the future, as opposed to the severity of the outcome of the incident. Groups also said that they would expect us to be transparent about the process and the process to be efficient.
54. Members of the public said that if they were making a referral, they would expect us to appreciate that the process may be distressing for them as a referrer, particularly if the case took a long time to resolve and concerned a family member. We

recognise that people don't take the decision to refer to us lightly, and it can be a very stressful experience.

55. The research tells us that the public expect us to be supportive. We know that we must listen to the voices of the public and keep them informed, to make sure that we have all the vital information we need to properly scrutinise the concern referred to us, so that we meet our overarching objective of protecting the public and maintain confidence in us as a regulator.
56. This approach is also in line with the PSA's recommendation from the Lessons Learned Review that we engage with patients and service users, make sure they are informed of the process and progress, and analyse and take their evidence seriously.

Perceptions

57. Similar themes emerged from the stakeholder groups. Participants agreed that the fitness to practise process is time-consuming and longer than they expected, and it needs to be more efficient. Employers were concerned by the time initial screening of cases can take. They believed that it became more challenging to provide investigations with quality fact-based evidence the longer the time window between them raising a concern and a full investigation being opened.
58. Members of the public who had been involved in a fitness to practise case found it 'extremely distressing', a feeling that was increased by the length of time it took to resolve a case. It was discussed that, in order to reduce the negative impact of fitness to practise cases, we would be expected to provide appropriate support and guidance to the registrant, referrer, employer and others concerned.
59. We've incorporated the results from sections three to seven (above) into the relevant categories of the consultation responses (below).

Public protection (questions 1-5)

60. Our overarching objective is protection of the public. Linked to this are the three sub-objectives of public safety, public confidence in the professions and the need to promote and maintain proper professional standards and conduct.
61. We proposed changes to how we undertake fitness to practise by refocusing public protection and by moving away from a culture of blame and punishment. This would mean that we would always need to interpret public safety, public confidence in the professions and the need to promote and maintain proper professional standards from a public protection viewpoint.
62. We proposed that we wouldn't take action to promote and maintain professional standards and public confidence in the professions unless there was a clear link to our overarching objective of public protection. To make this link, the regulatory concern would need to involve something that is so serious that it would have an impact on the likelihood of a member of the public using the services provided by registrants in the future.

Supportive responses

63. 89% of respondents agreed that fitness to practise should primarily be about managing the risk that a registrant poses to patients or members of the public in the future.
64. 77% of respondents agreed that fitness to practise is not about punishing people for past events. The key theme, from 20% who provided additional comments, was that registrants should be supported rather than punished and part of this support should be a culture of openness, so that individuals have opportunities to learn from their mistakes
65. Overall, 74% of respondents agreed that we should only take action to uphold public confidence when the conduct is so serious, that if we did not take action, the public wouldn't want to use the services of registrants. A lower proportion of organisations agreed (61%), compared to 75% of individuals. Others said that this proposal would reduce the time spent on issues that do not pose a risk to the public and would allow time to be spent on issues that do present a risk.
66. One organisation, which represents registrants, said:
"We welcome the attempt to identify a meaningful criteria for maintaining public confidence in the register"
67. 94% of respondents agreed that some clinical conduct, such as deliberately covering up when things go wrong, seriously damages public trust in the professions and undermines patient safety. 52% of respondents agreed that in these types of cases, the registrants should be removed from the register.
68. Those respondents agreed that patient or public safety should always be the primary aim and that risk management is the right way to ensure a proportionate and fair approach. The context in which incidents happen was also clearly important. There was support for an open culture, so that registrants can learn from their mistakes, or for mistakes to be used as learning opportunities by others.

Unsupportive, neutral or other responses

69. 9% of respondents disagreed that fitness to practise should primarily be about managing the risk that a registrant poses to patients or members of the public in the future.
70. 16% of respondents disagreed that fitness to practise shouldn't be about punishing people for past events, with comments that there may be occasions when it's necessary to consider past events, or that past events may have relevance to the current issue or that a past event that has had a negative impact upon safety or the quality of care should be considered. Those that disagreed cited the negative perceptions of the punitive nature of the fitness to practise process or us as an organisation.
71. 18% of respondents, 24% organisations and 17% individuals, disagreed with the proposal that we should only take actions to uphold public confidence when the

conduct is so serious, that if we did not take action, the public wouldn't want to use the services of registrants.

72. The PSA noted:

"We do not agree with the NMC's attempt to link public confidence to whether misconduct would have a 'material impact on the likelihood of a member of the public using the services provided by registrant in the future'... we also do not agree with the NMC's statement that there is a need to link public confidence to a direct risk to public safety in order to justify taking action...fitness to practise should give equal weight to all three limbs of public protection and 'willingness to see' as a concept may divert focus away from this principle which is well established in existing case law (GMC v Chaudhary 2017, para 53)... it also risks side-lining the importance of the regulator's role in upholding professional standards"

73. Additionally, the ability of members of the public to be able to decide whether or not to use the services of a specific registrant was queried by 3%, and 1% of respondents noted that what constitutes a serious concern may differ significantly between the general public and organisations.

74. Overall, only 3% of respondents disagreed that some clinical conduct, such as deliberately covering up when things go wrong, seriously damages public trust in the professions and undermines patient safety. However, 25% of the total respondents disagreed that in those types of cases, the registrant should be removed from the register. This was higher among organisations. The key theme emerging, cited by 33% of respondents was of a need to consider the context and any mitigating circumstances. Again, this position was higher among organisations.

Research responses

75. The research also tells us that 'public confidence' was perceived as hard to quantify and possibly changeable, making it particularly difficult to understand when and how the NMC would act. This indicates support for an identifiable threshold for when we will act to uphold and promote public confidence.

76. The research did suggest that participants felt the kinds of misconduct that could call into question a registrant's trustworthiness would usually involve major breaches of professional standards. Participants also noted that revalidation is now seen the established process for registrants to ensure they continue to meet professional standards.

Conclusion

77. We agree that when relevant we should consider the three sub-objectives of the overarching objective of public protection. Our strategy isn't about a focus on one and ignoring the others. It's about understanding what we mean by public confidence and defining when we will take action to promote and maintain it. It separately involves us trying to understand how fitness to practise, alongside our other regulatory functions, works to promote and maintain proper professional standards and conduct for registrants.

78. Our research and consultation responses indicate that there is confusion and misunderstanding of what public confidence means, what kinds of conduct actually affect the public's confidence in registrants, and how a regulator can measure what public confidence needs in any particular case. So we think that we can set our own threshold for when we say a case raises public confidence issues:
- In cases about clinical practice, taking action solely to maintain public confidence or uphold standards is only likely to be needed if the regulatory concern can't be remedied.
 - In cases that aren't about clinical practice, taking action to maintain public confidence or uphold standards is only likely to be needed if the concerns raise fundamental questions about the trustworthiness of a registrant as a professional.
79. We've changed this threshold because we recognise that respondents are concerned about how decision-makers could assess what sorts of conduct would discourage people from seeking treatment or care. Our new approach depends on whether or not the initial concern was about clinical practice. With this approach, decision makers will be able to focus more clearly on the nature of the conduct. It recognises that there a small number of cases of very serious clinical harm that can't be remedied. It also reflects the evidence from our qualitative research that we should take action to uphold professional standards when registrants do things that could affect their trustworthiness as a registered professional. We think these thresholds will help us adopt a consistent and proportionate approach in how we regulate. We'll publish them as part of new guidance later in the year."
80. Our research also suggests that the kinds of misconduct which are seen as major breaches of professional standards are often those that could affect a registrant's trustworthiness. It also confirms that fitness to practise is not our only means of promoting and maintaining proper professional standards and conduct. We've reflected these findings in how our amended policy principles now deal with promoting and maintaining proper professional standards and conduct.
81. We agree that automatic removal from the register in cases, such as deliberately covering up when things go wrong, is too restrictive and that removal will not always be appropriate in all circumstances. We agree that there may be other factors and context to consider. We've amended our policy principles to reflect this feedback and our position.
82. Having reviewed and considered the evidence base in the form of consultation responses, research and engagement, we intend to proceed with our proposals, but with modifications to our policy principles. We've changed how we want to set the thresholds for when we should take regulatory action against a registrant to promote and maintain public confidence or proper professional standards. We believe it is vital that we play our part in making sure that people have confidence in using the services of all the people on our register but we agree that using this as a threshold for taking action could cause confusion. For this reason, we have instead focused the thresholds on whether the concern can be remedied.

Public confidence in the regulatory process (questions 6 and 7)

83. We proposed that public confidence in the regulatory process goes beyond public confidence in our fitness to practise function. Our registration, revalidation, education and standards functions are a large part of ensuring patient safety and enabling professionalism. Fitness to practise can maintain the confidence established by those functions. If we follow the PSA principles of good regulation the public can have confidence in us a regulator.

Supportive responses

84. 82% of the total respondents agreed that cases should be resolved at an early stage in the process if a registrant has fully remediated their clinical failings, even where those clinical failings have led to serious patient harm. The key theme was reiteration of the need for registrants to demonstrate insight, remorse and remediation to reduce any future risk and to show that lessons have been learnt. This had the highest level of support from those who agreed with this proposal (30% compared to 5% who did not agree).

85. 65% of respondents agreed that every decision relating to a restriction being placed on a registrant's practice (including voluntary removal) should be published. Significantly, a higher proportion of organisations were more supportive than individuals (cited by 80% of organisations compared to 64% of individuals). The key theme emerging, and cited by a quarter of respondents, was of a need for openness and transparency within the professions. 16% of respondents who provided a comment noted the need for honesty and openness, specifically in reference to the public having confidence and trust in the professions.

Unsupportive, neutral or other responses

86. 9% of respondents disagreed that cases should be resolved at an early stage in the process if a registrant has fully remediated their clinical failings, even where those clinical failings have led to serious patient harm. There were general concerns that the employer investigation process is not robust enough to make sure that the public is properly protected. A small number of organisations noted concerns over what checks would be in place for a registrant who changes employers, or how we could regulate the workplace to ensure remediation is taking place and being effective.

87. One organisation queried:

"What is meant by resolved at an early stage...and what sort of cases could be considered remediable?"

88. 24% of total respondents disagreed that every decision that relates to a restriction being placed on a registrant's practice (including voluntary removal) should be published. Those disagreeing highlighted the impact of publication, namely the stress this can cause to a registrant or that it can damage a career. There were also comments from some respondents that a culture of 'naming and shaming' is not helpful.

Conclusion

89. We intend to proceed with our proposals. It's in the interests of patient safety that cases should be resolved as early on in the process as possible. This means either the employer takes action, or if the matter has been referred to us, dealing with the issue without any formal fitness to practise action. We know that delay and lengthy and adversarial fitness to practise proceedings can cause defensive practice among professionals, or cause professionals to disengage from their profession.⁸
90. Our processes and guidance will be designed to support registrants and employers to resolve cases at an early stage in the process and to encourage registrants to engage with us early on in the fitness to practise process. Our guidance will clearly set out the types of case we consider the hardest to remediate.
91. Openness and transparency in regulation is vital. We appreciate the concerns regarding privacy of registrants and it was never our intention to publish information relating to a registrant's physical or mental health. However, we're confident that the need to be fully transparent and accountable outweighs any concerns expressed in the responses we have received. The PSA, in the *Lessons Learned Review*, recommended that regulators should publish as much as they legitimately can, to improve public confidence through transparency.

Our regulatory outcomes (questions 8-10)

92. We proposed two regulatory outcomes that reflect our distinctive role as part of a wider system to ensure patient safety and enable professionalism:

- a professional culture that values equality, diversity and inclusion and prioritises openness and learning in the interests of patient safety
- registrants who are fit to practise safely and professionally.

Supportive responses

93. 95% of respondents agreed that a professional culture that values equality, diversity and inclusion and prioritises openness and learning in the interests of patient safety is the right regulatory outcome
94. 98% of respondents agreed that registrants who are fit to practise safely and professionally is the right regulatory outcome.
95. One in ten respondents focused on the support this gives to public confidence in nursing and midwifery and the reputation of the profession as a whole, and that registrants need to be professional and work to their professional standards.

⁸ See footnote 1, above.

Unsupportive, neutral or other responses

96. 3% of respondents disagreed that a professional culture that values equality, diversity and inclusion and prioritises openness and learning in the interests of patient safety is the right regulatory outcome
97. Respondents did have concerns over the implementation of this proposal and our ability to move forward with this and monitor this.
98. The PSA responded:
"We are unclear how this regulatory objective interacts with the NMC's overarching objective and the three limbs of public protection and what happens if there is a conflict between these..."
99. Only 1% of respondents disagreed that fitness to practise should ensure that registrants are fit to practise safely and professionally is the right regulatory outcome.
100. Respondents did comment that we would need to make sure that registrants and employers have the necessary support, training, skills and ongoing learning to meet required levels of safe practise and professionalism, and the need for standardised approaches to measure outcomes, for example, improved quality assurance, formal recording and monitoring.

Conclusion

101. We received overwhelming support for these regulatory outcomes and intend to proceed with them.
102. We agree with one NHS employer of nurses of midwives that:
"Professional regulation is about delivering safe and effective care through helping the registrant to be the best that they can be. If they are fearful of their regulator, we cannot achieve this."
103. We accept that we can't change institutional cultures overnight. It will require communication, collaboration and cooperation. We can achieve this through our proposals to prioritise effective local action by employers, by taking the context in which patient safety incidents occur into account, enabling registrants to remediate regulatory concerns at the earliest opportunity and holding full hearings only in exceptional circumstances.
104. We don't think that our proposals conflict with our overarching objective. The NMC has duties under the public sector equality duty, as well as under the Human Rights Act 1998
105. Our strategy doesn't mean that we may decide not to take action against registrants on equality grounds or that our threshold for regulatory action is being lowered by having regard to equality considerations or the public sector equality duty.

106. We also plan to follow up on the research we have undertaken in to the overrepresentation of minority ethnic groups in fitness to practise proceedings, once the first cycle of revalidation is concluded in 2019.

Achieving our regulatory outcomes (Questions 11-15)

Prioritising effective local action by employers (Question 11)

Supportive responses

107. 75% of respondents agreed that employers are usually in the best position to resolve concerns immediately, and we should only take regulatory action if the concern has already been raised with and investigated by the employer (where there is one), unless there is an immediate risk to patient safety that we have to deal with.

108. Supportive responses noted that local resolution should be explored in the first instance, and that employers need to take on more responsibility, and they are in the best position to make judgements.

Unsupportive, neutral or other responses

109. 16% of respondents disagreed with the proposal that employers are usually in the best position to resolve concerns immediately.

110. Respondents noted concerns about the impartiality of some employers, or the lack of robust in-house policies.

111. A professional trade union noted:

“Again the concept is a good one but [we are] concerned about how this will work in practice. In particular how the NMC will determine whether the employer is effectively managing the risk or requires support to do so.”

112. While overall support for this proposal was relatively high, respondents still perceived us as having a role in a number of instances, with some respondents noting a need for employers to be given guidance and support on how to resolve concerns and clarity regarding their responsibilities, or for employers and managers to be monitored and audited by the NMC.

Research responses

113. 96% of participants agreed that by prioritising effective local action, the fitness to practise process will be improved. Participants agreed that for most cases, the employer is best placed to conduct a thorough investigation and take action if required to protect patient safety and remediate concerns regarding a registrant’s practice.

114. A number of members of the public considered that a clear and transparent feedback loop between us, the employer, referrer and registrant is essential. They considered this an essential part of making sure that members of the public who

refer to us are confident that we take their concerns seriously and so that it will guard against employers being able to “sweep things under the carpet”.

Conclusion

115. Prioritising effective local action by employers is vital if we’re going to be a more proportionate and efficient regulator. When something goes wrong, our evidence tells us that members of the public generally want to know that it will be dealt with quickly and effectively so that it doesn’t happen again.
116. It will not be acceptable for us to accept the conclusions of an employer investigation when something calls into question the validity of an investigation, or the ability of an employer to conduct a full and fair investigation.
117. We intend to proceed with this proposal, but we will be producing very clear guidance for employers setting out what we expect from a referral so that they have a clear understanding of the matters that they can and should deal with. In assessing whether we accept the conclusions of an employer we will understand what the patient and referrer concerns are in the context of the investigation as part of a person-centered approach.
118. This is supportive of the PSA’s recommendation⁹ that we should work closely with employers and stakeholders to deal with concerns that can be remedied without fitness to practise procedure, while not compromising patient safety.

Taking the context into account (Question 12)

Supportive responses

119. 94% of the total of respondents agreed that we should always take the context in which a patient safety incident occurs into account when deciding what regulatory action is appropriate.
120. The workplace environment was cited as a contributory factor by a significant number of respondents, with 20% of respondents noting that the work environment and culture can be stressful and pressured, with heavy workloads and busy shifts. A further 15% noted that the processes and resourcing also need to be examined, for example, looking for possible system failures.
121. One regulator, while agreeing, warned:
“...However, context is relevant, rather than determinative when deciding what regulatory action is required”

Unsupportive, neutral or other responses

122. 3% of respondents disagreed with the proposal commenting that context has limits as a mitigating factor and cannot be used in many incidents, or that lower standards

⁹ Lessons Learned Review 2018

should not be accepted because of the context and that registrants should be accountable for their actions.

123. One organisational response said:

“...Context may mitigate particular errors in certain circumstances but it should not distract from looking at the individual actions of the registrant. For example, we consider that those professionals with management responsibility should be held to account for their failings in allowing a context where patient safety incidents can occur.”

Research responses

124. 91% agreed that the fitness to practise process will be improved by taking context into account. Across the stakeholder groups, most participants agreed with the principle of looking at the ‘whole picture’ when determining whether or not to take regulatory action. They believed patient safety incidents rarely happen in isolation of other contributing factors. It was discussed that taking context into account would make sure our investigation is fair and leaves ‘no stone unturned’.

125. Although the participants agreed that the proposed changes would improve our process, they identified some challenges. Participants were concerned that registrants may excuse their behaviour by blaming a patient safety incident on wider contextual factors. Others felt that the organisational culture and leadership may make it hard for us to investigate the context, and others were concerned with how we would monitor that the feedback that we provided resulted in meaningful action.

Conclusion (Question 13)

126. Taking the context into account is an important step in moving away from a blame culture and adopting a more holistic approach. We intend to proceed with this proposal. The PSA¹⁰ has told us that we need to make sure that our processes allow us to take account of all the available and relevant information about cases and that we share intelligence properly. We already take context into account in our approach to cases. We will now work towards developing a tool to standardise the way we assess context, and build this into our decision making. We’re also committed to improving how we communicate and share information with other organisations (see ‘How we operate’ later on in this report).

127. We agree that registrants with management responsibility should be answerable if it was their failings that allowed a culture to develop where patients and members of the public were put at risk of suffering harm. We will identify this type of conduct in the guidance we produce on seriousness factors.

¹⁰ Lessons Learned Review 2018

Enabling registrants to remediate concerns at the earliest opportunity

Supportive responses

128. 90% of respondents agreed that we should be exploring other ways to enable registrants to remediate at the earliest opportunity.

129. One employer organisation stated:

“Shifting towards a more proactive approach which enables registrants to remediate at the earliest opportunity by supporting professionalism and raising standards is much supported by employers.”

130. The key themes emerging related to the benefits of remediation, with 17% of respondents noting this will help to remedy problems and that everyone should be given the opportunity to correct, and learn from, their mistakes. 14% commented that early remediation is in everybody’s interests.

Unsupportive, neutral or other responses

131. Only 3% disagreed with the proposal. While many respondents were positive about the impact of remediation, small proportions of respondents noted that it depended on the severity of the incident (7%) or that some staff will not learn from their mistakes (3%).

132. One regulator expressed concerns over how we would assess remediation and advised that we shouldn’t go too far with guidance for registrants, as this would lessen the significance of the remediation and any insight expressed.

133. One senior nursing professional, while supportive of the proposal, commented:

“The NMC should not lose sight of the need for registrants to take responsibility themselves as well for improving their practice...but this is not about spoon feeding. It is about giving honest feedback and direction...”

Research responses

134. 94% of participants agreed that our fitness to practise process will be improved by enabling nurses and midwives to remediate regulatory concerns at the earliest opportunity. This rose to 100% for employers when the results were broken down into subgroups.

135. For each group, the acceptance of responsibility, openness about what happened, willingness to remediate concerns and the number of times a registrant had been involved in similar instances were considered important factors in determining whether remediation would be appropriate. Registrants believed that this change would encourage registrants to “open up” about honest mistakes if they understand that the issue can be remediated without serious sanctions from us.

136. Participants were clear that for issues such as competency and clinical mistakes, it would be appropriate for the registrant to undergo training to improve a specific skill and improve their competence and remediate the concern. However, participants

were less clear on how conduct involving misconduct or character issues that would call into question a person's trustworthiness could be remediated. So participants felt that it was less acceptable for such concerns to be remediated when a registrant's attitude or character was called into question.

Conclusion

137. We intend to proceed with this proposal as it's clearly in the interests of patient safety for registrants to remediate areas of weakness in their practice as soon as possible. However, we accept that there is conduct that is so serious that it cannot be remediated. We will identify this type of conduct in the guidance we produce on seriousness factors.

138. We assess remediation at all stages of process, so don't believe that we will have difficulty in assessing remediation that occurs 'at the earliest opportunity'. Our remediation guidance will be specific to the registrant but not bespoke. We accept that, ultimately, we can guide and assist but the onus is on individual registrants to take responsibility for their practice.

Holding full hearings only in exceptional circumstances (Question 14)

Supportive responses

139. There was majority support for this proposal, with 79% of respondents agreeing that unless there is a serious dispute about the facts or disposal of a case, or a registrant has requested a hearing, all cases should be dealt with at a meeting.

140. Respondents noted the advantages of the proposal:

- it will enable quicker processing of cases
- it will be less stressful for registrants and witnesses
- it will save money and costs
- it will encourage openness and transparency
- it is a more humane way to deal with a case.

Unsupportive, neutral or other responses

141. 11% of the respondents disagreed with the proposal. They outlined concerns about a lack of fairness and openness at meetings, commenting that public scrutiny is vital and allows for transparency. There was also a concern that issues would not be explored in enough detail at a meeting and a full hearing is needed to enable the case to be properly judged by an independent panel.

142. An organisation that represented registrants at fitness to practise hearings said: *"If implemented, the proposals would unfairly tilt the balance of the fitness to practise process away from the interests of registrants, leaving them under pressure to admit mistakes they have not made and with less recourse to a process that allows the proper testing of evidence against them."*

143. The PSA said:

“...we would highlight that the current case law suggests that in certain cases a hearing may be necessary to maintain public confidence, for example where there is a strong public interest element.”

144. In a related response to another question, the same organisation said:

“...we note that under its’ Order the NMC is required to refer any cases which meet the realistic prospect test to be dealt with in a public forum and to do otherwise is likely to require a change of legislation.”

145. Respondents who were supportive or neutral outlined some provisos in relation to the proposal:

- meetings to be structured properly and in a fair way so that all parties can put their case forward
- they need to include support and advice for registrants
- registrants need to be properly represented.

Research responses

146. 92% of participants agreed with our proposal to only hold a full hearing in exceptional circumstances. Participants believed that this proposal would improve the fitness to practise process for several reasons:

- speed up the FtP process and require less resources
- avoid the negative impact full hearings can often have on referrers, witnesses and registrants
- avoid duplication of effort where criminal proceedings have produced clear outcomes.

147. The research highlighted that there is poor understanding of the regulatory process and participants wanted us to clearly communicate what the different stages entail and what the range of sanctions are at each stage. Employers and registrants suggested that registrants who have been referred may be less likely to request a hearing if they knew the potential sanctions beforehand, and in particular if they knew that being removed from the register wasn’t a potential outcome.

148. There was a misunderstanding by members of the public as to what a meeting involves. Some thought that different and lesser sanctions were available at a meeting. This linked back to the idea of fitness to practise as some form of punishment.

Conclusion

149. We maintain that any registrant that wishes to have a hearing will always be able to have a hearing. Where there is a material dispute, a panel plays an important inquisitorial role in properly scrutinising and testing the evidence. However, there is no public interest in holding a hearing where there is no material dispute between us and the registrant. In this situation, the public interest is in making sure that the meeting decision is published and accessible. We think this will be clearer to people if we change how we describe this new approach. Rather than say we will only hold

hearings in exceptional circumstances, we will now say that we will only hold hearings if there is a material dispute.

150. We do not agree that our legislation requires us to refer any case where the realistic prospect test is met to be dealt with in a public forum and that to do otherwise would need a change to our legislation. In fact, if that test is met, our legislation requires our case examiners to either recommend undertakings to be agreed with the registrant, or refer the case to the Fitness to Practise Committee.
151. The Fitness to Practise Committee already has the power to deal with cases at meetings without members of the public, witnesses, registrants or our case presenter attending. A meeting is hearing on the papers. So, the Committee has all the same powers of sanction as it would have if it were sitting in public. There is an independent legal assessor present and the Committee will assess the written evidence as carefully as it would in a public hearing.
152. We will publish a full record of all decisions made at meetings. This will include the panel's reasons, so that anyone who wants to know what happened can find it on our website. The only exception to this will be matters concerning private information, such as information about a registrant's health condition.
153. We do not agree that any case law interpreting our current legislation, or that of any comparable healthcare regulator, requires us to hold hearings in these circumstances. Our rules are clear: if the case has been referred to the Fitness to Practise Committee, the Committee has the choice to hold a hearing or a meeting, unless the registrant asks for a hearing. We are confident that previous case law which does not directly address how regulators should exercise that choice, and was largely decided before we were able to hold Fitness to Practise Committee meetings in private, cannot override the discretion given to us by Parliament in our legislation.
154. Whether the matter is dealt with at a hearing or meeting, we will continue to listen to the voices of the patients or members of the public concerned and clearly communicate to them our decisions and the outcomes in the case.
155. For these reasons, we intend to proceed with this proposal.

How we operate (Question 16)

156. We know that from listening to our stakeholders, from the Lessons learned review and our own internal quality assurance processes that we can continue to improve how we operate.
157. We proposed that we would:
- manage public expectations and support vulnerable stakeholders better
 - work effectively with regulators and other key stakeholders within clearly defined boundaries
 - continuously improve.
158. We have identified that the change in how we communicate with members of the public must come from all our members of staff, at all levels. The newly established

Public Support Service aims to anticipate and meet the needs of members of the public who are involved in cases.

159. We are exploring joined up working with other regulators and developing written agreements and with other organisations, setting out the information we'll share in the interests of public protection.

160. To effectively continuously improve we proposed that we take a more systematic view of process improvement.

161. We asked respondents to tell us what they thought about our proposals to improve our processes. We asked if there were any other ways we could give more support to members of the public, or improve how we work with other organisations, including other regulators.

Improving processes

162. Respondents' comments included:

- Ensuring processes are completed in a timely fashion
- Better communication
- More support for witnesses
- Obtaining feedback from registrants who have been through the fitness to practise process.
- Greater use of technology

Support to the public

163. Respondents' comments included:

- Being more open and transparent
- Increase the public awareness of the role of the NMC
- Publish fitness to practise decisions
- Manage expectations of the public

Improving work with other organisations

164. Respondents' comments included:

- Support and do more work with voluntary professional nursing bodies
- Closer working with Care Quality Commission
- Shared approaches to incidents involving more than one type of healthcare professional
- Strengthened links with local providers and closer working with employers

Conclusion

165. We intend to continue with the proposals we have outlined to improve how we operate. We also intend to consider all the suggestions made by respondents, and where appropriate review how we can incorporate them. One charity that provides support to vulnerable people told us:

“Expertise within the fitness to practice function will be of great help when things go wrong, however, we also need the NMC to pay attention to how to get things right for people with a learning disability across all of its functions, including revalidation and education and training.

A family member told us: “We want people to recognise that people like our son matter, that what happened was wrong and how it will be stopped from happening again”. The nurse in this case, accused of physical assault “carried on practicing throughout the investigation and no action was taken against them, but other people were getting struck off for meds errors.”

166. We have shared this charity’s entire response with our Public Support Service, so that we can learn from it.

Impact on equality, diversity and inclusion

167. We have completed an equality assessment for our proposals, to assess against the potential impacts on the protected characteristics set out in the Equality Act 2010. In addition, in our consultation respondents were invited to comment on or evidence any equality impacts the proposed changes may have.

168. A culture that values that equality, diversity and inclusion is one of our regulatory outcomes. We proposed that this could result in fairer outcomes. We also proposed that we should support employers to incorporate the principles of equality, diversity and inclusion when considering making referrals.

Supportive responses

169. 77% of respondents agreed that having a fitness to practise process that values equality, diversity and inclusion could result in fairer outcomes. Slightly higher proportions of organisations agreed (86%) than individuals (76%).

170. An equalities advisory group for nurses responded:

“In theory outcomes should be fairer, however discriminatory practices continue to disproportionately affect BME staff and other registrants that demonstrate the 9 protected characteristics.

Employers need to be supported by the NMC outlining clearly what its expectations are in relation to equality, diversity and inclusion. Cases should not be accepted where thorough investigation by an employer would have not resulted in a referral and clear evidence of remediation where appropriate has occurred.

Every NMC panel should have a panellist that represents the depth and breadth of diversity including 9 protected characteristics and who is also up to date with clinical elements, possesses expertise and who fully understands the professional, discriminatory impacts for the public and registrants.”

171. 83% of respondents agreed that we should support employers to incorporate the principles of equality, diversity and inclusion when considering making referrals,

although higher levels of agreement came from organisations (92%) than individuals (82%).

172. One registrant representative body commented:

“Yes, we would expect to see this in response to the NMC’s findings relating to the overrepresentation of registrants from black and ethnic minority backgrounds in fitness to practise proceedings driven by disproportionate referrals from employers.”

Unsupportive, neutral or other responses

173. 7% of respondents disagreed with the proposal that having a fitness to practise process that values equality, diversity and inclusion could result in fairer outcomes.

174. 12% of the respondents who provided additional comments noted that overtly valuing equality, diversity and inclusion should not be required if the fitness to practise process is fair and transparent as these values are implicitly addressed within the process and that the same standards are required irrespective of a registrant’s background. This comment was higher among those who disagreed with the proposal (39% of respondents who disagreed, compared to 1% who agreed).

175. 8% of respondents disagreed with the proposal that we should support employers to incorporate the principles of equality, diversity and inclusion when considering making referrals.

176. Of the respondents that provided additional comments, 10% noted that a registrant’s background should be irrelevant to referrals as these should be dependent on unsafe or poor practice, and slightly fewer respondents (8%) noted concerns that this could lead to positive discrimination, for example, because of fears of accusations of racism. That said, a very small proportion (5%) of respondents felt that the number of BME referrals is disproportionate.

Conclusion

177. We recognise that we have more to do in this area. We have taken on-board the recommendations of the Williams Review,¹¹ and will continue our work and research. We will collaborate with registrants, representatives and valued stakeholders to properly understand and tackle the issues causing an overrepresentation of minority ethnic registrants in FtP to make sure that our referrals and outcomes are fairer.

Conclusion

178. We have received not only a high level of response to our consultation, but also a high level of support for our proposals from members of the public, registrants and organisations.

¹¹ [Williams review into gross negligence manslaughter in healthcare](#), see recommendation 8.

179. We have decided to implement our proposals as consulted upon, except where we have identified changes to our strategy in light of the responses we received or the findings of our research. We have reviewed and modified our policy principles to reflect this, as follows:

Strategic policy principles

1. Taking a person-centred approach to fitness to practise helps us to properly understand what happened, to make sure concerns raised by patients and families are properly addressed, and to explain to them what action we can take and why.
2. Fitness to practise is about managing the risk that a registrant poses to patients or members of the public in the future. It isn't about punishing people for past events.
3. We can best protect patients and members of the public by making final fitness to practise decisions swiftly and publishing the reasons openly.
4. Employers should act first to deal with concerns about a registrant's practice, unless the risk to patients or the public is so serious that we need to take immediate action.
5. We always take regulatory action when there is a risk to patient safety that is not being effectively managed by an employer.
6. We take account of the context in which the registrant was practising when deciding whether there is a risk to patient safety that requires us to take regulatory action.
7. We may not need to take regulatory action for a clinical mistake, even where there has been serious harm to a patient or service-user, if there is no longer a risk to patient safety and the registrant has been open about what went wrong and can demonstrate that they have learned from it.
8. Deliberately covering up when things go wrong seriously undermines patient safety and damages public trust in the professions. Restrictive regulatory action is likely to be required in such cases.
9. In cases about clinical practice, taking action solely to maintain public confidence or uphold standards is only likely to be needed if the regulatory concern can't be remedied.
10. In cases that aren't about clinical practice, taking action to maintain public confidence or uphold standards is only likely to be needed if the concerns raise fundamental questions about the trustworthiness of a registrant as a professional.
11. Some regulatory concerns, particularly if they raise fundamental concerns about the registrant's professionalism, can't be remedied and require restrictive regulatory action.

12. Hearings best protect patients and members of the public by resolving central aspects of a case that we and the registrant don't agree on.

Council

Review of Return to Practice standards

Action: Approval of plans for consultation on new Return to Practice (RtP) standards.

Issue: New standards are needed for individuals wishing to return to nursing or midwifery after a break from practice in order to align them with our new *Standards for education and training (2018) (SET)*, *Future Nurse* and the *Nursing Associate* standards. In order to deliver these new standards in 2019 we wish to consult in September 2018.

Core regulatory function: Registration.
Education and standards.

Strategic priority: Strategic priority 1: Effective regulation.

Decision required: The Council is asked to agree to go out to consultation on new Return to Practice standards in September 2018. This will enable publication of new RtP standards in 2019. Final draft standards will be brought back to the Council for approval before publication in 2019 (paragraph 20).

Annexes: None.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

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- Context:**
- 1 The Council's Strategy 2015–2020 identifies education as a priority. We are modernising and future proofing all our education standards.
 - 2 Our legislation specifies the minimum number of hours of practice that nurses and midwives have to complete to remain on our register through revalidation every three years or to rejoin our register if they cease to be registered for a period of up to five years.
 - 3 If they have not completed these minimum practice hours, or have been off the register for more than five years, then the Council can set standards specifying what education, training or experience they need to undertake in order to be allowed to stay on or rejoin the register¹. These standards are intended to ensure that registrants renewing their registration and individuals rejoining the register meet the standards of proficiency necessary for safe and effective practice. These are called the Return to Practice (RtP) standards.
 - 4 Under our current RtP standards, nurses and midwives are required to complete an approved re-training programme. Following the launch of our new set of education standards, we now need to review our approach to these RtP standards.
 - 5 We currently approve and quality assure RtP programmes² for nurses and midwives. 58 RtP nursing programmes for level 1 and level 2 nurses and 28 RtP midwifery programmes are recorded as 'in approval', however we cannot be sure how many of these programmes are running. Approximately 1,000 individuals are readmitted to the register via an RtP programme each year. The costs of such programmes are currently met by four country commissioners or employers or self-funded by returners.
 - 6 Workforce shortages are driving new models for preparation for return to practice which are not readily accommodated by our current standards. Health Education England has a dedicated RtP recruitment campaign to address predicted workforce shortages for general practice nurses. We are also seeing employers linking with AEs and advertising RtP as a work based learning (WBL) route.
 - 7 The current RtP standards also do not reflect the introduction of the test of competence (ToC) which provides an alternative route by which the Council can be assured that an individual who has not completed an NMC approved qualification has the requisite standard of proficiency for safe and effective practice.
 - 8 The ToC is used for for non EEA/EU trained nurses and midwives

¹ Rule 3(4) of the Registration Rules allows the Council to specify through standards of education and training or experience in accordance with Article 19(3) of the Nursing and Midwifery Order (2001) where an applicant does not meet the initial registration, renewal or readmission requirements.

² Programmes are run through NMC approved education institutions (AEIs). RtP programme criteria, previously set out in the PREP handbook and maintained in the Revalidation and readmission standards (October 2015).

wishing to join our register and practise in the UK. The ToC is based on our relevant standards of proficiency and education standards and includes a computer based test and a clinical examination tailored for the field of practice to which the applicant is applying. The cost of the ToC is met by employers or individuals.

- 9 The current RtP standards also do not distinguish between those seeking to revalidate and those seeking to re-join the register and do not provide for any flexibility for those whose shortfall in hours may be minimal. It is to be noted that self-declaration is used for readmission for registrants by some UK professional regulators such as the General Pharmaceutical Council (GPhC) and the Health and Social Care Council (HCPC).

Four country factors:

- 10 The RtP standards apply to all registrants across the four countries of the UK.

Discussion and options:

- 11 We want to develop a set of RtP standards that are proportionate in terms of any risks to public protection, outcome focussed and flexible enough to accommodate different models of delivery and the needs of different qualified individuals wishing to return to the nursing and midwifery workforce. As part of the consultation we will explore several options with external stakeholders including new RtP programme standards, whether a test of competence should be available as an alternative option and whether any other form of assurance, such as a declaration, would be appropriate in any circumstances.

RtP programmes

- 12 This option would include the development of new outcome-focused and flexible RtP standards which align with the *Standards for education and training* (SET), to be published in 2019.
- 13 Such new RtP programme standards would point to proficiencies for nurses and midwives and also for nursing associates from January 2019. The standards would allow the AEs to map an individual's proficiency and knowledge skills gaps and practice learning partners would facilitate achievement of proficiencies. It brings the benefit of an approved period of re-training and allows for supervised practice learning.
- 14 This approach aligns with several international nursing and midwifery regulators who require a programme of learning after a period away from practice.

Test of competence

- 15 This option would also allow individuals to rely on completion of the ToC as evidence that they have met the necessary standards of proficiency. The new ToC we will be introducing to align with the Future Nurse standards and the Nursing Associate standards will provide the necessary assurance and will be a clear outcome based benchmark for those seeking registration.
- 16 The ToC does not offer opportunities for refreshing practice and building confidence in practice settings but may be an attractive option for those looking to return to the UK register after a period working overseas or those in the future who have qualified on a programme under the new education standards.

Self declaration

- 17 We will also be consulting on whether there are any instances where it would be safe and proportionate for us to rely on any form of self-declaration or certification by another registered healthcare professional in relation to re-training which aligns with proficiencies for the nursing and midwifery professions. This approach works by submission of a declaration and individual portfolio for review which provides improved flexibility for applicants and aligns with some other UK regulators such as GPhC and HCPC, albeit they have much smaller registers than the NMC and will not experience the volume of readmissions that we currently have.
- 18 This option would be a new route to renewing registration or rejoining our register without the required practice hours, with a reduction in the level of assurance, so it will be important to consult on whether there are any instances where it might be appropriate.

Timelines

- 19 Consultation is planned for September to October 2018, draft standards will be brought back to the Council for approval in March 2019 with a target for publication in May 2019. Publication in 2019 is required to align with timescales for implementation of other new standards and with timescales for the regulation of nursing associates (RtP will also apply for nursing associates).

Recommendation

- 20 **The Council is asked to agree to go out to consultation on new Return to Practice standards in September 2018. This will enable publication of new RtP standards in 2019.**

Public protection implications:	21	The current RtP standards are outdated and do not align to our direction of travel in education nor to new proficiencies. However the need for public protection have to be balanced against improved accessibility. Our current standards may be creating unnecessary barriers to those seeking readmission to the register and may be contributing to current and future work force shortages in the sector.
Resource implications:	22	Provisions for this work have been included in the current business plan.
Equality and diversity implications:	23	In accordance with the Equality Act 2010, an equality and diversity impact analysis and Welsh language assessment will be completed. SET seeks to further the aims of the NMC in providing equitable access to the register.
Stakeholder engagement:	24	Extensive ongoing and targeted stakeholder engagement is critical to the success of this project. Engagement is planned for June to September 2018.
Risk implications:	25	<p>Risks to the commencement of this work stream include:</p> <p>25.1 The challenging timelines associated with the project for programmes to be approved in 2019.</p> <p>25.2 The extent to which we can secure stakeholder buy in. A comprehensive project and communications plan will be vital to the success of this project.</p>
Legal implications:	26	As required by the Nursing and Midwifery Order (2001) (the Order), and before establishing standards (for RtP), we must consult with representatives affected by the proposed changes (Articles 3(14), 19(3) and 19(4)). This will include registrants, employers, service users and AEs who provide RtP programmes.

Council

Standards for medicines management

Action: For decision.

Issue: To decide on a date for the withdrawal of our Standards for medicines management and to update the Council on progress regarding guidance on prescribing and medicines management issues.

Core regulatory function: Education and standards.

Strategic priority: Strategic priority 1: Effective regulation.

Decision required: The Council is recommended to approve that the NMC's Standards for medicines management are withdrawn on 28 January 2019 (paragraph 15).

Annexes: None.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

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- Context:**
- 1 The Standards for medicines management are the current NMC practice standards for all nurses and midwives, setting out our requirements for the safe and secure handling and use of medicines. They were published in 2007 and other than some minor amendments contained within subsequent circulars they have not been subject to review or update since publication.
 - 2 During 2017, we consulted on the withdrawal of the Standards for medicines management as part of our broader consultation exercise on the education programme and prescribing.
 - 3 The Council agreed at its March 2018 meeting to the withdrawal of the Standards for medicines management; to approve our new Standards for prescribing programmes; and to adopt the Royal Pharmaceutical Society's Competency Framework for all Prescribers as our competency standards for safe and effective prescribing practice.
 - 4 The Council agreed to set a date for withdrawal of the Standards for medicines management, and all underpinning circulars relating to medicines management, to be announced no later than 31 July 2018.
 - 5 The Council also requested an update on progress regarding the development of any new prescribing and medicines management guidance.
- Four country factors:**
- 6 Our standards and guidance in this area apply equally across all four countries. In addition, our consultation and engagement activities on this subject area all had a four country focus. A subject matter expert group that assisted in the analysis of responses to consultation and formulating the proposed way forward and the final version of our prescribing programme standards also had a four country composition.
- Discussion and options appraisal:**
- 7 As noted above, the Council approved the withdrawal of the Standards for medicines management at its March 2018 meeting. The Standards for medicines management will not be replaced with new NMC guidance, as provision of clinical practice guidance is not within our remit as a statutory regulator.
 - 8 It was apparent from responses to our recent consultation exercise that there is considerable support from registrants, educators and the public for guidance on this key area of practice to be produced that is readily applicable across the board to all health and social care professionals. We are committed to working in conjunction with key stakeholder partner groups to help develop such guidance.
 - 9 Responses to consultation also made it clear that withdrawing the Standards for medicines management without having something in place to replace them, was unpopular with many respondents. Signposting to a range of more up to date guidance published by other

organisations was not seen as sufficient by many respondents. Many respondents felt that a 'one-stop shop' for high-level guidance on medicines management practice was required.

- 10 We are currently working closely with the Royal Pharmaceutical Society (RPS) as they review and update their guidance *Professional Guidance on Safe and Secure Handling of Medicines in all Care Settings*, which we believe will provide an ideal model for guidance on medicines management and a suitable first port of call for all health and care professionals, including nurses and midwives.
- 11 The RPS are working in collaboration with a range of stakeholders across the health and care spectrum, including the Royal College of Nursing and the Royal College of Midwives, which will ensure that the guidance is fit for purpose from a nursing and midwifery perspective.
- 12 The RPS consulted on the draft version of the new guidance earlier this year and is currently working on analysing the responses to that consultation. The RPS will then work in conjunction with a working group, of which the NMC is a part, to finalise the new guidance ready for publication.
- 13 We propose that the current Standards for medicines management and any underpinning circulars are withdrawn on 28 January 2019. This allows nurses and midwives time to prepare for the withdrawal.
- 14 We will advertise the agreed withdrawal date well in advance via clearly stated information on our website. We will also give a clear indication as to what may be replacing our current standards in due course.
- 15 **Recommendation: The Council is recommended to approve that the NMC's Standards for medicines management are withdrawn on 28 January 2019.**
- 16 With regard to work on any future guidance on prescribing practice, consultation responses identified a range of subject areas that stakeholders considered suitable for further underpinning guidance. Subject areas identified included remote prescribing, cosmetic and aesthetic prescribing, prescribing for children, prescribing for pregnant women and sports prescribing.
- 17 We are currently seeking to identify where suitable guidance already exists that nurses and midwives could be referred to. For example, we are aware of good quality existing guidance on prescribing for children and pregnant women that is currently contained within the British National Formulary which would negate the need for us to develop guidance.
- 18 For other areas of prescribing practice, however, it is apparent that new guidance may be required due to a perceived lack of current clear

guidance for nurse and midwife prescribers. Areas where such perceived gaps may exist include: remote prescribing, particularly in the cosmetic and aesthetic context; and sports prescribing. These areas were not covered explicitly in our existing guidance, however guidance exists from other regulators, for example the GMC has guidance on remote prescribing for cosmetic and aesthetic purposes.

- 19 For these specific areas we will consider the following options:
- 19.1 Whether there is any existing guidance from other organisations that we could signpost to.
- 19.2 Whether to liaise with other regulators, as well as stakeholder groups such as royal colleges, to identify if there is an appetite for working jointly on new cross-regulatory guidance.
- 19.3 To consider if we should draft our own guidance for nurses and midwives and if so whether any such guidance is outside of our regulatory remit.
- 20 The Council will be kept informed as to future progress in this area through regular updates.
- Public protection implications:** 21 Ensuring that nurses and midwives refer to medicines management and prescribing guidance that is up to date and reflects modern, safe and effective practice in those areas, is central to ensuring patient safety and public protection. The current Standards for medicines management in particular are over a decade old and do not necessarily reflect modern, safe and effective approaches to medicines management, optimisation and administration practice.
- 22 It is therefore imperative that NMC registrants access and are directed to sources of guidance and information that are up to date rather than our current outdated Standards for medicines management.
- Resource implications:** 23 None arising from to this paper. This work is carried out as part of business as usual for the Education and Standards directorate and will therefore be staffed and funded under existing budgets.
- Equality and diversity implications:** 24 The proposal to withdraw the Standards for medicines management was subject to a full equality and diversity impact assessment as part of the education programme consultation.
- Stakeholder engagement:** 25 The proposal to withdraw the Standards for medicines management was subject to a full, formal public consultation exercise and extensive stakeholder engagement as part of the education programme consultation.

- Risk implications:** 26 The risk of referring to out of date standards, guidance and other supporting information in the prescribing and medicines management arena of practice is that considerable harm could potentially occur to patients and people receiving care as a result. We are aware that medicines management errors in particular are a leading contributor to referrals to fitness to practise. It is therefore essential that any out of date standards or guidance that we produce in this area are withdrawn as soon as is practicably possible, and that NMC registrants instead refer to the most appropriate up to date material available, whether that is produced by the NMC or not.
- Legal implications:** 27 None arising from this paper. All consultation proposals have been reviewed to ensure they are compliant with legal requirements as part of their development process.

Council

Overseas review – update

Action: For information.

Issue: To update the Council on the progress of the review of the overseas registration process.

Core regulatory function: Registration and Revalidation.

Strategic priority: Strategic priority 1: Effective regulation.

Decision required: None.

Annexes: None.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

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- Context:**
- 1 The current overseas process was introduced in 2014. We have a corporate commitment to review our processes to ensure they remain effective and efficient and reflect feedback from stakeholders and applicants. We know that applicants from overseas and employers find the current process costly and time consuming.
 - 2 We are introducing the new profession of nursing associate and developing and launching new education standards and proficiencies for nurses and midwives. We need to assess applications from overseas applicants against these new standards.
 - 3 This paper provides an update on the work we have carried out so far. In November 2018, Council will be asked to approve the revised overseas registration policy.

Objectives of the review

- 4 We will introduce a revised and updated process for all overseas applicants to the NMC register. This will provide a route for nursing associate applicants, ensure our requirements for overseas applicants are aligned with our new education standards and it will improve and streamline the process so that it is fair, proportionate and cost effective, whilst maintaining public protection.
- 5 We have progressed our work in accordance with the following principles:
 - 5.1 statutory objective: remaining focused on public protection with a proportionate approach to assessment and testing that fits with our Education framework.
 - 5.2 regulatory outcomes: ensuring that our overseas process enables us to have assurance that applicants from overseas meet the same standards as those trained in the UK.
 - 5.3 how we operate: identifying the main areas where our operation needs to be simpler and ensuring that we charge a fee appropriate to the cost of regulation.
 - 5.4 meeting the needs of our customers: providing a transparent process with information easily accessible by all applicants.
- 6 We know that choosing to come and work in the UK requires significant personal and financial investment. Living and working in a different country is challenging and applicants need us to help them to be able to work as soon as possible. They need a smooth process and help to understand what documents we want, why we want them and when we have received them. Unnecessary delays in registration mean they can not practise their chosen profession and could put them at risk of losing work or sometimes having to return

home.

- 7 Employers too often make substantial investments in recruitment from overseas and they need to understand the process so that they can plan effectively for safe staffing levels and have confidence that they will have the people they need in place.
- 8 Our aim is to deliver an improved experience to both the applicant and employers by accelerating our application process, making as much of it as automated as possible and improving the guidance we provide as to our requirements. We hope this will better support those professionals who want to come and work in the UK.
- 9 To support the new process we will deliver a new on-line system, new competence tests and improved guidance and support for applicants.
- 10 We aim to introduce the revised overseas registration route from January 2019, however we have also been looking at what we can change before that, in particular where we can improve the process. We will therefore also be delivering incremental improvements from this summer designed to streamline the current process and make it easier for applicants.

Four country factors:

- 11 The overseas registration process will apply to all applicants trained outside the EU regardless of where in the UK they intend to work. Applicants for the nursing associate register trained in the Devolved Administrations will also have their qualifications assessed as overseas applicants.

Discussion

- 12 We have already made substantial progress. Since March 2018, we have undertaken an end to end review of the current overseas process, taking into account the feedback we have had to date from stakeholders. So far we have:

- 12.1 developed a draft revised policy for assessing qualification comparability that enables a more streamlined, proportionate process for overseas applicants;
- 12.2 designed a testing framework which will allow assessment against NMC standards for nursing associates, nurses and midwives;
- 12.3 designed a tender process for procuring third party to design and deliver the test of competence;
- 12.4 continued work on phase two of the English language policy review, exploring further options for candidates to provide evidence of their English capability;

- 12.5 begun to engage with stakeholders using a detailed engagement strategy on the overseas process including our English language evidence requirements.
- 13 In addition to this we have identified a number of interim improvements to the current process which we propose to introduce over the coming months. These are:
- 13.1 introducing a new OSCE re-sit policy which will only require candidates to re-sit in the areas that they have failed. This change was introduced on 16 July 2018;
- 13.2 removing the requirement to have undertaken 12 months in practice prior to being eligible to undertake the test of competence;
- 13.3 introducing a more proportionate approach to requiring police clearances, relying on the UK Visa process where possible; and
- 13.4 introducing significantly improved preparation materials to help those sitting for OSCE.
- 14 Currently applicants pay the NMC an evaluation fee (£140) and, an assessment and registration fee (£153). In addition, there are costs associated with preparing to apply such as the costs for the test of competence payable directly to the test providers, language testing and obtaining references, training transcripts and police clearances. These are in addition to the personal costs such as for the visa and recruitment fees.
- 15 We have sought to identify where costs can be reduced by reviewing and rationalising the supporting evidence we require without compromising public safety. We anticipate savings in the cost of assessing applications through streamlining the process and supported by the introduction of a new IT system. The procurement of a new test of competence is expected to also bring some efficiency savings for us, as well as savings to the applicant for re-sits that will be achieved as a result of our new re-sit policy.
- 16 Interim improvements are being introduced from July 2018.
- Public protection implications:** 17 It is essential for public protection that we are able to assure ourselves that overseas applicants are trained to a comparable standard to that of registrants trained in the UK and that they are capable of safe and effective practice. As we develop and improve standards for UK nurses and midwives we need to apply the same standards when assessing overseas applicants.
- Resource** 18 The Overseas programme will be primarily resourced by permanent

- implications:** staff from the Registration and Revalidation and Resources directorates with the exception of a procurement specialist to assist with contract work, external legal advice where appropriate and secondment of education specialist resource given limited capacity within the education and standards directorate. We will continue to rely on third party providers for the development of systems and for test design and development of approximately £380,000.
- Equality and diversity implications:**
- 19 We have undertaken Equality Impact Assessments (EQIA) on all our proposed changes including changes to the test of competence and the qualification comparability process, as well as the overall process. Candidates for the OSCE element of the test of competence have the option of providing diversity data and we have specifically undertaken evaluations from an equality and diversity perspective on the current tests.
- 20 This analysis has shown areas for improvement in providing greater transparency for candidates, improved accessibility and clearer policies for providing reasonable adjustments. The results of these evaluations are being built into the specification for the design and delivery of the new tests.
- 21 The revised overseas process needs to be flexible to accommodate all categories of overseas applicants, including a proportionate approach for any applicants trained in the devolved nations to the nursing associate part of the register. Our analysis of our proposed changes has not so far identified any disproportionately negative impact on any particular group and we anticipate a positive impact on all groups from the improvements we intend to make in enhancing access.
- 22 However, we now need to test this analysis through our stakeholder engagement over the summer, particularly with hard to reach groups and patients and the public. We have been invited to the CNO's Strategic Advisory Group on black and minority ethnic issues in July 2018 and we are holding our own meeting with equalities stakeholders on 7 August 2018 to discuss the equality and diversity implications of the programme. Following this engagement and the engagement detailed below, we will update our EQIAs.
- Stakeholder engagement:**
- 23 We will be holding a series of events across all four countries during July, August and September 2018 for employers, candidates and the public to obtain their feedback and to discuss our emerging proposals. We will be meeting with patient representatives and seeking their input as to how we can best engage patient groups in this work. We have also sought the views of patients and the public, including hard to reach groups, on our English language requirements.

24 So far we have had meetings and calls with key stakeholders such as NHS Employers and the RCN to discuss how best to involve their members and the RCN, UNISON and Unite have agreed to promote our webinars and events and NHS employers have organised a meeting for us to discuss the overseas programme with their members.

Risk implications:

25 This review is complex and will significantly change how applicants are registered, introduce a new IT system and let new contracts for testing and qualification comparability services. We are taking legal advice at each stage of the programme. We are undertaking significant engagement and communications work with stakeholders to ensure the changes we make are understood and accepted. The programme has a full risk register to ensure we identify and mitigate potential threats.

Legal implications:

26 We have received legal advice throughout the development of our proposals and will continue to seek legal advice to ensure any proposals for change are in line with our own and wider legislation.

Council

Update on the consultation on registration fees for nursing associates

Action: For information.

Issue: To provide an update on the NMC's consultation on the registration fees for nursing associates.

Core regulatory function: All regulatory functions.

Strategic priority: Strategic priority 1: Effective regulation.

Decision required: None.

Annexes: None.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

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- Context:**
1. To introduce fees for nursing associates we need to make changes to the Nursing and Midwifery Council (Fees) Rules 2004 (Fees Rules).
 2. In November 2017, the Council agreed to consult on amending the Fees Rules. This consultation ran from 4 December 2017 to 26 February 2018 (12 weeks).
 3. The consultation proposed that:
 - 3.1. The fee structure for nursing associates should mirror that of nurses and midwives.
 - 3.2. Most nursing associates (those who have an NMC approved qualification and the pre-regulation students in England) who apply to join our register should pay £120 to register. All nursing associates then pay a £120 annual retention fee.
 - 3.3. As nursing associates will be regulated in England only, applicants who qualified in Scotland, Wales and Northern Ireland, non-EU/EEA and EU/EEA countries will need to have their qualification evaluated to see if it meets our requirements. The consultation proposed a qualification evaluation fee for these applicants.

- Four country factors:**
4. We regulate nurses and midwives across the UK, but we will only regulate nursing associates in England.

Discussion: Consultation response demographics summary

5. An independent research company was contracted to review the results. We are finalising our consultation report, based on this review, and plan to publish our report in August 2018 before we ask the Council to set the fees for nursing associates (see next steps at paragraphs 16-20).
6. A total of 863 respondents answered some or all of the questions in the consultation survey. The majority of responses were from individuals, and we also received 31 responses from organisations such as the RCN and Unison.
7. The 863 responses from individuals can be broken down into the following sub-groups:
 - 7.1. UK registered nurse: 49 per cent
 - 7.2. Nursing associate students: 16 per cent
 - 7.3. Educators: 6 per cent

7.4. UK registered midwives: 1 per cent.

Consultation findings high-level overview

8. The majority of respondents were supportive of the NMC's proposals. There was support across the different stakeholder groups, including registered nurses and organisations.
9. However, across all the consultation questions, support was much higher among registered nurses and midwives than among nursing associate students (who disagreed with many of the NMC's proposals). This is to be expected, as it is common for the group who are the subject of a consultation about introducing fees (in this case nursing associate students) to disagree with the proposals.
10. There was strong support (66% of all respondents agreed) for the overarching principle of the consultation, that the fee structure for nursing associates should mirror the NMC's current fee structure for nurses and midwives.
11. The most common reason provided acknowledged that as the same regulatory processes will apply to nursing associates, the fee should also be the same. For example, a UK-registered nurse said "*Given the parity in regulation and fitness to practise requirements it seems sensible to set the fees at the same level*" and Unite noted that "*...as the same model of regulation is proposed, it is only fair that the fee structure for nursing associates should be the same as that for nurses and midwives.*" Other comments included, "*We support equal fees for nursing associates, nurses and midwives as they are subject to the same regulations and benefits and this should not be at risk of being funded by other registrants*" (an NHS provider).
12. Respondents who disagreed with the principle that the same fee structure should apply felt that the fees should be lower for nursing associates as they are likely to be lower paid than registered nurses. Comments included "*...if nursing associates are to pay the same fees as a nurse this would be proportionately more from their take home pay*" (NHS Employers). The consultation document did make clear that our proposals for fees were based on the costs associated with regulation.
13. There were two questions where some of the comments made indicated a degree of misunderstanding. Overall, the NMC's proposals on these two questions received less support:
 - 13.1. The qualification evaluation fee for applicants to the nursing associate part of the register trained in Scotland, Wales and Northern Ireland. Only slightly more respondents (44%) disagreed rather than agreed (43%) with the proposal to charge these applicants a qualification evaluation fee of £140. Analysis identified some areas of misunderstanding. For example, one organisation said that if, in the future, the

decision was taken to regulate nursing associates in Scotland, Wales and Northern Ireland it would be unfair to treat applicants from these countries differently. However, if this was the case they would be subject to the same fee structure as those with an approved qualification from England. The consultation report will address this and other areas of misunderstanding.

- 13.2. In relation to the initial registration application fee for individuals training to be a nursing associate before regulation is in place (i.e. HEE test site students), just over half (53%) of all respondents agreed that the initial registration fee for these individuals should be £120. Agreement was highest amongst UK registered nurses and midwives (68%) and lowest among nursing associate students (19%). However, the qualitative data suggests that, again, there was some misunderstanding amongst respondents. For example, some respondents (11%) who gave a reason for their answer said that nursing associates should not have to pay a registration fee or join the register before regulation is in place. It is not the NMC's intention to charge nursing associates a fee before regulation is in place, therefore the consultation response will aim to address this misunderstanding.

14. Notwithstanding the lower levels of support for these two questions, we recommend that the proposals put forward in the consultation are adopted (see next steps at paragraphs 18-20).

Equality and diversity

15. The majority of respondents believed that the NMC's proposals will either have a mainly positive impact (23%) or no anticipated impact (48%) on people with protected characteristics (e.g. age, disability and race). More detail will be provided in the consultation report.

Summary and next steps

16. The Executive is of the view that no evidence has been provided in response to the consultation to justify amending our proposals, and the consultation findings are in line with what we expected. We are reassured that the majority of respondents agreed with our proposals, in particular with the principle that the same fee structure should apply to nursing associates.
17. We acknowledge that in general nursing associate students did not support the proposals. However, this is to be expected from any group who are to be asked to pay a fee and we note the high level of support across all questions from registered nurses and midwives. Therefore, we do not think there is any evidence from the consultation to suggest we deviate from the proposals set out in the

consultation.

18. We will seek the Council's approval of the fees framework for nursing associates in September 2018. The Council will also be asked to approve the resulting changes to the Fees Rules, which will take the form of a Statutory Instrument.
19. This Statutory Instrument will need to be approved by the Privy Council before passing through Parliament under the negative resolution procedure. This means that it will automatically become law without debate unless there is an objection from either House.
20. We will be aiming for the Privy Council to approve the Statutory Instrument at the meeting in October 2018 (exact date to be released in the summer). Subject to Parliamentary approval, the changes to the Fees Rules will then come into force in time for the opening of the nursing associate part of the register in January 2019.

Public protection implications:

21. The Secretary of State has taken the decision that statutory regulation of the nursing associate role is required in order to protect the public. Our fees are set at the level required to meet the global costs of regulating the professions on our register.

Resource implications:

22. In agreeing to regulate nursing associates, Council was clear that the costs of bringing a new profession into regulation must not be borne by nurses and midwives. The Department of Health and Social Care has agreed to provide the funds required.

Equality and diversity implications:

23. The NMC will receive applications to join the register from individuals who do not hold a qualification from education providers approved by the NMC to deliver nursing associate education. This will apply to applicants trained in Scotland, Wales and Northern Ireland, as well as those trained in the EU/EEA and outside of the EU/EEA. These applications are assessed to evaluate the comparability of the qualification. Although we recognise that there is a difference in terms of the fees paid by these applicants, this relates to the place of qualification and nature of the education programme. It does not relate to the protected characteristic of race (which includes nationality).
24. As is the currently the case for nurses and midwives, individuals working part time may be financially disadvantaged, as regards paying a fee, compared to those working full time. This may impact upon the protected characteristics of gender, age and pregnancy or maternity. The NMC makes no distinction between individuals that work full time or part time, and this is consistent with the approach taken by other regulators. The NMC offers a flexible payment system to allow registrants to pay their annual fee in quarterly instalments

and tax relief is available through HM Revenue and Customs.

- Stakeholder engagement:** 25. The NMC is engaging widely on the introduction of the regulation of nursing associates. In connection with the issues raised in this paper, the NMC has engaged with the Department of Health and Social Care (workforce and policy teams) and member of the Nursing Associate External Stakeholder Group (which includes representatives from professional associations and unions).
- Risk implications:** 26. In order to join our register, nursing associates will be required to pay a fee. Therefore the mechanism to allow them to do so must be in place when the nursing associates' part of the register opens at the start of 2019. This will be contingent upon securing parliamentary time towards the end of 2018 to lay the draft Fees Rules Amendment Order, and the section 60 Order coming into effect.
- Legal implications:** 27. Legislative change is required to enable the NMC to charge a fee to nursing associates. A revised draft Fees Rules Amendment Order will be placed before Council to approve in September 2018.

Council

Midwifery update

Action: For discussion.

Issue: Provides an update on midwifery matters.

Core regulatory function: Education. Standards.

Strategic priority: Effective regulation.

Decision required: None.

Annexes: None.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

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Context: 1 This report updates the Council on recent midwifery-related activity including the work of the Midwifery Panel, the development of the new standards of proficiency for registered midwives, the development of the midwifery programme standards, midwifery communications and engagement activity.

Four country factors: 2 There are different approaches across the four countries in relation to midwifery and maternity services. We are engaging across the UK to ensure we understand the current UK midwifery context.

Discussion: Midwifery Panel

3 The Midwifery Panel last met on 19 April 2018.

4 At this meeting the Council's request to oversee the development of new pre-registration midwifery standards was agreed. As a result, the Panel's terms of reference have been reviewed, along with its membership to make sure it includes the right expertise and representation.

5 The role of the Future Midwife Sponsoring Board (FMSB) was also reconsidered, noting the overlap between the various groups. The FMSB has now been disbanded, with its members invited to join other midwifery groups as appropriate.

6 The Panel considered an outline of the new draft standards of proficiency for registered midwives, presented by Professor Mary Renfrew, our Lead Adviser for this project. The Panel's views have been incorporated into the next version of the draft standards, and they will be considered again at the July 2018 meeting of the Panel.

External midwifery news

The Royal College of Midwives (RCM)

7 On 24 March 2018, the RCM welcomed the Government's announcement on maternity services in England, which included: training more midwives; continuity of carer; and maternity support workers. Jeremy Hunt MP, the previous Secretary of State for Health, stated in his Written Ministerial Statement that the Government was working with the RCM to identify better pathways to becoming a registered midwife in England. The RCM Chief Executive, Gill Walton, commented that the Government and trusts must commit to ensuring that newly-qualified midwives could get jobs in the NHS.

8 In June 2018, the RCM published a new position statement on infant feeding which recommended that maternity care should promote informed choices to parents so that they are supported in their chosen method of infant feeding.

External review of a sample of Local Supervising Authority (LSA)

supervisory investigations

- 9 NHS England commissioned an independent review following two previous commissions on the quality of midwifery supervision. A review of a sample of case reviews conducted between April and December 2016 was requested. This timeframe was selected as it immediately followed the implementation of an LSA single operating model in March 2016. The model aimed to ensure a consistent approach to supervisory processes in England. The review was led by Debbie Graham, Independent Consultant Midwife, and a report was published in June 2018.
- 10 The review had three aims:
 - 10.1 To establish whether each case had had a robust and objective supervisory investigation into the standard of midwifery practice and was in compliance with the relevant LSA process and guidance.
 - 10.2 To identify learning points that would inform and promote a strengthened investigatory process into incidents where there were concerns about the standard of midwifery practice.
 - 10.3 To share the findings and learning points of the review with each of the sample cohort families; the relevant Trust; NHS Improvement; and the Healthcare Safety Investigation Branch (HSIB).
- 11 297 cases were subject to a supervisory investigation between April and December 2016. Through systematic sampling 20 cases were subject to review. An opt-in review was required through signed consent of each woman.
- 12 The overall findings of this review show the supervisory investigations into midwifery practices were undertaken in accordance with LSA policy and good practice standards. However, all cases in the small cohort sample failed to comply with the statutory duty of candour.
- 13 Duty of candour is already a requirement under the Code. The NMC published joint guidance with the General Medical Council on the duty of candour, and a series of case studies to help nurses and midwives understand the professional duty of candour.
- 14 The Fitness to Practise (FtP) directorate has also undertaken a critical read of the report to identify whether there are any FtP-related issues arising which could be incorporated into current FtP practice or as part of the FtP strategy. There are lessons to learn in terms of the importance of engagement with patients and family members, and these are being taken forward.

Healthcare education funding for nursing and midwifery students

in Wales

- 15 In April 2018, the Welsh Health Secretary confirmed that the NHS bursary for eligible student nurses and midwives will be extended for students starting programmes in September 2019. The bursary is based on individuals committing in advance to work in Wales, post-qualification, for a period of two years as stated in the terms and conditions.

Update on the future midwife standards

- 16 Professor Mary Renfrew and the future midwife project team continue to develop the new draft standards of proficiency for registered midwives and pre-registration midwifery programme standards. Council members will have an opportunity to consider the draft proficiencies at the July 2018 Seminar. The draft proficiencies and the education programme standards will come to the Council in November 2018 seeking approval to go to consultation.
- 17 We continue to build our evidence base to support the development of the new standards of proficiency. This includes the insights gained from ongoing communications and engagement activity outlined below.
- 18 Once we have concluded the second phase of engagement we will undertake an in-depth analysis and evaluation of what we have heard which will be collated and developed into a comprehensive report.
- 19 The draft midwifery programme standards which will guide Approved Education Institutions (AEIs) in the development of their programmes are being developed under the direction of the NMC's Interim Senior Midwifery Adviser, through a UK-wide reference group. The group will be chaired by Professor Gwendolen Bradshaw, NMC Midwifery Thought Leadership member, and membership will comprise four heads of midwifery, four lead midwives for education (LMEs), two student midwives, a practice educator and a service representative.

Midwifery communications and engagement activity

- 20 Since the Council last met, we have written to everyone who took part in the first phase of future midwife engagement to update them on how we have used their input and our latest progress.
- 21 We have a range of communications and engagement planned over the coming months, both to specifically support the future midwife project and relating to midwifery matters more generally.
- 22 This includes seeking to increase our engagement with women and families, while being mindful of the ethical considerations when talking with individual service users about their maternity experiences. We intend to seek input from Maternity Services Liaison Committees and the Healthwatch network to assist us with gaining input from women

and families who are currently being, or who have recently been, cared for by midwives.

- 23 We intend to use a wide range of innovative social media platforms to engage with our stakeholders, particularly women and families.

Workshops and visits

- 24 In June 2018, as part of the future midwife phase two engagement, we held workshops in Northern Ireland and Scotland. We are hosting similar workshops in July 2018 in Wales and England, where we are asking small groups of clinical midwives, midwifery educators and students about the knowledge and skills the future midwife will need, as well as specific questions arising from the latest draft of the proficiencies – for example, whether the newborn and infant physical examination (NIPE) should be included in the new midwifery standards.
- 25 These have all been organised with the support of midwifery Thought Leadership Group (TLG) members in each of the four nations, helping us to target invitations to midwives and educators at a range of levels. We have used Twitter to share the questions asked at the workshops and seek additional views.
- 26 In each location we are offering the option of an informal drop-in session at a local maternity unit to maximise the opportunity for midwives on the ground to speak to us about the future midwife project, as well as NMC work more generally. We held a successful session at Antrim Hospital and hope to hold similar sessions linked to the workshops taking place in July 2018.
- 27 This reflects the positive feedback received by Donna Ockenden, Senior Midwifery Advisor to the Chief Executive, from her visits to maternity departments across the UK. We recently published a blog to share the insights gained from her visit to Chelsea and Westminster NHS Foundation Trust¹. Over the coming months, Donna will be visiting midwives in Edinburgh, Cardiff and Belfast and we will share the outcomes from these on social media and via our website.

Future midwife roundtables and forum

- 28 The Council previously commented that our engagement to date has been focused on midwives, and that we need to broaden the range of people and organisations we hear from. There was particular emphasis on women's voices and advocacy groups. In response, we are holding two roundtables in July 2018.
- 29 The first of these is for advocacy group representatives. They will be asked to discuss and feedback on what midwives need to know at the point of registration. We aim to have around 10-15 charities

¹ <https://www.nmc.org.uk/news/news-and-updates/blog-donna-ockenden-june-2018/>

represented at the event, covering a broad range of areas of interest (eg LGBT, cancer, refugees, and more).

- 30 The second of these roundtables is with multi-disciplinary professional groups who work with midwives and who have been under-represented in our engagement to date. They will be asked to consider similar questions.
- 31 We are also holding a large workshop-style forum event with a range of key senior stakeholders. This will provide a means of sharing, and gathering feedback on the draft proficiencies (or specific sections of them). Organisations invited include commissioners, midwifery educators, Chief Nursing Officer representatives, Heads/Directors of Midwifery, lead midwives for education, selected Royal Colleges and midwifery/maternity focused advocacy groups.

Webinars and social media

- 32 In early July 2018, we are holding a midwifery webinar, to which all 600 members of the future midwife virtual thought leadership group have been invited. We have advertised it on Twitter, and invited anyone with an interest in our work to take part. As well as seeking views to contribute to the future midwife project, this is a forum for us to provide information about our work more broadly and hear comments and queries from our stakeholders to inform our work.
- 33 We are planning to hold a Twitter chat focused on midwifery within the next two of months, working in partnership with an online forum such as Mumsnet or WeMidwives.
- 34 We will also be reviewing and updating the midwifery content on our website, using the expertise of our midwifery advisers.
- 35 As appropriate, we continue to post information about our engagement on social media. For example, during recent workshops in Northern Ireland and Edinburgh, we asked for views on the questions being discussed. Responses were shared with the future midwife team.

Strategic engagement

- 36 We continue to engage with a wide range of stakeholder organisations as part of our strategic engagement. Through sharing information about our work with charities and representatives bodies, over the coming months we aim to facilitate focus groups with seldom-heard groups, particularly those representing the voices of women and families.

Conferences and exhibitions

- 37 We recently had stands at the Midlands Maternity and Midwifery Festival 2018 and at the RCM's fifth annual education conference, where Jacqui Williams, our Interim Senior Midwifery Adviser presented

an update on the future midwife project.

- 38 Jacqui Williams will also be speaking at *The Golden Thread of Safety* conference at the University of Salford in July 2018.

Public protection implications:

- 39 None directly arising from this report.

Resource implications:

- 40 None directly arising from this report.

Equality and diversity implications:

- 41 We are tracking the diversity of engagement to date and will be targeting specific groups that are currently underrepresented.

Stakeholder engagement:

- 42 This is covered in the body of the report.

Risk implications:

- 43 No specific risk implications arising from this report. Risks relating to development of the future midwife standards are captured through the programme.

Legal implications:

- 44 None directly arising from this paper.

Council

Professional Standards Authority's Annual Performance Review 2016–2017

Action: For information.

Issue: The Council is recommended to consider the Professional Standards Authority's (PSA's) performance review report (Annexe 1) and to note progress on the 2017–2018 performance review and the consultation on revising the SOGR.

Core regulatory function: All regulatory functions.

Strategic priority: Strategic priority 1: Effective regulation.
Strategic priority 2: Use of intelligence.
Strategic priority 3: Collaboration and communication.
Strategic priority 4: An effective organisation.

Decision required: None.

Annexes: The following annexe is attached to this paper:

- Annexe 1: NMC Performance review report 2016–2017.

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- Context:**
- 1 The PSA oversees the nine UK healthcare regulators and reviews their performance annually against a set of 24 Standards of Good Regulation (SOGR).
 - 2 The report at Annexe 1, which covers our performance over the period 2016–2017, was published by the PSA on 4 June 2018. We originally received a draft of the report in September 2017 but the publication of the report was delayed pending the outcome of the Lessons Learned review.
 - 3 PSA has just commenced work on the performance review for 2017–2018. They are also undertaking a consultation on changing the SOGR.

- Four country factors:**
- 4 Not applicable for this paper.

Discussion: 2016–2017 Performance review outcome

- 5 PSA has judged that for the period 2016–2017 we met all apart from one of the SOGR (see Annexe 1). The Standard that we failed to meet was Standard 7 – ‘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’. PSA’s findings in relation to this Standard are largely based on the findings of the Lessons Learned review.
- 6 We fully accept this conclusion. We are sorry for our failings and we are committed to making improvements in relation to how we deal with families and others involved in our Fitness to Practise (FtP) cases. Our proposed action plan is detailed in a separate paper on the agenda on the Lessons Learned review.
- 7 We also met all but one of the SOGR in 2015–2016, but the Standard we failed then related to the timeliness of our work in FtP. PSA judged that we have now met this Standard.

2017–2018 Performance review process

- 8 With regard to the 2017–2018 review, there has been a delay because of the late conclusion of the 2016–2017 review. The process has now begun and on 22 June 2018, we received the PSA’s recommendation on the scope of our performance review for the period 2017–2018. A detailed review will be carried out by the PSA for the following areas:
 - 8.1 Education QA processes
 - 8.2 Registration applications, appeals and customer service

- 8.3 Accuracy and integrity of the register
- 8.4 Fitness to practise (FtP) screening
- 8.5 FtP process
- 8.6 FtP customer service
- 8.7 FtP decisions.

PSA's consultation on revising the SOGR

9 In addition, PSA has launched the second phase of their consultation on the revision of the SOGR, and are seeking views on redrafted standards. The proposed revised SOGR include five new "General Standards" which focus on:

- 9.1 How regulators provide fully accessible information.
- 9.2 How regulators apply learning from one area to other applicable areas.
- 9.3 How regulators apply equality and diversity.
- 9.4 How regulators report on their performance and address concerns related to it.
- 9.5 How effectively regulators work with employers and other stakeholders.

10 The deadline for response to the consultation is 10 September 2018. Given this timescale we will share our draft response with Council by correspondence during August 2018.

11 During the first phase of this consultation, which was held during the summer of 2017, the Council had the opportunity to express their views in relation to the various proposed approaches to revising the SOGR. Those views were incorporated into our formal response to the consultation which was sent to the PSA on 12 September 2017.

Public protection implications:

12 Taking appropriate measures to respond to learning from the PSA report will help us to provide improved regulation and better public protection.

Resource implications:

13 None.

Equality and diversity implications:

14 None.

Stakeholder engagement: 15 We are committed to engaging constructively with the PSA and to maximise opportunities to improve from the feedback we receive and to be open and transparent with all our stakeholders about how we are addressing areas for learning.

Risk implications: 16 None.

Legal implications: 17 None.

Annual review of performance 2016/17

Nursing and Midwifery Council



About the Professional Standards Authority

The Professional Standards Authority for Health and Social Care¹ promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament.

We oversee the work of nine statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.

We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards.

To encourage improvement we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation.² We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care. We also undertake some international commissions to extend our understanding of regulation and to promote safety in the mobility of the health and care workforce.

We are committed to being independent, impartial, fair, accessible and consistent. More information about our work and the approach we take is available at www.professionalstandards.org.uk.

¹ The Professional Standards Authority for Health and Social Care was previously known as the Council for Healthcare Regulatory Excellence

² *Right-touch regulation revised (October 2015)*. Available at www.professionalstandards.org.uk/policy-and-research/right-touch-regulation

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6. Fitness to Practise	24

About the Nursing and Midwifery Council

The Nursing and Midwifery Council (the NMC) regulates the nursing and midwifery professions in the United Kingdom. Its work includes:

- Setting and maintaining standards of practice and conduct in the professions
- Maintaining a register of qualified professionals (registrants)
- Assuring the quality of education and training for nurses and midwives
- Requiring registrants to keep up their skills up to date through continuing professional development
- Taking action to restrict or remove from practice registrants who are not considered to be fit to practise.

As at 31 March 2017, the NMC was responsible for a register of 690,773 nurse and midwives. Its annual retention fee for registrants is £120.



At a glance

Annual review of performance

Regulator reviewed: **Nursing and Midwifery Council**

Standards of good regulation

Core functions

Met

Guidance and Standards

4/4

Education and Training

4/4

Registration

6/6

Fitness to Practise

9/10

1. The annual performance review

- 1.1 We oversee the nine health and care professional regulatory organisations in the UK, including the NMC.³ More information about the range of activities we undertake as part of this oversight, as well as more information about these regulators, can be found on our website.
- 1.2 An important part of our oversight of the regulators is our annual performance review, in which we report on the delivery of their key statutory functions. These reviews are part of our legal responsibility. We review each regulator on a rolling 12-month basis and vary the scope of our review depending on how well we see the regulator is performing. We report the outcome of reviews annually to the UK Parliament and the governments in Scotland, Wales and Northern Ireland.
- 1.3 These performance reviews are our check on how well the regulators have met our *Standards of Good Regulation* (the Standards) so that they protect the public and promote confidence in health and care professionals and themselves. Our performance review is important because:
- It tells everyone how well the regulators are doing
 - It helps the regulators improve, as we identify strengths and weaknesses and recommend possible changes.

The Standards of Good Regulation

- 1.4 We assess the regulators' performance against the Standards. They cover the regulators' four core functions:
- Setting and promoting guidance and standards for the profession
 - Setting standards for and quality assuring the provision of education and training
 - Maintaining a register of professionals
 - Taking action where a professional's fitness to practise may be impaired.
- 1.5 The Standards describe the outcomes we expect regulators to achieve in each of the four functions. Over 12 months, we gather evidence for each regulator to help us see if they have been met.
- 1.6 We gather this evidence from the regulator, from other interested parties, and from the information that we collect about them in other work we do. Once a year, we collate all of this information and analyse it to make a recommendation to our internal panel of decision-makers about how we believe the regulator has performed against the Standards in the previous 12

³ These are the General Chiropractic Council, the General Dental Council, the General Medical Council, the General Optical Council, the General Osteopathic Council, the General Pharmaceutical Council, the Health and Care Professions Council, the Nursing and Midwifery Council, and the Pharmaceutical Society of Northern Ireland.

months. We use this to decide the type of performance review we should carry out.

- 1.7 We will recommend that additional review of the regulator's performance is unnecessary if:
- We identify no significant changes to the regulator's practices, processes or policies during the performance review period; and
 - None of the information available to us indicates any concerns about the regulator's performance that we wish to explore in more detail.
- 1.8 We will recommend that we ask the regulator for more information if:
- There have been one or more significant changes to a regulator's practices, processes or policies during the performance review period (but none of the information we have indicates any concerns or raises any queries about the regulator's performance that we wish to explore in more detail) or;
 - We consider that the information we have indicates a concern about the regulator's performance in relation to one or more Standards.
- 1.9 This targeted review will allow us to assess the reasons for the change(s) or concern(s) and the expected or actual impact of the change(s) or concern(s) before we finalise our Performance Review report.
- 1.10 We have written a guide to our performance review process, which can be found on our website www.professionalstandards.org.uk

2. What we found – our judgement

- 2.1 During May 2017 we carried out an initial review of the NMC’s performance from 1 April 2016 to 31 March 2017. Our review included an analysis of the following:
- Council papers, performance and committee reports and meeting minutes
 - Policy and guidance documents
 - Statistical performance dataset (see paragraph 2.11 below)
 - Third party feedback
 - A check of the NMC register
 - Information available to us through our review of final fitness to practise decisions under the Section 29 process.⁴
- 2.2 As a result of this assessment, we carried out a targeted review of Standards 2 and 3 of the *Standards of Good Regulation* for Registration and Standards 6 and 9 of the *Standards of Good Regulation* for Fitness to Practise.
- 2.3 We obtained further information from the NMC relating to these Standards, which we considered in detail.
- 2.4 We delayed publication of the performance review report whilst we carried out our Lessons Learned Review into the NMC’s handling of fitness to practise cases concerning midwives at Furness General Hospital.⁵ Some work on the cases had taken place in this reporting period and we decided that we may make findings in our Lessons Learned Review which could affect our view of the NMC’s performance against the Fitness to Practise Standards.
- 2.5 Following publication of the Lessons Learned Review⁶ and a detailed consideration of that report and the information we obtained from the NMC, we decided that the NMC had met 23 out of 24 of the Standards. The reasons for this are set out in the following sections of the report.

Summary of the NMC’s performance

- 2.6 For 2016/17 we have concluded that the NMC:
- Met all of the *Standards of Good Regulation* for Guidance and Standards
 - Met all of the *Standards of Good Regulation* for Education and Training
 - Met all of the *Standards of Good Regulation* for Registration.

⁴ Each regulator we oversee has a ‘fitness to practise’ process for handling complaints about health and care professionals. The most serious cases are referred to formal hearings in front of fitness to practise panels. We review every final decision made by the regulators’ fitness to practise panels. If we consider that a decision is insufficient to protect the public properly we can refer them to Court to be considered by a judge. Our power to do this comes from Section 29 of the [NHS Reform and Health Care Professions Act 2002 \(as amended\)](#).

⁵ Discussed in detail at 2.16.

⁶ See: www.professionalstandards.org.uk/docs/default-source/publications/nmc-lessons-learned-review-may-2018a0851bf761926971a151ff000072e7a6.pdf?sfvrsn=6177220_0

- Met nine out of 10 of the *Standards of Good Regulation* for Fitness to Practise. The NMC did not meet standard 7.

2.7 The NMC has maintained last year's performance when it met 23 out of 24 of the Standards. However, the NMC's performance against the sixth Standard for Fitness to Practise, which it failed to meet last year, has improved and it has now met this standard. We determined this year that the NMC did not meet the seventh Standard for Fitness to Practise.

Key comparators

2.8 We have identified with all of the regulators the numerical data that they should collate, calculate and provide to us, and what data we think provides helpful context about each regulator's performance. Below are the items of data identified as being key comparators across the Standards.

2.9 We expect to report on these comparators both in each regulator's performance review report and in our overarching reports on performance across the sector. We will compare the regulators' performance against these comparators where we consider it appropriate to do so.

2.10 Set out below is the comparator data provided by the NMC for the period under review.⁷

2.11

1	The number of registration appeals concluded, where no new information was presented, that were upheld	0 ⁸
2	Median time (in working days) taken to process initial registration applications for <ul style="list-style-type: none"> • UK graduates • EU (non-UK) graduates • International (non-EU) graduates 	1 2 13
3	Time from receipt of initial complaint to the final Investigating Committee/Case Examiner decision <ul style="list-style-type: none"> • Median • Longest case • Shortest case 	51 weeks 401 weeks 7 weeks
4	Time from receipt of initial complaint to final fitness to practise hearing <ul style="list-style-type: none"> • Median 	87 weeks

⁷ The period under review is 1 April 2016 to 31 March 2017.

⁸ The NMC reports that there were no appeals where no new information has been provided, including information provided orally at the appeal hearing stage. The NMC advised that there were two appeals upheld during the period where no new *written* information was provided.

	<ul style="list-style-type: none"> • Longest case • Shortest case 	<p>395 weeks</p> <p>25 weeks</p>
5	Median time to an interim order decision from receipt of complaint	26 days
6	<p>Outcomes of the Authority's appeals against final fitness to practise decisions</p> <ul style="list-style-type: none"> • Dismissed • Upheld and outcome substituted • Upheld and case remitted to regulator for re-hearing • Settled by consent • Withdrawn 	<p>0</p> <p>1</p> <p>1</p> <p>8</p> <p>0</p>
7	Number of data breaches reported to the Information Commissioner	0
8	Number of successful judicial review applications	0

Other developments in 2016/17: the decision to regulate nursing associates

- 2.12 At its meeting in January 2017 the NMC's Council agreed to the request from the Secretary of State for Health to be the regulator for the new role of nursing associates. Plans to create the role were announced by the Government in late 2015.
- 2.13 The role is designed to bridge the gap between health care assistants and registered nurses. It is intended that this will be a stand-alone role as well as a new route to becoming a registered nurse.
- 2.14 Taking on the regulation of the role will require changes to the NMC's legislation and may also involve changes to existing guidance and standards for registrants and employers. The NMC reports that it has begun a two-year programme of work to ensure that it is ready to begin registering nursing associates in early 2019.
- 2.15 In the interim, Health Education England has been running nursing associate pilots at 35 test sites across England. The first nursing associates are expected to complete their training and start work in 2019.

Independent lessons learned review of the NMC's handling of concerns about midwives at Furness General Hospital

- 2.16 On 17 February 2017 the Department of Health wrote on behalf of the Secretary of State to the Authority to ask whether the Authority would be willing to exercise its discretion under section 26 of the Health Care Professions Act 2002 and carry out an independent 'lessons learned' review into the NMC's handling of fitness to practise cases concerning midwives at

the Furness General Hospital. The NMC welcomed the review, stating that it considered that the Authority was best placed to conduct it.

- 2.17 Terms of reference for the review were published in May 2017 and the review formally commenced on 15 June 2017, following the conclusion of the last of the relevant cases.
- 2.18 Concerns around the midwifery unit at Furness General Hospital arose in 2008 and the NMC first received complaints about it in 2009. The review was, therefore, largely looking at matters which took place well before the period that is the subject of this report. The NMC's processes have changed significantly in that time and it is important to stress that this report deals simply with our view of the NMC's performance in 2016/17, by which time the bulk of the work on these cases had been completed.
- 2.19 However, some work on the cases did take place in this reporting period. In particular, decisions were taken about a number of cases both by the NMC team and by Fitness to Practise panels and there was significant correspondence between the NMC and some complainants in respect of information held by the NMC. These matters are clearly relevant to the Fitness to Practise Standards. We therefore delayed publication of this performance review so that we could take into account findings from the Lessons Learned Review.
- 2.20 We are pleased that, on the evidence that we examined for the purposes of this report, the NMC has met 23 out of 24 of the *Standards of Good Regulation*. However, we should stress that we did not undertake an audit of the NMC's processes this year, as this was not judged to be necessary on the evidence available and because we were assured by the targeted audit we carried out in our review of the NMC's performance in 2015/16.

3. Guidance and Standards

- 3.1 The NMC has met all of the *Standards of Good Regulation* for Guidance and Standards during 2015/16. Examples of how it has demonstrated this are indicated below each individual Standard.

Standard 1: Standards of competence and conduct reflect up-to-date practice and legislation. They prioritise patient and service user safety and patient and service user centred care

- 3.2 The NMC last revised its Code, setting out professional standards of practice and behaviour for nurses and midwives, in March 2015. We have not seen any evidence that this needs further revision.
- 3.3 The NMC reports that it will be working to develop standards of proficiency and practice for the new nursing associate role over the coming year. An early working draft of the standards of proficiency will be developed so that those who will complete their nursing associate training before the final standards are in place can work towards readiness to meet the NMC's likely

expectations. The final standards are scheduled to be approved in October 2018. We will monitor the progress of this piece of work.

Standard 2: Additional guidance helps registrants apply the regulators' standards of competence and conduct to specialist or specific issues including addressing diverse needs arising from patient and service user centred care

- 3.4 The NMC publishes online guidance supplementary to the Code on issues including the professional duty of candour, the use of social media, and raising concerns at work. This guidance is supported by case studies to assist understanding of their practical application.

Standard 3: In development and revision of guidance and standards, the regulator takes account of stakeholders' views and experiences, external events, developments in the four UK countries, European and international regulation and learning from other areas of the regulators' work

- 3.5 Although the NMC did not issue new guidance in the period under review, we note that existing guidance has been developed with reference to the views and experiences of a wide range of stakeholders.
- 3.6 The NMC worked with other healthcare regulators to develop a joint statement on avoiding, managing and declaring conflicts of interests. This was published in August 2017 and outlined how health professionals were expected to manage conflicts of interest and to formally declare them when they arise.

Standard 4: The standards and guidance are published in accessible formats. Registrants, potential registrants, employers, patients, service users and members of the public are able to find the standards and guidance published by the regulator and can find out about the action that can be taken if the standards and guidance are not followed

- 3.7 The NMC has not made any changes to the way in which it publishes its guidance and standards in the period under review.
- 3.8 The NMC continues to publish the Code and supporting guidance on its website. Welsh versions of the documents are available. The website was last redesigned in April 2015 to make content more accessible for people with differing needs.

4. Education and Training

- 4.1 The NMC has met all of the *Standards of Good Regulation* for Education and Training during 2016/17. Examples of how it has demonstrated this are indicated below each individual Standard.

Standard 1: Standards for education and training are linked to standards for registrants. They prioritise patient and service user safety

and patient and service user centred care. The process for reviewing or developing standards for education and training should incorporate the views and experiences of key stakeholders, external events and the learning from the quality assurance process

- 4.2 The NMC undertook extensive work during this review period to develop new standards in education. Updates on the progress of the work are provided at NMC Council meetings. There are also pages dedicated to this area of work on the NMC's website and an education newsletter is available to interested parties.

Standards of proficiency for the future graduate registered nurse

- 4.3 The new standards of proficiency for the future graduate registered nurse will separate the requirements for individuals and those for institutions. A set of competencies for nursing students to achieve at the point of entry to the register will be created and the education requirements that underpin the competencies will be moved into a new education framework.
- 4.4 A formal consultation on the new nursing standards was launched on 13 June 2017 and closed on 12 September 2017. Respondents were given the option of responding to the full consultation document or completing a short survey on the proposals. An Easy Read version of the survey designed to be accessible to people with learning disabilities was also available.
- 4.5 The final standards are scheduled to be published in early 2018, for adoption by September 2019, and with an option for approved education institutions to take up early adoption from September 2018.
- 4.6 We received positive feedback from two third party organisations about the work of the NMC in developing these standards. The NMC's UK-wide engagement with stakeholders in undertaking the work was highlighted in particular.

Standards of proficiency for the future graduate registered midwife

- 4.7 The development of competencies for the future graduate midwife is running a year behind that of the nursing standards. The NMC reports that this is to allow it to maintain its focus on the legislative changes to the way in which midwives are supervised and regulated,⁹ which came into force in April 2017.
- 4.8 In September 2016, the NMC's Council approved the following proposed timeline for the work, commencing in late 2016:
- 2016/2017: develop an evidence base and early engagement with midwifery stakeholders alongside work on the education framework.
 - 2017/2018: draft a set of new standards with input from midwifery education stakeholders.

⁹ From 1 April 2017 statutory midwifery supervision provisions were removed from the NMC's governing legislation and the statutory Midwifery Committee was removed from the its governance structures.

- Spring 2018: formal consultation on the new midwifery standards.
- Early 2019: publish the new midwifery standards.
- September 2019: 'early adoption' of new midwifery standards and new education framework in place.
- September 2020: deadline for adoption of new midwifery standards.

4.9 In September 2017 the NMC's Council approved a new timeline which includes a consultation on new standards in early 2019, and full adoption of the new standards in September 2020, with no provision for 'early adoption'.

4.10 The NMC reports that it plans to undertake an extensive programme of engagement to obtain the views of new and experienced midwives, educators, students, women and their families.

Reviews of other standards

4.11 The length of time since some post-registration standards had last been reviewed was highlighted in our Performance Review report for 2015/16.

4.12 The NMC reports that it is reviewing post-registration education and practice standards in order to ensure alignment with its new approach to standards of proficiency and the new education framework.

4.13 As part of this work, the NMC is updating its Standards of Proficiency for Nurse and Midwife Prescribers, taking into account the principles behind the Royal Pharmaceutical Society's new single competency framework for all prescribers and engaging with the General Pharmaceutical Council.

4.14 The consultation on the new standards for prescribers was run alongside that on the new standards of proficiency for the future graduate registered nurse and closed on 12 September 2017. The draft standards, and a copy of the Royal Pharmaceutical Society's competency framework for prescribers, were available on the NMC's website.

4.15 Following the introduction of revalidation, the NMC will also review its current return to practice standards.

Conclusion

4.16 The NMC's work to develop new standards for education and training has progressed in line with proposed timelines for activity over the period under review. The work has involved extensive engagement with stakeholders, which has been welcomed by organisations responding to our call for feedback this year.

4.17 The NMC has stated its intention to ensure that the introduction of new standards will mean that nurses and midwives have the right knowledge, skills and professional attributes when they join the register, so that they can deliver safe and effective care throughout their careers.

Standard 2: The process for quality assuring education programmes is proportionate and takes account of the views of patients, service users, students and trainees. It is also focused on ensuring the education

providers can develop students and trainees so that they meet the regulator's standards for registration

- 4.18 Each year the NMC produces an annual report on its quality assurance (QA) activity in respect of both approved education institutions (AEIs) and midwifery local supervising authorities (LSAs) for the previous year.
- 4.19 The reporting year covered in the last report, published in November 2016, was from 1 September 2015 to 31 August 2016 for AEIs (the academic year) and from 1 April 2015 to 31 March 2016 for LSAs.
- 4.20 The NMC ceased conducting routine monitoring reviews of LSAs from 1 April 2015 and discontinued risk-based monitoring visits of LSAs from 1 April 2016. Legislative changes removing the requirement for statutory supervision of midwives came into effect in April 2017. The LSAs were replaced with new models of midwifery supervision in each of the four countries of the UK and the NMC no longer has a role in quality assuring midwifery supervision. The final reporting information on this aspect of the NMC's work is set out below.

Approval of AEIs and education programmes

- 4.21 The NMC's annual report recorded that there were 79 AEIs in the UK. It stated that a number of applications had been received from new providers seeking to become AEIs for the first time and that this appeared to be linked to the discontinuance of bursaries for pre-registration nursing and midwifery students in England.
- 4.22 From 1 September 2015 to 31 August 2016 two new providers were approved to become AEIs and 93 programmes were approved, bringing the total number of approved programmes to 925.
- 4.23 The annual report described changes made to improve the efficiency of the approval process, including requiring AEIs to demonstrate the readiness of their curriculum documentation before an approval event is confirmed and setting minimum timeframes between the approval event date and the programme start date.

AEI self-assessment and monitoring

- 4.24 Each year all AEIs are required to undertake a self-assessment and complete a declaration on their current ability to meet the NMC's standards. In 2015/16:
- Four AEIs were selected for monitoring based on their self-assessments, of which three were found to be non-compliant with one or more of the NMC's standards.
 - 16 AEIs were selected for monitoring based on identified risk, of which 12 were found to have failed to meet one or more of the standards.
 - Notable practice identified through monitoring work included AEIs enabling better support networks for pre-registration students and the creation of a new role to complement link teachers and practice education facilitators.
- 4.25 When an AEI fails to meet the NMC's standards during a monitoring review visit, an action plan is agreed against a set timeline and the AEI will provide

evidence for the actions required. If this evidence is not provided on time or does not provide sufficient assurance, the NMC will take further action, the nature of which will depend on the severity of the risks of the non-compliance with its standards and any resulting patient safety risks. The NMC may determine that a follow up review is necessary to review progress against action plans in place. In the most serious cases, the NMC has the power to remove programme approval.

Quality assurance of local supervising authorities (LSAs)

- 4.26 In July 2016 all LSAs were required to submit a self-assessment and a declaration on their ability to meet the Midwives Rules and Standards (2012). Following a risk-based selection, the NMC conducted monitoring visits to two LSAs. Concerns were identified during both visits and the LSAs were required to formulate action plans to address them.

Independent review of education quality assurance

- 4.27 Work on an independent review of the NMC's education QA model and process is underway. The new QA model will apply to both nursing and midwifery programmes.
- 4.28 The NMC reports that external consultants have been commissioned to undertake an independent review of the possible options for the future model. The review will include a comparator analysis of alternative QA frameworks and engagement with key external stakeholders.
- 4.29 We received feedback from one third party organisation that engagement opportunities for stakeholders in the QA review had thus far been more limited than those to engage in the NMC's work to develop new education standards. However, it should be noted that this work is at an earlier stage than the standards work. The NMC has told us that it intends to share options and timelines for this work with all stakeholders in the near future.

Education framework

- 4.30 The NMC has undertaken work to develop a new education framework over this review period. The framework will set out a single set of requirements for becoming an approved provider of nursing and midwifery education. These will include programme requirements, and requirements relating to selecting, supporting and assessing students.
- 4.31 A formal public consultation on the new education framework was opened alongside other consultations on future nurse standards and standards for prescribers. The consultation closed on 12 September 2017. It is planned that the framework will be published and adopted by early 2018.

Standard 3: Action is taken if the quality assurance process identifies concerns about education and training establishments

Exceptional reporting

- 4.32 It is noted in the NMC's most recent education QA annual report that changes to the NMC's QA framework have led to an increase in the number

of exceptional reports received from AEIs of potential concerns over their compliance with the NMC's standards. In 2015/16, 58 exceptional reports were received – around 50 per cent more than in 2014/15.

- 4.33 The report stated that in response to these, the NMC communicated proportionately with AEIs to ensure actions were in place to control risks to compliance. The information was also used in the risk-based approach to selection of AEIs for monitoring activity.
- 4.34 The NMC received 10 exceptional reports from LSAs in 2015/16, one of which resulted in an extraordinary review and follow-up visit.

Targeted review of an education programme

- 4.35 In response to whistleblowing allegations about a pre-registration nursing programme and after follow-up discussions with the AEI, the NMC conducted a targeted review of one AEI's pre-registration nursing and nurse and midwife prescribing programmes. Non-compliance with the NMC's standards was identified during the review. The NMC reported that it will follow up on actions required during the 2016/17 academic year.

Follow up visits

- 4.36 Follow up visits were conducted in North Wales and Guernsey to monitor progress made against action plans put in place as a result of past extraordinary reviews. In both cases all standards were found to be met. Reports on the visits were published on the NMC's website.

Standard 4: Information on approved programmes and the approval process is publicly available

- 4.37 Information on approved nursing and midwifery education programmes and the approval process is available on the NMC website.
- 4.38 The NMC reports that it has updated its processes for institutions wishing to become AEIs and has published updated guidance on its website.
- 4.39 A search function on the website enables visitors to search for courses by country, educational institution, and qualification.

5. Registration

- 5.1 As we set out in Section 2, we considered that more information was required in relation to the NMC's performance against Standards 2 and 3 and carried out a targeted review. The reasons for this, and what we found as a result, are set out under the relevant Standards below. Following the review we concluded that both these Standards were met and therefore the NMC has met all of the *Standards of Good Regulation* for Registration in 2016/17.

Standard 1: Only those who meet the regulator's requirements are registered

- 5.2 We have not seen any information which suggests the NMC has added anyone to its register who has not met the registration requirements.
- 5.3 The NMC has made some changes to its requirements for registration in this review period.

English language requirements

- 5.4 English language competency requirements for applicants trained in EU countries have been introduced. From 19 July 2016, all applications from EU-trained applicants have been required to demonstrate English language competency.
- 5.5 In addition, in June 2016, the NMC amended English language test requirements for all applicants trained outside the UK.
- 5.6 The changes were designed to increase the flexibility for applicants, while still ensuring that the appropriate standard of English language is achieved. Under the previous system, applicants had to achieve the International English Language Testing (IELTS) Academic Test Level 7 in reading, writing, speaking and listening in a single sitting. A Level 7 in all areas is still required, but this can now be achieved over two sittings of the tests. Both tests must be within six months of each other and no single score must be below 6.5 in any of the areas across both tests.
- 5.7 In response to concerns raised that the IELTS testing arrangements remain too stringent, the NMC reported in July 2017 that it had undertaken an initial 'stocktake' of the current arrangements and found no compelling evidence that the IELTS was not fit for purpose or that the level of competency required was set too high. The matter remains under review.

Indemnity requirements

- 5.8 In January 2017, the NMC announced its decision that the indemnity scheme used by some independent midwives who are members of the organisation Independent Midwives UK (IMUK) was inappropriate in that it was not able to call upon sufficient financial resources to meet the costs of a successful claim for damages for a range of situations, including rare cases of catastrophic injury. The decision meant that independent midwives who were indemnified by the scheme were no longer permitted to practise until alternative cover was obtained.
- 5.9 We note that this decision is currently subject to judicial review and that a hearing is scheduled for October 2017. We will consider this issue in the light of the outcome of those proceedings in the next performance review.
- 5.10 We have concluded that the NMC continues to review its requirements for registration and to amend its processes accordingly.

Standard 2: The registration process, including the management of appeals, is fair, based on the regulator's standards, efficient, transparent, secure, and continuously improving

- 5.11 This Standard was considered as part of the targeted review this year.
- 5.12 We noted an increase in the number of registration appeals received by the NMC in recent years which was not in proportion to changes in the overall number of applications received. The proportion of those registration appeals received that were upheld had also increased.
- 5.13 In addition, we received concerns from some individuals and third party organisations about registrants lapsing unintentionally from the NMC's register and the time taken to get back on to the register following a change to the NMC's policy. We therefore decided to seek further information about the NMC's registration appeals and annual renewals processes through our targeted review.

Registration appeals

- 5.14 Last year was the first in which our new Performance Review process was implemented. Due to the changes to the timing of the annual review cycle we requested data for only quarters three and four of 2015/16 from the NMC, except where the dataset measure was an annual figure. As such, we did not have data for the full year on the number of registration appeals received by the NMC. We noticed that the total number of appeals this year was significantly higher than that in 2013/14 and 2014/15, although the number of new applications had not greatly increased.
- 5.15 There was also an increase in the proportion of concluded registration appeals that were upheld.
- 5.16 We requested annual data for 2015/16 so that a comparison could be made. Comparative annual data from 2013/14 to 2016/17 is set out in the table below:

	2013/14	2014/15	2015/16	2016/17
Number of new registration applications received	28,959	28,517	30,157	28,932
Number of registration appeals:				
<i>Received</i>	51	64	109	105
<i>Concluded</i>	49	53	104	97
Of those appeals concluded, the				

number of appeals:				
<i>Upheld</i>	16 ¹⁰	20 (38%)	63 (61%)	49 (50%)
<i>Rejected</i>	23	13 (25%)	16 (15%)	30 (31%)
<i>Withdrawn</i>	4	20 (38%)	25 (24%)	18 (19%)

- 5.17 The comparison above shows that, while the current trend in both the number of appeals received and the number of those that are upheld is a decrease, there was a large increase between 2014/15 and 2015/16. However, the number of appeals as a proportion of all applications received remains very low, at less than 0.5 per cent each year.
- 5.18 Last year, we reported on the timeliness with which the NMC was concluding registration appeals. This year, data provided on request by the NMC confirmed that performance is broadly similar to that of last year. The NMC aims to conclude all registration appeals within six months.
- 5.19 At the time of responding to our targeted questions, the NMC told us that there were currently three outstanding appeals between six and 12 months, and one further appeal which had been received over 12 months ago. The NMC provided explanations of the reasons for the delay in those appeals and showed that the cases were being monitored by the relevant team. In each case, the original appeal hearing had been scheduled within six months of receipt of the notice of appeal, in line with the NMC's process.
- 5.20 We requested information from the NMC to assist our understanding of the way in which it manages its registration appeals process and captures learning from individual appeals to update and improve the process. The NMC provided copies of relevant internal guidance which set out clearly the process followed on receipt of an appeal and the timeframes for each stage.
- 5.21 The guidance also set out a process for withdrawing appeals that are likely to succeed. If new information is received in support of an appeal and the NMC lawyer reviewing the appeal considers that it might result in the Registrar reaching a different decision, the appellant will be asked whether they wish to withdraw the appeal to allow the Registrar to reconsider the application, rather than proceeding to an appeal hearing. If the appellant decides to withdraw their appeal, the Registrar will consider the original application, together with the new written information, and reach a decision. If the Registrar refuses the application for a second time, the NMC will make every effort to ensure that the appeal hearing takes place as originally scheduled.
- 5.22 This may account for the number of appeals which are made and subsequently withdrawn (between 19 and 38 per cent of those concluded each year in the past three years).
- 5.23 We consider that this is a pragmatic approach and is consistent with the fairness of the process.

¹⁰ Percentages are not provided for this year because the number of outcomes provided was less than the number of appeals concluded.

- 5.24 We also asked the NMC for further information about the appeals upheld in 2016/17 where no new written information had been provided. Initially the NMC had informed us that there were seven such cases this year, the hearings for which were all held in the first quarter. On review, the NMC subsequently informed us that it had changed its criteria during the year when calculating this measure and that when the new criteria were applied to the full year, there were only two cases upheld where no new written information was provided.
- 5.25 In both cases, oral evidence was provided at the appeal hearing in relation to the circumstances leading to a past criminal conviction. In each case the oral evidence persuaded the appeal panel to overturn the original decision to reject the application.
- 5.26 The NMC told us that all appeal determinations are reviewed by a lawyer to identify any learning. Based on the review, the lawyer will make recommendations for change which might relate to the work of the team handling the appeals process, the NMC staff presenting the appeal to the appeal panel, or to the panel itself. Where learning relates to the decision or reasons of the panel, the case may be referred to the NMC's Decision Review Group, which also considers learning from fitness to practise panel hearings. The NMC told us that it began formally recording reviews of registration appeals and recommended further actions from May 2017.

Annual renewal of registration

- 5.27 In November 2015, the NMC changed its process for annual renewal of registration. The change meant that if a registrant failed to pay their annual registration fee on time, they would be removed from the register and would need to submit a completely new registration application to be readmitted. Previously, there had been a period during which the registrant could regain access to the register quickly without submitting a full new application, on payment of the outstanding registration fee. The NMC website states that it can take up to six weeks to process the new registration application in those circumstances.
- 5.28 This year we received a number of concerns from individuals and third party organisations about the number of registrants lapsing unintentionally following this change and the time taken to get back on to the register following a lapse. Some of those raising concerns referred to an error on the part of the NMC in September 2016, whereby a second and final email reminder to registrants to pay their renewal fee was not sent. The error was not detected until the end of September, by which time a number of registrants were reported to have unintentionally lapsed from the register. The NMC confirmed that these reminders were automated from November 2016.
- 5.29 In order to assess the fairness and efficiency of the process, we requested more information from the NMC on the impact of the error in September 2016 and more widely, the actions taken by the NMC to limit the number of registrants unintentionally lapsing as far as possible since the change to its process in November 2015.

5.30 The NMC provided data on the number of registrants whose registration lapsed, the number applying for readmission and the median length of time take to process completed applications¹¹ for readmission in each month of the review period:

Month	Number lapsed	Number applying for readmission	Median days to process readmission applications
April 2016	1,400	507	19
May 2016	1,059	428	9
June 2016	881	339	21
July 2016	1,514	306	7
August 2016	1,111	247	4
September 2016	2,030	273	5
October 2016	958	1,813	7
November 2016	1,709	828	28
December 2016	1,284	374	14
January 2017	897	431	11
February 2017	897	324	6
March 2017	1,420	306	3
Total	15,160	6,176	Annual median: 7

5.31 The data provided shows that a higher number of registrants lapsed in September 2016 than in any other month in the review period. That month 2,030 registrants lapsed whereas the next highest monthly total was 1,709 in

¹¹ This measure refers to the time taken by the NMC to process completed applications only, and therefore does not include the time taken by the registrant following a lapse to complete a full new application for registration and obtain all supporting evidence required.

November 2016. It can also be seen that there was a significant increase in the number of registrants applying for readmission to the register in October 2016 (1,813, compared to a high of 828 in any other month in the period).

- 5.32 The median time taken to process applications for readmission rose in November 2017 to 28 days, which would seem to correspond with the spike in such applications the previous month.
- 5.33 However, in the absence of any more sophisticated data, it is difficult to reach a conclusion on the impact of the NMC's failure to send registrants a second reminder to renew their registration in September 2016. The available data does not show which of the individuals applying for readmission had only very recently lapsed, which could be an indicator that lapsing was unintentional. Furthermore, we note that September is the NMC's busiest month for annual renewals, in line with the UK academic calendar, which could account for some of the higher figures described.
- 5.34 The NMC confirmed that it does monitor and review the number of registrants who lapse and that, as part of its continuous improvement programme, mechanisms are being developed to monitor also the number of registrants who lapse and then subsequently apply for readmission.
- 5.35 The NMC provided information on the paper and email notices¹² it sends to registrants in relation to revalidation and annual retention of registration. The NMC told us that, with the support of bodies representing registrants, it had produced information and a short animation reminding registrants of the importance of not letting their registration lapse. It has also produced posters for employers to help remind registrants to renew their registration and pay their annual fee to the NMC. These resources are available on the NMC's website.

Processing of registration applications

- 5.36 Last year we noted a dip in the NMC's performance in processing EU/EEA and other international applications for registration from December 2015 to February 2016. The NMC's key performance indicator (KPI) at that time was to process 90 per cent of those applications within 70 days of receipt, but at one point only 53 per cent of applications were meeting that target. We took into account the NMC's explanation that this dip in performance was the result of a significant increase in EU applications prior to the introduction of language testing as well as a temporary relocation of the registration team due to building maintenance issues.
- 5.37 This year the NMC has set a new KPI of 90 per cent of EU/EEA and other international applications to be processed within 68 days. Only 61 per cent of applications were processed within that time in April 2016, but the target was exceeded in each subsequent month to March 2017.
- 5.38 It was noted in the Council papers for the meeting in July 2016 in relation to processing EU/EEA and other international applications that individual team members now took ownership of the cases they were assessing and that a

¹² Paper notices are sent only to those few remaining registrants yet to sign up to online registration.

new management structure had enabled managers to allocate work and focus on tackling the oldest cases first. Where applications were not complete when received by the NMC and the applicant had failed to submit all the information required, the applicant was given a single named contact to further improve customer service.

- 5.39 We noted last year a less significant dip in performance against the KPI for processing UK applications in December 2015 which had improved by February 2016. The KPI, which remains unchanged this year, is to process 95 per cent of UK applications within 10 days and 99 per cent within 30 days.
- 5.40 This year the 10-day KPI has been met in every month from April 2016 to March 2017 except May and June 2016, but the rate of applications processed within 10 days never dropped below 94 per cent. The 30-day KPI was only met in five of the 12 months,¹³ but again, the lowest proportion of applications meeting the KPI in any month (97 per cent) was not significantly lower than the target. In March 2017, the year average of both measures met the NMC's KPI.

Customer service

- 5.41 Last year we noted that satisfaction levels among those customers responding to the NMC's registration customer service survey were consistently high throughout the year. However, we also highlighted the fluctuation in the proportion of calls to the call centre that had been abandoned across the year, with a peak in January to February 2016 of 19 per cent of calls.
- 5.42 This year the rate of abandonment of calls was 7 per cent or below in every month except April 2016 (14 per cent) and October 2016 (18 per cent).
- 5.43 Customer satisfaction levels decreased in September and October 2016, with the proportion of respondents rating their experience as 'good' or 'very good' dropping to 59 per cent and the proportion reporting that their query had been resolved dropping to 63 per cent. This appears to have been linked to the NMC's failure to send out a second annual registration renewal reminder email in September 2016, in addition to a number of IT issues encountered at the beginning of October which meant that staff could not access systems and some customers could not get through to the call centre.
- 5.44 The NMC reported that the combination of these two issues meant that the call centre struggled with demand for the first week in October and, although performance recovered, there was an impact on the overall October call centre performance on proportion of calls answered.
- 5.45 In our report last year we noted the NMC's intention to commission a review of its registration call centre, particularly in relation to resourcing, forecasting and technology. The NMC told us that improvement work had taken place in the call centre, which was reflected in its improved performance this year. Larger scale improvement work was reported to have been overtaken by the

¹³ August, September and October 2016; February and March 2017.

decision of the NMC's Council to commence a Transformation Programme which will involve the development of a new Contact Centre.

Conclusion

- 5.46 The information provided by the NMC in response to our targeted review has assisted our understanding of how its registration appeals process is managed and the way in which learning from appeals is identified and used to update and improve it.
- 5.47 There was a notable increase in the number of appeals received in 2015/16, followed by a slight decrease this year. However, these figures relate to a very small proportion of the total registration applications received each year by the NMC. The NMC continues to monitor the timeliness with which registration appeals are concluded and performance on that measure has remained stable this year.
- 5.48 The data provided on registrants lapsing then subsequently applying for readmission, and the NMC's potential contribution to the increased numbers through its error in September 2016, is inconclusive. We therefore welcome the NMC's plans to capture more sophisticated data in the future, which should enable it to better assess the number of registrants unintentionally lapsing in any given month. However, we consider that it is the responsibility of registrants to ensure that they remain on the register by paying fees on time. The failure to send a renewal reminder to registrants in September 2016 should not be repeated, as the process is now automated. The NMC has worked with bodies representing registrants and has taken action to limit the number of registrants unintentionally lapsing their registration as far as possible. We concluded that this matter should be monitored by the NMC, but that it was not a cause for significant concern.
- 5.49 The NMC's improved performance in processing applications for registration is a positive development and the NMC continues to report on processing times and customer satisfaction measures at each NMC Council meeting.
- 5.50 For these reasons, we have concluded that the Standard continues to be met.

Standard 3: Through the regulator's registers, everyone can easily access information about registrants, except in relation to their health, including whether there are restrictions of their practice

- 5.51 As in previous years, we conducted a check of a sample of entries on the NMC register. This year we checked 30 entries. The registrant entries checked were randomly selected, but all related to registrants who had been subject to a final fitness to practise decision in the relevant period. While this sample represents a very small proportion of the NMC's total register, we are nevertheless pleased to report that for the fourth consecutive year we identified no errors or inaccuracies.
- 5.52 However, as was the case last year, one error was identified through the routine work undertaken as part of our Section 29 process. In contrast to the error described in our report last year, this error had already been identified

and resolved by the NMC by the time it came to our attention. The error involved a registrant who had been made subject to a caution order, and who had subsequently omitted to pay her annual registration fee, remaining on the NMC's published register despite not having fulfilled that requirement of ongoing registration. We noted that this error arose out of an unusual set of circumstances.

- 5.53 In reviewing the circumstances of the error, we noted what appeared to be differences in the way in which the NMC publishes fitness to practise outcomes on the published register accessible on its website. We wanted to understand the NMC's processes for publishing different types of fitness to practise outcomes and to ensure that the guidance provided on its website to the public accurately reflects those processes. Based on the information provided, we were satisfied that the NMC's approach to publishing fitness to practise outcomes is consistent.
- 5.54 The NMC provided information on the timeframes for updating its register with interim and final fitness to practise outcomes. It was explained that the published register is updated once every 24 hours to incorporate all the changes made the previous day to the NMC's registration system.
- 5.55 When reviewing recent decisions on the NMC's website we noted two examples of fitness to practise decisions that were not updated within the timeframes provided. The NMC confirmed that in both cases the register had been updated one day outside of the timeframe.
- 5.56 The NMC provided further information about the way in which compliance with timeframes for updating the register with fitness to practise outcomes was monitored. All updates to the register are subject to checks, including a review of the register and the NMC's case management system, to ensure that information recorded is correct. The results of checks are recorded and an error log is reviewed weekly to inform performance management and staff training. Daily missing outcome and reconciliation reports are run to further ensure that the data is complete and that registration and fitness to practise systems are consistent. The NMC told us that staff from the Fitness to Practise and Registration teams met regularly to review the assurance processes in place to ensure that they are fit for purpose and remain aligned.

Conclusion

- 5.57 The NMC has provided information to demonstrate that there is a clear process in place to ensure that fitness to practise outcomes are published on the NMC's register within agreed timeframes. We note that in the two cases where we identified a delay to the register being updated, the delay was of one working day only.
- 5.58 We concluded that the single register error described above, and the short delay identified in two cases, were not of sufficient concern to support a finding that this Standard is not met. Therefore, this Standard continues to be met.

Standard 4: Employers are aware of the importance of checking a health professional's registration. Patients, service users and members of the public can find and check a health professional's registration

- 5.59 The registration search function is clearly visible on the front page of the NMC website. Employers may search multiple entries at once.
- 5.60 The NMC continues to provide guidance for employers on its website which sets out their responsibilities in recruiting, managing and supporting nurses and midwives.
- 5.61 Opportunities for engagement with employers on regulatory matters have increased through the development the NMC's Employer Link Service. The NMC reports that the service has now met with every NHS Trust and Health Board across the four countries.

Standard 5: Risk of harm to the public and of damage to public confidence in the profession related to non-registrants using a protected title or undertaking a protected act is managed in a proportionate and risk-based manner

- 5.62 We have not identified any changes to the NMC's approach to managing this risk.
- 5.63 The Nursing and Midwifery Order 2001 makes the illegal use of the protected titles 'registered nurse' and 'midwife,' an offence.
- 5.64 The NMC's website sets out the legal requirement for all nurses and midwives practising in the UK to be on the NMC's register. Applications for readmission to the register from nurses and midwives who are found to have been working unregistered after allowing their registration to lapse will be referred to the Registrar's Advisory Group and may be refused.

Standard 6: Through the regulator's continuing professional development/revalidation systems, registrants maintain the standards required to stay fit to practise

- 5.65 This was the first year of the implementation of revalidation for nurses and midwives.

Outcomes and evaluation of revalidation

- 5.66 The NMC has published quarterly revalidation reports detailing the numbers of nurses and midwives revalidating and lapsing by country and registration type. The reports include data for each of the four UK countries separately and for those registrants not practising in the UK.
- 5.67 The first annual report on revalidation was published by the NMC on 12 July 2017. In addition to the summary data on rates of revalidation, the report includes sections on employment, practice and work settings, the impact of revalidation on groups with protected characteristics, and the verification process.
- 5.68 Revalidation rates have been similar across the four countries, ranging from 93 to 94 per cent. However, among those registrants practising outside the

UK, the revalidation rate was just 59 per cent. At the Council meeting in July 2017 the NMC confirmed that, while lower revalidation rates among this group were to be expected, some registrants practising outside the UK had reported difficulties in finding an appropriate reflective discussion partner for revalidation. The NMC confirmed that consideration would be given to whether additional support could be offered to this group.

- 5.69 There was no material difference in revalidation rates for nurses (92 per cent) and midwives (91 per cent).
- 5.70 The NMC reports that the rate of registrants allowing their registration to lapse was 5-6 per cent across the UK and that this is in line with rates in previous years.
- 5.71 The NMC commissioned Ipsos MORI Social Research Institute to conduct a wide-ranging longitudinal evaluation of revalidation over its first three years.
- 5.72 The evaluation began in 2016 with surveys of registrants who had revalidated and of those yet to revalidate, and qualitative interviews with registrants, confirmers and reflective discussion partners.
- 5.73 An interim report on the findings of the evaluation over the first year of revalidation was published on 12 July 2017. It stated that there was no evidence to suggest substantial problems with revalidation were being experienced by any one group of registrants, though the survey of registrants had highlighted differences in how some groups experience revalidation. Factors that might contribute to this included the level of support provided to registrants by employers, registrants' access to and time to undertake continual professional development activities, and the ease with which registrants could find a reflective discussion partner.
- 5.74 While there did not appear to be any significant shift in the numbers of registrants lapsing in the first year of revalidation, there had been an apparent decrease in the rate of renewal amongst older registrants (aged 56 or over). It was noted that the potential impact of this on the NMC register, particularly if registrants under 60 were choosing to retire rather than revalidate or were citing an inability to meet the requirements of revalidation, requires further exploration.
- 5.75 It was also noted that the revalidation rate was lower for registrants who reported having a disability or long-term health condition (84 per cent) than for those who did not (95 per cent). However, the interim report stated that there was no evidence to suggest that registrants in this group found meeting the requirements of revalidation substantially more difficult than registrants overall. The interim report concluded that this did not, therefore, suggest any significant issue for further exploration. The NMC may wish to keep this issue under review in its assessment of revalidation in the coming years.
- 5.76 In terms of outcomes of revalidation, the interim report stated that there was evidence of incremental changes in the behaviours of those registrants who had revalidated. It was suggested that these changes had the potential to contribute to the development of a culture of sharing, reflection and improvement across the sector. Initial survey findings also suggested that

revalidation may play a role in delivering attitudinal change towards key elements of the NMC's Code.

- 5.77 The interim report made a number of suggestions for the ongoing development of the revalidation process. These included:
- maintaining the level of communications activities with those registrants who have yet to revalidate to ensure they have a similarly positive experience to those revalidating in the first year of the process
 - focusing updates to existing guidance and supporting materials on the areas of the register in which registrants may be more isolated (and may therefore have greater concerns about revalidating), and also on those materials that are specific to feedback and reflective practice
 - sharing details of planned communications to registrants with stakeholder organisations to aid transparency and assist stakeholders with coordinating their own communications
 - communicating to stakeholders details of the NMC's ongoing work to explore potential issues experienced by those lapsing from the register
 - continuing to undertake work to check that verification is successfully identifying potential cases of fraud or other issues and communicating to stakeholders and registrants details of the robustness of the process.

Feedback we have received on revalidation

- 5.78 We received positive feedback from a third party organisation in relation to its extensive collaboration with the NMC in work to implement revalidation and to support registrants to revalidate.
- 5.79 The organisation praised the NMC's revalidation website and resources and stated that the NMC had responded proactively to feedback from stakeholders and registrants to improve them.
- 5.80 The organisation also welcomed the NMC's plans for the long-term evaluation of revalidation and the opportunity to be interviewed as part of that process.

Conclusion

- 5.81 Initial findings and evaluation of the process indicate that revalidation has been successfully implemented in its first year and the NMC continues to monitor its effectiveness and impact on different registrant groups.

6. Fitness to Practise

- 6.1 As we set out in Section 2, we considered that more information was required in relation to the NMC's performance against Standards 6 and 9 and carried out a targeted review. The reasons for this, and what we found as a result, are set out under the relevant Standards below. Following the review, we concluded that both these Standards were met. Following consideration of our Lessons Learned Review we determined that Standard 7 was not met.

The reasons for this are set out under the relevant Standard below. Therefore the NMC has met nine out of 10 of the *Standards of Good Regulation* for Fitness to Practise in 2016/17.

Standard 1: Anybody can raise a concern, including the regulator, about the fitness to practise of a registrant

- 6.2 On its website, the NMC continues to offer comprehensive information for registrants and other healthcare workers, employers and members of the public explaining the type of concern that the NMC can handle (and where other concerns might be better directed), how to make a referral, and what action the NMC will take in respect of referrals received.
- 6.3 The Employer Link Service continues to offer services to employers including support to enable them to determine whether to make a referral, advice on the information to include in referrals, and training on fitness to practise thresholds. The NMC reports that the service received around 2000 calls in 2016/17 and that approval ratings from users were high.

Standard 2: Information about fitness to practise concerns is shared by the regulator with employers/local arbitrators, system and other professional regulators within the relevant legal frameworks

- 6.4 The number of occasions a fitness to practise concern was referred to another investigating body or regulator by the NMC was 52 in quarter one; 22 in quarter two; 24 in quarter three and 33 in quarter four, a total of 131 in the review period.
- 6.5 The NMC's website lists memoranda of understanding, setting out how information will be shared, with: Healthcare Improvement Scotland; the Disclosure and Barring service; the Scottish Public Services Ombudsman; Care Council for Wales; the Health and Social Services Department of Jersey; the Care Quality Commission; Health Inspectorate Wales; NHS Education for Scotland; and the Care Inspectorate.
- 6.6 We received one report from a third party in relation to a concern it had about the NMC's level of information sharing on fitness to practise matters.
- 6.7 The NMC subsequently met with the organisation in question in order to better understand its concerns and told us that it will review its memorandum of understanding with the organisation and take steps to ensure that NMC staff understand the importance of sharing appropriate information with it.
- 6.8 With the exception of the report referred to above, which the NMC has taken steps to rectify, the available evidence indicates that the NMC is sharing information on fitness to practise frequently and appropriately.

Standard 3: Where necessary, the regulator will determine if there is a case to answer and if so, whether the registrant's fitness to practise is

impaired or, where appropriate, direct the person to another relevant organisation

- 6.9 This Standard was found to have been met last year following a targeted review of performance in this area.
- 6.10 There have been no changes to the NMC's processes for determining whether there is a case to answer in respect of fitness to practise allegations in this review period.
- 6.11 However, significant changes were implemented in July 2017 via an Order under Section 60 of the Health Act 1999, including:
- Giving the Investigating Committee (IC) and case examiners additional powers to make decisions in relation to agreeing undertakings, issuing warnings and giving advice to registrants
 - Extending the powers under Rule 7(a) of the NMC's Fitness to Practise Rules 2004 (as amended)¹⁴ to encompass review of a recommendation of undertakings, a decision that undertakings should no longer apply, and the issuing of advice and warnings.
- 6.12 We will review the initial impact of those changes in the next performance review cycle.

Standard 4: All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and where appropriate referred to an interim orders panel

- 6.13 This year we have not seen evidence of any concern in relation to the NMC's risk assessment and prioritisation of fitness to practise cases.
- 6.14 The median time taken to an interim order committee decision from receipt of a complaint has decreased from 28 days in 2015/16 to 26 days this year.
- 6.15 The number of interim order extension applications made by the NMC to the relevant court steadily decreased year on year from 619 in 2013/14 to 342 in 2015/16. This year the figure has increased to 407.
- 6.16 As was the case last year, there is no current evidence to suggest that this Standard is not met. The time taken by the NMC to impose interim orders has improved slightly and although the number of extension applications has increased, it has not reached the level over which we expressed concern in previous years. We will continue to keep this under review.

¹⁴ See: www.nmc.org.uk/globalassets/sitedocuments/legislation/legislation-updated/nmc-fitness-to-practise-rules-consolidated-text-effective-from-2016.01.19.pdf

Standard 5: The fitness to practise process is transparent, fair, and proportionate and focused on public protection

Failures to provide panels with representations from registrants

- 6.17 Last year we highlighted the NMC's failure to provide panels at final fitness to practise hearings with representations made by registrants in five cases (two of which were linked) as a result of administrative errors.
- 6.18 This year similar failings have been identified in four cases. We accept that this is a very small proportion of the NMC's caseload. However, we remain of the view that this issue has significant implications for the fairness of the fitness to practise process. We recommend that the NMC reviews the circumstances leading to these errors and makes any necessary changes to its processes to prevent their repetition.

Voluntary removal (VR)¹⁵

- 6.19 Last year we identified some concerns in our targeted audit in cases disposed of by VR, but we noted that these were not as prevalent or as significant as those identified in previous years. We also observed some improvement in the quality of VR recommendations.
- 6.20 We expressed the view that VR decisions should be subject to a more formal and consistently applied mechanism for quality assurance to allow the NMC to monitor the consistency of decisions and assist ongoing learning for decision-makers.
- 6.21 At its May 2017 Council meeting, the NMC reported that it had strengthened its quality assurance frameworks to include assessment of VR cases. We will review the changes made as part of the performance review next year.
- 6.22 This year we have seen no evidence of any further concerns in relation to the way in which the NMC manages the VR process, though it should be noted that those decisions are not subject to routine review under our Section 29 process unless the VR application is made during a final fitness to practise hearing.

Consensual panel determinations (CPD)¹⁶

- 6.23 Last year we highlighted in our report that the Authority had appealed two CPD cases in that review period and that these featured similar concerns to those identified in previous appeals, namely the level of information provided to panels and the handling of dishonesty allegations.

¹⁵ The voluntary removal process, which was introduced by the NMC in January 2013, allows a nurse or midwife who admits that their fitness to practise is impaired and does not intend to continue practising to apply to be permanently removed from the register without a full public hearing of the fitness to practise allegations against them.

¹⁶ The consensual panel determination process allows a nurse or midwife who is subject to a fitness to practise allegation to agree a provisional sanction with the NMC. The consensual panel determination provisional agreement is then considered by a fitness to practise panel, which has discretion to decide whether to accept or to require a full hearing to be held.

- 6.24 In the targeted audit undertaken as part of our review last year, we identified a number of concerns in relation to the way in which the NMC managed the CPD process. We concluded that our concerns may indicate that the NMC's CPD process is insufficiently transparent. However, we took into account that none of the CPD cases audited suggested that the decision ultimately reached by the panel was not in the public interest.
- 6.25 This year we identified further concerns about the way in which the NMC had managed CPD cases through our review of all final fitness to practise decisions. These included: failures to provide panels with sufficient information in CPD provisional agreements; an omission to contact the referrer for their view of the CPD, contrary to the NMC's own guidance; and concerns in relation to the mitigating and aggravating factors listed in CPD provisional agreements.
- 6.26 We appealed one case which had been resolved by CPD. We considered that the NMC had failed to provide the panel with all the available evidence. As a result, the panel was not in a position to carry out an effective assessment of the basis of the impairment and of which sanction was necessary to protect the public. The appeal was allowed and the sanction imposed was substituted for a more restrictive order.
- 6.27 In all other CPD cases in which we identified concerns, we were satisfied that the decision was not insufficient to protect the public.

Concerns in cases not disposed of consensually

- 6.28 We also identified concerns in cases that were not disposed of via CPD or VR that are relevant to performance against this Standard.
- 6.29 These included: further failures to provide sufficient information to panels; concerns over the NMC's approach to offering no evidence; administrative errors pertinent to the fairness of the process; and concerns over the quality of the NMC's investigation and/or case preparation.

Conclusion

- 6.30 There are ongoing concerns in relation to the NMC's management of some fitness to practise cases. Some of the concerns identified this year are similar to those we have highlighted in previous years.
- 6.31 However, we recognise that our concerns relate to only a very small proportion of the NMC's overall caseload. On balance, we concluded that the concerns identified this year were not so serious or prevalent as to require a finding that this Standard is no longer met.
- 6.32 Significant changes to the NMC's fitness to practise processes were introduced in July 2017. This will necessitate detailed scrutiny of the way in which the NMC is managing fitness to practise cases in future performance reviews.

Standard 6: 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 and service users. Where necessary the regulator protects the public by means of interim orders

- 6.33 This Standard was considered as part of our targeted review this year.
- 6.34 The Standard was found to be not met in the performance review last year, as a result of concerns over: continued high adjournment and part-heard rates of final fitness to practise hearings; an increase in the median time from receipt of a case to a case to answer decision; an increase in the NMC's caseload of older cases; and evidence from our audit of periods of inactivity in investigating cases. We were concerned that a backlog of cases awaiting conclusion may be developing.
- 6.35 This year the data provided by the NMC for our quarterly and annual dataset, as well as performance data published by the NMC, indicated some positive developments in timeliness in fitness to practise. However, some data which was highlighted in our last Performance Review report was no longer routinely published by the NMC.
- 6.36 We decided to seek further information through a targeted review of this Standard to enable us to better understand the data available and to draw meaningful comparisons with the NMC's performance in previous years. We also wanted to understand the NMC's approach to balancing the need to close older cases (including those subject to third party investigations) and managing its caseload at the earlier stages of the fitness to practise process.

Adjournments of final fitness to practise hearings

- 6.37 There has been an improvement in the proportion of all final fitness to practise hearings running part-heard this year, while the proportion of hearings being adjourned has remained stable:

	Adjourned	Part-heard
2013/14	22%	
2014/15	5%	19%
2015/16	6%	19%
2016/17	6%	14%

- 6.38 The NMC also provides data as part of our dataset on the proportion of *first* substantive hearings (excluding hearings that resume following an adjournment) that conclude within their original hearing day allocation. This rose from 72 per cent last year to 87 per cent this year.

Timeliness of fitness to practise case progression

- 6.39 The NMC has significantly reduced its caseload of older cases this year.
- 6.40 Comparative data for 2015/16 and 2016/17 is set out below:

Number of cases:	2015/16 year end	2016/17 year end	Change
>52 weeks old	1,437	1,170	- 267
>104 weeks old	281	294	+13
>156 weeks old	48	71	+23
Total >52 weeks old	1,766	1,535	- 231

- 6.41 There has been a significant reduction in the number of cases over 52 weeks held by the NMC, from 1,437 last year to 1,170 this year. The numbers of cases older than 104 weeks and 156 weeks have only increased by 13 and 23 respectively, indicating that the reduction in cases over 52 weeks has not just been achieved by cases passing the threshold into the next age category. The overall caseload over 52 weeks has reduced this year by 231 cases.
- 6.42 We were concerned last year that the median time taken from the NMC receiving a case to the IC or case examiners reaching a case to answer decision had steadily increased in recent years. We had data last year for only the second two quarters of the year, but noted that the median had risen from 39 weeks in 2013/14 to 45 weeks in 2014/15 and that it was 50 weeks in Q3 and 55 weeks in Q4 last year.
- 6.43 Performance on this measure has improved slightly this year to an annual median of 51 weeks. While this remains high by comparison to most of the other regulators, it should be noted that, unlike some of those regulators, the NMC conducts a significant proportion of the full investigation prior to the case to answer decision and so might be expected to take longer than others to reach this stage. We note that the NMC's performance at the adjudication stage (the median time in weeks from a case to answer decision to a final hearing) has been consistently strong over the last two years, at 26 weeks. This is lower than most of the other regulators.
- 6.44 The NMC informed us that its current target timescale for progressing cases to a case to answer decision was 52 weeks, but that this would be reduced to 39 weeks by December 2017.
- 6.45 The NMC's median time taken from receipt of a case to a final hearing has increased slightly from 83 weeks last year to 87 weeks this year. However, this remains low by comparison to other similarly sized regulators.

Balancing the fitness to practise caseload

- 6.46 We asked the NMC to describe its current approach to balancing the need to conclude older cases with the need to progress cases received more recently.
- 6.47 The NMC reported that it prioritises all cases over nine months old by setting aside two case investigation teams to focus solely on them and bring them to a conclusion as quickly as possible. Cases less than nine months old are managed by the remaining five investigation teams, who concentrate on concluding them wherever possible before they reach nine months' old. The NMC told us that this allocation of resources was based on careful analysis of its caseload data and team capacity.
- 6.48 We requested information about the proportion of the NMC's adjudication caseload that was (or had been) subject to third party investigations,¹⁷ which can cause delays to case progression. We also asked the NMC to describe its current approach to managing such cases to limit delay.
- 6.49 The data¹⁸ provided by the NMC is set out in the table below:

Age of case	Non third party	Third party
0-65 weeks	324 (90%)	35 (10%)
66-103 weeks	338 (84%)	65 (16%)
104-156 weeks	124 (70%)	52 (30%)
Over 156 weeks	23 (48%)	25 (52%)

- 6.50 From the data provided, it can be seen that the proportion of cases held in adjudication that are or have been subject to third party investigations increases with the age of the case. Among cases aged 0 to 65 weeks, just 10 per cent are third party cases, among cases aged 66 to 103 weeks (the largest group in adjudication), this rises to 16 per cent. Among cases aged 104 to 155 weeks, 30 per cent are third party cases, and among the oldest cases over 156 weeks, this rises to 52 per cent.
- 6.51 The NMC told us that it does not have separate targets for the disposal of cases subject to third party investigations but that these cases are reviewed on a regular basis to ensure that they are not delayed for any longer than is necessary. Third party cases are included in the NMC's overall timeliness measures, including its end to end timescales and the median age of case progression at each stage of the process. The NMC has also confirmed that it will continue to publish timeliness data on cases subject to third party investigations at each stage of the process in its Council papers.
- 6.52 The NMC shared with us its internal operational guidance on managing cases subject to third party investigations. The guidance sets out that all

¹⁷ These might include investigations by the police, a Coroner, NHS counter-fraud and other regulators.

¹⁸ The NMC provided this to us on 14 July 2017 and reflects the position in May 2017.

cases should be investigated without delay and that there must be clear and compelling reasons for a decision to put an investigation on hold. It states that the owner of the case must record why putting an investigation on hold is in the public interest. The guidance acknowledges that in some cases, the third party investigation may mean that it is not possible or practical for the NMC's investigation to proceed in the interim, but that consideration should be given to whether it is possible for the NMC to investigate other aspects of the case while the third party investigation continues.

- 6.53 The guidance states that generally, the NMC's investigation should proceed unless:
- There is a real and significant risk that the NMC's investigation will cause prejudice to the third party investigation;
 - The existence of the third party investigation makes it impractical for the NMC's investigation to continue; or
 - Placing the NMC's investigation on hold until that of the third party is complete is likely to result in significant time and cost savings as a result of reliance on the outcome of the third party investigation.

Conclusion

- 6.54 The available data on timeliness in fitness to practise indicates that the concern expressed in our last performance review that a backlog of cases may be developing has not been borne out.
- 6.55 The proportion of hearings running part-heard has been a concern over a number of years and the reduction this year is to be welcomed.
- 6.56 The NMC has closed a significant number of its older cases, while slightly improving timeliness at the earlier stages of the process, during which the bulk of its investigative work takes place. It is clear that the NMC is monitoring the progression of cases closely and that it has capacity to reallocate resources should timeliness worsen at any stage of the process. We have also seen data for the first quarter of the next performance review period, which confirms that these improvements are currently being sustained.¹⁹
- 6.57 The increase this year in the end to end median timescale for the NMC from 83 to 87 weeks is relatively small given the size of its overall caseload. Performance on that measure should be monitored closely. The NMC reports at each of its Council meetings on performance against its KPI of concluding 80 per cent of cases within 15 months.
- 6.58 It can be seen from the data provided that third party investigations cause delays, but the NMC has a clear policy in place for progressing those cases as quickly as possible.
- 6.59 There are no separate target timescales for conclusion of third party cases. However, the NMC's openness in reporting on the number of cases delayed for this reason and the inclusion of the cases in overall timeliness measures

¹⁹ We will report in detail on performance in 2017/18 in our next Performance Review report.

provides reassurance that it is monitoring progression of these cases appropriately.

- 6.60 Taking all of the above into account, we have concluded that the NMC has made sufficient improvements this year to meet this Standard.

Standard 7: 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

- 6.61 In the 2015/16 performance review, we considered that the NMC, on balance, met this Standard, while noting some concerns about the experience of one family in dealing with the NMC. Since then, we have carried out the *Lessons Learned Review of the NMC's handling of the concerns about midwives' fitness to practise at the Furness General Hospital*.²⁰ While this review largely considered matters which had happened before this review period, we identified a number of concerns about the way in which the NMC dealt with families which are ongoing and apply beyond the relatively small number of cases that we looked at as part of that review.
- 6.62 The concerns are set out at paragraphs 5.35-5.45 of the Lessons Learned Review. The NMC has set up a Public Support Service to address the way in which it deals with members of the public who have concerns about the fitness to practise of nurses and midwives and who make complaints about them. We regard this as a positive move but, since it has yet to be fully operational, it will not be possible to assess whether it makes a difference for some time.
- 6.63 We considered carefully whether our concerns simply applied to a small number of complex cases. We recognised also that the NMC has provided some strong support to witnesses before panels. However, some of the problems that we identified (for example, the approach to informing complainants about decisions and the other points that were identified at 5.44 of the Lessons Learned Review) apply across the board to the NMC's complaints handling and are not restricted to these cases.

Other matters

- 6.64 Last year we identified some inaccuracies in the guidance provided to registrants under investigation and noted that these had subsequently been corrected by the NMC. A further inaccuracy was identified this year in the NMC's guidance on consensual panel determinations. The document incorrectly stated that the charges in a case resolved by consensual panel determination, as in all other cases, will be published prior to the hearing.
- 6.65 This does not accurately reflect the NMC's decision to cease publishing charges in advance of hearings from September 2016.²¹ We highlighted the matter to the NMC.

²⁰ Professional Standards Authority, (May 2018). *Lessons Learned Review, The Nursing and Midwifery Council's handling of concerns about midwives' fitness to practise at the Furness General Hospital*. See: www.professionalstandards.org.uk/docs/default-source/publications/nmc-lessons-learned-review-may-2018a0851bf761926971a151ff000072e7a6.pdf?sfvrsn=6177220_0

²¹ This change of policy is discussed in more detail below, under the ninth Standard.

- 6.66 The NMC acknowledged that the guidance was not appropriately updated to reflect the change of policy due to an oversight when conducting the review of the guidance documents likely to be affected by the change.
- 6.67 The NMC noted that, at the time of its response, it held approximately 40 individual guidance documents which existed independently of each other, meaning that each document had to be individually reviewed each time a change of policy is made. The NMC told us that the risk of such an error being repeated in the future would be mitigated by the introduction of a new fully integrated online guidance library in August 2017 which, in its view, should simplify the process for searching and, where necessary, updating existing guidance.
- 6.68 While the issue of the NMC's guidance did not appear to us to be significant, our findings following the Lessons Learned Review mean that we cannot be satisfied that the NMC meets this Standard.

Standard 8: 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

- 6.69 Last year we noted that we had held case meetings regarding, and appealed, fewer of the NMC's final fitness to practise decisions than was the case in the previous year. This year the proportion of all decisions received which were discussed at case meetings has increased. Although more appeals were lodged this year, the number, as a proportion of all decisions received, was unchanged. In any event, the numbers concerned, as a proportion of the all final decisions, remain very small.

	Number of decisions	Case meetings held	Appeals lodged
2015/16	2,212	14 (0.6%)	6 (0.3%)
2016/17	2,656	12 (0.9%)	8 ²² (0.3%)

- 6.70 In our targeted audit last year, we identified no concerns in relation to decision-making at the initial stages of the fitness to practise process and few in relation to the quality of the case examiners' reasoning in making those decisions. There has been no evidence of concerns in that area this year.
- 6.71 The number of no case to answer decisions reviewed by the Registrar under Rule 7(a) of the NMC's Fitness to Practise Rules 2004 (as amended) remains small. Of the seven decisions reviewed by the Registrar this year, the original decision was upheld in five cases. In the other two cases, the Registrar determined that a fresh decision was required.
- 6.72 There were concerns arising from our audit last year over the quality and sufficiency of the Registrar's decisions in respect of VR applications. These

²² One appeal lodged was subsequently withdrawn. The percentage of appeals lodged remains 0.3%.

included cases in which there was no assessment in the reasons as to the seriousness of the misconduct and cases in which there was either no assessment or an incomplete assessment of the public interest in the Registrar's reasons. We were particularly concerned to note that in one case no reasons had been produced by the Registrar, though this appeared to have been an isolated incident.

6.73 We remain of the view that, having regard to the NMC's VR guidance, the Registrar's reasons should contain evidence that all relevant factors have been considered and taken into account.

6.74 The NMC has recruited a senior lawyer to lead on and bring greater consistency to decisions taken in the role of assistant registrar (on behalf of the Registrar), including VR decisions.

6.75 In the absence of any new concerns over the NMC's work in this area, this Standard continues to be met.

Standard 9: All fitness to practise decisions, apart from matters relating to the health of a professional, are published and communicated to relevant stakeholders

6.76 This Standard was considered as part of our targeted review this year.

6.77 In September 2016, the NMC took the decision to stop publishing charges on its website in advance of a final hearing.

6.78 We considered that further information in relation to the basis for this decision was required before a final judgement on performance against this Standard could be reached.

6.79 The NMC shared with us extracts from an audit report from the Information Commissioner's Office (ICO) which advised that there were risks in publishing details of allegations in advance of hearings of possible Data Protection Act breaches. Further, that any disclosure of the type of information contained within allegations prior to a hearing should be based upon very clear reasons due to the potential detrimental impact it may have, particularly in cases where the facts in the case are then found not proved.

6.80 The NMC told us that it subsequently took legal advice on a review of its publication and disclosure policy. It also undertook a benchmarking exercise to review the policies of other regulators before reaching a final decision. That exercise indicated a range of different approaches.

6.81 There have been no other changes to processes or evidence of concerns about the way in which the NMC publishes fitness to practise information and communicates it to stakeholders.

6.82 As noted elsewhere in this report, the NMC's power to issue advice, warnings and undertakings came into effect in July 2017. The NMC has confirmed that it will publish undertakings and warnings issued to registrants on its register. In health cases the register entry will state that a warning or undertakings have been issued, but the content will remain private. Advice will be issued privately to the registrant only, but the referrer will be informed that the case was closed with advice.

- 6.83 We confirmed in our response to the NMC's consultation on the new powers in fitness to practise that we broadly support this proposed approach to publication.

Conclusion

- 6.84 In respect of the NMC's decision to change its publication policy, we recognise that there are competing concerns between registrants' right to confidentiality and the need to maintain confidence in the transparency of the fitness to practise process. We also note that there is no clear consensus on how a balance between conflicting interests may best be reached. This may be an area for further consideration for all of the regulators.
- 6.85 Given the steps that the NMC has taken, we did not feel able to conclude that their decision was unreasonable and have therefore concluded that this Standard continues to be met.

Standard 10: Information about fitness to practise cases is securely retained

- 6.86 The NMC reports that its policies require all information security incidents, including any loss of personal data, to be reported internally without delay. Incidents are monitored by the NMC's Information Governance and Security Board which is accountable to its Executive Board for ensuring learning is identified to prevent recurrence.
- 6.87 In 2016/17 there were a total of 114 incidents recorded, of which four were graded as 'critical', 36 as 'moderate', 63 as 'minor' and 11 as 'insignificant'. The NMC reports that none of the four critical incidents were data breaches.
- 6.88 The NMC maintains and regularly reviews a comprehensive analysis of the information security risks it faces and implements an annual information security work programme, which is mapped to the international information security standard ISO 27001.
- 6.89 This year, no data breaches were reported to the Information Commissioner's Office by the NMC.
- 6.90 There is no evidence of any significant change to processes or of any concern in this area.

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Council

Audit Committee Annual Report 2017–2018

Action: For discussion.

Issue: Reports on the work of the Audit Committee during 2017–2018 and meetings in April and June 2018.

Core regulatory function: Supporting functions.

Strategic priority: Strategic priority 4: An effective organisation.

Decision required: None.

Annexes: None.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

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Chair: Marta Phillips

- Context:**
- 1 Reports on the work of the Audit Committee during the 2017–2018 financial year and the Committee’s meetings in April and June 2018.
 - 2 The remit of the Audit Committee is to support the Council and the Executive by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report.
 - 3 The Committee meets quarterly and has a busy schedule of work.

Committee membership

- 4 In March 2018, it was decided to continue with the existing Council membership of the Committee to ensure continuity and avoid any unnecessary disruption.
- 5 On 30 April 2018, one member of the Committee completed their second, and final term of office with the Council, thereby also leaving the Committee. It was agreed that the Committee membership would remain at three for the present.
- 6 The Committee has welcomed the regular attendance of the Chair of Council and the Chief Executive and Registrar, as Accounting Officer, along with the Directors of Resources and Registration and Revalidation at its meetings. Other senior executives attend when internal audit reports for their areas are being considered.
- 7 The Committee has also welcomed the consistent attendance of the Head of Internal Audit, the External Auditors and the National Audit Office at its meetings and in keeping with good practice, has held private meetings with each at appropriate junctures during the year.

Committee effectiveness review

- 8 The Committee undertook a review of its effectiveness in April 2018, assessing itself against the National Audit Office checklist for Audit Committee effectiveness.
- 9 The Committee had a follow on session in June 2018 to look further at training and development needs. A number of innovative suggestions were made, including meeting with Audit Committee members from other regulators to share best practice.

- Four country factors:**
- 10 The Committee is mindful of the need to ensure that the NMC is compliant with relevant legislation in all four countries, for example charity law.

Discussion: Internal controls, risk management and assurance

Risk management

- 11 During the year the Committee received reports on the operation of risk management, including comprehensive reviews of the risk and assurance arrangements in the following directorates:
- 11.1 Registration and Revalidation;
 - 11.2 Fitness to Practise (FtP);
 - 11.3 Education and Standards;
 - 11.4 Resources.
- 12 The Committee was pleased to note that more active risk management processes have been introduced and the complexity of the risk register had been reduced, but considered that more work was needed to embed effective risk management at directorate level.
- 13 The Committee also identified several areas to be addressed by the Executive in the coming year:
- 13.1 Further clarity on the ownership of risk below Council and Executive level and the need to escalate risks when necessary;
 - 13.2 Ensuring staff are aware of risks facing the organisation and receive training in risk management; and
 - 13.3 Ensuring sufficient resources are provided to senior staff to undertake risk management effectively.

Assurance map

- 14 The Committee has reviewed the corporate assurance map and requested further information on the process for compiling the assurance map and how it is used across the organisation. This will be considered at a future meeting.

Whistleblowing policy

- 15 The Committee has monitored the use of the Whistleblowing policy throughout the year. During 2017–2018 there were no invocations of the policy.
- 16 The Committee was pleased to note action taken to raise staff awareness of the policy and that training had been conducted by Public Concern at Work for staff across the organisation throughout

the year.

Anti-fraud, bribery and corruption

- 17 The Committee has monitored the use of the Anti-fraud, bribery and corruption policy to assure itself that any issues raised are comprehensively investigated and action and learning is taken forward. There have been no reported instances of fraud, bribery or corruption since March 2017.
- 18 The Committee was pleased to note that there is mandatory anti-fraud training for all staff on joining and every two years thereafter. Steps have also been taken to increase awareness via articles in the staff newsletter and on the intranet.
- 19 The Committee asked the Executive to ensure that controls in relation to fraud and risk are reviewed across the organisation to ensure that risks are appropriately identified and mitigated. The Committee will continue to monitor progress in this area.

Serious events and data breaches

- 20 The Committee has received reports throughout the year on serious events and data breaches and sought assurance on action to address the most serious events. The Committee welcomed the Executive's assurance that themes emerging from serious events generally were being identified and addressed, through process change; and staff induction and training.
- 21 In December 2017, there was a serious incident in the Wiser system, which is the software application that supports the Register. Following initial triage and rectification of the issue by the Executive, the Internal Auditor was asked to carry out a review. The Committee is cognisant of the potential risks given the importance of the integrity of the register and has monitored progress towards clearance of the Internal Auditor's recommendations at each of its meetings. It will continue to do so until these have been fully implemented. In addition, the Committee has sought assurance that staff were aware of how and when to invoke the escalation plans which are in place for when incidents occur.
- 22 The measures that have been put in place so far, along with escalation plans, will be comprehensively tested as part of a live disaster recovery exercise. The Committee will consider the results of the exercise at its next meeting.

Cyber security

- 23 The Committee continued to monitor risk management arrangements in relation to cyber security, in particular steps taken to mitigate the risks identified in the Infrastructure and Capability Internal Audit review carried out in September 2017. The three key

risks are: infrastructure; ageing systems and security controls.

- 24 At the Committee's request a self-assessment gap analysis of our cyber security framework was carried out by the Executive against the National Audit Office's helpful guidance: *Cyber security and information risk guidance for Audit Committees*.
- 25 The Committee will continue to monitor progress in this area with a view to seeking accreditation under the Cyber Essentials scheme in the future.

Single tender actions

- 26 The Committee scrutinised single tender actions (STAs) from April 2017 to May 2018 and potential forthcoming STAs, with the aim of assuring itself that proper processes are being adhered to by the Executive.
- 27 During the year the Committee asked for sight of cumulative STAs at each meeting in the form of an STA register. This increased transparency has enabled the Committee to identify an upward trend in the number of STAs. The Committee has requested additional contextual information to enable it to understand the reasons for the increase in STAs. This includes the number and value of contracts broken down by directorate as well as the reasons for STAs, so that the Committee can be satisfied about the appropriateness of use of the STA process.
- 28 Procurement continues to be an area of risk and the Committee continues to monitor progress in this area. Whilst a number of improvements are in hand, there remains significant work to be done.

Internal Audit

- 29 The Committee approved the Internal Audit work programme for 2017–2018 and monitored progress throughout the year. The Committee is pleased to report that all planned Internal Audit assignments have been completed. A total of 12 audit assignments were undertaken. These included additional advisory reviews on the FtP legal costs accruals process, directorate accruals process and the Wiser IT incident referred to in paragraph 21.
- 30 The Committee has continued to closely monitor progress in relation to implementing outstanding recommendations from previous Internal Audits to ensure these are followed through to closure. The Committee is pleased to report that good progress has been made over the year. Two follow up Internal Audit reviews of previous Internal Audit recommendations have also been completed, confirming that those recommendations reviewed had been properly implemented.

- 31 Following an open tender process, RSM were appointed as Internal Auditors from 1 April 2018 for three years. Following this, the Committee approved the draft Internal Audit work programme for 2018–2019, setting clear expectations around planning work on key areas.
- 32 The Committee considered the annual review of the effectiveness of the Internal Audit service, reflecting performance to January 2018. Key areas for improvement were identified for both Internal Audit and the Executive and are being addressed. The Committee extended its thanks to the outgoing Internal Auditors, Moore Stephens LLP.

General Data Protection Regulation

- 33 In June 2018 the Committee considered the new Internal Auditor's first report on our readiness for the General Data Protection Regulation (GDPR) which took effect on 25 May 2018. The Internal Audit was undertaken before the implementation date and concluded that the NMC had made good progress towards compliance with the requirements of GDPR. While further work still needed to be completed, the NMC was well placed in terms of the work and plans in place at that time. The Committee will continue to monitor progress against the recommendations contained in the report and has asked for an update at its next meeting.

Integrity of reports and financial statements

Review of accounting policies

- 34 The Committee reviewed the accounting policies for the financial reporting year 2017–2018 and considered that these remained appropriate for 2018–2019.

External Audit

- 35 The Committee approved the arrangements proposed by the External Auditors and the National Audit Office for the external audit and certification of the NMC's annual accounts for the year ending March 2018.
- 36 The Committee reviewed the letters of representation and draft audit reports from the External Auditors and the National Audit Office and noted that, subject to post-balance sheet review, both reports were expected to be unqualified.
- 37 The Committee was pleased to receive confirmation from the External Auditors and the NAO that the Audits had proceeded smoothly with the timely provision of financial data and other information by the Executive. It asked the Executive to thank the staff concerned.

Draft Annual Report and Accounts 2017–2018

- 38 The Committee scrutinised the draft Annual Report and Accounts 2017–2018, including the Annual Governance Statement. The Committee endorsed the Annual Report and Accounts for approval by the Council subject to:
- 38.1 Minor amends suggested to the Performance Review section and the Annual Governance Statement.
 - 38.2 The completion of the post balance sheet review before the report is laid in Parliament after the summer recess.
- 39 The Committee noted that the Annual Report and Accounts are due to be signed after the summer Parliamentary recess, when the current Accounting Officer (the Chief Executive and Registrar) will have left the NMC. Adequate arrangements will need to be put in place to enable the new Accounting Officer to obtain satisfactory assurance to support their signing of the 2017–2018 Annual Report and Accounts.

Draft Annual Fitness to Practise report 2017–2018

- 40 The Committee scrutinised the draft Annual Fitness to Practise Report 2017–2018. The Committee endorsed the draft for approval by the Council, subject to a number of comments and suggestions and a full quality check of the data contained in the report. The Committee extended its thanks to the staff concerned for drafting the report.

Committee's views on governance, risk management and control

- 41 The Committee has reflected on a range of issues including the Internal Audit annual opinion and report, the findings of the External Auditors and NAO and the views of the Accounting Officer.
- 42 In considering the draft Internal Audit annual opinion and report for 2017–2018, the Committee accepted the annual opinion of the Internal Auditors that the risk and control environment remained unchanged from the previous year. It noted that while there were improvements in some areas, technology issues in particular remain a concern.
- 43 Overall, the Committee's view is that the Council can have confidence that arrangements for governance, risk management and controls are satisfactory, notwithstanding the fact that there is further work to be done to create sustainable improvements in the areas of procurement, contract management, IT (core systems including Wiser), HR (core controls) and accruals processes. Improvements are planned in these areas and the Committee intends to monitor

progress rigorously.

Public protection implications:	44	No public protection issues arising directly from this report.
Resource implications:	45	No resource implications arising directly from this report.
Equality and diversity implications:	46	No equality and diversity implications arising directly from this report.
Stakeholder engagement:	47	None.
Risk implications:	48	The role of the Audit Committee is to give assurance to Council that the NMC has effective governance, risk management and internal controls in place.
Legal implications:	49	None.

Council

Revalidation Annual Data Report 2017–2018

Action: For decision.

Issue: Provides the Revalidation Annual Data Report 2017–2018.

Core regulatory function: Registration and Revalidation.

Strategic priority: Strategic priority 1: Effective regulation.

Decision required: Council is recommended to approve the Revalidation Annual Data Report 2017–2018 (paragraph 6).

Annexes: The following annexe is attached to this paper:

- Annexe 1: Revalidation Annual Data Report 2017–2018.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

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- Context:** 1 Implementation of revalidation began in April 2016. Since that time we have shared our data regularly and published an annual report and an interim evaluation report. This is the second annual report and will be published alongside the second interim evaluation report in August 2018.
- Four country factors:** 2 Revalidation applies equally across all four countries. Revalidation rates across all four countries are very similar, ranging from 93.8% to 94.3%- in line with historical renewal rates. The proportion of nurses and midwives revalidating by country was what we would expect given the proportion of people registered in each country.
- Discussion:** 3 The proportion of nurses and midwives revalidating is very similar to last year and the picture continues to be very positive with 204,218 nurses and midwives revalidating – an average revalidation rate of 94% across the UK. There is no evidence that revalidation is having a negative impact on the number of nurses and midwives choosing to remain on the register.
- 4 Revalidation rates for nurses and midwives are very similar. The large majority of nurses and midwives who revalidated kept the same registration type(s) after revalidation.
- 5 The second interim report by Ipsos MORI will be published at the same time as the NMC annual report. The final section of this report outlines how we intend to take forward the recommendations.
- 6 **Recommendation: Council is recommended to approve the publication of the report.**
- 7 Following Council's approval the report will be published in August 2018. The report will be published on our website. There is a full communications plan in place.
- Public protection implications:** 8 Revalidation is designed to ensure public protection, bringing about improvements in the practice of nursing and midwifery and strengthening public confidence in the professions. The feedback we get continues to be positive and the second interim evaluation report shows increasing numbers of nurses and midwives are reporting the positive impact revalidation is having on their practice. We will not know the full impact revalidation has had until we have completed the first cycle at the end of March 2019.
- Resource implications:** 9 Resource implications arising from this report relate to the compilation, translation and publication of the report which are within existing staff budgets.

- Equality and diversity implications:**
- 10 As part of the revalidation application process we ask nurses and midwives to provide a range of equality and diversity data. Using this data we have carried out a detailed analysis of the impact on groups with different protected characteristics. As with last year, this has shown some differences in revalidation rates for older nurses and midwives; those declaring a disability, and some ethnic groups. Next year the evaluation will focus on the perceived benefit and burden of revalidation. As part of this we have asked the evaluation team to focus in particular on any obstacles faced by those who share protected characteristics. We will report on this next year.
- 11 We will also be engaging with our stakeholders over the next six months on a review of our guidance, including our guidance on reasonable adjustments and will continue to monitor revalidation rates for all groups.
- Stakeholder engagement:**
- 12 Feedback from stakeholders is still positive but our evaluation partners have recommended that we need to find more innovative ways of engaging to ensure that we maintain the impetus for change that revalidation has already brought about. We will engage with all our stakeholders fully over the next few months as we seek to put the report's recommendations into practice – particularly as we update our guidance.
- Risk implications:**
- 13 We have carried out analysis of why people come off the register and while revalidation was not a factor cited by the majority, it was clearly a factor for some people. The surveys we have carried out so far for the evaluation have shown that there is anxiety about revalidation prior to going through the process, but this disappears once someone has revalidated. We think there may be more we can do to reassure those who have yet to revalidate to avoid this becoming a factor in a decision to come off the register. We will continue to monitor and report on reasons for coming off the register.
- Legal implications:**
- 14 None.

REVALIDATION

Annual data report

Year 2: April 2017 to March 2018



FOREWORD

Welcome to our second annual data report on revalidation.

We publish this report alongside the second year evaluation report from our evaluation partners. We publish our data because we believe in being transparent and that sharing information with our partners is an essential step towards our goal of becoming an intelligence led regulator. As revalidation progresses, our understanding of those on our register increases, allowing us to adapt and improve how we support nurses and midwives. From January next year we will be regulating the new profession of nursing associate and we will be applying the lessons we have learned from these last two years when we introduce the revalidation requirements for these new professionals.

I'm delighted that this year's report shows revalidation continuing to be a success with 204,218 nurses and midwives revalidating – an average revalidation rate of 94% across the UK.

The evaluation shows that nurses and midwives are preparing earlier for revalidation and using the Code more. Increasing numbers are reporting the positive impact revalidation is having on their practice. It's very encouraging that the reflective elements of revalidation are seen as playing the biggest role, and we're hearing the same thing when we talk to nurses and midwives. We know that these changes would not be possible without the dedication and commitment to patient and public care that nurses and midwives demonstrate every day.

It's also important that we acknowledge the support of so many others in the healthcare system. We're grateful to employers and those who take time out of their own busy practice to provide their colleagues with feedback, and act as reflective discussion partners and confirmers.

I'm pleased that those revalidating continue to value the advice and support provided by our contact centre and our regular email communications. Our guidance documents and website are being used more and more. It's vital we continue to provide this support and we're committed to doing so. We know that the level of communication with stakeholders hasn't been as strong as in previous years and as we head towards the completion of the first three years of revalidation, we'll ensure we find innovative ways of engaging all of those with an interest in how revalidation is working and how it progresses.

We said last year that we knew we had more to do. We have said that we don't intend to make any change to the model of revalidation for the first three years, until we fully understand the impacts of the existing model and all nurses and midwives have been through revalidation for the first time. But our own experience and evaluation shows that there is still scope to improve our guidance in the interim. The three year anniversary of the publication of How to revalidate with the NMC is an ideal time for us to do this. We'll be reaching out to all sectors of the professions to enable us to do this over the next few months. Following the completion of the evaluation in March 2019, we'll begin to focus our discussions on how we might develop our model.

Emma Broadbent

Director of Registration and Revalidation

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ABOUT THE DATA

All of the data reporting is broken down by registration type and by country. In this report, the 'country' means the country of a nurse or midwife's current or most recent practice (if we have their employer's address), or their home address. For most people who revalidated, their country is the country of their current or most recent employment. For those who lapse and for some self-employed nurses and midwives, it's the country where they live.

The data doesn't include nurses and midwives who submitted a revalidation application but by the end of their renewal month had not had their revalidation application fully processed. Reasons for this may include:

- they were going through the process of verification
- they had declared cautions and convictions
- they had declared a determination from another regulator
- they were subject to fitness to practise sanctions.

INTRODUCTION

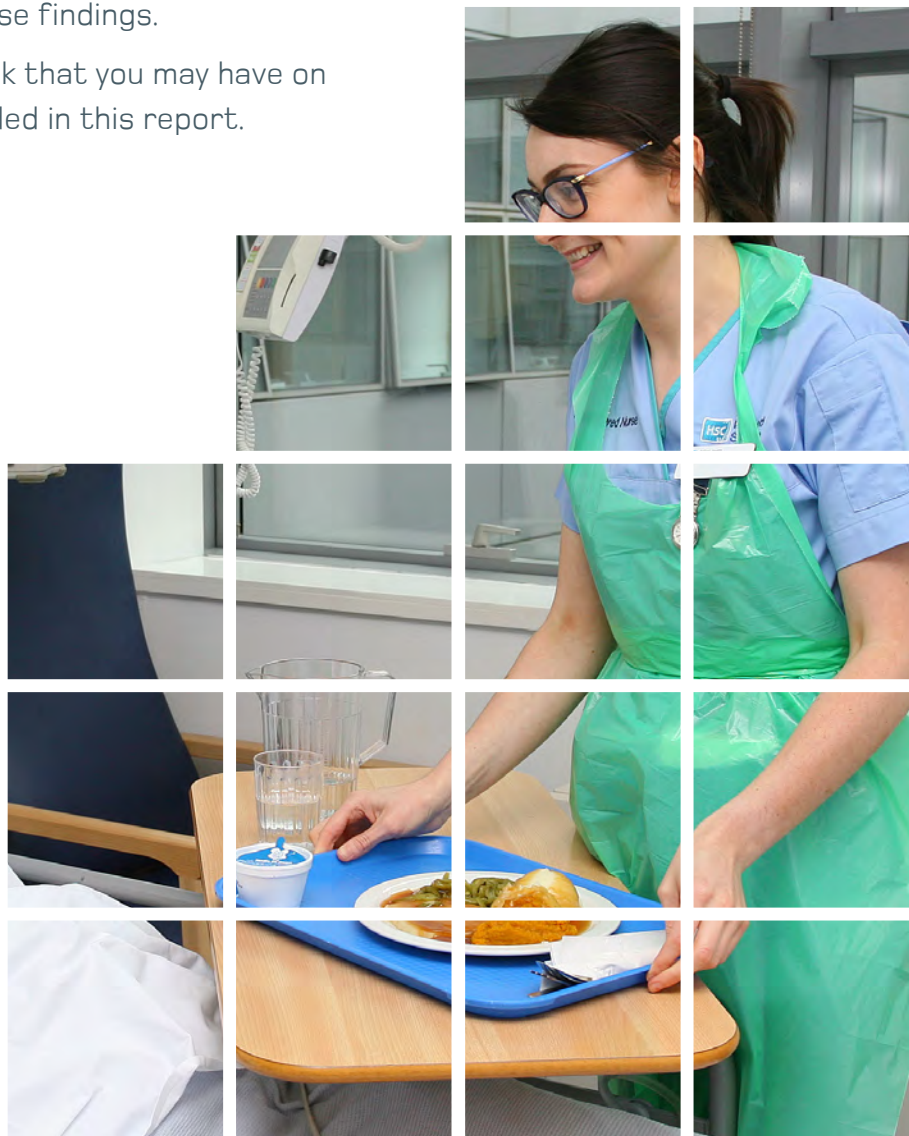
Revalidation has enabled us to gather more information about the professionals on our register. This report shares this information and provides insights into where nurses and midwives work, the diversity of their different types of practice and the support that they get in the workplace.

The report analyses the information we've been given as to why some nurses and midwives have chosen not to revalidate. We have compared the revalidation rates of nurses and midwives with different protected characteristics under the Equality Act. For example, we have compared the revalidation rates of those who said they had a disability with those who said they did not. We've also introduced a section on verification and how we're developing our approach to this.

Finally, as with last year's report, we've included a section on the independent findings of the evaluation of the second year of revalidation and our response to those findings.

We continue to welcome any feedback that you may have on the structure and information provided in this report.

Sara Kovach Clark,
sara.kovach-clark@nmc-uk.org



AIMS & OBJECTIVES

What is revalidation?

Every three years nurses and midwives are required to renew their registration with us to be able to continue to practise in the UK. Revalidation is the set of requirements they must meet, and the process they must go through, in order to successfully renew their registration. Revalidation replaces the previous post-registration education and practice (Prep) scheme by introducing several new requirements for reflection and engagement. Following extensive public consultation in 2014 and a pilot in 2015 we published our revalidation guidance in October 2015. The first nurses and midwives revalidated in April 2016.

Why did we introduce revalidation?

We introduced revalidation to improve public protection by making sure that nurses and midwives demonstrate their continued ability to practise safely and effectively throughout their career. With revalidation we want to:

- raise awareness of the Code and professional standards expected of nurses and midwives
- provide nurses and midwives with the opportunity to reflect on the role of the Code in their practice and demonstrate that they're 'living' these standards
- encourage nurses and midwives to stay up to date in their professional practice by developing new skills and understanding the changing needs of the public and fellow healthcare professionals
- encourage a culture of sharing, reflection and improvement
- encourage nurses and midwives to engage in professional networks and discussions about their practice.





What are the revalidation requirements?

Nurses and midwives are required to declare via an online form that they have:

- practised for a minimum of 450 practice hours (900 hours for those registered as both a nurse and a midwife) over the three years prior to the renewal of their registration
- carried out 35 hours of continuing professional development (CPD), of which at least 20 hours must be participatory learning
- collected five pieces of practice-related feedback over the three years prior to the renewal of their registration
- completed five written reflective accounts on their CPD and/or practice-related feedback and/or an event or experience in their practice, and how this relates to the Code, over the three years prior to the renewal of their registration
- had a reflective discussion with another nurse or midwife
- received confirmation from an appropriate person that they have met all the requirements.

In addition they must:

- provide a health and good character declaration
- declare that they have (or will have when they practise) an appropriate professional indemnity arrangement.

For more information on the revalidation requirements and the guidance and support available [please visit our website](#).

THE BIG PICTURE

SUMMARY OF YEAR 2 REVALIDATION DATA – APRIL 2017 TO MARCH 2018

204,218 nurses and midwives renewed their registration in the second year of revalidation².

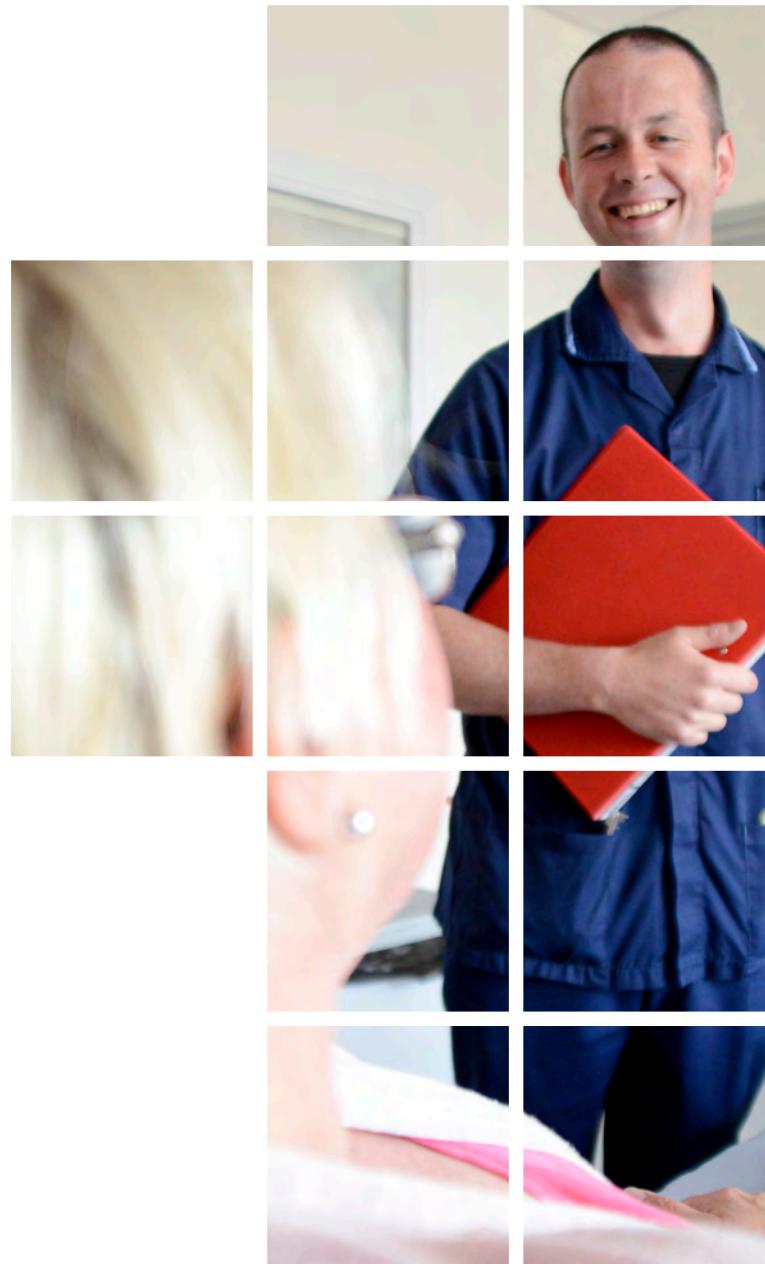
Across the UK revalidation rates were very similar, ranging from **93.8%** to **94.3%**.

The proportion of nurses and midwives revalidating by country was what we would expect given the proportion of people registered in each country. This breaks down as follows:

England	80.0%
Scotland	9.9%
Wales	5.2%
Northern Ireland	3.5%
Practising mainly outside the UK	1.4%

The percentage lapsing in the four UK countries was also very similar, at **5.1%–5.6%**.

² Nurses and midwives can hold dual registration.



SUMMARY OF FINDINGS FROM SECOND YEAR OF REVALIDATION

THE NUMBERS REVALIDATING

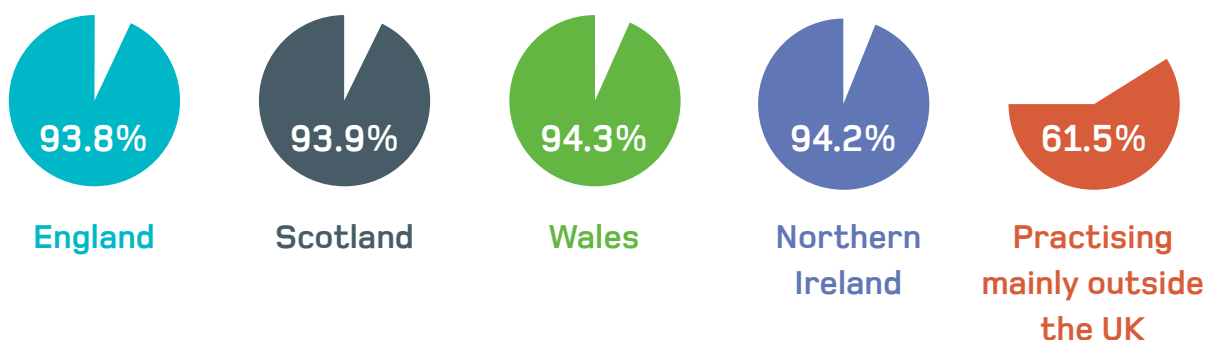
Tables 1–5 break down the proportion of nurses and midwives revalidating by country and registration type. The numbers of nurses and midwives revalidating in the second year of revalidation are similar to or higher than the first year. They are also in line with historical averages under the previous renewal scheme – post-registration education and practice (Prep).

There is little difference in revalidation rates between the professions or between the countries of the UK. The relatively small proportion of people who mainly work abroad have historically had lower renewal rates under Prep than those working in the UK. The renewal rate for this group has dropped since the introduction of revalidation. If we compare the average revalidation rate across the UK (94%) with the rate for those working outside the UK (61.5%), we can see this remains the case. This is in line with what we expect as the register is intended to be a register of those practising in the UK. If an individual nurse or midwife doesn't intend to practise in the UK, it's entirely appropriate that they allow their registration to lapse until they intend to practise again.

The large majority of nurses and midwives who revalidated kept the same registration type(s) after revalidation. Of the 1,203 people who changed their registration, most were people who were registered as nurse/midwife who dropped one of their registrations when they revalidated. 560 nurse/midwives dropped their nursing registration to become a midwife only and 229 dropped their midwifery registration to become a nurse only.

Another common change was for nurse SCPHNs to drop their SCPHN registration to become a nurse only (133 people). We also saw 149 people registered as nurses gain SCPHN registration, either by gaining a SCPHN qualification or reactivating an existing SCPHN qualification.

The revalidation rates by country are:



APRIL 2017 TO MARCH 2018

Table 1: Revalidation summary table

This table summarises the number and percentage of nurses and midwives who renewed their registration with us during the second year of revalidation (April 2017 – March 2018).

Quarter		England	Scotland	Wales	Northern Ireland	Practising outside the UK***	Total
Q1	Number due to revalidate*	30,236	3,205	2,111	1,339	928	37,819
Apr – Jun 2017	Number (percentage) who revalidated**	27,959 (92.5%)	2,922 (91.2%)	1,958 (92.8%)	1,224 (91.4%)	548 (59.1%)	34,611 (91.5%)
Q2	Number due to revalidate	64,111	8,784	4,001	2,984	1,509	81,389
Jul – Sep 2017	Number (percentage) who revalidated	60,977 (95.1%)	8,383 (95.4%)	3,828 (95.7%)	2,866 (96.0%)	1,005 (66.6%)	77,059 (94.7%)
Q3	Number due to revalidate	36,529	4,366	2,168	1,894	921	45,878
Oct – Dec 2017	Number (percentage) who revalidated	33,832 (92.6%)	4,029 (92.3%)	2,006 (92.5%)	1,776 (93.8%)	540 (58.6%)	42,183 (91.9%)
Q4	Number due to revalidate	43,254	5,261	2,957	1,417	1,168	54,057
Jan – Mar 2018	Number (percentage) who revalidated or renewed	40,592 (93.8%)	4,957 (94.2%)	2,800 (94.7%)	1,325 (93.5%)	691 (59.2%)	50,365 (93.2%)
Total		174,130	21,616	11,237	7,634	4,526	219,143
Total		163,360 (93.8%)	20,291 (93.9%)	10,592 (94.3%)	7,191 (94.2%)	2,784 (61.5%)	204,218 (93.2%)

* Includes all nurses and midwives who were sent a formal notice to revalidate for April 2017 – March 2018.

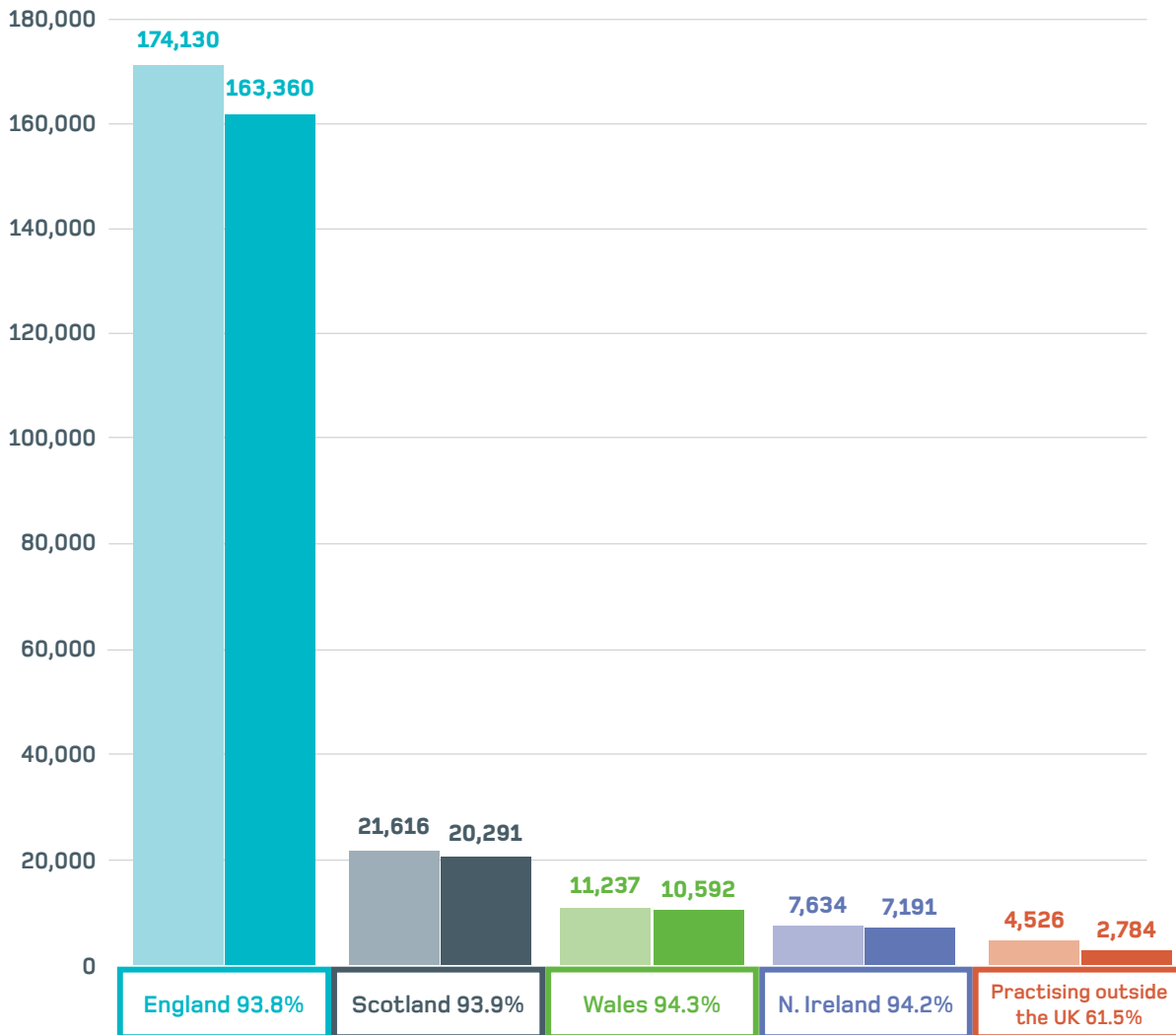
** All nurses and midwives who revalidated (including those who revalidated with alternative support arrangements).

*** This includes nurses and midwives whose current or most recent practice (if we have their employer's address) or their home address is either in the EU/EEA or overseas (outside the EU/EAA).

APRIL 2017 TO MARCH 2018

Table 2: Number due to revalidate vs numbers revalidating

This chart shows the number of nurses and midwives due to revalidate and the number who actually revalidated broken down by country for the second year of revalidation, April 2017 – March 2018.

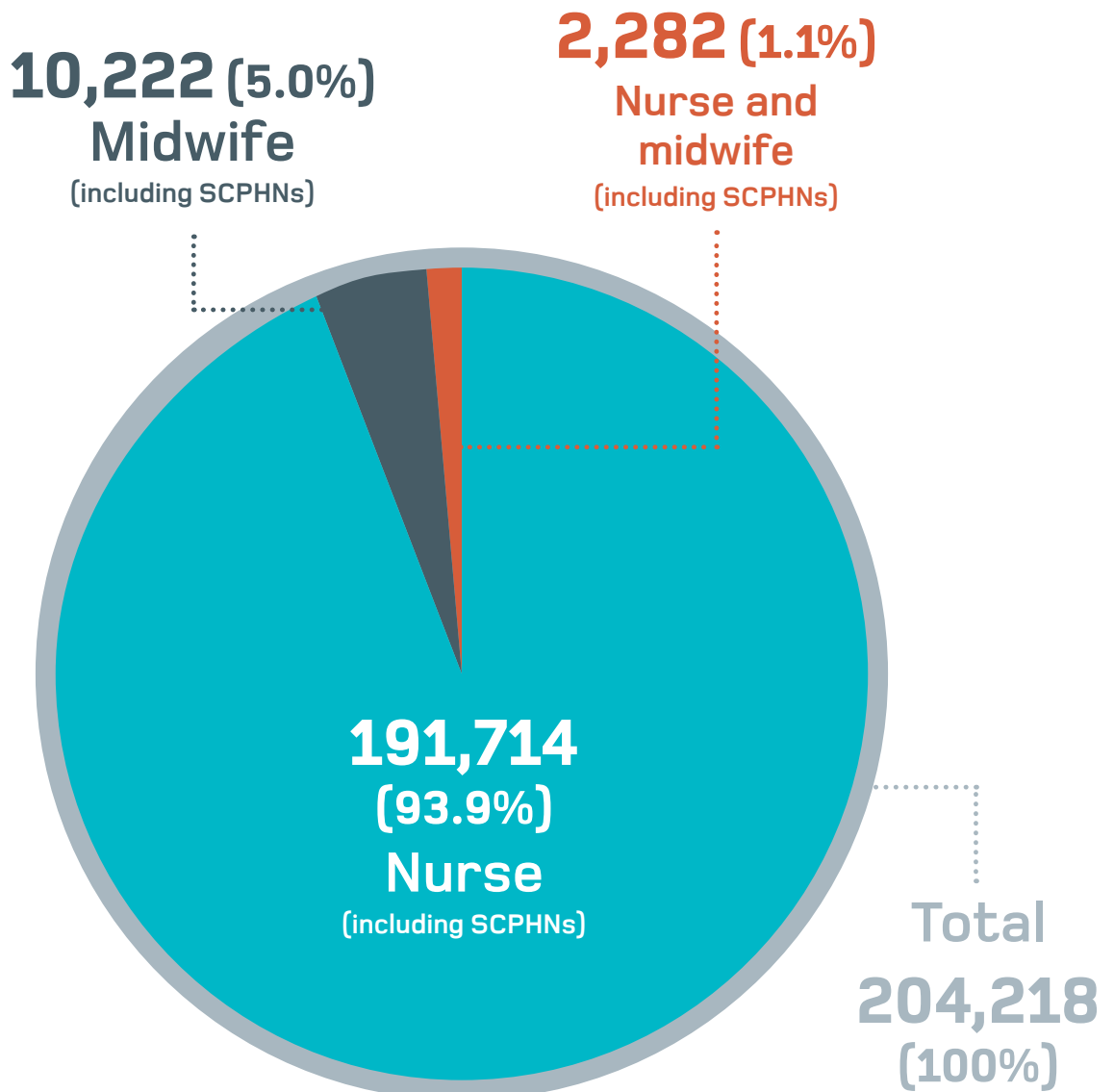


For each country, the light coloured bar represents those who were due to revalidate, and the dark coloured bar represents those who actually revalidated.

APRIL 2017 TO MARCH 2018

Table 3: Revalidated by registration type after revalidation

This chart shows the number and percentage of nurses and midwives who revalidated broken down by registration type after revalidation. This is a nurse or midwife's registration type **after** their registration is renewed, partially renewed or lapsed.



APRIL 2017 TO MARCH 2018

Table 4: Number due to revalidate*

This table shows the number of nurses and midwives who were due to revalidate in the second year of revalidation, broken down by country.

Registration type** before revalidation	England	Scotland	Wales	Northern Ireland	Practising outside the UK***	Total
Nurse	155,260 (89.2%)	19,586 (90.6%)	10,096 (89.8%)	6,843 (89.6%)	4,117 (91.0%)	195,902 (89.4%)
Midwife	8,093 (4.6%)	928 (4.3%)	415 (3.7%)	341 (4.5%)	174 (3.8%)	9,951 (4.5%)
Nurse and midwife	2,497 (1.4%)	192 (0.9%)	185 (1.6%)	117 (1.5%)	128 (2.8%)	3,119 (1.4%)
Nurse and SCPHN	7,783 (4.5%)	888 (4.1%)	518 (4.6%)	323 (4.2%)	99 (2.2%)	9,611 (4.4%)
Midwife and SCPHN	337 (0.2%)	15 (0.1%)	13 (0.1%)	5 (0.1%)	1 (<0.1%)	371 (0.2%)
Nurse, midwife and SCPHN	160 (0.1%)	7 (<0.1%)	10 (0.1%)	5 (0.1%)	7 (0.2%)	189 (0.1%)
Total	174,130	21,616	11,237	7,634	4,526	219,143

* This includes all nurses and midwives who were sent a formal notice to revalidate for April 2017 – March 2018.

** This is a nurse or midwife's registration type **before** their registration is renewed, partially renewed or lapsed..

*** This includes nurses and midwives whose current or most recent practice (if we have their employer's address) or their home address is either in the EU/EEA or overseas (outside the EU/EEA).

APRIL 2017 TO MARCH 2018

Table 5: Total number who revalidated

This table shows the number of nurses and midwives who revalidated in the second year of revalidation, broken down by country. It includes both those who went through the standard revalidation process and those who completed our exceptional circumstances process.

Registration type after revalidation*	England	Scotland	Wales	Northern Ireland	Practising outside the UK**	Total
Nurse	145,859 (89.3%)	18,387 (90.6%)	9,509 (89.8%)	6,442 (89.6%)	2,503 (89.9%)	182,700 (89.5%)
Midwife	8,051 (4.9%)	905 (4.5%)	424 (4.0%)	347 (4.8%)	127 (4.6%)	9,854 (4.8%)
Nurse and midwife	1,727 (1.1%)	128 (0.6%)	142 (1.3%)	81 (1.1%)	71 (2.6%)	2,149 (1.1%)
Nurse and SCPHN	7,279 (4.5%)	851 (4.2%)	495 (4.7%)	311 (4.3%)	78 (2.8%)	9,014 (4.4%)
Midwife and SCPHN	332 (0.2%)	16 (0.1%)	15 (0.1%)	4 (0.1%)	1 (<0.1%)	368 (0.2%)
Nurse, midwife and SCPHN	112 (0.1%)	4 (<0.1%)	7 (0.1%)	6 (0.1%)	4 (0.1%)	133 (0.1%)
Total	163,360	20,291	10,592	7,191	2,784	204,218

* This is a nurse or midwife's registration type **after** their registration is renewed, partially renewed or lapsed.

** This includes nurses and midwives whose current or most recent practice (if we have their employer's address) or their home address is either in the EU/EEA or overseas (outside the EU/EEA).

This table **doesn't** include nurses and midwives who submitted a revalidation application but by the end of their renewal month hadn't had their revalidation application fully processed. This may be because they were going through the process of verification, had declared cautions and convictions, had declared a determination from another regulator, or were subject to fitness to practise sanctions.

EMPLOYMENT, PRACTICE AND WORK SETTINGS

Nurses and midwives provide information on their most recent employment type, scope of practice and work setting as part of revalidation. They can provide information about more than one type of employment, scope of practice or work setting. For example, if someone is currently working in two or three different jobs, each of these is counted. **Tables 6 – 10** provide a detailed breakdown of this information.

The tables show findings similar to last year. The majority of employment types for those currently practising (93.6%) are in direct employment (not via an agency). The majority of scopes of practice are in direct clinical care or management (63.3%), with mental health nursing (10.6%), children’s and neo-natal nursing (5.9%) and midwifery (5.2%) being the next largest declared scopes of practice.

The nurses and midwives revalidating work in a wide variety of work settings. Just over half of work settings (55.8%) are in hospital or other secondary care, with community nursing (17.9%) and care home (8.0%) nursing being the next largest work settings. As might be expected, there are some differences in work settings between nurses and midwives. The proportion of work settings that are in hospital or other secondary care is much lower for midwives than for nurses (33.7% compared with 57.1%). The highest proportion of work settings for midwives (43.1%) is in a maternity unit or birth centre, as we would expect.

Tables 11 and 12 provide a breakdown of the types of confirmers that nurses and midwives chose. As with last year, most people chose either their NMC-registered line manager (68.7%) or another NMC-registered nurse or midwife (27%) to be their confirmer. A higher proportion of midwives (34.8%) chose another registrant, who isn’t their line manager, to be their confirmer, compared to 26.6% of those with a nursing registration.

Appraisals

Finally, **tables 13 and 14** provide a breakdown of the numbers of people who have an appraisal and of those who have an NMC-registered line manager. Having a line manager registered with us is an important factor in whether a nurse or midwife has an annual appraisal or not. Those without an NMC-registered line manager are less likely to have an annual appraisal than those who do have an NMC-registered line manager (86.6% compared to 98.2%), a picture which is similar to last year.

APRIL 2017 TO MARCH 2018

Table 6: Breakdown of current employment types for those who revalidated

This includes employment types for all current jobs that have been reported, so the totals add up to more than the number of people in each country. If someone has two or three current jobs, each of these is included in the relevant cell in the table. For example, someone who is self-employed and who does additional voluntary work would record both employment types.

The percentages are worked out based on the total current types of employment reported for those who were practising at the time of revalidation. This table doesn't include those who were not in employment but had met the practice hours requirement at the time of revalidation.

Employment type	England	Scotland	Wales	Northern Ireland	Practising outside the UK**	Total
Employed directly (not via UK agency)	158,099 (93.0%)	20,430 (97.0%)	10,530 (96.1%)	7,316 (96.3%)	2,572 (89.1%)	198,947 (93.6%)
Employed via an agency	9,268 (5.5%)	504 (2.4%)	323 (2.9%)	223 (2.9%)	227 (7.9%)	10,545 (5.0%)
Self employed	2,424 (1.4%)	107 (0.5%)	99 (0.9%)	43 (0.6%)	50 (1.7%)	2,723 (1.3%)
Volunteering	211 (0.1%)	14 (0.1%)	10 (0.1%)	14 (0.2%)	37 (1.3%)	286 (0.1%)
Total current periods of practice	170,002	21,055	10,962	7,596	2,886	212,501

APRIL 2017 TO MARCH 2018

Table 7: Employment type by registration type

The table shows a breakdown of current employment types for people who revalidated and had a nursing registration, and for people who revalidated and had midwifery registration. Please note that as some people are registered as both a nurse and a midwife, they will be included in both groups. As in the table above, the percentages are worked out based on the total current types of employment reported. This table doesn't include those who weren't practising at the time of revalidation.

Employment type	People with a nursing registration	People with a midwifery registration
Employed directly (not via UK agency)	188,718 (93.4%)	12,651 (96.5%)
Employed via an agency	10,416 (5.2%)	333 (2.5%)
Self-employed	2,652 (1.3%)	108 (0.8%)
Volunteering	276 (0.1%)	24 (0.2%)
Total current periods of practice	202,062	13,116

APRIL 2017 TO MARCH 2018

Table 8: Breakdown of the current scope of practice for those who revalidated

Individuals can declare more than one scope of practice, so the totals add up to more than the number of people in each country. For example, a person who works in a policy development role part time, and in direct clinical care part time, would record both scopes of practice.

The percentages are worked out based on the total reported current periods of practice.

The table doesn't include those who weren't practising at the time of revalidation.

Scope of practice	England	Scotland	Wales	Northern Ireland	Practising outside the UK*	Total current scopes of practice
Commissioning	1,035 (0.6%)	16 (0.1%)	38 (0.3%)	13 (0.2%)	5 (0.2%)	1,107 (0.5%)
Direct clinical care or management – adult and general care nursing	107,550 (63.3%)	13,336 (63.3%)	6,995 (63.8%)	4,894 (64.4%)	1,774 (61.5%)	134,549 (63.3%)
Direct clinical care or management – children's and neo-natal nursing	10,539 (6.2%)	953 (4.5%)	559 (5.1%)	406 (5.3%)	166 (5.8%)	12,623 (5.9%)
Direct clinical care or management – health visiting	4,464 (2.6%)	696 (3.3%)	358 (3.3%)	210 (2.8%)	39 (1.4%)	5,767 (2.7%)
Direct clinical care or management – learning disabilities nursing	2,489 (1.5%)	314 (1.5%)	175 (1.6%)	201 (2.6%)	27 (0.9%)	3,206 (1.5%)
Direct clinical care or management – mental health nursing	17,720 (10.4%)	2,511 (11.9%)	1,268 (11.6%)	731 (9.6%)	194 (6.7%)	22,424 (10.6%)

Direct clinical care or management – midwifery	8,976 (5.3%)	922 (4.4%)	529 (4.8%)	399 (5.3%)	163 (5.6%)	10,989 (5.2%)
Direct clinical care or management – occupational health	1,446 (0.9%)	242 (1.1%)	85 (0.8%)	38 (0.5%)	22 (0.8%)	1,833 (0.9%)
Direct clinical care or management – other	3,907 (2.3%)	555 (2.6%)	236 (2.2%)	170 (2.2%)	119 (4.1%)	4,987 (2.3%)
Direct clinical care or management – public health	1,040 (0.6%)	154 (0.7%)	77 (0.7%)	84 (1.1%)	37 (1.3%)	1,392 (0.7%)
Direct clinical care or management – school nursing	1,906 (1.1%)	162 (0.8%)	113 (1.0%)	53 (0.7%)	60 (2.1%)	2,294 (1.1%)
Education	3,268 (1.9%)	437 (2.1%)	185 (1.7%)	129 (1.7%)	132 (4.6%)	4,151 (2.0%)
Policy	108 (0.1%)	27 (0.1%)	14 (0.1%)	18 (0.2%)	11 (0.4%)	178 (0.1%)
Quality assurance or inspection	827 (0.5%)	100 (0.5%)	57 (0.5%)	30 (0.4%)	18 (0.6%)	1,032 (0.5%)
Research	1,334 (0.8%)	142 (0.7%)	59 (0.5%)	33 (0.4%)	25 (0.9%)	1,593 (0.7%)
Other	3,393 (2.0%)	488 (2.3%)	214 (2.0%)	187 (2.5%)	94 (3.3%)	4,376 (2.1%)
Total current periods of practice	170,002	21,055	10,962	7,596	2,886	212,501

* This includes nurses and midwives whose current or most recent practice (if we have their employer's address), or their home address is either in the EU/EEA or overseas (outside the EU/EAA).

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Table 9: Breakdown of work settings for those who revalidated

Individuals can declare more than one work setting, so the totals add up to more than the number of people in each country. If someone has two or three current work settings, each of these is included in the relevant cell in the table. For example, if a person worked part time in a hospital and part time in a university, they would record both work settings.

Work setting	England	Scotland	Wales	Northern Ireland	Practising outside the UK*	Total
Ambulance service	218 (0.1%)	19 (0.1%)	39 (0.4%)	3 (<0.1%)	9 (0.3%)	288 (0.1%)
Care home sector	13,213 (7.8%)	1,871 (8.9%)	801 (7.3%)	903 (11.9%)	158 (5.5%)	16,946 (8.0%)
Community setting, including district nursing and community psychiatric nursing	30,807 (18.1%)	3,580 (17.0%)	2,055 (18.7%)	1,408 (18.5%)	273 (9.5%)	38,123 (17.9%)
Consultancy	454 (0.3%)	67 (0.3%)	24 (0.2%)	13 (0.2%)	12 (0.4%)	570 (0.3%)
Cosmetic or aesthetic sector	460 (0.3%)	33 (0.2%)	21 (0.2%)	13 (0.2%)	12 (0.4%)	539 (0.3%)
Governing body or other leadership	477 (0.3%)	45 (0.2%)	19 (0.2%)	12 (0.2%)	14 (0.5%)	567 (0.3%)
GP practice or other primary care	9,903 (5.8%)	1,161 (5.5%)	594 (5.4%)	351 (4.6%)	112 (3.9%)	12,121 (5.7%)
Hospital or other secondary care	94,577 (55.6%)	11,825 (56.2%)	6,355 (58.0%)	4,110 (54.1%)	1,773 (61.4%)	118,640 (55.8%)
Inspectorate or regulator	242 (0.1%)	52 (0.2%)	21 (0.2%)	11 (0.1%)	2 (0.1%)	328 (0.2%)
Insurance or legal	230 (0.1%)	28 (0.1%)	4 (<0.1%)	6 (0.1%)	9 (0.3%)	277 (0.1%)

Maternity unit or birth centre	4,745 (2.8%)	511 (2.4%)	257 (2.3%)	222 (2.9%)	86 (3.0%)	5,821 (2.7%)
Military	291 (0.2%)	16 (0.1%)	7 (0.1%)	5 (0.1%)	18 (0.6%)	337 (0.2%)
Occupational health	1,315 (0.8%)	242 (1.1%)	70 (0.6%)	43 (0.6%)	19 (0.7%)	1,689 (0.8%)
Police	325 (0.2%)	21 (0.1%)	18 (0.2%)	–	1 ($<0.1\%$)	365 (0.2%)
Policy organisation	66 ($<0.1\%$)	15 (0.1%)	5 ($<0.1\%$)	14 (0.2%)	3 (0.1%)	103 ($<0.1\%$)
Prison	869 (0.5%)	94 (0.4%)	31 (0.3%)	15 (0.2%)	13 (0.5%)	1,022 (0.5%)
Private domestic setting	339 (0.2%)	29 (0.1%)	8 (0.1%)	16 (0.2%)	11 (0.4%)	403 (0.2%)
Public health organisation	1,374 (0.8%)	137 (0.7%)	68 (0.6%)	63 (0.8%)	65 (2.3%)	1,707 (0.8%)
School	1,019 (0.6%)	111 (0.5%)	45 (0.4%)	31 (0.4%)	68 (2.4%)	1,274 (0.6%)
Specialist or other tertiary care including hospice	2,155 (1.3%)	222 (1.1%)	114 (1.0%)	64 (0.8%)	50 (1.7%)	2,605 (1.2%)
Telephone or e-health advice	419 (0.2%)	124 (0.6%)	35 (0.3%)	16 (0.2%)	13 (0.5%)	607 (0.3%)
Trade union or professional body	72 ($<0.1\%$)	11 (0.1%)	6 (0.1%)	7 (0.1%)	1 ($<0.1\%$)	97 ($<0.1\%$)
University or other research facility	1,902 (1.1%)	258 (1.2%)	140 (1.3%)	61 (0.8%)	54 (1.9%)	2,415 (1.1%)
Voluntary or charity sector	1,033 (0.6%)	122 (0.6%)	46 (0.4%)	48 (0.6%)	29 (1.0%)	1,278 (0.6%)
Other	3,497 (2.1%)	461 (2.2%)	179 (1.6%)	161 (2.1%)	81 (2.8%)	4,379 (2.1%)
Total current periods of practice	170,002	21,055	10,962	7,596	2,886	212,501

* This includes nurses and midwives whose current or most recent practice (if we have their employer's address), or their home address is either in the EU/EEA or overseas (outside the EU/EEA).

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Table 10: Work setting by registration type

The table shows a breakdown of current work settings for people who revalidated and had a nursing registration, and for people who revalidated and had a midwifery registration. Please note that as some people are registered as both a nurse and a midwife, they will be included in both groups. Therefore, some of the work settings in the column for people who have a midwifery registration will relate to their nursing registration, if they hold joint registration.

Where there are no cases in a cell, this is reported as a dash (-).

Work setting	People with a nursing registration	People with a midwifery registration
Ambulance service	286 (0.1%)	9 (0.1%)
Care home sector	16,941 (8.4%)	24 (0.2%)
Community setting, including district nursing and community psychiatric nursing	36,141 (17.9%)	2,259 (17.2%)
Consultancy	561 (0.3%)	20 (0.2%)
Cosmetic or aesthetic sector	538 (0.3%)	7 (0.1%)
Governing body or other leadership	560 (0.3%)	23 (0.2%)
GP practice or other primary care	12,096 (6.0%)	76 (0.6%)
Hospital or other secondary care	115,437 (57.1%)	4,417 (33.7%)
Inspectorate or regulator	320 (0.2%)	12 (0.1%)
Insurance or legal	274 (0.1%)	5 (<0.1%)

Maternity unit or birth centre	1,039 (0.5%)	5,654 (43.1%)
Military	336 (0.2%)	3 (<0.1%)
Occupational health	1,688 (0.8%)	6 (<0.1%)
Police	365 (0.2%)	–
Policy organisation	99 (<0.1%)	9 (0.1%)
Prison	1,022 (0.5%)	–
Private domestic setting	382 (0.2%)	28 (0.2%)
Public health organisation	1,658 (0.8%)	73 (0.6%)
School	1,272 (0.6%)	11 (0.1%)
Specialist or other tertiary care including hospice	2,595 (1.3%)	25 (0.2%)
Telephone or e–health advice	604 (0.3%)	10 (0.1%)
Trade union or professional body	85 (<0.1%)	15 (0.1%)
University or other research facility	2,226 (1.1%)	240 (1.8%)
Voluntary or charity sector	1,265 (0.6%)	26 (0.2%)
Other	4,272 (2.1%)	164 (1.3%)
Total current periods of practice	202,062	13,116

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Table 11: Total number who revalidated by confirmer type

This table shows the number of nurses and midwives who revalidated by the standard revalidation process (that is, not through exceptional circumstances) in the second year of revalidation, broken down by confirmer type.

Confirmer type	England	Scotland	Wales	Northern Ireland	Practising outside the UK*	Total
A line manager who is also an NMC registered nurse or midwife	109,107 (67.1%)	15,614 (77.2%)	8,083 (76.6%)	5,977 (83.3%)	926 (33.4%)	139,707 (68.7%)
A line manager who is not an NMC registered nurse or midwife	5,516 (3.4%)	655 (3.2%)	299 (2.8%)	200 (2.8%)	376 (13.5%)	7,046 (3.5%)
A regulated healthcare professional	1,035 (0.6%)	92 (0.5%)	58 (0.5%)	46 (0.6%)	32 (1.2%)	1,263 (0.6%)
An overseas regulated healthcare professional	32 (<0.1%)	1 (<0.1%)	1 (<0.1%)	2 (<0.1%)	187 (6.7%)	223 (0.1%)
Another NMC registered nurse or midwife	46,766 (28.7%)	3,853 (19.0%)	2,097 (19.9%)	944 (13.2%)	1,240 (44.7%)	54,900 (27.0%)
Another professional in line with 'How to revalidate with the NMC'	217 (0.1%)	13 (0.1%)	13 (0.1%)	5 (0.1%)	14 (0.5%)	262 (0.1%)
Total	162,673	20,228	10,551	7,174	2,775	203,401

Note: This table doesn't include four cases where the confirmer type was not recorded on the system.

* This includes nurses and midwives whose current or most recent practice (if we have their employer's address), or their home address is either in the EU/EEA or overseas (outside the EU/EAA).

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Table 12: Confirmer type by registration type

This table shows the number of people who revalidated and had a nursing registration, broken down by their confirmer type; and the number of people who revalidated and had a midwifery registration, broken down by their confirmer type. Please note that as some people are registered as both a nurse and a midwife, they will be included in both groups. As in the table above, this includes those who revalidated by the standard revalidation process.

Confirmer type	People with a nursing registration	People with a midwifery registration
A line manager who is also an NMC registered nurse or midwife	133,043 (68.9%)	7,964 (64.0%)
A line manager who is not an NMC registered nurse or midwife	6,998 (3.6%)	77 (0.6%)
A regulated healthcare professional	1,237 (0.6%)	35 (0.3%)
An overseas regulated healthcare professional	211 (0.1%)	24 (0.2%)
Another NMC registered nurse or midwife	51,484 (26.6%)	4,336 (34.8%)
Another professional in line with 'How to revalidate with the NMC'	249 (0.1%)	15 (0.1%)
Total	193,222	12,451

Note: This table doesn't include four cases where the confirmer type was not recorded on the system.

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Table 13: Numbers revalidating who have/ do not have a regular appraisal

This table shows the number of nurses and midwives who revalidated by the standard revalidation process (that is, not through exceptional circumstances) in the second year of revalidation, broken down by whether they said they have a regular appraisal.

Appraisal	England	Scotland	Wales	Northern Ireland	Practising outside the UK*	Total
Have a regular appraisal	158,071 (97.2%)	19,078 (94.3%)	10,269 (97.3%)	6,977 (97.3%)	2,550 (91.9%)	196,945 (96.8%)
Do not have a regular appraisal	4,602 (2.8%)	1,150 (5.7%)	282 (2.7%)	197 (2.7%)	225 (8.1%)	6,456 (3.2%)
Total	162,673	20,228	10,551	7,174	2,775	203,401

* This includes nurses and midwives whose current or most recent practice (if we have their employer's address), or their home address is either in the EU/EEA or overseas (outside the EU/EEA).

Note: This table doesn't include four cases where information about appraisals was not recorded on the system.

Table 14: Numbers revalidating who have/do not have a regular appraisal, by whether they have an NMC-registered line manager

Appraisal	Has an NMC-registered line manager	Does not have an NMC-registered line manager	Total
Have a regular appraisal	175,857 (98.2%)	21,088 (86.6%)	196,945 (96.8%)
Do not have a regular appraisal	3,181 (1.8%)	3,275 (13.4%)	6,456 (3.2%)
Total	179,038	24,363	203,401

Note: This table doesn't include four cases where information about appraisals wasn't recorded on the system.



IMPACT ON GROUPS BY

PROTECTED CHARACTERISTIC

Demographic profile of those renewing

Tables 15–22 provide a breakdown of revalidation numbers and rates by protected characteristics. Looking at the **age** profile, we can see that almost 60% of those revalidating are between the ages of 41 and 60. The age group percentages are in proportion to those recorded on the register as a whole.

The revalidation rate for those over 60 is lower than for younger groups. The revalidation rate for those aged up to 50 is over 95%, whereas for the 61–70 age group it's 75.5%. This is similar to the picture last year and may be because nurses and midwives in this age group (in particular those working in the NHS) are able to retire. The renewal rate for this age group was also lower than those in other age groups under Prep. This age group is a relatively small percentage of the total and therefore doesn't have a large impact on the overall revalidation rates.

Looking at reported **ethnicity** (table 19), most people (78.9%) said white (including white British, white Gypsy or Irish Traveller, white Irish and any other white background). The next most frequently reported ethnicity (8.9%) is black (including black/black British African, black/black British Caribbean and any other black background). Revalidation rates (table 20) are largely similar across all the declared ethnicities but those declaring Asian/Asian British Chinese and any other black background are lower than for other ethnic groups (86.2% and 88.9% respectively). The overall numbers in both these categories are low, however.

3.8% of those revalidating declared they had a **disability (Table 21)**. Those who declare a disability have a markedly lower revalidation rate (85.6%) than those who don't (95.1%) **(Table 22)**. A far higher proportion of people with a disability declare they are lapsing due to ill health (36.7% compared to 2.3% of people who don't have a disability) and so this lapsing rate may not be impacted by revalidation. However, we think we may be able to do more to support those with long-term health conditions who are able to practise safely and effectively. We're reviewing our guidance on health and will be discussing how we can improve it with unions and representative bodies. We'll also make use of the intelligence we have gained since we introduced revalidation. The final year evaluation of revalidation will look in more detail to see if there are any barriers to revalidation, particularly for those who have protected characteristics.



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Table 15: Numbers who revalidated by age group

This table shows the breakdown of revalidation rates by country and age group. This includes all those who revalidated both in the standard way and through exceptional circumstances.

Age group	England	Scotland	Wales	Northern Ireland	Practising outside the UK*	Total revalidated (percentage of total revalidated)
21-30	20,411 (12.5%)	2,406 (11.9%)	1,023 (9.7%)	920 (12.8%)	387 (13.9%)	25,147 (12.3%)
31-40	35,746 (21.9%)	4,428 (21.8%)	2,148 (20.3%)	1,580 (22.0%)	614 (22.1%)	44,516 (21.8%)
41-50	48,380 (29.6%)	6,013 (29.6%)	3,241 (30.6%)	2,065 (28.7%)	863 (31.0%)	60,562 (29.7%)
51-60	48,156 (29.5%)	6,604 (32.5%)	3,539 (33.4%)	2,150 (29.9%)	767 (27.6%)	61,216 (30.0%)
61-70	10,168 (6.2%)	822 (4.1%)	624 (5.9%)	458 (6.4%)	142 (5.1%)	12,214 (6.0%)
Aged 71 and above	499 (0.3%)	18 (0.1%)	17 (0.2%)	18 (0.3%)	11 (0.4%)	563 (0.3%)
Total	163,360	20,291	10,592	7,191	2,784	204,218

* This includes nurses and midwives whose current or most recent practice (if we have their employer's address), or their home address is either in the EU/EEA or overseas (outside the EU/EAA).

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Table 16: Revalidation rate by age group

Age group	Total revalidated	Total due to revalidate	Revalidation rate by age group
21-30	25,147	26,156	96.1%
31-40	44,516	46,261	96.2%
41-50	60,562	62,850	96.4%
51-60	61,216	66,703	91.8%
61-70	12,214	16,171	75.5%
Aged 71 and above	563	1,002	56.2%
Total	204,218	219,143	93.2%

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Table 17: Numbers who revalidated by gender

This table shows the breakdown of those who revalidated by gender and country.

Where there are no cases in a cell, this is reported as a dash (-).

Gender	England	Scotland	Wales	Northern Ireland	Practising outside the UK*	Total revalidated (percentage of total revalidated)
Female	145,673 (89.2%)	18,351 (90.4%)	9,563 (90.3%)	6,681 (92.9%)	2,409 (86.5%)	182,677 (89.5%)
Male	17,680 (10.8%)	1,940 (9.6%)	1,029 (9.7%)	510 (7.1%)	375 (13.5%)	21,534 (10.5%)
Unknown	7 (<0.1%)	-	-	-	-	7 (<0.1%)
Total	163,360	20,291	10,592	7,191	2,784	204,218

* This includes nurses and midwives whose current or most recent practice (if we have their employer's address), or their home address is either in the EU/EEA or overseas (outside the EU/EAA).

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Table 18: Revalidation rate by gender

Gender	Total revalidated	Total due to revalidate	Revalidation rate by age group
Female	182,677	195,578	93.4%
Male	21,534	23,557	91.4%
Unknown	7	8	87.5%
Total	204,218	219,143	93.2%

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Table 19: Numbers who revalidated by ethnic group

This table gives a breakdown of those who revalidated by ethnic group. Where there are fewer than 50 cases in a cell, this is reported as an asterisk (*) so that small groups of people can't be easily identified. Therefore, the total for a country or an ethnic group may be greater than the total of the numbers shown.

Where there are no cases in a cell, this is reported as a dash (-).

Ethnic group	England	Scotland	Wales	Northern Ireland	Practising outside the UK*	Total
White British	112,557	18,503	9,178	5,390	1,613	147,241 (72.1%)
White – Gypsy or Irish Traveller	66	*	*	*	*	97 (<0.1%)
White Irish	2,636	177	67	998	116	3,994 (2.0%)
Any other white background	8,790	309	212	173	318	9,802 (4.8%)
Mixed – white and black Caribbean	1,766	216	152	78	*	2,248 (1.1%)
Mixed – white and black African	525	*	*	*	*	568 (0.3%)
Mixed – white and Asian	508	*	*	*	*	600 (0.3%)
Any other mixed background	663	*	*	*	*	738 (0.4%)
Asian/Asian British Indian	6,141	211	219	181	177	6,929 (3.4%)
Asian/Asian British Pakistani	868	*	*	*	*	927 (0.5%)

Asian/Asian British Bangladeshi	208	*	*	*	—	218 (0.1%)
Asian/Asian British Chinese	623	*	*	*	*	697 (0.3%)
Any other Asian background	7,045	172	296	155	124	7,792 (3.8%)
Black/black British African	12,366	188	139	*	137	12,859 (6.3%)
Black/black British Caribbean	3,094	*	*	*	*	3,166 (1.6%)
Any other black background	323	*	*	*	*	352 (0.2%)
Any other ethnic group	1,654	*	*	*	*	1,804 (0.9%)
Prefer not to say	3,527	292	152	112	103	4,186 (2.0%)
Unknown	—	—	—	—	—	—
Total	163,360	20,291	10,592	7,191	2,784	204,218

* This includes nurses and midwives whose current or most recent practice (if we have their employer's address), or their home address is either in the EU/EEA or overseas (outside the EU/EAA).

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Table 20: Revalidation rate by ethnic group

Ethnic group	Total revalidated	Total due to revalidate	Revalidation rate by ethnic group
White British	147,241	155,444	94.7%
White – Gypsy or Irish Traveller	97	106	91.5%
White Irish	3,994	4,435	90.1%
Any other white background	9,802	10,894	90.0%
Mixed – white and black Caribbean	2,248	2,344	95.9%
Mixed – white and black African	568	599	94.8%
Mixed – white and Asian	600	641	93.6%
Any other mixed background	738	797	92.6%
Asian/Asian British Indian	6,929	7,133	97.1%
Asian/Asian British Pakistani	927	959	96.7%
Asian/Asian British Bangladeshi	218	223	97.8%
Asian/Asian British Chinese	697	809	86.2%

Any other Asian background	7,792	8,045	96.9%
Black/black British African	12,859	13,361	96.2%
Black/black British Caribbean	3,166	3,391	93.4%
Any other black background	352	396	88.9%
Any other ethnic group	1,804	1,906	94.6%
Prefer not to say	4,186	4,598	91.0%
Unknown	–	3,062	–
Total	204,218	219,143	93.2%

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Table 21: Numbers who revalidated by whether they had a self-declared disability

Disability declared?	England	Scotland	Wales	Northern Ireland	Practising outside the UK*	Total revalidated (percentage of total revalidated)
Has a disability	6,392 (3.9%)	653 (3.2%)	391 (3.7%)	215 (3.0%)	59 (2.1%)	7,710 (3.8%)
Does not have a disability	150,760 (92.3%)	18,863 (93.0%)	9,780 (92.3%)	6,725 (93.5%)	2,632 (94.5%)	188,760 (92.4%)
Prefer not to say	6,204 (3.8%)	775 (3.8%)	421 (4.0%)	251 (3.5%)	93 (3.3%)	7,744 (3.8%)
Unknown	4 (<0.1%)	–	–	–	–	4 (<0.1%)
Total	163,360	20,291	10,592	7,191	2,784	204,218

* This includes nurses and midwives whose current or most recent practice (if we have their employer's address), or their home address is either in the EU/EEA or overseas (outside the EU/EAA).

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Table 22: Revalidation rate by whether the nurse or midwife had a disability

Disability declared?	Total revalidated	Total due to revalidate	Revalidation rate by whether they have a disability
Has a disability	7,710	9,005	85.6%
Does not have a disability	188,760	198,476	95.1%
Prefer not to say	7,744	8,582	90.2%
Unknown	4	3,080	0.1%
Total	204,218	219,143	93.2%

Note: Only four people who revalidated have 'unknown' disability status. The 3,080 people 'due to revalidate' who were unknown, are mainly people who are no longer on the register because they lapsed instead of revalidating.



APPLICANTS REQUIRING

ADDITIONAL SUPPORT

TO REVALIDATE

There are provisions in place for those who haven't been able to meet the revalidation requirements due to not having enough time in practice when the requirements were introduced or due to having a protected characteristic. Nurses and midwives in this position are able to renew through the exceptional circumstances process as long as they meet the Prep.

Table 24 shows the numbers and proportion of applicants revalidating through this route. These figures have reduced compared to last year (0.4% of those revalidating in Year 2 compared to 1.1% of those revalidating in Year 1). This was largely a transitional provision and we expect this to reduce further over the next year. These figures don't include those who met the full revalidation requirements but were given an extension to their revalidation date (862 people).

The demographic profile of those revalidating through this route (**tables 25 – 27**) is similar to last year. Almost two thirds of this group (65.3%) are aged up to 40 (compared to 34.1% of all those revalidating in Year 2); 95.8% are female (compared to 89.5% of all those revalidating); and 11.7% had a self-declared disability (compared to 3.8% of all those revalidating). These demographic characteristics reflect the fact that most people use this route due to maternity leave or long term illness.

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Table 23: Number who revalidated through the standard revalidation process

This table shows the number of nurses and midwives who revalidated through the standard revalidation process. It doesn't include those who renewed through exceptional circumstances.

Registration type after revalidation**	England	Scotland	Wales	Northern Ireland	Practising outside the UK	Total
Nurse	145,256 (89.3%)	18,327 (90.6%)	9,472 (89.8%)	6,428 (89.6%)	2,495 (89.9%)	181,978 (89.5%)
Midwife	8,012 (4.9%)	904 (4.5%)	422 (4.0%)	347 (4.8%)	127 (4.6%)	9,812 (4.8%)
Nurse and midwife	1,719 (1.1%)	128 (0.6%)	142 (1.3%)	80 (1.1%)	71 (2.6%)	2,140 (1.1%)
Nurse and SCPHN	7,246 (4.5%)	849 (4.2%)	493 (4.7%)	310 (4.3%)	78 (2.8%)	8,976 (4.4%)
Midwife and SCPHN	331 (0.2%)	16 (0.1%)	15 (0.1%)	4 (0.1%)	1 (<0.1%)	367 (0.2%)
Nurse, midwife and SCPHN	111 (0.1%)	4 (<0.1%)	7 (0.1%)	6 (0.1%)	4 (0.1%)	132 (0.1%)
Total	162,675	20,228	10,551	7,175	2,776	203,405

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Table 24: Number who revalidated through the exceptional circumstances process

This table shows the number of nurses and midwives who revalidated through our alternative route. This includes nurses and midwives who were unable to meet the standard revalidation requirements, for example due to maternity leave or long term illness. Where there are no cases in a cell, this is reported as a dash (-).

Registration type after revalidation*	England	Scotland	Wales	Northern Ireland	Practising outside the UK	Total
Nurse	603	60	37	14	8	722
Midwife	39	1	2	-	-	42
Nurse and midwife	8	-	-	1	-	9
Nurse and SCPHN	33	2	2	1	-	38
Midwife and SCPHN	1	-	-	-	-	1
Nurse, midwife and SCPHN	1	-	-	-	-	1
Total	685	63	41	16	8	813

* This is a nurse or midwife's registration type **after** their registration is renewed, partially renewed or lapsed.

** This includes nurses and midwives whose current or most recent practice (if we have their employer's address), or their home address is either in the EU/EEA or overseas (outside the EU/EAA).

APRIL 2017 TO MARCH 2018

Table 25: Age group of those who revalidated through the exceptional circumstances process, and through standard revalidation

Age group	Total (%) renewed through the exceptional circumstances process	Total (%) renewed through standard revalidation
21-30	162 (19.9%)	24,985 (12.3%)
31-40	369 (45.4%)	44,147 (21.7%)
41-50	134 (16.5%)	60,428 (29.7%)
51-55	62 (7.6%)	36,163 (17.8%)
56-60	55 (6.8%)	24,936 (12.3%)
61-65	21 (2.6%)	9,814 (4.8%)
66-70	10 (1.2%)	2,369 (1.2%)
71-75	—	481 (0.2%)
Aged 75 and above	—	82 (<0.1%)
Total	813	203,405

APRIL 2017 TO MARCH 2018

Table 26: Gender of those who revalidated through the exceptional circumstances process, and through standard revalidation

Gender	Total (%) renewed through the exceptional circumstances process	Total (%) renewed through standard revalidation
Female	779 (95.8%)	181,898 (89.4%)
Male	34 (4.2%)	21,500 (10.6%)
Unknown	—	7 (<0.1%)
Total	813	203,405

APRIL 2017 TO MARCH 2018

Table 27: Disability status of those who revalidated through the exceptional circumstances process, and through standard revalidation

Disability	Total (%) renewed through the exceptional circumstances process	Total (%) renewed through standard revalidation
Has a disability	95 (11.7%)	7,615 (3.7%)
Does not have a disability	653 (80.3%)	188,107 (92.5%)
Prefer not to say	65 (8.0%)	7,679 (3.8%)
Unknown	—	4 (<0.1%)
Total	813	203,405

WHY PEOPLE CHOOSE

NOT TO REVALIDATE

The overall numbers of people due to revalidate who lapsed their registration is detailed in **table 28**. The numbers lapsing are similar or lower than last year.

Table 29 shows a breakdown of the reasons given by those lapsing at the time of renewal in Year 2. These show a similar pattern to last year. Retirement is the most frequently cited reason (50.4%), which is compatible with the information we have about older nurses and midwives choosing to lapse at a higher rate. Opting not to practise or not being in current practice represents 37.3% of the reasons cited, and this is what we would expect responsible nurses and midwives to do. Only 6.1% of the reasons given are because the individual wasn't able to meet the revalidation requirements. The proportions are similar for both professions (although a slightly smaller proportion of midwives declare that they are unable to meet the revalidation requirements).

When we published our data on overall numbers of people on the register in April 2018, we also examined in more detail the reasons why people chose to lapse. We did this by sending out a survey to nurses and midwives who had recently lapsed (regardless of whether they were approaching their revalidation date or not). We asked them to select from a list of options their top three reasons for leaving the register. The most common reasons selected were:

- Retirement – 47.2% of the 3,496 respondents cited this
- Staffing levels – 25.5%
- Change in personal circumstances – 25.0%

Concern about meeting the revalidation requirements appeared as part of a group of factors given by 22% of respondents, so this is clearly a factor for some people choosing to lapse, albeit not as important as other factors. The surveys we've carried out so far for the evaluation have shown that there is anxiety about revalidation prior to going through the process, but this disappears once someone has revalidated. We think there may be more we can do to reassure those who have yet to revalidate to avoid this becoming a factor in a decision to lapse.

The breakdown of reasons given by UK country are similar, although a higher proportion of registrants in Wales seem to be retiring (64.7%) compared to the other three UK countries (England – 54.5%; Scotland – 54.7%; Northern Ireland – 58.7%). This is a similar breakdown to Year 1.

Table 32 shows that a smaller proportion of people with a self-declared disability (4.1%) say that they are lapsing because they can't meet the revalidation requirements compared to those not declaring a disability (7.1%). They do, however, declare ill-health as a reason for not revalidating at a much higher level (36.7%) than those not declaring a disability (2.3%). There is evidence that people with a disability are more likely to be out of work than those without. Being in work is an important factor in being able to revalidate and there may be a correlation here. As we indicate above, we have asked our evaluation partners to look at whether there are barriers to revalidation for any particular group.

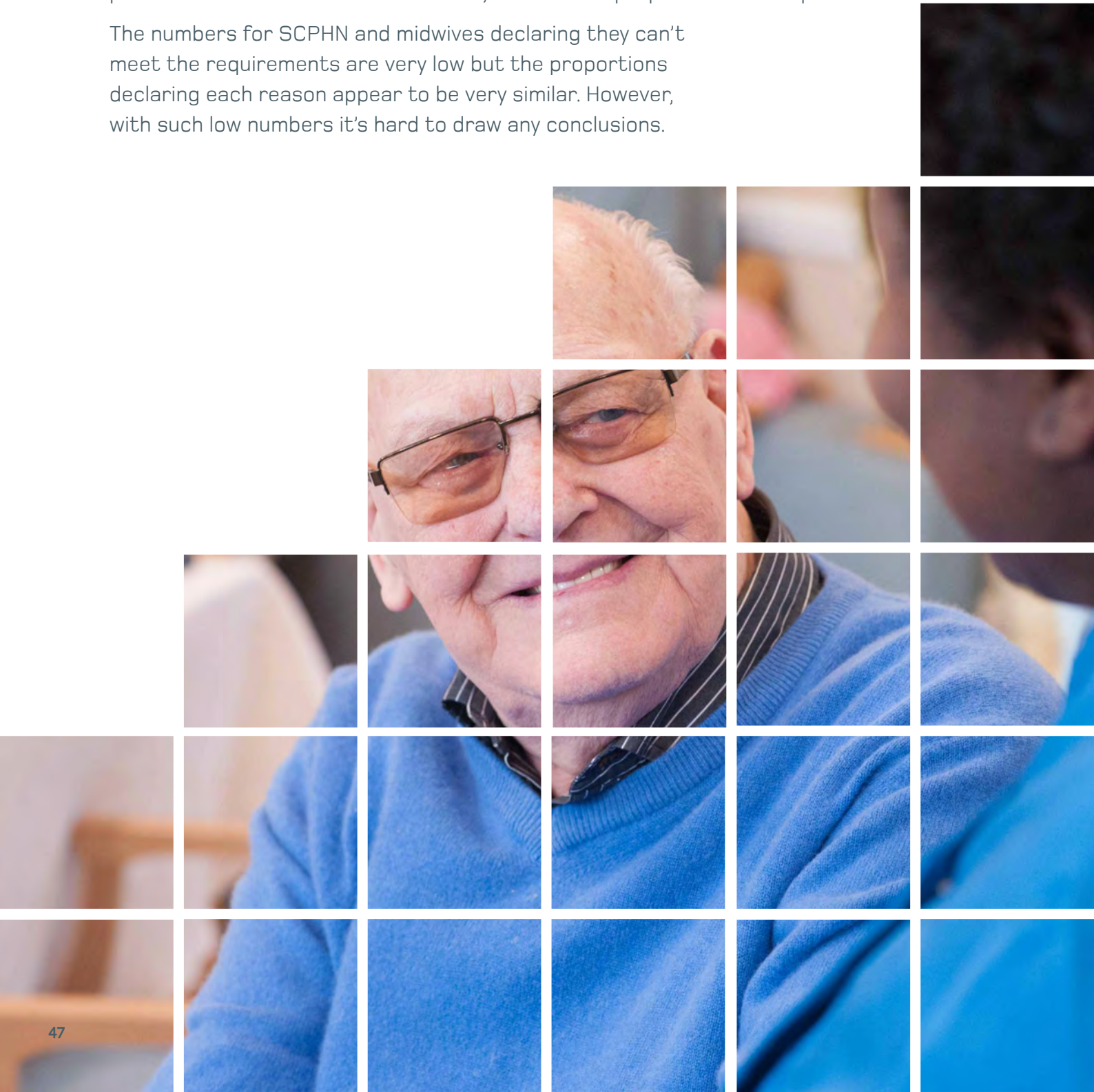
Tables 33–35 look in more detail at the aspects of revalidation that some nurses and midwives state they can't meet. The most frequently stated reason for those with a nursing registration (49.4%) is inability to have a reflective discussion, followed by not being able to meet the practice hours (39.5%) and not being able to do the written reflective accounts (39.3%). These three requirements are often linked as if someone is not doing sufficient practice it will be challenging to obtain feedback on that practice. It is also important to note that the practice hours requirement was in place under Prep.

As in Year 1, those not practising in the UK were more likely to say they didn't meet the revalidation requirements than people in the UK. For those not practising in the UK, the most common revalidation requirements that they could not meet were the reflective discussion requirement (62.9% of this group – 88 out of 140) and the written reflective accounts (37.1% – 52 out of 140).



These findings accord with much of the feedback that we have from those working mainly outside the UK, who aren't able to find a reflective discussion partner who is registered with us. This isn't surprising as they aren't generally working in UK practice. We've made a number of adjustments to support those working outside the UK (for example allowing discussions to take place over video) but both the reflective discussion and the requirement to have the discussion with another NMC-registered nurse or midwife are fundamental to the integrity of revalidation. The evaluation of revalidation is showing the importance of reflection to the change in attitudes and behaviour that we want to see. It's essential that reflective discussion partners are accountable to the NMC, which is the purpose of this requirement.

The numbers for SCPHN and midwives declaring they can't meet the requirements are very low but the proportions declaring each reason appear to be very similar. However, with such low numbers it's hard to draw any conclusions.



APRIL 2017 TO MARCH 2018

Table 28: Total number who lapsed

In all the tables relating to people who lapsed, the country refers to a nurse or midwife's registered address after they lapsed. Where there are no cases in a cell, this is reported as a dash (-).

Registration type at point of lapsing*	England	Scotland	Wales	Northern Ireland	Practising outside the UK	Total
Nurse	8,553 (89.0%)	1,097 (90.2%)	522 (91.4%)	372 (91.4%)	1,569 (93.2%)	12,113 (89.8%)
Midwife	425 (4.4%)	54 (4.4%)	14 (2.5%)	16 (3.9%)	52 (3.1%)	561 (4.2%)
Nurse and midwife	132 (1.4%)	14 (1.2%)	4 (0.7%)	4 (1.0%)	42 (2.5%)	196 (1.5%)
Nurse and SCPHN	487 (5.1%)	50 (4.1%)	30 (5.3%)	15 (3.7%)	18 (1.1%)	600 (4.4%)
Midwife and SCPHN	9 (0.1%)	-	-	-	-	9 (0.1%)
Nurse, midwife and SCPHN	3 (<0.1%)	1 (0.1%)	1 (0.2%)	-	3 (0.2%)	8 (0.1%)
Total (percentage of those due to revalidate who lapse)	9,609 (5.5%)	1,216 (5.6%)	571 (5.1%)	407 (5.3%)	1,684 (37.2%)	13,487 (6.2%)

APRIL 2017 TO MARCH 2018

Table 29: Reasons for lapsing

This table only includes those people who recorded a reason for lapsing, either through the online revalidation screens, or by lapsing through our 'cease to practise' mechanism. If someone lapsed both through revalidation and through cease to practise, both of the reasons have been counted. Where an individual has lapsed both their nurse and midwife or SCPHN registration, their reason for lapsing for each of these registration types would be counted.

Reason	Number of reasons for lapsing	Percentage
Retirement	3,638	50.4%
Currently not practising / opted not to practise	2,691	37.3%
Ill health	422	5.8%
Does not meet the revalidation requirements	444	6.1%
Deceased	24	0.3%
No professional indemnity arrangement	5	0.1%
Total	7,224	100.0%

APRIL 2017 TO MARCH 2018

Table 30: Reasons for lapsing by registration type

The table shows the number of people who lapsed with a nursing registration, broken down by their reason for lapsing; and the number of people with a midwifery registration, broken down by their reason for lapsing. Please note that as some people have both registration as a nurse and as a midwife, they will be included in both groups. As in the table above, this includes only those for whom we have a recorded reason for lapsing. Where there are no cases in a cell, this is reported as a dash (-).

Reason for lapsing	Number of reasons for lapsing for people with a nursing registration	Number of reasons for lapsing for people with a midwifery registration
Retirement	3,471 (50.2%)	257 (51.8%)
Currently not practising / opted not to practise	2,575 (37.2%)	184 (37.1%)
Ill health	403 (5.8%)	32 (6.5%)
Does not meet the revalidation requirements	439 (6.3%)	22 (4.4%)
Deceased	23 (0.3%)	1 (0.2%)
No professional indemnity arrangement	5 (0.1%)	-
Total	6,916	496

APRIL 2017 TO MARCH 2018

Table 31: Reasons for lapsing by practitioner country

Where there are no cases in a cell, this is reported as a dash (-).

Reason for lapsing	England	Scotland	Wales	Northern Ireland	Practising outside the UK	Total
Retirement	2,872 (54.5%)	376 (54.7%)	198 (64.7%)	111 (58.7%)	81 (10.5%)	3,638 (50.4%)
Currently not practising / opted not to practise	1,790 (34.0%)	246 (35.8%)	78 (25.5%)	56 (29.6%)	521 (67.7%)	2,691 (37.3%)
Ill health	331 (6.3%)	40 (5.8%)	15 (4.9%)	17 (9.0%)	19 (2.5%)	422 (5.8%)
Does not meet the revalidation requirements	250 (4.7%)	25 (3.6%)	15 (4.9%)	5 (2.6%)	149 (19.4%)	444 (6.1%)
Deceased	24 (0.5%)	-	-	-	-	24 (0.3%)
No professional indemnity arrangement	5 (0.1%)	-	-	-	-	5 (0.1%)
Total	5,272	687	306	189	770	7,224

APRIL 2017 TO MARCH 2018

Table 32: Reasons for lapsing by self-declared disability

Where there are no cases in a cell, this is reported as a dash (-).

Reason for lapsing	Has a disability	Does not have a disability	Prefer not to say	Unknown	Total
Retirement	163 (28.9%)	2,743 (50.7%)	199 (44.3%)	533 (66.3%)	3,638 (50.4%)
Currently not practising / opted not to practise	167 (29.6%)	2,142 (39.6%)	166 (37.0%)	216 (26.9%)	2,691 (37.3%)
Ill health	207 (36.7%)	126 (2.3%)	51 (11.4%)	38 (4.7%)	422 (5.8%)
Does not meet the revalidation requirements	23 (4.1%)	382 (7.1%)	33 (7.3%)	6 (0.7%)	444 (6.1%)
Deceased	4 (0.7%)	10 (0.2%)	—	10 (1.2%)	24 (0.3%)
No professional indemnity arrangement	—	4 (0.1%)	—	1 (0.1%)	5 (0.1%)
Total	564	5,407	449	804	7,224

APRIL 2017 TO MARCH 2018

Table 33: Revalidation requirements that nurses were unable to meet

Please note that each person was able to select as many requirements as were applicable. Therefore the number of requirements in each column totals more than the number of people lapsing. Each person was asked the reasons for lapsing each registration if they lapsed more than one.

Where there are no cases in a cell, this is reported as a dash (–).

Revalidation requirement that they did not meet	England	Scotland	Wales	Northern Ireland	Practising outside the UK	Total
Confirmation	61	7	7	1	40	116 (28.0%)
CPD	80	6	5	2	21	114 (27.5%)
Health and character declaration	33	5	5	1	9	53 (12.8%)
Practice hours	118	17	6	3	20	164 (39.5%)
Practice-related feedback	87	8	6	4	40	145 (34.9%)
Professional indemnity arrangement declaration	34	4	3	1	17	59 (14.2%)
Reflective discussion	99	7	8	3	88	205 (49.4%)
Written reflective accounts	91	7	10	3	52	163 (39.3%)
* Total number of registrants lapsing their nursing registration	231	24	15	5	140	415

* This is the total number of registrants who lapsed their nursing registration and declared that they 'do not meet the revalidation requirements'. This only includes those who lapsed from the register completely. It doesn't include 'partial lapsers' who lapsed one or more registrations but retained other registrations.

APRIL 2017 TO MARCH 2018

Table 34: Revalidation requirements midwives were unable to meet

This is the total number of people who lapsed their midwifery registration and declared that they 'do not meet the revalidation requirements'. This only includes those who lapsed from the register completely. It doesn't include 'partial lapsed' who lapsed one or more registrations but retained other registrations.

Where there are no cases in a cell, this is reported as a dash (-).

Revalidation requirement that they did not meet	England	Scotland	Wales	Northern Ireland	Practising outside the UK	Total
Confirmation	3	-	-	-	1	4
CPD	2	-	-	-	2	4
Health and character declaration	3	-	-	-	-	3
Practice hours	6	1	-	-	2	9
Practice-related feedback	4	-	-	-	1	5
Professional indemnity arrangement declaration	3	-	-	-	-	3
Reflective discussion	4	-	-	-	-	4
Written reflective accounts	4	-	-	-	1	5
Total number of registrants lapsing their midwifery registration	8	1	-	-	4	13

APRIL 2017 TO MARCH 2018

Table 35: Revalidation requirements SCPHNs were unable to meet

This is the total number of people who lapsed their SCPHN registration and declared that they 'do not meet the revalidation requirements'. This only includes those who lapsed from the register completely. It doesn't include 'partial lapsers' who lapsed one or more registrations but retained other registrations.

Where there are no cases in a cell, this is reported as a dash (-).

Revalidation requirement that they did not meet	England	Scotland	Wales	Northern Ireland	Practising outside the UK	Total
Confirmation	1	-	-	-	1	2
CPD	6	-	-	-	2	8
Health and character declaration	1	-	-	-	-	1
Practice hours	4	-	-	-	2	6
Practice-related feedback	4	-	-	-	-	4
Professional indemnity arrangement declaration	1	-	-	-	-	1
Reflective discussion	5	-	-	-	2	7
Written reflective accounts	4	-	-	-	-	4
Total number of registrants who lapsed their SCPHN registration	11	-	-	-	5	16

THE VERIFICATION

PROCESS

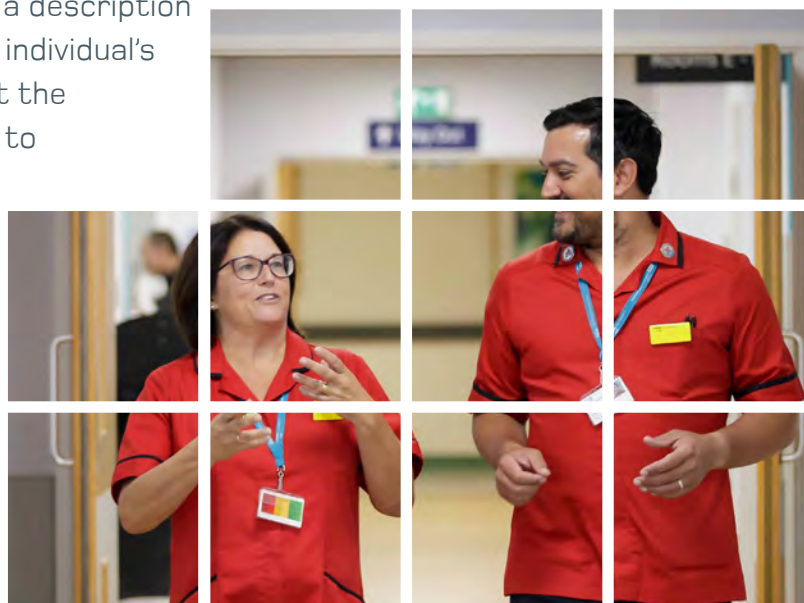
Verification is one of the tools we use to gain assurance that nurses and midwives are complying with the revalidation guidance and that the declarations that they make are accurate. It's not an audit but is part of a package of assurance we have that includes the requirement to have a reflective discussion with another registered nurse or midwife and a confirmation discussion with another professional.

Checking every single application would be disproportionate as well as operationally impracticable, which is why we've chosen to take an approach based on risk. For the first three years of revalidation we decided that we would select applicants for verification based on risk factors such as whether they have an NMC-registered line manager or other factors that might indicate an applicant might not get the support they need to revalidate.

We also select a group of applicants by a random sampling method in order to be able to compare results and test to see if our approach is correct or not. This means we're selecting around 1,000 people a year on the basis of risk, with a further 1,000 selected by random sampling. We've used standard statistical confidence measures to select our sample, which enables us to have a high degree of confidence that all applicants are behaving in this way.

Selection for verification is automated via an algorithm. This is based on information that the nurse or midwife provides through the online revalidation portal that they use to submit their revalidation applications.

Selection happens once the nurse or midwife has submitted their application. They are notified at that stage and asked to provide additional documentary evidence in support of their application, to allow us to verify that they have met all the revalidation requirements. We ask applicants for detailed evidence of practice hours and details of CPD (including a description of courses undertaken and relevance to the individual's declared scope of practice). We also contact the confirmer and reflective discussion partner to verify that these discussions took place and in accordance with our guidance, as well as further information about their professional indemnity.



If an applicant doesn't provide the information requested within a reasonable time period or the information provided shows that the applicant hasn't met the revalidation requirements, their registration will lapse. Any subsequent application for readmission will be decided by an Assistant Registrar.

Numbers of refusals are still small and so it's hard to draw firm conclusions but we've recently increased the numbers of applications that we select and will provide a full analysis in the third year report. Common reasons for refusal are:

- incorrect declarations on practice hours
- failure to provide additional information on practice hours or CPD
- lack of response or information from the confirmer.

The evaluation conducted by our evaluation partner concluded that the overall volume of cases being selected for verification, as well as the spread of cases sampled across the risk categories, makes sense. At the end of this year we'll be reviewing all of the data we've collected through revalidation, including verification data, and considering whether any other risk factors could be included in our selection process. Our evaluation partners have made some further suggestions, including focusing on areas of greatest risk to patients, involving employers in the verification process and seeing if there is any learning from our fitness to practise data. We'll consider these as we develop our evidence base throughout the next year.





THE EVALUATION

OF REVALIDATION

The second interim report on the evaluation shows the same positive picture as last year with no adverse effect on renewal rates, or any difficulties experienced by any particular group of nurses and midwives. There has been no repeat of the technical problems experienced by some nurses and midwives in the first half of the first year and we're pleased to see the report acknowledge that nurses and midwives continue to value the support and guidance that we offer and that there is an increase in the positive experiences that they have when contacting us for support. NMC Online seems to work well for all those who are revalidating. The report recommends that we continue to ensure this level of support and make guidance available. We agree it's crucial we do that.

We're also pleased to see that the picture reported last year of attitudinal changes appearing as a result of revalidation continues, with even larger proportions of nurses and midwives reporting a thorough knowledge of the Code and its centrality to their practice. In particular the report highlights that nurses and midwives are more likely to agree that the Code impacts positively on their practice.

The importance and value applicants place on reflection is clear from the report, with participants considering reflective discussion to be the most beneficial aspect of revalidation. This is consistent with the findings of the GMC's evaluation of revalidation, *Evaluating the regulatory impact of medical revalidation*, which identified reflection as key to behavioural change. As healthcare professionals work together increasingly in multi-disciplinary teams we think that there is scope to work with other regulators to promote the value of reflection in practice across teams.

Discussions with reflective discussion partners and confirmers have shown the seriousness with which these professionals undertake these roles which is very welcome. Discussions have, however, highlighted that we need to provide more guidance on how to judge the quality of reflection and we intend to update our guidance with clearer criteria for assessing this. In addition, they recommend some further guidance on practice-related feedback. The evaluation report also makes many suggestions for improvements in our guidance (for example guidance to those who need additional support or reasonable adjustments to revalidate). We intend to update all aspects of our guidance later in 2018. This will include updated guidance for employers, confirmers and reflective discussion partners, as well as an update to *How to revalidate*.

We also welcome the fact that the report recognises our willingness to act on feedback but we accept its conclusion that we need to find more innovative ways of engaging with stakeholders to ensure that we maintain the positive changes that revalidation has already brought about. We intend to engage with all our stakeholders fully over the next few months as we seek to put the report's recommendations into practice – particularly as we update our guidance.

The evaluation also highlights an increased awareness of verification and the importance of the perception that verification is a robust process.

Next year the evaluation will focus on the perceived benefit and burden of revalidation. As part of this we've asked the evaluation team to focus in particular on any obstacles faced by those who share protected characteristics. We're continuously monitoring to ensure we understand the impact of revalidation on those in these groups and the evaluation will be a valuable source of evidence to help us in this work.

Overall the feedback we have had demonstrates that the existing model of revalidation appears to be having a positive impact and going a considerable way to achieving its objectives. As we complete the third year we'll begin to engage with our partners on proportionate ways we might develop revalidation so that it continues to make a positive contribution to nursing and midwifery practice.

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Council

Appointments Board Annual Report 2017–2018

Action:	For information.
Issue:	Provides the annual report of the Appointments Board to the Council.
Core regulatory function:	Supporting functions.
Strategic priority:	Strategic priority 4 – An effective organisation.
Decision required:	None.
Annexes:	None.
Further information:	If you require clarification about any point in the paper or would like further information please contact the author below.

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Chair of Appointments Board:
Belinda Phipps

- Context:**
- 1 This report serves to satisfy paragraph 9 of the Appointments Board's (the Board) terms of reference, which state that the Board will report 'annually to the Council on the Appointments Board's activities, including an assessment of compliance with, and effectiveness of, policies in place.'
 - 2 The Board met three times in 2017–2018. This report details the Board's work over the period and how the Board has met its terms of reference.

- Four country factors:**
- 3 Same in all four countries.

Discussion:

Board membership

- 4 The Board's membership is comprised entirely of non-Council members to ensure an appropriate separation of the Board's work from that of the Council's.
- 5 In January 2018 two members of the Board completed their second, and final terms of appointment. Following an open recruitment campaign, two new members were appointed to the Board in March 2018 bringing the Board's membership back up to full complement (five members including the Chair). Both new members have received induction.
- 6 The current members of the Board are:
 - 6.1 Belinda Phipps (Chair)
 - 6.2 Angie Loveless (appointed 1 March 2018)
 - 6.3 Frederick Psyk
 - 6.4 Clare Salters (appointed 1 March 2018)
 - 6.5 Fiona Whiting
- 7 A new Chair of the Committee, Jane Slatter, was appointed to take office from August 2018, when the current Chair's term of office comes to an end. The Chair designate has received induction.

Board's role and work programme

- 8 The Board's remit is to assist the Council with the appointment of fitness to practise (FtP) panel members and legal assessors. The Board's primary objective is to make

sure that effective arrangements are in place to recruit, train and manage FtP panel members and legal assessors.

- 9 The Board has a well-structured programme of work to monitor and review:
 - 9.1 current and future campaigns to recruit FtP panel members and legal assessors;
 - 9.2 the contractual arrangements and the supporting policies relating to panel members and legal assessors including performance management;
 - 9.3 the training provided to panel members and legal assessors; and
 - 9.4 information on performance of panel members and legal assessors.

- 10 The Board also scrutinises appointments, reappointments, transfers between practice committees for panel chairs and members and legal assessors, and makes recommendations to the Council. In the past year the Board has made recommendations to Council on the:
 - 10.1 appointment of 58 panel members and 45 panel chairs;
 - 10.2 reappointment of 30 panel members;
 - 10.3 transfer of 4 members between the practice committees; and
 - 10.4 the removal of 1 panel member.

Implementation of Section 60 changes

- 11 Throughout the year, the Board provided oversight of the blended training programme which was designed to prepare all panel members and legal assessors for the introduction of the Section 60 changes to the fitness to practise process.
- 12 The training programme was conducted across the UK with a near 100 percent attendance rate of over 400 individuals. In conjunction with this, legal assessors (114 individuals) were for the first time provided with in house training by the NMC.
- 13 The Board was impressed with the implementation of the training programme by a small number of staff in the Adjudication department, with high attendance rates and

positive learning outcomes recorded.

- 14 No issues with the performance of the practice committees or legal assessors resulting from the Section 60 changes have been reported to the Board.

Panel Member Services Agreement

- 15 In June 2017 the Board approved the publication of a guidance document for the Panel Member Services Agreement and its supporting policies which clarified the operation of the agreement and supporting policies.
- 16 In response to the publication of the PSA's Lessons Learned Review in May 2018, the Board has initiated a full review of the Panel Member Services Agreement which will focus on ensuring appropriate emphasis on the values and behaviours expected of panel members.
- 17 The Board will ensure any changes to the Panel Member Services Agreement and supporting policies reflect the Council's response to the Lessons Learned Review.
- 18 The Board will consider a draft timeline and plan for completion of the review at its next meeting, along with a paper setting out the values and behaviours expected of a panel member.
- 19 The Board is also scrutinising the panel member performance framework to ensure sufficient weight is given to the NMC's corporate values and the framework reflects the importance of how the NMC treats those involved in the fitness to practise process.

Panel member recruitment

- 20 The Board continues to review and make recommendations to Council on the appointment and reappointment of FtP panel members.
- 21 In the past year, the Board has reviewed and scrutinised the design and implementation of the current panel member recruitment campaign which is due to be completed by September 2018.
- 22 Previous campaigns have focused on the need to secure high calibre appointments to maintain the operational capacity of the practice committees. While previous campaigns have sought to ensure the membership of the committees reflected the diversity of the register, this has

not been reflected in the outcomes of the recruitment exercises.

- 23 The Board has ensured that the current campaign is focused on attracting, and appointing a diverse range of candidates.
- 24 The Board will receive a report on the outcome of the campaign at its next meeting.

Performance monitoring

- 25 The Board continues to receive, at each meeting, copies of the FtP key performance indicators and dashboard, once these have been reviewed by the Council.
- 26 The Board has also received information on the work of the Quality Outcomes Review Group (QORG) and Decision Review Group (DRG). The Board will continue reviewing output from the QORG and DRG at future meetings to support FtP in identifying learning points from the data.
- 27 Board members have attended meetings of the DRG to gain further understanding of the way in which FtP cases are analysed. Members of the Board also plan to attend meetings of the Panel Member Forum to aid their understanding of the issues affecting the operation of the practice committees.
- 28 Board members will also be attending training and engagement events with panel members to ensure it maintains an up-to-date picture of developments.

Conclusion

- 29 The Board considers that the rigorous scrutiny and oversight it has exercised has helped and supported Fitness to Practise's efforts to strengthen the quality of decision-making. In particular the Board has ensured that stronger management of the performance of panel members and legal assessors is in place.
- 30 The Board's focus continues to be on the contribution of panel members and legal assessors to the timeliness and quality of fitness to practise outcomes, which in turn should have a positive impact on the throughput of FtP cases.
- 31 Over the next year, the Board will focus on reviewing the Panel Member Services Agreement and performance monitoring framework to ensure the response of Council to

the Lessons Learned Review is reflected in the operation of the practice committees.

- 32 The Board will continue to review data from FtP on non-completed hearings in an effort to help FtP identify the contribution of panel members and legal assessors to improve the completion rate of hearings.
- 33 The Board is grateful for the support it has received from the Director of Fitness to Practise, Adjudication staff and the Panel Support Team.

Public protection implications: 34 There are no public protection implications arising directly from this report.

Resource implications: 35 None arising directly from this report.

Equality and diversity implications: 36 None arising directly from this report.

Stakeholder engagement: 37 None.

Risk implications: 38 There are no risk implications arising directly from this report.

Legal implications: 39 None.

Council

Performance and Risk report

Action: For discussion.

Issue: Reports on performance and risk management for 2018–2019.

Core regulatory function: All regulatory functions.

Strategic priority: All.

Decision required: The Council is invited to discuss our financial, KPI and corporate commitment performance for April 2018 to June 2018.

Annexes: The following annexes are attached to this paper:

- Annex 1: Performance and risk report.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

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- Context:**
- 1 The report at Annexe 1 provides an overview of financial performance, non-financial performance and risk for the period from April 2018 to June 2018.
 - 2 In order to present a rounded view, we have brought together financial and non-financial performance into a single report.
 - 3 We continue to be committed to delivering on the PSA Lessons Learned review recommendations in the year ahead and recognise that there are areas where we have much to do.
 - 4 At Annexe 1 we have provided an amended report format to show data alongside performance commentary. This provides a more consistent structure and improved appearance for the report. Feedback on the revised format from Council would be welcome.
- Four country factors:**
- 5 Four country factors are taken into account in considering our risks and through our operational performance.

Discussion: Corporate Commitments and KPIs

- 6 Of our 11 corporate commitments, nine have delivered their Q1 milestones and two have experienced some delays. These were in the development of our education quality assurance model and modernising our ICT. Based on our forecasts these two areas will continue to be a risk during the remainder of the year alongside the Overseas Programme, which is also rescheduling some activity. The implication is that some milestones are expected to be delivered in 2019–2020 instead of this year. This will be factored into our three year budget.
- 7 All five of our corporate KPIs are currently on target.

Financial Position

- 8 Our financial position remains stable and is stronger than budgeted. Income exceeded expenditure by £2.9 million at the end of the first quarter compared to budgeted £0.5 million. This is due to:
 - 8.1 Income being £0.5 million higher than budgeted. A key factor is higher than anticipated registrant numbers where a deliberately cautious position was taken when the budget was set. This positive variance is likely to increase over the full year.
 - 8.2 Fitness to Practise hearing volumes being lower than anticipated, resulting in a £0.5 million underspend. Over the full year, we expect around 120 fewer hearings compared to the 966 planned for. This would result in a £1.1 million underspend. This is at least in part due a backlog in the number of investigations in progress. Looking ahead, plans

are being put in place to use this underspend to reduce the number of investigations in progress and help deliver action in response to the PSA Lessons Learned recommendations. As a result, FtP is expecting spend to budget by the year end.

- 8.3 Other directorates have spend totalling £0.6 million behind budget for a variety of reasons such as higher than planned staff vacancies and, for Resources, re-phasing of planned building maintenance.
- 8.4 Slippage in originally planned project activity totalling £0.9 million. In particular, replanning of nursing associate and education projects has led to activity totalling £0.8 million now being planned for later in the year.
- 9 The year end forecast reflects the better than expected income, resulting in a lower deficit (at £1.3 million) than budgeted (£2.6 million). Whilst the forecast does include proposals for Accommodation, the Modernisation of Technology Services, and Overseas projects where business cases have not finally been approved, it does not yet make full provision for the cost of any actions required in response to the PSA Lessons Learned report and the Gosport inquiry report. These actions are still being considered.
- 10 Performance to date for both business as usual (BAU) and project activity, as well as our experience of outturn last year, indicates that there is a risk of some plans for delivery by directorates and projects being over-ambitious in terms of speed of delivery. If this is the case, it will result in spend being lower than currently forecast. We will test this further at the mid-year.
- 11 Council will also want to note that there is a degree of risk to income with respect to funding due from the Department of Health and Social Care (DHSC) for the nursing associates programme. Internal DHSC processes to confirm the budget for the year (£2.7 million) have not yet been completed.
- 12 We take assurance from the Memorandum of Understanding we signed with the DHSC last year, which set out the budget. But, given delays in its confirmation, we are seeking further assurance from DHSC that this income, which is intended to reimburse us for the costs we are incurring for this programme, will be provided. Income and costs of £0.5 million are reflected in the outturn to end June 2018.

Risk

- 13 The corporate risk register represents the position as at the March 2018 Council meeting. An update to the register is due in July 2018 after the Council meeting. Critical risks continue to be our capacity, resilience and capability to deliver our commitments and potential

failure of our ICT infrastructure. A number of targeted actions are being progressed to mitigate these risks. In the meantime, these risks are deemed to be stable.

Public protection implications:	14	Public protection implications are considered when reviewing performance and the factors behind poor or good performance.
Resource implications:	15	Performance and Risk Reporting are a corporate requirement and are resourced from within BAU budgets with no additional cost attached. We do not anticipate future additional costs above and beyond day to day management costs unless we make refinements to our framework which will be fully costed. No external resources have been used to produce this report.
Equality and diversity implications:	16	Equality and diversity implications are considered in reviewing our performance and risks.
Stakeholder engagement:	17	KPI and risk information is in the public domain. There is therefore the opportunity for the public to ask questions of the information provided at Open Council
Risk implications:	18	The impact of risks is assessed and rated within our corporate risk register.
Legal implications:	19	None.

NMC Performance and Risk Report for 2018–2019

Report period: April 2018 – June 2018

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Section 1: Performance against Income and Expenditure

a. Current status at June 2018

Year to Date Income and Expenditure at June 2018	Current status
Income (June actual: £22.4 million / 2% over budget)	Green
Expenditure (June actual: £19.5 million / 9% under budget)	Amber

b. Forecast status at 31 March 2019

June 2018 Forecast Income and Expenditure at 31 March 2019	31 March 2018 Status
Income (June Forecast: £88.7 million / 3% over budget)	Green
Expenditure (June Forecast: £90.0 million / 1% above budget)	Green
Deficit: (June Forecast: £1.3 million compared to £2.6 million deficit budget)	Green

c. ACTUALS TO 30 JUNE 2018. FORECAST TO 31 MARCH 2019

Nursing and Midwifery Council Financial Monitoring Report

Income	Year-to-date June 2018				FULL YEAR Outturn			
	Actual £'m	Budget £'m	Var. £'m	Var. %	Forecast £'m	Budget £'m	Var. £'m	Var. %
Total Income	22.4	21.9	0.5	2%	88.7	86.4	2.3	3%
Directorates								
Fitness to Practise	9.1	9.7	0.5	6%	38.2	38.2	0.0	0%
Resources	4.0	4.1	0.2	4%	16.7	16.7	0.0	0%
Registration and Revalidation	1.5	1.6	0.1	7%	6.4	6.6	0.2	2%
OCCE	0.7	0.7	0.0	5%	3.2	3.1	(0.1)	(4%)
Education and Standards	0.6	0.8	0.1	20%	2.9	3.0	0.2	6%
People & Organisational Development	0.6	0.6	0.1	9%	2.6	2.6	0.0	0%
External Affairs	0.3	0.4	0.1	21%	1.5	1.5	0.0	0%
Total Directorates - BAU	16.8	17.9	1.1	6%	71.3	71.7	0.3	0%
Programmes & Projects								
Modernisation of Technology Services	0.1	0.1	0.0	0%	3.5	3.0	(0.5)	(17%)
Education Programme	0.3	0.5	0.3	51%	1.7	1.7	0.0	0%
Overseas Programme	0.2	0.1	0.0	0%	1.0	1.4	0.4	31%
FtP Change Strategy	0.2	0.3	0.1	38%	0.9	0.9	0.0	0%
People Strategy	0.0	0.1	0.1	80%	0.5	0.5	0.0	0%
Other Projects	0.3	0.3	0.0	0%	0.3	0.3	0.0	0%
Strategic Projects Reserve	0.0	0.0	0.0	0%	0.2	0.2	0.0	0%
Nursing Associates	0.5	1.0	0.5	50%	2.7	2.7	0.0	0%
Accommodation Project	0.0	0.0	0.0	0%	1.0	0.0	(1.0)	(100%)
Total Programmes/Projects	1.5	2.4	0.9	37%	12.0	10.7	(1.3)	(12%)
Corporate								
Depreciation	0.7	0.7	0.0	0%	2.7	2.7	0.0	0%
PSA Fee	0.4	0.4	0.0	0%	1.8	1.8	0.0	0%
Other	0.0	0.0	0.0	49%	0.2	0.2	0.0	0%
Contingency	0.0	0.0	0.0	100%	2.0	2.0	0.0	0%
Total Corporate/Central	1.2	1.1	(0.1)	(8%)	6.6	6.6	0.0	0%
Total Expenditure	19.5	21.4	1.9	9%	90.0	89.0	(1.0)	(1%)
Net Position	2.9	0.5	2.4		(1.3)	(2.6)	1.3	
Available Free Reserves (Actuarial Basis)	25.9	23.5	2.4	10%	23.7	19.8	4.0	20%
Available Free Reserves (Cash Committed Basis)	27.7	25.3	2.4	10%	25.5	21.6	4.0	18%

Notes:

1. Some totals and variances may not calculate exactly due to rounding differences.
2. Nursing associates: budgeted and actual income includes refunds from the Department for Health and Social Care. These match exactly the actual programme costs for nursing associates shown above. This presentation differs from our approach last year where income and costs were netted off, providing a more transparent view of finances for this project.

3. The forecast includes potential costs for the Accommodation project. A business case is due to be considered by Council in September 2018.
4. Results do not include any adjustments that will come from the year end actuarial review for 2018-2019 of the defined benefit pension scheme for the financial statements. This will reflect the annual payment of £1.2 million to reduce the pensions deficit and may result in either an increase or decrease in costs.
5. Budgeted costs, primarily for programmes and projects, include elements that may be classified as capital. This is typically major development of new IT software and building refurbishment. Items subsequently classified as capital will reduce expenditure reported in the financial statements in the short term, but will not impact on Available Free Reserves.

d. Balance Sheet at 30 June 2018

BALANCE SHEET	Mar-18	Jun-18	Var.	Var.
	£'m	£'m	£'m	(%)
Fixed Assets				
Tangible Assets	18.9	18.2	(0.7)	(4%)
Current Assets				
Cash	16.7	16.2	(0.5)	(3%)
Debtors	4.1	3.9	(0.2)	(5%)
Investments	65.5	65.6	0.0	0%
Total Current Assets	86.3	85.7	(0.6)	(1%)
Total Assets	105.2	103.9	(1.3)	(1%)
Current Liabilities				
Creditors	(50.4)	(44.2)	6.2	12%
Provisions	(0.5)	(0.5)	0.0	0%
Total Current Liabilities	(50.9)	(44.6)	6.2	12%
Non-current liabilities				
Creditors	(0.5)	(2.6)	(2.2)	(445%)
Provisions	(1.0)	(1.1)	(0.1)	(11%)
Total Non-current Liabilities	(1.4)	(3.7)	(2.3)	(157%)
Total Liabilities	(52.3)	(48.4)	4.0	8%
Net Assets (excl pension liability)	52.9	55.5	2.6	5%
Pension Liability	(11.7)	(11.4)	0.3	3%
Total Net Assets	41.2	44.1	2.9	7%
Total Reserves	41.2	44.1	2.9	7%

Notes:

1. The movement of £6.2m on Creditors (Current Liabilities) is mainly due to the release of deferred income to the appropriate periods in the Income & Expenditure Statement.
2. For non-current liabilities, Creditors (over 1 year) will increase each month as the NMC receives registration fees for periods that span beyond current financial year.

e. Detail financial commentary

Financial Commentary			
Quarter 1 position			
<p>Overview: NMC's financial position remains stable. Income exceeds expenditure by £2.9 million at the end of the first quarter compared to a near breakeven budget at this point in the year. This is due to higher than expected income, combined with lower than planned spend on FtP adjudication hearings and spend on certain projects as a result of delays.</p>			
	Year to Date Actual at June 18	Year to Date Budget at June 18	Variance to budget
Income	£22.4 million	£21.9 million	2% above
Expenditure	£19.5 million	£21.4 million	9% below
<p>Year to date income: income is £0.5 million higher than budget. A significant part of this is that the budget was set based on a pessimistic view of register volumes, as reported in autumn 2017. More recent data, such as that published in April 2018, suggests a flatter trend in overall register volumes in the short term, with this reflected in the forecast. Other smaller sources of income are also higher than planned. This forecast remains under careful review to track any fluctuations.</p> <p>There is also a risk to income due from the Department of Health and Social Care (DHSC) to refund the costs of the nursing associates programme. Included in actual income to date is £0.5 million for this. Whilst we have a Memorandum of Understanding (MoU) with the DHSC for the full refund of budgeted costs, the budget is subject to annual DHSC internal approval processes. We have been given verbal assurances by DHSC that obtaining this approval for our 2018-2019 budget, originally expected in July 2018, presents no potential issue given the MoU and the high priority this project represents to DHSC. DHSC has informed us that it expects matters to be resolved within the month. We are pressing DHSC for increased assurance.</p>			
<p>Year to date expenditure: Spend across Business As Usual (BAU) and Programmes and Projects is £1.9 million (9%) below budget. Key factors are lower than anticipated adjudications in FtP and project slippage. We discuss in detail below.</p>			
Expenditure on business as usual activities			
<p>The year-to-date spend is £1.1 million (6%) below budget, and is broadly expected to remain flat at year-end. Underspends have been redeployed towards actions in response to the Lessons Learned recommendations and to speed up FtP investigations. This will continue to be tested to ensure that planned vacancy filling and other planned spend is implemented.</p> <p>Key points are:</p> <ul style="list-style-type: none"> • Fitness to Practise: In the year to date, we have underspent £0.5 million because we 			

Financial Commentary

have run fewer hearings than planned. This is due to lower output of cases at the investigations stage of the FtP process.

At this early stage in the year, we anticipate that we will run around 120 fewer hearings this year as a whole compared to the 966 planned for, reducing spend by around £1.1 million during 2018–2019 compared to plan. This is partly due to fewer referrals than expected and partly due to a lower output backlog in the number of investigations in progress. Part of the underspend will be redeployed to investigations to reduce the caseload, with the other part invested to help take action to address the PSA Lessons Learned recommendations. With this redeployment, FtP's overall expenditure forecast remains within budget.

The implication of fewer hearings this year may mean more during 2019–2020. This may be offset through improvements being piloted as part of the FtP Strategy.

- **Resources:** spend is below budget by £0.2 million due to rephasing of planned maintenance spend.
- **Registrations & Revalidation:** An underspend of £0.1 million year-to-date is due to posts not being filled. This is part of efficiency plans for the Directorate. If the trajectory continues the full year spend will be £0.2 million below budget. The forecast underspend of £0.2 million is available to be redeployed for corporate priorities.
- **Education & Standards:** The £0.1m underspend is mainly due to reduced Quality Assurance activity than originally planned. Council approved a new more efficient model of quality assuring Approved Educational Institutions (AEIs) and we anticipate this will result in £0.2 million lower spend compared to budget by year end.
- **Office of the Chair and Chief Executive (OCCE):** spend is forecast to be £0.1m above budget mainly due to recruitment costs.

Expenditure on Strategic Programmes and Projects

The year to date expenditure on Strategic Programmes and Projects, including nursing associates, is £0.9 million (37%) below budget. This is because of project activities starting later in the year than originally planned.

Subject Council approving business cases in July 2018, and with the exception of the Overseas programme, we currently anticipate that we will fully use the budgets by the end of the year to deliver project objectives in line with the corporate plan. We will continue to test this as the year progresses.

The key areas are:

- **Modernisation of Technology Services (MOTS) project:** The project life is expected to span at least two financial years (2018–2020) with higher costs than budget falling into 2018–2019, but with some offset in 2019–2020.

Expenditure is subject to approval of the detailed business case by Council. The

Financial Commentary

current forecast is that expenditure will be £0.5 million above the current £3 million budget by year end. The forecast already reflects an offsetting £0.5 refund expected from the DHSC which relates to specific additional costs incurred for establishing a register for nursing associates.

- **Education Programme:** work to consult on future midwife, return to practice and post registration evaluation will commence later than we initially planned and partly contributes to the YTD underspend of £0.3 million alongside IT system development that has also been delayed. Activity is expected to significantly increase over the remaining months with the anticipated full year spend expected to be in line with budget and delivery of programme objectives.
- **Overseas Programme:** is currently in line with budget. However, following more detailed planning of the project, we now plan to defer £0.4 million of the £1.4 million current year budget into 2019-2020. This is due to the programme rescheduling full implementation of the Future Nurse route to July 2019. Planned delivery remains in line with the 2018-2019 corporate plan commitment to 'Review and start to introduce a new approach to register nurses and midwives from outside the UK'.
- **Nursing Associates:** Following re-planning, activities that will incur costs are going to happen later in the year resulting in an underspend of £0.5 million YTD. However, the full budget of £2.7 million is currently expected to be spent by year end along with delivery of the project's key objectives. Subject to the risk set out in the discussion of income above, the project costs are fully refunded by the DHSC and are cost-neutral to the NMC.
- **Strategic Projects Reserve:** A reserve of £0.5 million was established at the time of the programme and project budget being approved by Council in March 2018. To date, £0.3 million has been allocated to essential projects that slipped from 2017–2018 into the current year. These relate to GDPR and to improvements to Registration processes. This leaves £0.2 million available to offset other project pressures.
- **Accommodation:** We have reflected, in the forecast, costs contained in the business case due to be considered separately by Council.

Corporate Expenditure

The Executive Board has accessed the contingency fund to support some BAU expenditure not anticipated in full. This means that the contingency fund now has £2 million still available to support pressures. This compares to the initial budget of £2.3 million. Areas supported include additional costs for data storage following the implementation of the Digital Audio Recording project, net costs of the Apprenticeship Levy, and additional costs following the reorganisation of the People and Organisational Development directorate.

Budget reconciliation

The budget position set out above has changed slightly from that agreed by Council in

Financial Commentary

March 2018. Any changes to high level totals simply reflect Council decisions or presentation. These are set out below.

	Budget paper March 2018 £'m	Change £'m	Budget reported above £'m
Budgeted Income for year	83.7	+2.7	86.4
Budgeted total spend for year	83.3	+2.7 +3.0	89.0
Excess of income over expenditure/(deficit)	0.4	-(3.0)	(2.6)

Notes:

1. £2.7m has been added to income and to costs to reflect expected income from the DHSC for refunds of costs associated with establishing nursing associates. In the budget discussed at 30 March income and spend associated with nursing associates were netted off to nil. The treatment adopted here reflects that in the annual audited financial statements.
2. Since March, Council has agreed an additional budget of £3.0m for the Modernisation of Technology Services. This has been added to budgeted costs.

Full year forecast

Net income forecast: Income is expected to be higher than budget and spend broadly in line with, or slightly less than, budget. This position assumes that business cases for Accommodation, Overseas registration, and Modernisation of Technology, due to be considered by Council, will be agreed as they currently stand. It also includes an element of possible cost relating to actions in response to the PSA Lessons Learned review.

It also assumes that income of £2.7 million due from DHSC (discussed under the 'year to date income' section above) is received to offset the costs of the nursing associate programme.

Expenditure forecast: We are forecasting a slightly better than budget net spend position by year end, with a proportion of budget underspends being redeployed. This will potentially take us to the upper target level for Available Free Reserves of £25 million.

	June Forecast £'m	Full Year Budget £'m	Variance to budget
Income	88.7	86.4	3% above
Total spend	90.0	89.0	1% below
Excess of income over expenditure/ (deficit)	(1.3)	(2.6)	£1.3 million better

Section 2: Performance against the corporate business plan

2.1 Corporate commitments

a. Current Status at June 2018

9 On track	2 Challenges to delivery	0 Delivery at risk	0 Closed
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Amber areas:

- **(1c)** Nursing and midwifery education programmes: implement our new approach to quality assurance of education institutions.
- **(6.a)** Invest in replacing outdated IT systems and deliver ICT solutions to improve our use of intelligence, improve our efficiency and support our staff and the people we regulate.

b. Forecast status at 31 March 2019

8 Delivered	3 Challenges to delivery	0 Delivery at risk	0 Closed
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Amber areas:

- **(1c)** Nursing and midwifery education programmes: implement our new approach to quality assurance of education institutions.
- **(3)** Review and start to introduce a new approach to register nurses and midwives from outside the UK.
- **(6.a)** Invest in replacing outdated IT systems and deliver ICT solutions to improve our use of intelligence, improve our efficiency and support our staff and the people we regulate.

c. Detailed Commentary

	Current quarter status	Forecast year-end status
Strategic Priority 1 – Effective Regulation		
1. Education Programme		
(1.a) Nursing: implement the new standards of proficiency for the future nurse.	Green	Green
We published the new standards in May 2018. A full plan is in place for engagement, communications, and support for implementation throughout the 2018-2019 year.		

	Current quarter status	Forecast year-end status
<p>(1.b) Midwifery: draft the new standards for the future midwife in readiness for public consultation.</p>	Green	Green
<p>We have further developed the draft outline for the standards of proficiency for registered midwives using the evidence base and the outcome of early engagement listening events. We will test this draft with midwives and other professionals, educators, women, the public and other stakeholders during of 2018–2019.</p>		
<p>(1.c) Nursing and midwifery education programmes: implement our new approach to quality assurance of education institutions.</p>	Amber	Amber
<p>We published the new education framework for nursing and midwifery education, standards for student supervision and assessment and programme standards for pre-registration nursing and nurse and midwife prescribing in May 2018.</p> <p>Council agreed the new quality assurance (QA) framework in March 2018. We have developed the QA framework standards document. We will publish it on our website from July 2018. We have developed a communication and engagement plan to support this publication.</p> <p>We have contacted Approved Education Institutions (AEIs) to scope timescales for programme approvals against the new standards. Approvals against the new standards are on schedule to begin in quarter three of 2018-2019.</p> <p>The procurement process for the new QA services provider has commenced, but this does not include Information Technology requirements. An IT tender to support the use of data for QA services is being prepared in line with the modernising of technology services programme (MOTs) and will be initiated no later than September 2018. The amber status reflects key interdependencies with other programmes that we need to manage.</p>		
<p>2. Nursing Associates</p>		
<p>(2) Open the register for the first nursing associates.</p>	Green	Green
<p>The Council approved the launch of our NA consultation in April 2018. We have completed a programme of engagement to support this.</p> <p>Preparation is underway for the first NA programme approvals from October 2018.</p> <p>We have engaged with AEIs on our expectations of them in relation to registering the first cohort of applicants onto the register. Only three sites are yet to be rated as green for QA compliance.</p>		

	Current quarter status	Forecast year-end status
<p>Legislation to register NAs is now in place. This is the result of briefings and meetings with parliamentarians in advance of the Commons and House of Lords debates on section s60 to ensure the legislation is fit for purpose.</p> <p>Responses to our NA fees consultation have been analysed. We will submit the findings to the Council for consideration in due course.</p>		
<h3>3. Overseas Registration</h3>		
<p>(3) Review and start to introduce a new approach to register nurses and midwives from outside the UK.</p>	Green	Amber
<p>The Council approved the strategic investment for a review of our overseas registration process in March 2018. We have developed a full business case for the programme. We will present this to Council in July 2018 so they can approve the direction and expected costs.</p> <p>Continuing work is subject to this decision, reflecting the year-end forecast of Amber.</p> <p>During quarter one we completed our end to end review of the overseas process taking into account feedback from stakeholders. We have also completed a full review of the high level Overseas registration policy. We are presenting revised policy principles to the Council in July 2018 for feedback.</p> <p>We have completed our stakeholder engagement plan and started our engagement with key stakeholders. For example, we held webinars with employers and recruiters to share our thinking about the overseas review and to seek views.</p> <p>We have identified interim improvements to the overseas process which we aim to implement from July 2018. The Council will consider these proposals at their meeting in July 2018 meeting. Proposals include removing the requirement to have undertaken 12 months in practice prior to being eligible to undertake the test of competence, and changes to our re-sit policy.</p>		
<h3>4. Fitness to Practise</h3>		
<p>(4.a) Set a new strategic direction for fitness to practise, taking account of the views of the public, patients, and other stakeholders.</p> <ul style="list-style-type: none"> - Resolve cases at the earliest opportunity - Reduce the number of full hearings 	Green	Green
<p>Consultation and research on the FtP Strategy was completed during April and May 2018, with the final reports received in June 2018.</p>		

	Current quarter status	Forecast year-end status
<p>The full strategy proposal will be submitted to the Council for approval July 2018. The proposals take account of the consultation and research, input gathered from other external engagement events with key stakeholders, and recommendations of the PSA Lessons Learned report.</p> <p>Subject to this approval we will roll out our new policies from 3 September 2018, and start to implement the strategic change initiatives and pilots.</p>		
5. Effective Organisation		
(5.a) Maintain strong performance against our key targets for registration and fitness to practise.	Green	Green
<p>Registrations and Revalidation: All corporate KPIs for registrations applications (UK and Overseas) were met during the quarter and are forecast as Green for year end.</p> <p>FtP: Both corporate KPIs (Interim Orders and Timeliness) were met during the quarter and forecast as Green for year end.</p> <p>Customer service and feedback: We recognise that there is more to do to improve how we gather and respond to customer feedback. Next steps and actions in this area will form part of our Lessons Learned review action plan.</p> <p>We continue to review and act upon customer satisfaction information on a day to day basis within our operations.</p>		
Strategic Priorities 2, 3 and 4 – Use of Intelligence, Collaboration & Communication, An Effective Organisation		
(6.a) Invest in replacing outdated IT systems and deliver ICT solutions to improve our use of intelligence, improve our efficiency and support our staff and the people we regulate	Amber	Amber
<p>There are some risks associated with this programme including a slight delay in securing an external delivery provider to deliver the new ICT solutions. The programme will commence once next steps have been agreed.</p>		
(6.b) Develop our accommodation strategy to better use our buildings and deliver long term cost savings	Green	Green
<p>Initial plans have been presented to Executive Board. We will develop detailed plans as the future organisational requirements become clearer.</p>		

	Current quarter status	Forecast year-end status
(6.c) Strengthen our organisational capacity and capability through improvements to recruitment, induction, management development and employee engagement.	Green	Green
<p>This commitment will be delivered by our three year People Strategy. We are on track at quarter one to deliver critical milestones during 2018–2019.</p> <p>Progress during quarter one was:</p> <ul style="list-style-type: none"> - successful delivery of our leadership development programme modules coupled with 360 feedback and coaching for senior staff - a review and relaunch all employee policies related to family and disciplinary procedures - creation of a ‘wellbeing working group’ who will deliver strategies to increase employee wellbeing and ensure that wellbeing remains a key theme of workforce engagement - securing a new occupational health provider who will help us to ensure wellbeing and health of employees - implementation of a new appraisal system which puts the individual employee at the heart of the process, recognises achievements, provides performance feedback, and focuses on continued development and engagement. 		
(6.d) Continue to fulfil our commitments to equality, diversity and inclusion as set out in our strategic framework.	Green	Green
<p>We are on track at quarter one to deliver critical milestones during 2018–2019.</p> <p>In May 2018, we published our Reasonable Adjustment policy for customers on our website.</p> <p>We submitted the ‘Business in the Community’s’ race benchmark assessment data, and will receive feedback later in the year which will help us to understand the gaps in best practice and how we might remove any barriers for ethnic minorities in our employment and as a regulator.</p> <p>We have launched our updated equality impact assessment (EQIA) toolkit with revised guidance and template. This will support staff in considering all the right quality, diversity and inclusion aspects when undertaking new work or changes to existing policies and processes. We have arranged discrimination case law training for our policy leads and lawyers, and unconscious bias training for managers has begun to be rolled out.</p>		

2.2. Corporate KPIs

a. Current Status at June 2018

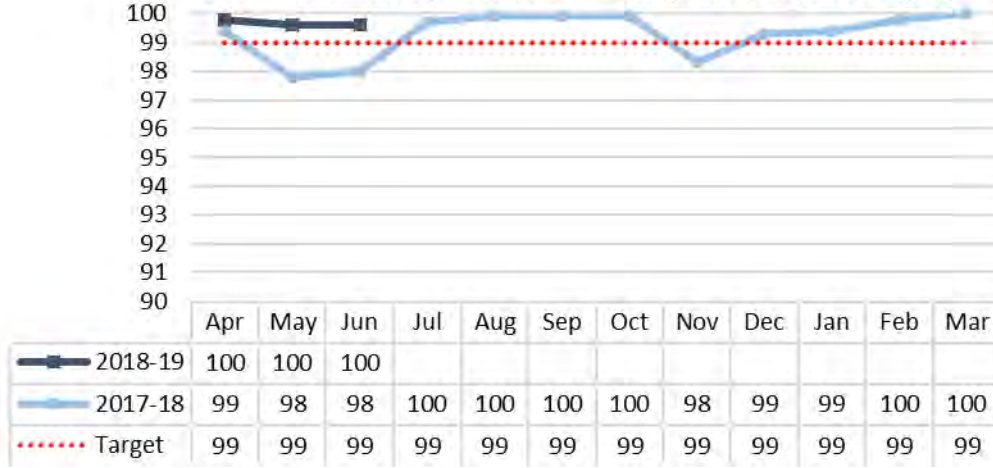
5 Currently above target	0 Marginally below target	0 Significantly below target
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b. Detailed Commentary

Progress against corporate KPIs	Current Status																																																				
Registrations and Revalidation																																																					
<p>KPI 1: Percentage of UK initial registration applications completed within 10 days. Target: 95%</p> <p>Result: We are above the 95% target at June 2018 having briefly dipped below this figure to 94.4% in May 2018.</p> <p style="text-align: center;">UK Initial Registration Completed (10 days)</p> <table border="1"> <thead> <tr> <th></th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Sep</th> <th>Oct</th> <th>Nov</th> <th>Dec</th> <th>Jan</th> <th>Feb</th> <th>Mar</th> </tr> </thead> <tbody> <tr> <td>2018-19</td> <td>97</td> <td>94</td> <td>96</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>2017-18</td> <td>97</td> <td>96</td> <td>96</td> <td>98</td> <td>99</td> <td>100</td> <td>97</td> <td>91</td> <td>95</td> <td>99</td> <td>98</td> <td>98</td> </tr> <tr> <td>Target</td> <td>95</td> <td>95</td> <td>95</td> <td>95</td> <td>95</td> <td>95</td> <td>95</td> <td>95</td> <td>95</td> <td>95</td> <td>95</td> <td>95</td> </tr> </tbody> </table>		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018-19	97	94	96										2017-18	97	96	96	98	99	100	97	91	95	99	98	98	Target	95	95	95	95	95	95	95	95	95	95	95	95	Green
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar																																									
2018-19	97	94	96																																																		
2017-18	97	96	96	98	99	100	97	91	95	99	98	98																																									
Target	95	95	95	95	95	95	95	95	95	95	95	95																																									
<p>KPI 2: Percentage of UK initial registration applications completed within 30 days. Target: 99%</p> <p>Result: We remain above the 99% target at June 2018.</p>	Green																																																				

Progress against corporate KPIs	Current Status
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UK Initial Registration Completed (30 days)

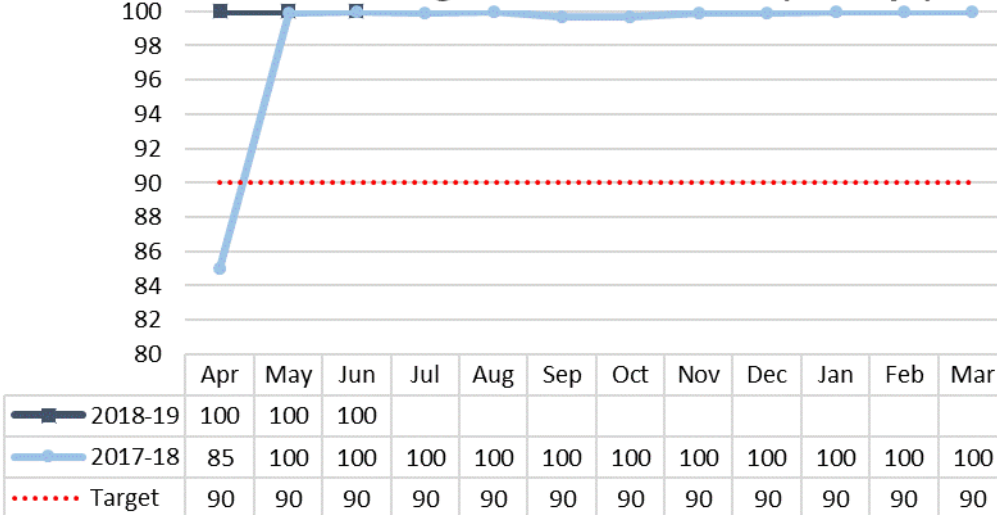


KPI 3: Percentage of EU/Overseas registration applications assessed within 60 days. **Target:** 90%

Green

Result:
We remain above the 90% target at June 2018.

Overseas Registration Assessed (60 days)



Fitness to Practise

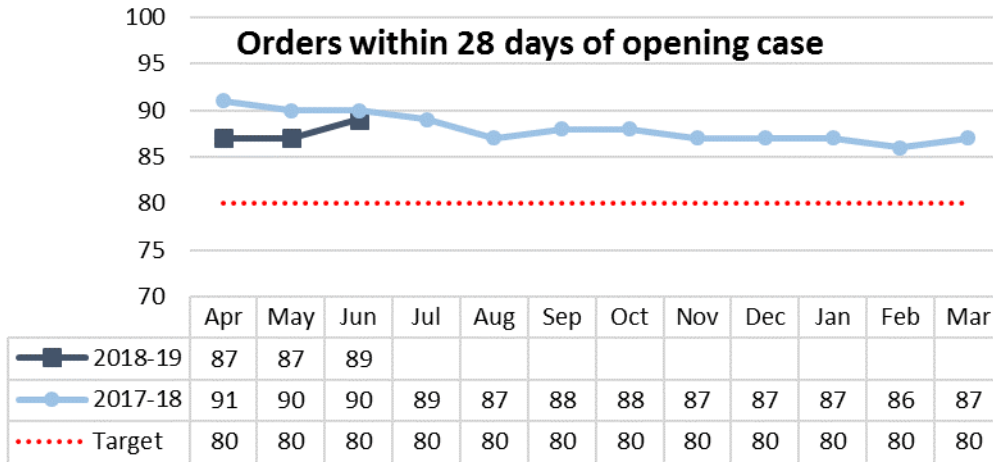
KPI 4: Percentage of interim orders (IOs) imposed within 28 days of opening the case (12 month rolling average). **Target:** 80% by March 2018.

Green

Result:
Performance over the first quarter was consistently high with spot rates of 89% in March,

Progress against corporate KPIs	Current Status
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87% in April and 92% in June. The 12 month rolling average at the end of June was 89%.



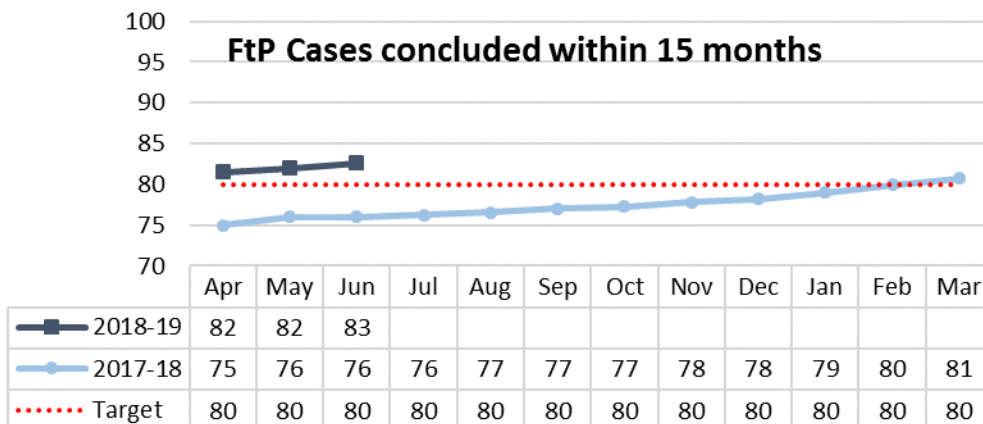
12 month rolling average

KPI 5: Percentage of FtP cases concluded within 15 months of being opened (12 month rolling average). **Target:** 80% by March 2018.

Green

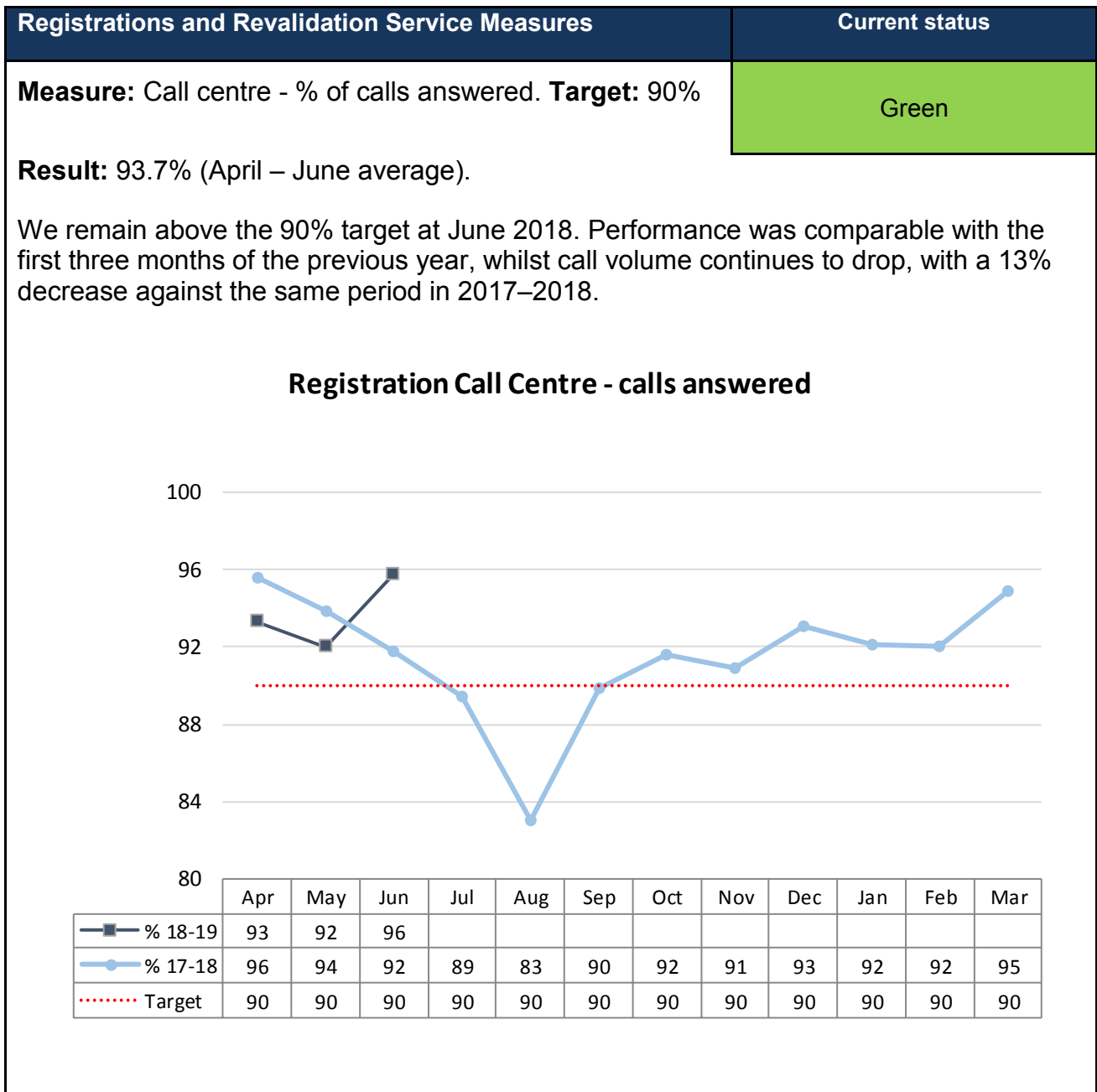
Result:

We remain above our target of 80% at June 2018. In April, we concluded 87% of cases within 15 months, followed by a slight decrease to 85% in May. We ended the quarter in June with 86% of cases concluding within 15 months. The 12 month rolling average was 83% at the end of June 2018.



12 month rolling avera

Section 3: Call centre



Section 4: People

People Measures	Current status																										
<p>Measure 1: Overall staff turnover (12 month rolling). Target: Reduce</p> <p>June 2018: 20.5%</p> <ul style="list-style-type: none"> • Turnover has risen by 0.3% since April 2018. • Compared to June 2017, turnover has decreased by 6.1%. • The most common reason cited for leaving is career progression. <p>Commentary In accordance with the governance arrangements approved by the Council, the Remuneration Committee approved a settlement agreement reached with an employee on the basis that the relationship between the employee and the NMC had broken down. The Committee was satisfied on the basis of information provided by the Executive that, in accordance with the criteria approved by the Council, in the exceptional circumstances presented and given the operational importance of the role, approval was justified and defensible. The settlement agreement provides for a non-contractual payment equivalent to three months' salary not exceeding £25k, in addition to a contractual payment in lieu of notice. A contribution to legal fees has also been made in accordance with normal practice.</p> <div data-bbox="159 1115 1391 1637"> <p style="text-align: center;">Overall Staff Turnover vs Previous Year</p> <table border="1"> <caption>Overall Staff Turnover vs Previous Year</caption> <thead> <tr> <th>Month</th> <th>Staff Turnover Percentage</th> </tr> </thead> <tbody> <tr><td>Apr</td><td>20.3</td></tr> <tr><td>May</td><td>21.1</td></tr> <tr><td>Jun</td><td>20.5</td></tr> <tr><td>Jul</td><td>26.2</td></tr> <tr><td>Aug</td><td>23.8</td></tr> <tr><td>Sep</td><td>22.1</td></tr> <tr><td>Oct</td><td>22.8</td></tr> <tr><td>Nov</td><td>23.0</td></tr> <tr><td>Dec</td><td>23.3</td></tr> <tr><td>Jan</td><td>22.5</td></tr> <tr><td>Feb</td><td>22.7</td></tr> <tr><td>Mar</td><td>22.1</td></tr> </tbody> </table> </div>	Month	Staff Turnover Percentage	Apr	20.3	May	21.1	Jun	20.5	Jul	26.2	Aug	23.8	Sep	22.1	Oct	22.8	Nov	23.0	Dec	23.3	Jan	22.5	Feb	22.7	Mar	22.1	<p>Reducing</p>
Month	Staff Turnover Percentage																										
Apr	20.3																										
May	21.1																										
Jun	20.5																										
Jul	26.2																										
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Sep	22.1																										
Oct	22.8																										
Nov	23.0																										
Dec	23.3																										
Jan	22.5																										
Feb	22.7																										
Mar	22.1																										
<p>Measure 2: Staff turnover of leavers within 6 months of joining. Target – reduce.</p> <p>Results: 23.3% of new starters left within their first 6 months of service as at June 2018, down from 25% in April 2018. There was a marginal increase in May 2018 at 27.3% which indicates that our trend for the first three months of the year is variable. This links to</p>	<p>Marginally reducing</p>																										

People Measures	Current status
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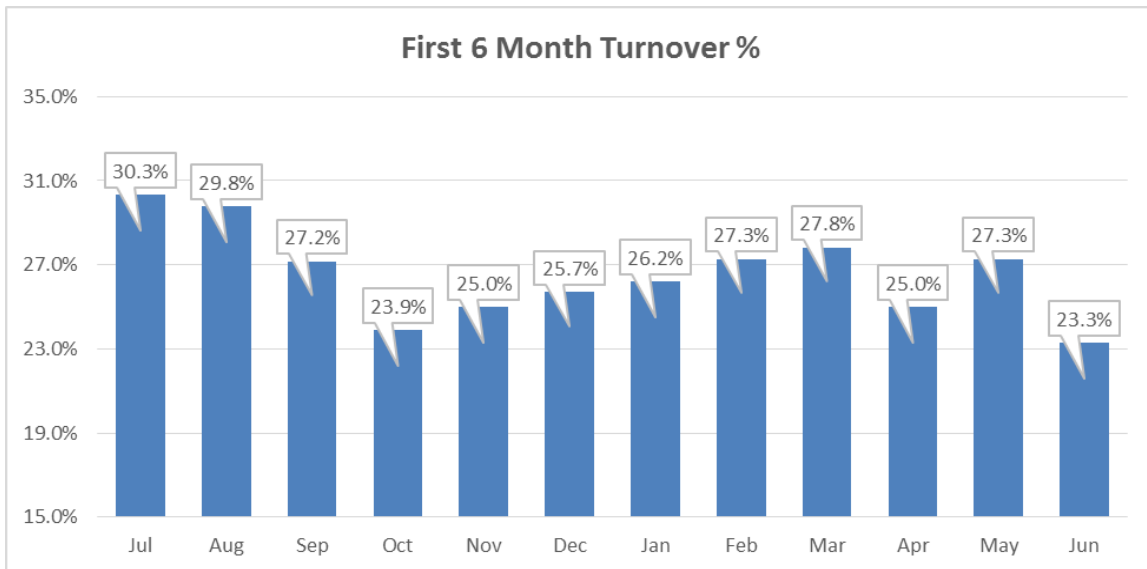
Corporate risk 3 regarding capacity, resilience and capability to deliver our plans.

It is currently too early to draw conclusions from the interventions that have been taken by management, which include how we recruit and induct new joiners into the NMC. These will be monitored over the coming 6–12 months and the outcomes of these interventions will become clearer over that period.

Specific Actions being taken to mitigate departures were:

- Additional recruitment training for managers to ensure correct methodology is utilised in the interview process;
- 1 and 3 month reviews with new joiners to check how the induction process is working;
- Review of assessment practices for roles with high turnover and high probation failure rates;
- A recent launch of a probation success initiative.

We will continue to monitor whether these improvements drive a reduction in leavers over the next 6-12 months.





Section 5: Corporate Risks

This risk summary reflects events and changes to NMC's corporate risk register for the period of January 2018 to March 2018. A draft corporate risk register for 2018-2019 has been prepared and will be considered by the Council at the confidential session in July 2018, with changes published within the September 2018 Council meeting papers. Although risk was considered at the June 2018 confidential Council meeting, amendments to the register were made following the public meeting to reflect the discussions regarding the PSA's Lesson Learned Review.

Current rating = a rating of the risk as it currently stands (with mitigation in place).



Movement = score movement since last review / meeting [◀▶ = No change since last report]

Detailed Summary	Current Rating
<p>1. Risk that we may register, or may have registered people who do not meet our requirements or standards</p>	<p>High impact, low likelihood ◀▶</p>
<p>Controls and Mitigations:</p> <p>In place:</p> <ul style="list-style-type: none"> • Registration and revalidation processes to ensure only those who meet requirements join the register or revalidate. • Identity and quality checks for UK, EU, Overseas initial registrants. • Strengthened reconciliation process. • Increased automation of processes. • Quality assurance framework to assure education providers. • Strengthened staff induction, training and communication. • Stronger links between Serious Event Reviews and complaints and assurance controls. • Business-wide legal compliance review. <p>Planned:</p> <ul style="list-style-type: none"> • Data and systems work to improve robustness. • Further automation of processes to reduce human errors. • Strengthening of process for early identification of failures and risks. • Strengthening of delegation of decision making. • Continued improvements to training. • Review of Overseas registrations process. • Updated guidance to Higher Education Institutions. 	

Detailed Summary	Current Rating
2. Risk that we may fail to take appropriate action to address a regulatory concern	High impact, low likelihood 
<p>In place:</p> <ul style="list-style-type: none"> • Registration and revalidation processes to ensure only those who meet requirements join the register or revalidate. • Identity and quality checks for UK, EU, Overseas initial registrants. • Strengthened reconciliation process. • Increased automation of processes. • Quality assurance framework to assure education providers. • Strengthened staff induction, training and communication. • Stronger links between Serious Event Reviews and complaints and assurance controls. • Business-wide legal compliance review. <p>Planned:</p> <ul style="list-style-type: none"> • Data and systems work to improve robustness. • Further automation of processes to reduce human errors. • Strengthening of process for early identification of failures and risks. • Strengthening of delegation of decision making. • Continued improvements to training. • Review of Overseas registrations process. • Updated guidance to Higher Education Institutions 	
Risk 3¹: Risk that we may have insufficient capacity, resilience and capability to deliver change activities (service improvements, projects and programmes) and business as usual.	High impact, probable likelihood 
<p>In place:</p> <ul style="list-style-type: none"> • Limit placed on commitments in corporate plan 2017–2018. • Department of Health funding to deliver new Nursing Associates role. • Corporate portfolio management office and related processes strengthened to manage change initiatives. • Robust recruitment processes for staff and contractors. • Trend analysis of declining register built into assumptions underpinning corporate budgeting process. <p>Planned:</p> <ul style="list-style-type: none"> • Strengthening of Executive Board with new directorates established for People and 	

¹ Note: there is no “Risk 4” in the current risk register since Risk 4 (“capability to deliver” was merged with Risk 3 during 2017–201, being closed as a separate risk.

Detailed Summary	Current Rating
<p>Organisational Development and External Affairs.</p> <ul style="list-style-type: none"> • Staff recruitment and retention analysis to identify capacity and capability pressure points and targeted action plan to reduce risks locally. • Targeted recruitment for key roles. • Updated staff reward strategy. • Implement employee engagement action plans. • Complete leadership development programme. • Review of NMC employer brand to attract the best staff. <p>Implement action plans for identified low capacity areas.</p>	
<p>Risk 5: Risk that there may be adverse incidents related to business continuity and health and safety</p>	<p>High impact, possible likelihood</p> <p style="text-align: center;">◀▶</p>
<p>In place:</p> <ul style="list-style-type: none"> • Business Impact Assessments. • Business continuity and disaster recovery plans. • IT infrastructure disaster recovery arrangements. • Business Continuity Working Group. • Training and desktop exercises. • Fire Risk Assessments across all premises. • Lockdown procedure in event of an emergency. <p>Planned:</p> <ul style="list-style-type: none"> • Implement updated business continuity policy. <p>IT infrastructure disaster recovery test planned</p>	
<p>Risk 6: Risk of information security and data protection breaches</p>	<p>High impact, possible likelihood</p> <p style="text-align: center;">◀▶</p>
<p>In place:</p> <ul style="list-style-type: none"> • Information security risk register and treatment plan. • Technical controls e.g. updating patches, IT security measures, encrypted email. • Staff awareness. • Audit action plans implemented. • Oversight by Information Governance and Security Board. • Maintaining and strengthening controls. Insurance cover for cyber security threats. <p>Planned:</p> <p>GDPR project which will deliver updates required to meet data protection regulations.</p>	

Detailed Summary	Current Rating
Risk 7: Risk that we may lack the right capability to influence and respond to changes in the external environment	High impact, possible likelihood 
<p>A. Mitigations for external risks: We have some influence over likelihood but focus remains on controlling the impact of external changes by anticipating and planning for possible eventualities.</p> <p>In place:</p> <ul style="list-style-type: none"> • External monitoring. • Brexit scenario planning via working group. • Strengthened leadership of external affairs. <p>B. Mitigations for internal risks</p> <p>In place:</p> <ul style="list-style-type: none"> • A Regulatory Intelligence unit providing critical regulatory intelligence for internal and external stakeholders. <p>Planned: Detailed stakeholder mapping.</p>	
Risk 8: Risk that we may not meet external expectations of us (reputation and perceptions)	Medium impact, possible likelihood 
<p>In place:</p> <ul style="list-style-type: none"> • Ongoing engagement with key stakeholders. <p>Planned: Delivery of commitments we have publically made.</p>	
Risk 9: Risk that ICT failure impedes our ability to deliver effective and robust services for stakeholders or value for money for the organisation	High impact, probable likelihood New Risk
<p>In place:</p> <ul style="list-style-type: none"> • Management plan for systems failures. • External review of recent failures and updated escalation plan. • Penetration and vulnerability testing. • Automated payments process in place with robust controls. <p>Planned:</p> <ul style="list-style-type: none"> • Investment plan to resolve cyber risks. • IT infrastructure disaster recovery test. 	

Detailed Summary	Current Rating
<ul style="list-style-type: none"> • Full penetration testing. • IT strategy an implementation plan. • Plan to improve cyber and other vulnerabilities. Secure a satisfactory contract with key suppliers.	

Section 6: Operational Performance

6.1. Registrations and Revalidation

Registrations and Revalidation Service Measures	Year end result												
<p>Measure: Revalidation volumes and percentages for the whole register. No target – track only.</p> <p>Results:</p> <table border="1"> <thead> <tr> <th></th> <th>April 18</th> <th>May 18</th> <th>June 18</th> </tr> </thead> <tbody> <tr> <td>Volume</td> <td>14,116</td> <td>10,796</td> <td>9,654</td> </tr> <tr> <td>% (of those due to revalidate)</td> <td>91.8%</td> <td>92.1%</td> <td>91.4%</td> </tr> </tbody> </table>		April 18	May 18	June 18	Volume	14,116	10,796	9,654	% (of those due to revalidate)	91.8%	92.1%	91.4%	<p>Trend remains stable</p>
	April 18	May 18	June 18										
Volume	14,116	10,796	9,654										
% (of those due to revalidate)	91.8%	92.1%	91.4%										
<p>Revalidation rates continue to be in line with historical averages and are consistent with the same period last year, both in terms of volume and percentage. All applications verified were compliant with the requirements.</p>													

6.2. Fitness to Practise

Performance Summary
<ol style="list-style-type: none"> 1. At the start of 2018-2019, our overall caseload was 3,016. During this quarter, the caseload has risen slightly to 3,133. We have seen increases within both screening and investigations. 2. Screening caseload has increased slightly over this period. Screening output has been slightly lower than planned in the first quarter and caseload has risen by 60 cases. At this stage, we do not foresee any risk to output for the year. 3. We have reported on low output at investigations previously. The investigation caseload is around 400 cases above the optimal caseload. We are working with external advisers to improve performance. We have also allocated additional funding to undertake more investigation work. 4. Case Examiner and Adjudication caseloads are on track. We have reforecast hearings

Performance Summary

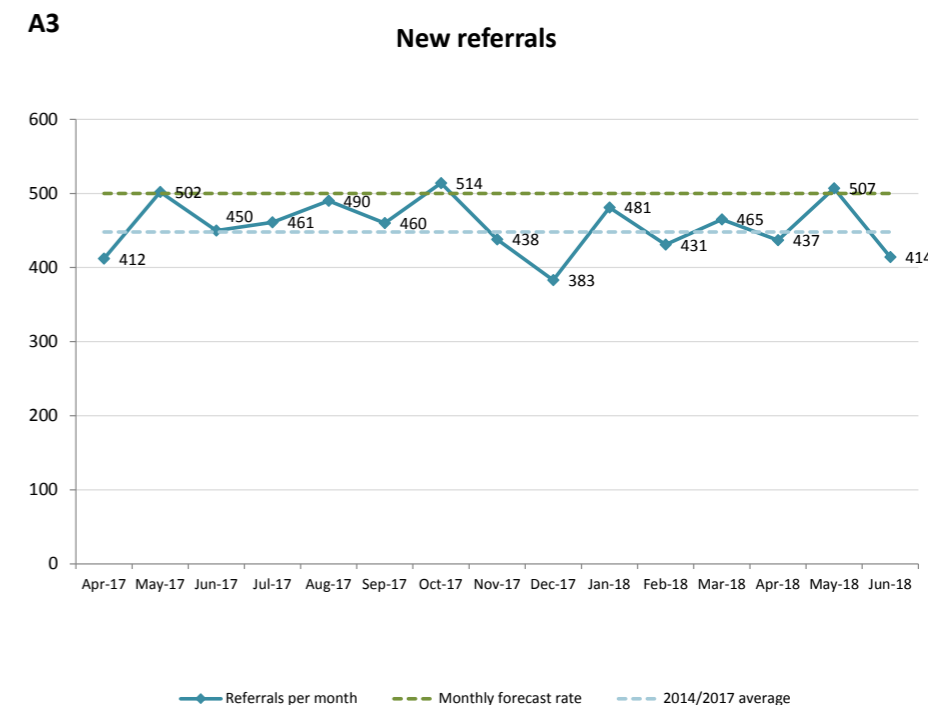
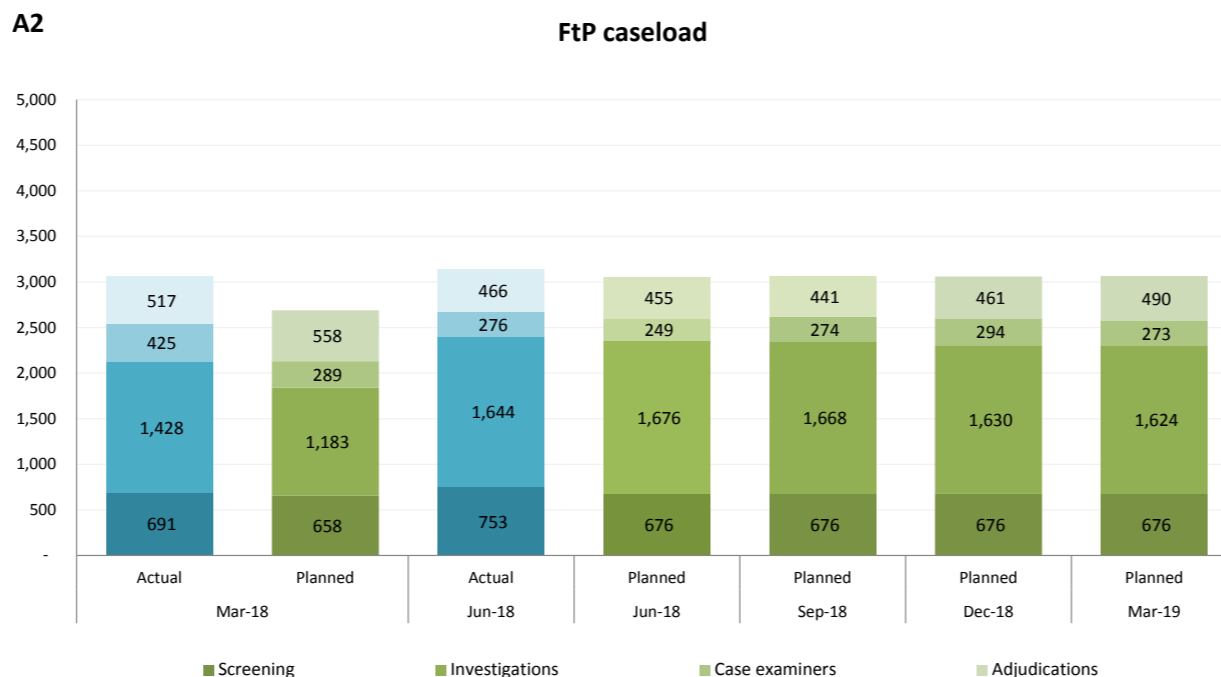
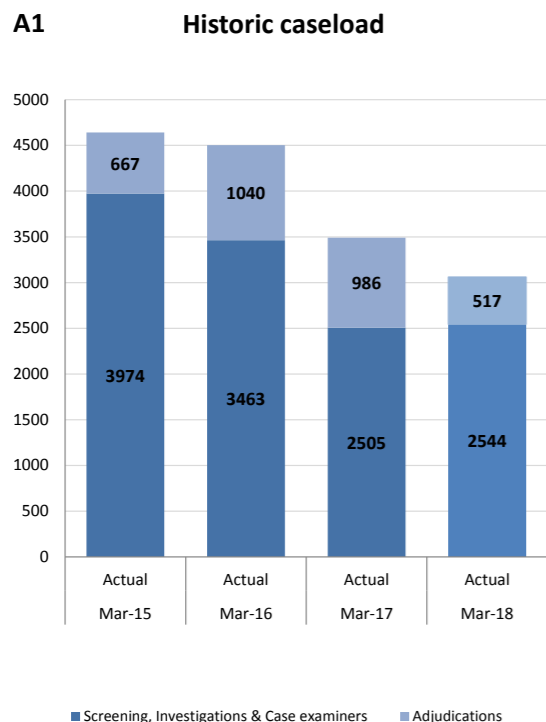
activity for the year in light of the lower investigations output and estimate that we will need to run around 120 fewer hearings.

5. On current assumptions, around 140 more cases will need to be adjudicated in 2019–2020 as output in investigations improves; there is a risk that the financial cost will be carried forward. This may be mitigated in part by future work to reduce the need for fully contested hearings.

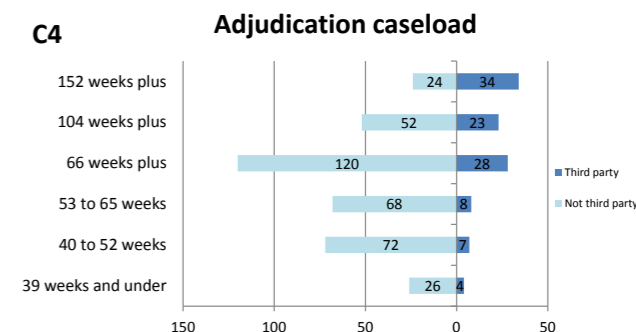
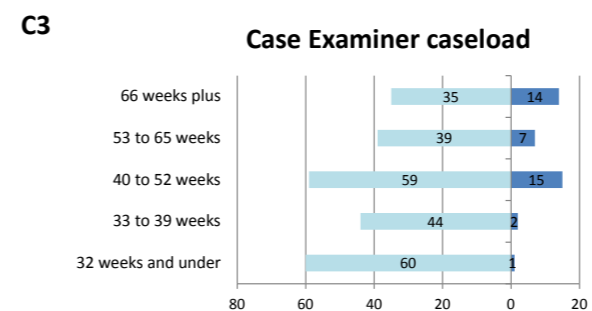
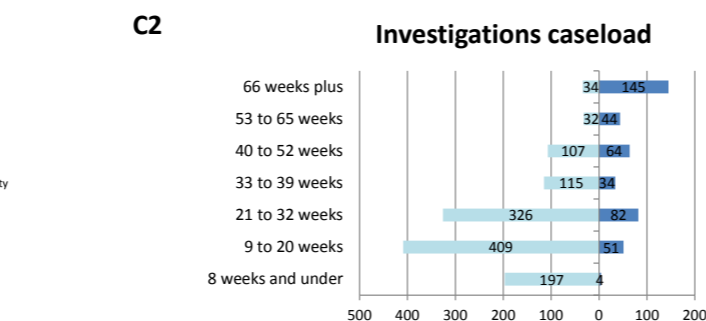
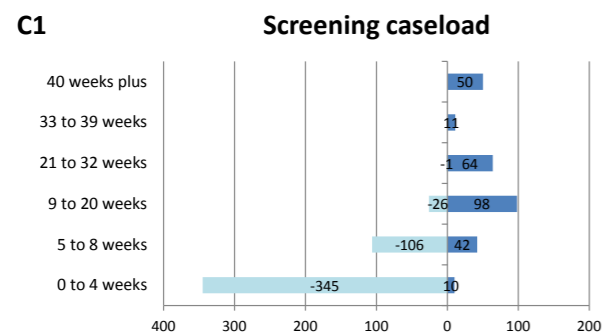
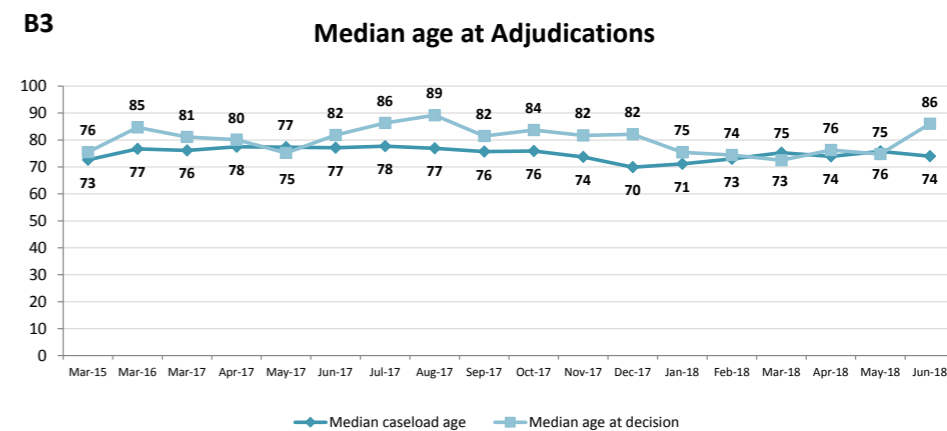
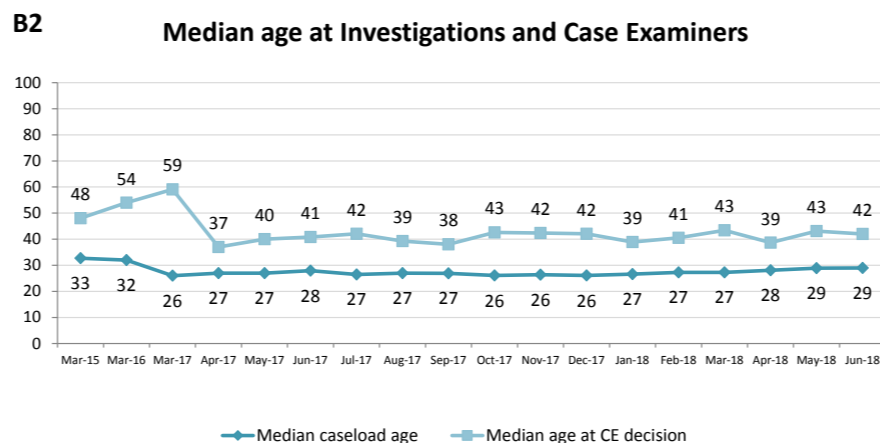
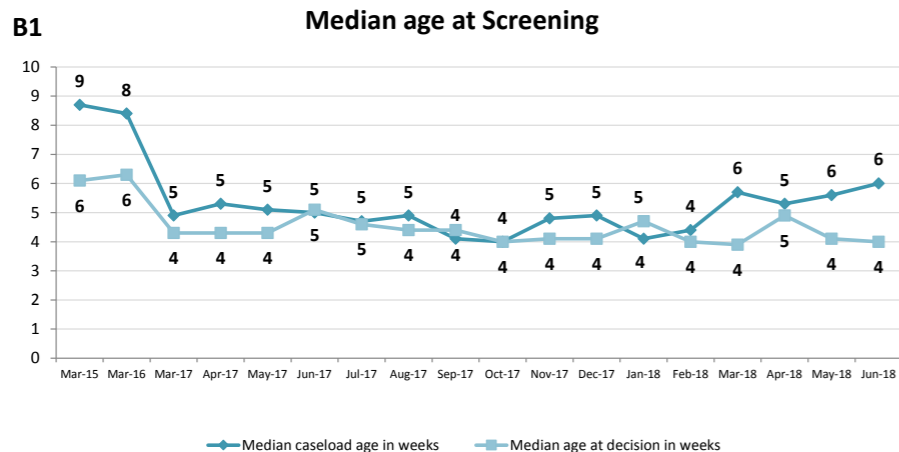
Notes on the FtP dashboard

6. Graph A1 shows the historical caseload data for comparison. Caseload has reduced significantly over the last three years.
7. Graph A2 shows the caseload forecast for 2018–2019. We expect the caseload to be broadly stable during the year. At the end of this quarter, our caseload is slightly above our expected position as outlined above.
8. Graph A3 shows the referral rate, which remains slightly under our maximum capacity of 500 referrals / month.
9. Graphs B1 to B3 show the median ages of cases in the caseload and at the key decision points. The increase in the median age at adjudication decisions reflects the make up of cases in the month: around a third of cases adjudicated were over 2 years old. The underlying median caseload age has not increased.
10. Graphs C1, C2, C3, and C4 reflect the ages of the cases at each stage of the process, split between active cases and cases on hold because of third party proceedings. The dotted lines reflect the timeliness pathway: we are aiming not to have any active cases older than the dotted line at each stage. As noted at the last meeting, the pathway has been realigned from 32 to 33 weeks for investigations, to better reflect the operational handover points. Achieving the timeliness pathway is largely dependent on improving output at the investigation stage.

FtP performance dashboard June 2018



Note: The Case Examiner and Investigation caseloads have been realigned to better reflect the operational handover point between the two case stages. Case Examiners has decreased and Investigations has increased when compared to previous reports.



Caseload Movement Summary
June 2018

Opening caseload 3,115

414 cases received

384 cases closed

3,139 Closing caseload

Glossary

A. Performance Traffic Light Definitions

(Applies to sections 2, 4, and 7)

Red	Significant challenges that put successful delivery at risk
Amber	Challenges to delivery exist but management action is being taken to bring on track
Green	On track

B. Income and Expenditure Traffic Light Definitions (draft)

(Applies to section 3)

	Income	Expenditure	Actions
Red	2% or more below budget	<ul style="list-style-type: none"> 2% or more over budget 10% or more under budget 	<ul style="list-style-type: none"> Escalate to the Council Check whether underspend have affected delivery of the corporate plan Re-prioritise the corporate business plan
Amber	1-2% or more below budget	<ul style="list-style-type: none"> 1-2% over budget 5-10% under budget 	<ul style="list-style-type: none"> Managed by Executive Board Check whether underspend have affected delivery of the corporate plan Adjust the budget to manage variances
Green	Under 1% below budget	<ul style="list-style-type: none"> Less than 5% under budget 	No action

C. Corporate Risk Traffic Light Definitions

(Applies to section 6)

Red	<ul style="list-style-type: none"> High likelihood with high impact
Amber	<ul style="list-style-type: none"> Medium to low likelihood but high impact High likelihood but moderate to minor impact
Green	<ul style="list-style-type: none"> Low likelihood but moderate to minor impact High likelihood but minor to insignificant impact