Meeting of the Council

To be held from 09:30am on Wednesday 26 September 2018
at 23 Portland Place, London W1B 1PZ

Agenda

Philip Graf
Chair

Fionnuala Gill
Secretary

1	**Welcome and Chair's opening remarks**	NMC/18/73	**09:30**
2	**Apologies for absence**	NMC/18/74	
3	**Declarations of interest**	NMC/18/75	
4	**Minutes of the previous meeting** Chair	NMC/18/76	
5	**Summary of actions** Secretary	NMC/18/77	
6	**Chief Executive's report** Interim Chief Executive and Registrar	NMC/18/78	09:40
7	**Delivery Plan** Interim Chief Executive and Registrar	NMC/18/79	09:50
8	**Nursing Associates**	NMC/18/80	10:10
	8a Regulation of nursing associates		
	8b Nursing associates fees		
	Director of Education and Standards		
9	**Gosport Independent Panel report – next steps** Director of Registration and Revalidation	NMC/18/81	10:50
	Coffee		**11:05**

10	**Lessons Learned review: Putting patients and the public at the heart of what we do** Director of Registration and Revalidation	NMC/18/82	11:20
11	**Public Support Service** Director of Fitness to Practise	NMC/18/83	
12	**Midwifery update** Director of Education and Standards	NMC/18/84	12:20
13	**Questions from observers** Chair	NMC/18/85 **(Oral)**	12:35
	Lunch		**12:45**
14	**Investment proposals** Interim Director of Resources/Secretary	NMC/18/86	13:25
15	**Our work with employers and other regulators** Director of Fitness to Practise	NMC/18/87	13:35
16	**Annual equality, diversity and inclusion report 2017–2018** Director of Registration and Revalidation	NMC/18/88	13:50
17	**Welsh language scheme monitoring report 1 April 2017–31 March 2018** Director of Registration and Revalidation	NMC/18/89	14:10
18	**Annual Health and Safety Report 2017–2018** Interim Director of Resources	NMC/18/90	14:20
19	**Performance and Risk report** Interim Director of Resources	NMC/18/91	14:30
20	**Questions from observers** Chair	NMC/18/92 **(Oral)**	14:50

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.

21	**Chair's action taken since the last meeting** Chair	NMC/18/93
22	**Council meeting dates 2019–2020** Secretary	NMC/18/94
	CLOSE	**15:00**

Item 4
NMC/18/76
26 September 2018

Meeting of the Council
Held on 25 July 2018 at 23 Portland Place, London, W1B 1PZ

Minutes

Present

Members:

Philip Graf	Chair
Sir Hugh Bayley	Member
Karen Cox	Member
Maura Devlin	Member
Robert Parry	Member
Marta Phillips	Member
Derek Pretty	Member
Stephen Thornton	Member
Lorna Tinsley	Member
Ruth Walker	Member

NMC Officers:

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/18/50 Welcome and Chair's opening remarks

1. The Chair welcomed all attendees to the meeting.

NMC/18/51 Apologies for absence

1. Apologies had been received from Anne Wright and Jackie Smith.

NMC/18/52 Declarations of interest

1. All registrant members and Geraldine Walters declared an interest in the following items:
   - NMC/18/58 - A new strategic direction for fitness to practise.
   - NMC/18/59 - Education
   - NMC/18/6 - Registration fees for nursing associates
   - NMC/18/68 - Annual Revalidation Report 2017–2018

   In each case this was not considered prejudicial as the individuals were not affected any more than other registrants.

2. Lorna Tinsley and Ruth Walker declared an interest in NMC/18/62 – Midwifery update. This was not considered prejudicial as the individuals were not affected any more than other registrants.

NMC/18/53 Minutes of the previous meeting

1. The minutes of the meeting on 6 June 2018 were agreed as an accurate record.

NMC/18/54 Summary of actions

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

2. Arising from NMC/18/25 and NMC/18/26, the Director of Education and Standards advised that the new Education Quality Assurance (QA) framework was still being finalised. This would be circulated to Council when ready in a few weeks time.

Action:	**Circulate Education QA framework to Council**
For:	**Director of Education and Standards/Secretary**
By:	**31 August 2018**

NMC/18/55 Chief Executive's report

1. The Council considered a report on key external developments. The following points were noted in discussion:
   a) The NMC had become the regulator in England for nursing

associates (NAs) from 13 July 2018 following assent by the Privy Council to the legislative changes to the Order.

b) The NMC had co-hosted a briefing session on regulatory reform in the House of Lords with the General Medical Council (GMC). The event was attended by the Chair and Chief Executive of the NMC and the GMC.

2. The Council paid tribute to the NHS on its 70th anniversary and welcomed the recognition of the significant contribution made by nurses and midwives to the remarkable achievements of the NHS.

NMC/18/56 Lessons Learned – report back

1. The Chair reiterated the Council's commitment and determination to moving forward at pace with the changes and improvements needed in the light of the Lessons Learned review. There was ongoing engagement with those families affected who were willing to be in contact; this would continue as we shaped the work programme. The Health Committee evidence hearing had discussed some of these issues and we would continue to keep the Committee and other stakeholders informed of progress.

2. The Director of Registration and Revalidation introduced the report which focused on the two key areas for improvement identified by the PSA: how we engage better with and listen to patients and the public day to day; and being open and transparent. Other areas for improvement were detailed in the work programme. Other points highlighted included:

a) Engagement with staff on the PSA report showed a keen desire across the organisation to move forward.
b) Council would receive more detailed reports on various aspects of the programme in September, including work to refocus the People Strategy around values and behaviours; work to improve handling of complaints and requests for information; the Public Support Service; and the Employer Link Service.
c) Subject to Council's comments on the proposed work programme, clear objectives, responsibilities, measures and timescales would be identified for each of the proposed actions.
d) This was a substantial programme of activity in terms of both capacity and resources but the Executive was committed to delivery.

3. In discussion, the following points were noted:

a) The ongoing efforts to engage with the families concerned were welcome and should continue.
b) The work on culture, values and behaviours was critically important. Cultural change took time and the Council would want a good understanding of what this change would look like and how it would

be measured. Any changes must be properly embedded and sustainable. Reducing the high turnover rate could be key part of this and an early indicator of change.

c) The Council would also want to look at how members could be facilitated and enabled to lead the culture change, in terms of setting the tone from the top.
d) Similarly, Council would want to be clear about the outcomes of the other improvements proposed and the evidence that would demonstrate things were different: for example, how the Council could assess whether we were being more transparent. The Council would be seeking assurance not reassurance.
e) In relation to complaints, FOI and other requests, in future Council would receive regular reports on learning, trends and themes. It was important that such reports included the bad as well as the good and what we were doing to put things right when they went wrong.
f) The review of all correspondence and letters to make sure they were clear, empathetic and offered the right level of support was welcome. This was a significant task: Council members offered to share expertise which could assist.
g) In relation to record-keeping, Council would want to be clear how it would know robust processes were in place so that information received was easily retrieved. FTP was undertaking more work on sources of assurances and planned to report back to the next Audit Committee in October 2018.
h) Work to better understand expectations of the NMC and what people want from us was planned. Some initial research was proposed which would include listening to and engaging with patients, service users, mothers, families, members of the public and registrants.
i) It was important for observers to recognise that, in addition to public scrutiny, the Council also scrutinised information in private sessions, for example, about complex and live cases which understandably could not be shared in open session.
j) There was also a need to consider how the Council could capture the 'zeitgeist' in terms of the experience of individuals and families who had contact with us: for example, a suitably adapted 'patient story' approach used by Trust Boards. This could be valuable and very powerful. There may also be a need to hear from registrants. The Executive were asked to consider how this might be introduced.

4. This represented a major programme of work, with many deadlines set for the autumn. The Council was absolutely clear that it must be delivered. The Executive needed to give a realistic assessment about capacity to deliver in the light of other major ongoing work programmes, so that the Council could ensure that the right resources were there to enable delivery. The Executive's enthusiasm and commitment to delivering 'at pace' was welcome, but it was important that changes made were long-term and sustainable.

5. Summing up the Chair stressed the Council's determination and

commitment to implementing the Lessons Learned. The Council would want to see:

i. Clear specific timelines, including milestones and allocation of responsibilities, with a realistic assessment of what could be achieved by when.
ii. Clarity about the Council's role and how it would be enabled to play its part.
iii. A clear overall picture setting out what would come back to the Council and when.
iv. Regular ongoing progress reports, with deep dives as appropriate until such time as Council was assured that all the required improvements were securely in place and being sustained.

6. **Decision: Subject to the above, the Council approved the work programme.**

Action:	**Report back as set out in paragraph 5 above.**
For:	**Director of Registration and Revalidation**
By:	**26 September 2018**

NMC/18/57 Gosport Independent Panel report

1. The Chair apologised unreservedly on behalf of the Council and staff to the families affected. Everyone at the NMC was very sorry for what had happened and for the part we had played and the distressed caused. The work of the Independent Panel was commended and tribute paid to the courage and determination of the families in pursuing these matters.

2. The Director of Registration and Revalidation introduced the paper and highlighted a number of points:

a) Whilst there were parallels with the lessons learned review, the Panel's report was being considered independently, so that we did not fall into the trap of assuming that the issues were the same.
b) There were also some differences: until the Panel's report had been published, the NMC was unaware of the full scale of the issues. The report was currently being reviewed carefully and a full report to Council would be provided in September 2018. We had written to those families who had previously had contact with the NMC.
c) It was important to recognise the courage of the nurses who had initially raised concerns but not been listened to at the time. This predated the statutory protections, such as those which now existed for whistleblowers raising concerns and developments such as the duty of candour. However, we should not be complacent and it was important that health care professionals were supported to speak up.

3. The following points were made in discussion:

a) It was important not to be complacent and to assess whether the developments set out in paragraphs 14-16 of the report had made a difference to what we do.

b) The question of recognising when a complaint was a complaint where there was scope for the NMC to act was key and was being carefully considered. The NMC's remit was limited to addressing the actions of individuals; it had no locus to act on systemic issues where no specific individual was referred. What it could do was ensure effective sharing of information with system and other regulators. An escalation protocol with CQC and other health care professional regulators was due to be signed and released in the next few days. Arrangements were also in place for regulators and other agencies involved in a specific case/wider issues to meet and identify the scope and need for action.
c) Whilst there may be cases where NMC action would have to await the outcomes of investigations by others such as the police or coroner, the NMC's duty to protect the public was equally important and may require us to act regardless. Engaging the National Police Chief's Council had proved particularly challenging.
d) Ensuring that our memoranda of understanding with others were not only up-to-date but working in practice was critical. A fuller report on escalation processes and joint working between regulators would be provided in the Employer Link Service Annual Report coming to Council in September 2018.
e) The Council would welcome a detailed analysis of cases being held up due to police investigations as part of the fitness to practise update in the confidential session.
f) It would also be helpful to know whether there were further similar reports pending. This work was being centralised under the Director of Registration and Revalidation.
g) Further work on highlighting to registrants that it was right thing to speak up and continue to raise concerns, even when not being listened to, would be important.

4. The Council noted that a programme of work, including timescales, for both the lessons learned review and the Gosport Independent Panel report was being developed. This should set out clearly which actions derived from each report.

5. **Decision: Subject to the above, the Council approved the proposed next steps.**

Action:	**Provide a report on actions to be taken in the light of the Gosport Independent Panel report**
For:	**Director of Registration and Revalidation**
By:	**26 September 2018**
Actions:	**For the next confidential meeting: i. Provide a detailed analysis of cases being held up due to police investigations; and ii. provide an update on progress of the outstanding memorandum of understanding with the police**
For:	**Director of Fitness to Practise**

By:	26 September 2018

NMC/18/58 A new strategic direction for fitness to practise

1. The Director of Fitness to Practise introduced the report which set out a new strategic direction for fitness to practise. Modifications had been made to the original proposals to take account of the responses to the consultation and research findings and the PSA lessons learned review.

2. In discussion, the following points were noted:
   a) A new approach to FTP had long been an aspiration of the Council as set out in the 2015-2020 Strategy, predating the Lessons Learned review. The Council was pleased that we were now moving this forward.
   b) How we communicated the changes to the public and patients and helped them understand what FTP was for would be challenging but extremely important.
   c) The phrase 'person-centred' approach should be explained. The final documents would be subject to scrutiny by the Head of the Public Support Service (PSS) to ensure that the language was appropriate for all audiences.
   d) This was the beginning of a journey: during the remainder of the year aspects of the new approach, including initial activities of the PSS, would be piloted to assess the impact and resource requirements.
   e) The impact of the FTP process on registrants was recognised. It was not appropriate for the NMC to provide support but it would treat them fairly and signpost them to support from professional bodies, unions and other agencies.
   f) The significance of the changes should not be underestimated. The Council would want to be assured that staff were making the right decisions at the right levels and were being supported to do so.
   g) Our communications with employers about our expectations would also need to be clear.

3. The Council congratulated the Director of Fitness to Practise and all those involved in this work on this significant achievement.

4. **Decision: the Council approved the new strategic direction for fitness to practise.**

NMC/18/59 10a. Review of Return to Practice standards

1. The Director of Education and Standards introduced the paper which sought approval of plans for consultation on the new Return to Practice (RtP) standards.

2. The new standards would need to be 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. The Director of Education and Standards would pick up the issues around routes to rejoin the third part of the register separately.

4. **Decision: The Council approved the proposal to consult on new Return to Practice standards in September 2018.**

10b. Standards for medicines management

1. The Director of Education and Standards introduced the paper which sought approval for the NMC's Standards for medicines management to be withdrawn on 28 January 2019.

2. There remained concern amongst registrants and it was important that the standards were not withdrawn before the Royal Pharmaceutical Society's guidelines were in place. There must not be a gap as this would place registrants in a very difficult position.

3. **Decision: The Council approved withdrawal of the Standards for medicines management once the Royal Pharmaceutical Society's guidelines were in place.**

NMC/18/60 Overseas review – update

1. The Director of Registration and Revalidation introduced the paper which provided an update on the progress of the review of the overseas registration process. Key points highlighted included:

a) Nurses and midwives from outside the UK made a vital and substantial contribution to health care in the UK. The review sought to facilitate suitably qualified overseas applicants joining the register by making the process quicker and less expensive.
b) There was significant interest and engagement in the review.
c) Work was moving at pace with changes were being introduced as and when they could be, for example from 16 July, candidates only needed to re-sit those elements of OSCE that they had failed. Improvements were also being made to the preparatory materials available to help those sitting for OSCE.
d) Work continued on phase two of the English language policy review including exploring further options for candidates to provide alternative evidence of capability.
e) The numbers of overseas applicants joining the register had increased in the past few months and we could be cautiously optimistic that the changes were having a positive impact.
f) As with the rest of the public sector, we were making appropriate preparations should the Government not reach an EU exit agreement. In effect, all former EU applicants would be subject to the same process as overseas applicants.

2. The Council welcomed the report.

NMC/18/61 Update on the consultation on registration fees for nursing associates

1. The Director of Education and Standards introduced the paper which provided an update on the NMC's consultation on the registration fees for nursing associates.

2. The consultation proposed that the fee structure for nursing associates should mirror that of nurses and midwives, as the cost for regulation was the same. There was no reason to change the approach in the light of the responses to the consultation.

3. It was pleasing to see that 16 per cent of nursing associate trainees had responded and we should continue to encourage them to engage actively with the NMC.

4. The Council noted the report and that it would be asked to approve the fees in September 2018.

NMC/18/62 Midwifery update

1. The Director of Education and Standards introduced the midwifery update. In discussion, the following points were noted:
   a) The Midwifery Panel had agreed to the Council's request oversee and provide assurance on development of the new pre-registration midwifery standards.
   b) Professor Bradshaw had agreed to Chair a reference group to assist in development of the new Education programme requirements.
   c) Identification of an independent Chair of the Midwifery Panel was ongoing and Council would be kept informed.
   d) The importance of ensuring that the new standards were informed by learning and in this respect the Fitness to Practise directorate's critical read of the of the recent NHS England external review of a sample of Local Supervising Authority (LSA) supervisory investigations was welcome.
   e) There was concern about whether it was possible to deliver within the current timelines given that there remained a significant amount of work to be done. The Director of Education and Standards was cautiously confident that it would be possible to meet the timescales.
   f) The proposals to make more effective use of social media platforms to engage with women and families were welcome. It was important to think this through carefully and have a considered plan before we approached new mothers and fathers or those who had had difficult or traumatic experiences.
   g) The positive feedback from the Chief Executive's Senior Midwifery Advisor was welcome. It was important that the Council had access to a wide range of views and heard both the good and the bad.

h) The Council would also want to understand how it would receive assurance on the activities and outcomes of the work of the Senior Midwifery Advisor following the departure of the Chief Executive and Registrar. It was noted that the Royal College of Midwives had offered to provide access to it's' networks which was welcome.

2. The Council noted the report.

NMC/18/63 Professional Standards Authority's Annual Performance Review 2016–2017

1. The Director of Registration and Revalidation introduced the Professional Standards Authority's (PSA's) performance review report for 2016-2017, publication of which had been delayed until after completion of the Lessons learned review.

2. The PSA was undertaking a targeted review of seven standards for 2017-2018. The PSA was also now consulting on the revision of the Standards of Good Regulation (SOGR).

3. In discussion, the following points were noted:
   a) It was important to recognise the significant achievement in meeting 23 of the 24 standards.
   b) In relation to the 2017-2018 review, it was unclear to what extent PSA would take account of ongoing work to address the Lessons Learned review. There was a need to be realistic about what the outcomes might be in terms of the number of standards which might be met. The Executive had requested a discussion on this with the PSA.
   c) The outdated guidance referred to in the PSA report had now been corrected.
   d) In terms of revision of the SOGR, the Council would not wish to see any increase in the number of standards and for the emphasis to remain on 'right touch' regulation.

4. The Council noted the report.

NMC/18/64 Comments and questions from Observers

1. The Chair invited questions from observers. The following comments were made:
   a) The discussion of the Gosport Independent Panel Report and the tribute paid to the families affected were welcome. An update in September on the progress made would be welcome.
   b) It was right to recognise the courage of the nurses who tried to raise concerns. However, it should also be recognised that other nurses had been responsible for sub-optimal and negligent care and this should not be glossed over. The Council should look at the case studies in the report.

c) The public's understanding of the role of the NMC was still as poor as it had been as 20 years ago and the Council may wish to consider this.
d) It was also important that the Council's awareness extended to social care and social care services users.
e) An observer noted that the Council's duties included promoting and maintaining health and well being and more could be done in terms of using available intelligence to consider what made it difficult for nurses and midwives to achieve the highest standards of practice.
f) In relation to retention, it was noted that the salary level for some roles may be a contributing factor and should be considered.
g) An RCM observer asked for clarification around the constitution of the Midwifery Panel and its future. The NMC needed to be clear with how it would engage with the midwifery profession going forward. The Director of Education and Standards noted that as a starting point the new Terms of Reference and membership details would be included with the next Midwifery Panel papers.
h) In response to a query about both the time taken and the high success rate of registration appeals referenced in the PSA 2016-2017 report, the Director of Registration and Revalidation advised that the position was now much better. The main reason for success at appeal was production on the day of new information: work had been done to encourage registrants to provide this information at an earlier stage.

NMC/18/65 Audit Committee Annual Report 2017–2018

1. The Chair of the Audit Committee introduced the report and thanked colleagues for their commitment and work over the past year. The following points were highlighted:
a) The Committee had kept its own training and development needs under review throughout the year.
b) In response to the Wiser incident, this would continue to be a key focus for the Committee to re more work to do in that area over the coming year.
c) The Committee had scrutinised the draft Annual Report and Accounts 2017–2018, including the Annual Governance Statement. The Committee had endorsed the letters of representation and Annual Report and Accounts for approval by the Council.

2. In discussion, the following points were noted:
a) The disaster recovery test had been initiated but had not been fully completed due to technical issues. Another test would be undertaken in a couple of months' time.
b) The good relationship between the new internal auditors and the Executive was noted.
c) The Committee's continued focus on GDPR was welcome. It was important not to lose sight of this given other significant work programmes.

NMC/18/66 Draft Annual Report and Accounts 2017–2018

1. The Secretary to the Council introduced the report. Subject to approval by the Council, the Annual Report and Accounts would be signed by the Chair and Interim Chief Executive before submission to Parliament in the autumn.

2. In discussion, the following points were noted:
   a) The accounts were unqualified.
   b) Arrangements for effective assurance handover were in place, given that neither the Chair nor the interim Chief Executive had been in post during the financial year.
   c) There were currently £65m in investments. New proposals had been drawn up for investments going forward but due to the heavy agenda of the meeting, there was not time to discuss these. These would be discussed in September 2018 to ensure
   d) The final post balance sheet review would happen in September 2018 and there were well-established arrangements for this.

3. **Decisions-The Council:**
   a) Authorised the Chair to sign the letter of representation to the external auditors and the Chair and interim Chief Executive to sign the letter of representation to the NAO.
   b) Approved the draft Annual Report and Accounts 2017–2018
   c) **Approved the post balance sheet review process.**

NMC/18/67 Draft Annual Fitness to Practise Report 2017–2018

1. The Director of Fitness to Practise introduced the draft Annual Fitness to Practise Report 2017–2018.

2. In discussion, the following points were noted:
   a) It would be helpful to do further work on cases which reached adjudication and where the finding was that fitness to practise was not impaired, given the impact this had, often over prolonged periods, for both individuals or families raising concerns and the registrants involved.
   b) This was the first report following removal of local supervision: no discernible impact had been seen in terms of referrals of midwives.
   c) Helping people understand our role and potential case outcomes would be part of the work of the PSS. Improving communications about our FTP work more generally would also help.
   d) The significant savings as a result of digital audio recording were noted. There were a few mobile units which could be used in locations outside of London but there was a considerable resource involved in transporting and setting these up.
   e) The report demonstrated the sheer size and scale of FTP operations and the need to put this into perspective when things go wrong.

3. **Decision: The Council approved the draft Annual Fitness to Practise report 2017–2018.**

NMC/18/68 Revalidation Annual Data Report 2017–2018

1. The Director of Registration and Revalidation introduced the Revalidation Annual Data Report 2017–2018. In discussion, the following points were noted:
   a) Revalidation rates remained very positive. The final year of the first 3 year cycle was now underway. The messages in the report aligned with positive feedback and experiences in the workforce.
   b) The report identified scope to work with other regulators to promote the value of reflection in practice across multi-professional teams.
   c) The evaluation next year would focus on the perceived benefit and burden of revalidation with a particular focus on any obstacles faced by those who share protected characteristics.
   d) The number of over 71 year olds who revalidate was impressive: it may be helpful to find out why people chose to stay on the register.
   e) The evaluation by IPSOS Mori would be reviewed with a view to consider how to capture more and better data in the future.
   f) Going forward, there would be a greater reliance on employers in line with the new strategic direction for fitness to practise. It may be worth considering whether it was possible to tap into employers records about employee development needs and quality of practice. This was unlikely to be practical. There were also self-employed nurses and others employed in other sectors; or small employers such as single GP practices. Fitness to practise and revalidation already come together in that an investigation would look at revalidation evidence and the quality of the sign off process.

2. The Council congratulated Karen Cox on her successful revalidation.

3. **Decision: the Council approved the Revalidation Annual Data Report 2017–2018.**

NMC/18/69 Appointments Board Annual Report 2017–2018

1. The Council considered the Appointments Board Annual Report 2017–2018.

2. The Council welcomed the Board's recognition of the importance of addressing the lessons learned review in its work. This should go further than reviewing the Panel Member Service Agreement and performance monitoring framework. Elements of re-training should also be a feature here. The Council was reassured that such training was already underway.

3. The Council thanked the outgoing Chair and members of the Board and noted that the new Chair would take up the role from August 2018.

NMC/18/70 Performance and Risk report

1. The Council considered the performance and risk report. Although funding for the NA programme had yet to be released, the DHSC had given assurance that this should be approved shortly. The position was significantly different from the previous year, since the overall budget for the programme had been approved.

2. In discussion, the following points were noted:
   a) A clearer explanation of performance against KPI 5: FTP timeliness would be helpful.
   b) The increasingly holistic nature of performance and risk reporting was helpful. As a general approach, progress on all major programmes integrated into a single report rather than separate updates would be welcome.
   c) Progress on the People Strategy would be reported back in September 2018. Overall staff turnover had decreased by 6 per cent. The feedback from leavers remained that career progression, feeling valued and pay were key issues. A probation success initiative had been launched which involved a celebratory event once probation had been passed. Council members offered to engage in any initiatives to recognise and value staff, as helpful or appropriate.

Action:	**Provide clearer information about performance against KPI 5 (FTP timeliness)**
For:	**Director of Fitness to Practise**
By:	**26 September 2018**

NMC/18/71 Chair's action taken since the last meeting

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

NMC/18/72 Questions from observers

1. The Chair invited questions and comments.

2. An observer raised a number of issues arising from the annual report and accounts:
   a) Financial charges: the interim Director of Resources advised that these were incurred due to provision for quarterly fee payments.
   b) Pension fund deficit: there were various options available to the Council. An appropriate recovery plan was in place.
   c) Proportion of budget spend on FTP (77%): a key aim of the NMC's strategy was to rebalance that spend.
   d) Staff turnover, helpful comments about working with other regulators around secondments and the value of preceptorship projects were noted and would be considered.

The next meeting of the Council in public will be held on Wednesday 26 September 2018 at the NMC, 23 Portland Place.

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

SIGNATURE: .....

DATE: .....

Item 5
NMC/18/77
26 September 2018

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.

Secretary: Fionnuala Gill
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Fionnuala.gill@nmc-uk.org

Summary of outstanding actions arising from the Council meeting on 26 July 2018

Minute	Action	Action owner	Report back to: Date:	Progress to date
NMC/18/54	**Summary of actions** Circulate Education QA framework to Council	Director of Education and Standards/Secretary	31 August 2018	The QA framework was circulated to Council on 8 August 2018.
NMC/18/56	**Lessons Learned – report back** Report back with: i. Clear specific timelines, including milestones and allocation of responsibilities, with a realistic assessment of what could be achieved by when. ii. Clarity about the Council's role and how it would be enabled to play its part. iii. A clear overall picture of what will come back to the Council and when. iv. Regular ongoing progress reports, with deep dives as appropriate until such time as Council is assured that all the required improvements are securely in place and being sustained.	Director of Registration and Revalidation	26 September 2018	Please see the Lessons Learned report on the agenda.

Minute	Action	Action owner	Report back to: Date:	Progress to date
NMC/18/57	**Gosport Independent Panel report** Provide a report on actions to be taken in the light of the Gosport Independent Panel report	Director of Registration and Revalidation	26 September 2018	A report is on the agenda.
NMC/18/70	**Performance and Risk report** Provide clearer information about performance against KPI 5 (FTP timeliness)	Director of Fitness to Practise	26 September 2018	We have tried to make this clearer in the performance and risk report on the agenda.

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/18/46	**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 26 September 2018	A presentation will be given to Council in confidential session.

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 provide assurance on a) appropriate use of simulation and b) practice placement quality through QA reports.	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. The new QA framework was published on 16 August 2018 and is effective from 1 September 2018. The new QA framework is available on our newly refreshed QA web pages.
NMC/18/26	**Education quality assurance framework** Update the Council on the final QA framework, including i. the differences between major and minor modifications; ii. further work on enhanced scrutiny arrangements;	Director of Education and Standards	25 July 2018 26 September 2018	The QA framework was circulated to Council on 8 August 2018.

Minute	Action	Action owner	Report back to: Date:	Progress to date
	and iii. the criteria and process for withdrawing approvals.			
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 26 September 2018	This information will be included in the new reports we are developing for Council on complaints and customer feedback.

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 27 March 2019	Proposals will be presented to the Remuneration Committee in February 2019, with Council to consider in March 2019.

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.
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	Further information is provided in the report on the confidential agenda.
NMC/17/103	**Annual equality, diversity and inclusion report 2016–2017 and strategic action plan** Provide more analysis of data in future reports and planed action to address findings	Director of Registration and Revalidations	26 September 2018	This information has been provided in the EDI Annual Report on the agenda.

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 as follows: i. It would be helpful if any future ELS activity map could present a picture of the frequency with which Trusts and other employers used the service with some qualitative information about the types of issues being raised, for example, by the two most frequent and two least frequent users. ii. Whilst the report this year was welcome and encouraging, it was focused on activity and process. For the future reports should present a cost effectiveness analysis with a focus on outcomes, costs and benefits. iii. The need to ensure the ELS	Director of Fitness to Practise	26 September 2018	On the agenda for this meeting.

Minute	Action	Action owner	Report back to: Date:	Progress to date
	engages with all relevant employers, including the independent sector, the third sector and in the other countries engagement with other professional regulators. iv. It would be helpful to look at trends across the four countries, with discussions taken forward in the UK advisory forum.			

Item 6
NMC/18/78
26 September 2018

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.

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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. The focus of recent strategic engagement has been primarily around nursing associates, education, fitness to practise and our overseas registration review.

Discussion:

A. External developments

Department of Health and Social Care (DHSC)

2 We continue to engage with senior officials at the DHSC on a range of issues. The interim Chief Executive had an introductory meeting with the Director General, Acute Care and Workforce at DHSC on 13 August 2018 at which she discussed progress on lessons learned, nursing associates and the regulatory reform agenda.

Chief Nursing Officers (CNO)

3 The Interim Chief Executive held a series of introductory discussions with the Chief Nursing Officers for the four countries in August and September 2018. She is keen to maintain direct and regular engagement with the CNOs individually and collectively over the next six months. Issues raised included the Bawa-Garba judgement, nursing associates, and progress on the development of midwifery standards.

Engagement with Parliamentarians

4 After our Council meeting in July 2018, we sent a number of parliamentarians a short update on our activities following the publication of the Professional Standards Authority's (PSA) Lessons Learned review on 27 July 2018. The Directors of External Affairs and Fitness to Practise met Lord Hunt of Kings Heath on 4 September 2018 to discuss our approach to the implementation of the review's recommendations.

5 At the beginning of September 2018, we sent a written submission to the Health and Social Care Select Committee on the lessons learned review and our progress following our oral evidence session on this matter in July 2018.

6 Following the Education Select Committee's oral evidence session on nursing degree apprenticeships on 17 July 2018, we wrote to the Minister of State for Skills and Apprenticeships, the Minister of State for Health and the Chair of the Education Select Committee, clarifying some points raised in the hearing and offering to continue to explore options for the safe management of practice-based learning for student nurses and nursing associates.

7 Ahead of the adjournment debate on the training of nurses in the UK

which took place on Wednesday 5 September 2018, we sent a briefing to parliamentarians expected to take part in the debate. The briefing covered our role in education and standards setting and the introduction of nursing associates.

B. Accountability and oversight

8 On 14 August 2018, we submitted our response to a series of targeted questions we received from the PSA as part of our performance review process for 2017–2018. On 28 August 2018, we had a follow up meeting with the PSA's Assistant Director for Scrutiny and Quality and the Scrutiny Officer responsible for our performance review; the meeting was very helpful for both sides to provide additional clarification on some of the points raised in our response.

9 Subject to the PSA requiring further information, it will present final conclusions to its internal assessment panel who will make a final decision on the outcome of our 2017–2018 performance review. This is expected by the end of September 2018; and publication of the final report proposed by the end of November 2018.

10 The Interim Chief Executive met the PSA's Chief Executive on 7 August 2018 for an introductory discussion and an update on the lessons learned review.

C. Stakeholder Engagement and Communication

Education

11 Following the future nurse and education standards publication launch event in Westminster in May 2018, we are holding further events in Scotland, Wales and Northern Ireland in October 2018. The events will be attended by the NMC Chair and some NMC Council members.

12 We are currently developing stakeholder engagement and communications activity to support the implementation of the new standards which will begin in September 2018. This will include 14 workshops in the four countries; interactive webinars; online information and digital and social media content.

13 Our engagement will also include updating relevant stakeholders on our Quality Assurance (QA) plans via webinars in September 2018.

14 We completed the second phase of early engagement for the future midwife project in July 2018, which fed into the first draft of the new proficiencies. To date we have spoken with over 500 people across the UK.

15 We have held successful webinars on Return to Practice with a wide range of stakeholders including educators and commissioners, and

we'll hold focus groups with students and others in September 2018.

Fitness to practise

16 We have been keeping stakeholders informed of our new approach to fitness to practise through regular written communications, enhanced website content, engagement events and media activity. On 21 September 2018, we conducted a live Twitter Q&A with the Director of Fitness to Practise and the Head of the Public Support Service to raise awareness of our new approach and give people the opportunity to ask questions and share their views.

Nursing associates

17 Ministers and members of the Education Select Committee received briefings from our Public Affairs Team to inform their evidence session on nursing degree apprenticeships, specifically on the training models and supernumerary status implemented in the nursing associate test sites.

18 Last month we launched our film on nursing associates, which showed trainees and registered nurses sharing their aspirations and ambitions for the role and how regulation will benefit patient care. The film has received a very positive response from audiences and has been shared widely by our stakeholder organisations.

Nursing

19 The Interim Chief Executive met with the Acting Chief Executive and General Secretary at the Royal College of Nursing on 23 August 2018. A range of issues were discussed including progress on nursing associates and work relating to Brexit.

20 The Chair and the Interim Chief Executive attended the meeting of the Shelford Group of nurses which took place on 18 September 2018. The Chair shared an update on ongoing activities at NMC, his initial thoughts on the organisation since taking up the role and the progress with the recruitment of a substantive chief executive.

Midwifery

23 On 16 July 2018, the Senior Midwifery Advisor to the Chief Executive visited the Simpson Centre for Reproductive Health at the Edinburgh Royal Infirmary. During her visit, she met midwives and members of the wider multi-professional team and heard about the work that is being undertaken in the area of bereavement care. The team in Edinburgh are working with a charity that supports the provision of compassionate care to families following the death of their baby.

24 On 14 August 2018, the Interim Chief Executive met the Chief Executive of the Royal College of Midwives. Discussion focused on

the progress on the development of the midwifery standards.

Brexit

25 We are continuing to closely monitor and respond to matters relating to the UK's exit from the European Union (Brexit). An internal Brexit working group meets regularly to review the latest regulatory developments, and risks and impacts to nurses and midwives and our operations. We continue to engage with various stakeholders and our planning is well underway for dealing with the various possible scenarios.

Overseas

26 We are reviewing our entire overseas registration process. We are midway through a period of engagement to hear people's views about how we can improve our policies and processes.

27 We have held workshops in Glasgow, Belfast, London, Manchester and Cardiff with around 300 people including employers, recruitment agencies and applicants.

28 Over 200 people have joined our webinars to share their views, many of whom have been through our overseas registration process and were able to share their experiences.

29 We have been holding focus groups with key groups such as NHS and independent sector employers and equalities stakeholders. We will also be holding focus groups at hospitals including Barts Health NHS Trust.

D. Collaboration

30 The interim Chief Executive has had introductory meetings with the Chief Executive of the General Medical Council on 22 August 2018 and the Chief Executive of the General Pharmaceutical Council on 6 September 2018.

31 The NMC Chair met with his opposite number at the Health Care and Professions Council (HCPC) for an initial meeting on 6 September 2018.

32 We continue to be keen to explore regulatory reform with our regulatory body partners. We keenly anticipate the DHSC's response to their 2017 consultation on regulation which is expected in autumn 2018.

E. Media activity

33 In July 2018, we issued a press release highlighting the number of nurses and midwives from outside the EU on our register was increasing. This announcement was made alongside changes to our

overseas registration processes. This received widespread national print coverage including in the Daily Mail and the Sun. The Director of Registration and Revalidation was quoted widely. This coverage also referenced analysis by the Health Foundation of our April 2018 data report which showed a drop in the number of EU nurses and midwives registered in the UK.

34 In August 2018, there was significant coverage in national broadcast and print media of the decision to reinstate Dr Bawa-Garba to the medical register after she previously struck off, following the GMC's appeal of the original MPTS decision. We were not mentioned directly in the coverage, however, the nurse who was struck off our register following a conviction for gross negligence manslaughter was referenced in some of the coverage.

35 In September 2018, there was substantial national media coverage of the decision to widen the investigation into maternity care at Shrewsbury and Telford hospital trust after more families came forward with concerns about the care they received.

36 Following the publication of our second revalidation annual report and a separate independent analysis by IPSOS Mori, we issued a press release which highlighted the key findings and stated how positive nurses and midwives are finding the process. There was positive coverage in Nursing Times and Nursing Standard.

Public Protection Implications

37 No direct public protection implications.

Resource implications:

38 No direct resource implications.

Equality and diversity implications:

39 No direct equality and diversity implications.

Stakeholder engagement:

40 Stakeholder engagement is detailed in the body of this report.

Risk implications:

41 No direct risk implications.

Legal implications:

42 No direct legal implications.

Item 7
NMC/18/79
26 September 2018

Council

Delivery plan

Action: For discussion.

Issue: Provides Council with an update on the organisational priorities and programmes of work for the next 12 months.

Core regulatory function: All regulatory functions.

Strategic priority: All strategic priorities.

Decision required: None.

Annexes: The following annexe is attached to this paper:

- Annexe 1: Key deliverables.

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 At its confidential meeting in July 2018, the Council was presented with a report which set out the current picture of corporate priorities and risks, in the light of the Lessons Learned review.

2 The Council recognised that the Lessons Learned programme would need considerable energy and focus. Given existing corporate commitments and major work programmes, such as delivering Nursing Associate regulation, reviewing our overseas processes and modernising our IT, this represented a significant organisational challenge.

3 The Council therefore asked the interim Chief Executive and Registrar to undertake a thorough examination of the organisational priorities with the Executive and to look at capacity and resource challenges that these may present over the next six to 12 months.

Four country factors:

4 None.

Discussion:

5 Over the summer, the Executive undertook a review of each of the organisational priorities, with a view to identifying opportunities to pause or defer some of the projects. A large amount of work is underway falling into three main areas:

5.1 Changing our approach:

- Lessons Learned
- Fitness to Practise
- Value and behaviours

5.2 Core Business and new initiatives:

- Overseas registration
- Nursing Associates
- Education

5.3 Enhancing our capability and infrastructure:

- Modernising our technology
- Developing our people
- Improving our communications

6 After a thorough examination of the programmes and extensive debate, the Executive did not feel that any of the existing priority programmes should be paused or deferred and there was sufficient

capacity to deliver. However we will need to monitor progress carefully and re-prioritise if new issues arise in-year. We will report regularly to Council on progress.

7 The key dealines that we have to meet are set out in Annexe 1. These must remain our top priority.

8 Although we have made considerable progress in defining key work programmes, further work is needed on the 'enhancing our capability and infrastructure' workstreams to fully develop the future timelines for this work and get a better understanding of impact on the other workstreams:

8.1 Modernising our technology – we now have a contract in place for the modernisation of technology services and a new Director of Technology and Business Innovation, and a programme manager in place. This work is therefore moving ahead. However, once the full modernisation programme is better defined we will need to review how this impacts other workstreams.

8.2 Developing our people – work on tackling the need for cultural change highlighted by the PSA Lessons Learned review is already in train as part of the fitness to practise strategy. We are also clearer about the factors driving our staff turnover rate and the rate of turnover has started to move in the right direction. This is not a quick fix however. Developing our people will be a long term programme. A key date over the next few months will be the employee conference on 1 November 2018.

8.3 Improving our communications – considerable work is already underway in this area and there will be a more detailed report to Council in October 2018 on developing our work on engagement and stakeholder relationships.

Public protection implications: 9 None arising from this paper.

Resource implications: 10 None arising from this paper.

Equality and diversity implications: 11 None.

Stakeholder engagement: 12 Each of the priority programmes includes extensive stakeholder

engagement.

13 To build trust in the organisation and show how we are changing we need to think about a series of events and engagement activity including with patients and the public, registrants and key stakeholders across the four countries. This will be included as part of the work outlined on stakeholder engagement at 8.3.

Risk implications: 14 None arising from this paper.

Legal implications: 15 None.

Item 7: **Annexe 1**
NMC/18/79
26 September 2018

Key deadlines	Programme	Activity	Director responsible
September 2018	FtP strategy	FtP pilots launched	Matthew McClelland
	Education	Return to Practise consultation launched	Geraldine Walters
	Education	New QA framework launched	Geraldine Walters
	Modernising IT	Signing of contract with delivery partner	Richard Sheldon
October 2018	Nursing associates	Fees, Code and Standards published	Geraldine Walters
	Lessons Learned Review	New approach to Complaints and FOIs agreed and launched	Emma Broadbent
	Accommodation	New lease signed	Andy Gillies
	Education	Approvals of nursing programmes against new QA framework begins	Geraldine Walters
November 2018	People and OD	Annual Staff Conference	Sarah Daniels
	Corporate	Professional Standards Authority publishes NMC annual review	All
January 2019	Modernising IT	NA and overseas infrastructure go live	Richard Sheldon
	Nursing Associates	Open NA register and register first NAs	Geraldine Walters
	Overseas	Open overseas route for NAs	Emma Broadbent
February 2019	Education	Midwifery standards consultation launched	Geraldine Walters
April 2019	People and OD	Implement new	Sarah Daniels

		employee pay and reward strategy	
	FtP Strategy	Implementation of new approach	Matthew McClelland
	Education	Return to Practise standards published	Geraldine Walters
June 2019	Accommodation	Decant from Aldwych	Andy Gillies
July 2019	Modernising IT	New register infrastructure go live	Richard Sheldon
	Overseas	New overseas route for nurses and midwives opens	Emma Broadbent
	Accommodation	Decant from Kemble St	Andy Gillies
September 2019	Accommodation	Lease ends Aldwych	Andy Gillies
December 2019	Accommodation	Lease ends Kemble St	Andy Gillies
January 2020	Education	Publish new midwifery standards and proficiencies	Geraldine Walters
	Modernising IT	FtP case management service infrastructure go live	Richard Sheldon
September 2020	Education	All nursing and midwifery programmes to be approved against new standards.	Geraldine Walters

Item 8a
NMC/18/80
26 September 2018

Council

Regulation of nursing associates

Action: For decision.

Issue: Seeks Council's approval of the standards and guidance we will use to regulate nursing associates.

Core regulatory function: All regulatory functions.

Strategic priority: Strategic priority 1: Effective regulation.
Strategic priority 4: An effective organisation.

Decision required: The Council is recommended to approve:

- the amended Code (paragraph 18)
- the Standards of proficiency for nursing associates (paragraph 30)
- the Standards for pre-registration nursing associate programmes (paragraph 42)
- the updating of our policies to reflect that our standards and guidance relating to registration, revalidation and fitness to practise will now apply to nursing associates (paragraph 45)

Annexes: The following annexes are attached to this paper:

- Annexe 1: Draft Code for nurses, midwives and nursing associates.
- Annexe 2: Draft Standards of proficiency for nursing associates.
- Annexe 3: Draft Standards for pre-registration nursing associate programmes.
- Annexe 4: Background note on protected learning time in pre-registration nursing associate programmes.

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 Government has amended our legislation (Nursing and Midwifery Order 2001 ('the Order')) to give us new powers to regulate nursing associates. These came into effect on 12 July 2018.

2 The changes to our legislation provide for the regulation of nursing associates to be broadly the same as the approach we take to nurses and midwives.

3 To develop our approach to the regulation of nursing associates we have engaged with a wide range of stakeholders including members of our Nursing Associate External Stakeholder Group, nurses, educators, service users, employers and trainee nursing associates. We have also benefited from the close involvement of the Council in the development of our regulatory approach.

4 On 9 April 2018 we launched our main consultation on our proposed approach for nursing associate regulation. The consultation was open for 12 weeks. There was a full online consultation and a shorter more accessible consultation. We hosted a series of events across England to provide further opportunities for engagement, and met with specific groups where opportunities arose, such as children's nurses and GP practice nurses. We commissioned focus groups with particular stakeholders, such as people with learning difficulties, to make sure we had the benefit of an inclusive range of perspectives.

5 In line with Council's steer, and the changes to our legislation, we consulted on broadly the same regulatory approach which is in place for nurses and midwives and how it may apply to nursing associates. Our consultation covered:

5.1 **Extending current standards and guidance for nursing associates:** The Code (see paragraphs 12-18) and regulatory processes such as the quality assurance of education, registration, revalidation and fitness to practise (see paragraphs 43-45).

5.2 **New regulatory standards for nursing associates:** Standards of proficiency (see paragraphs 19-30), education standards and programme standards (see paragraphs 35-42).

Four country factors:

6 Health policy and workforce are devolved matters. The NMC is a four country regulator, regulating nurses and midwives in England, Wales, Northern Ireland and Scotland. This is the first instance in which the NMC will regulate a profession only in England.

7 From the NMC's perspective, all four countries of the UK retain a

stake in the NMC's approach to regulation, as we are a UK-wide regulator. We sought and received responses to the consultation from stakeholders across the UK and we responded positively to requests for engagement on nursing associates from the devolved administrations. For example, we have provided inputs to directors of nursing in Northern Ireland and other regulators in Wales.

Detail: **Consultation summary**

8 A total of 1149 respondents answered some or all of the questions included within the full consultation survey. The majority of responses are from individuals, but 113 responses have also been received from organisations – the majority of which are employers or education providers.

9 The responses from individuals, can be broken down into the following sub-groups:

9.1 UK registered nurses – 56 per cent, of which:

9.1.1 – 63 per cent adult nurses

9.1.2 – 10 per cent children and young people nurses

9.1.3 – 8 per cent mental health nurses

9.1.4 – 1 per cent learning and disability nurses

9.1.5 – 18 per cent other nurses

9.2 Nursing associate students – 24 per cent

9.3 Nursing educators – 14 per cent

9.4 Others – 6 per cent

10 In total, 93 per cent of individual respondents identified their country of residence as England. This is in line with what we expect as the consultation mainly concerns regulation in England and all of the nursing associate student responses will be from England.

11 Overall, there was a consistent and strong degree of support for our proposals for the regulation of nursing associates. We analysed all of the comments made in the consultation and incorporated good suggestions where applicable.

The Code

12 People on our register are required to uphold the standards in the

Code. The Code sets out public expectations of behaviour and practice on the part of registered professionals. The latest version was published in 2015.

13 We proposed a single Code for the professions we regulate, in line with our current practice and that of other multi-professional regulators. This means the public can have confidence that everyone we regulate upholds the same high standards, whatever their level and sphere of practice. The standards in the Code are substantially unchanged but we proposed a small number of textual amendments to make the Code suitable for the regulation of all three professions.

14 89 per cent of respondents agreed that the revised introduction explains how the Code applies to nursing associates as well as the other professions the NMC regulates. 90 per cent of respondents felt that the standards within the Code should also apply to nursing associates.

15 Following the consultation we have updated the wording of the Code to provide further clarity in some areas.

16 The updated Code is at Annexe 1. If agreed, this Code will apply to all the professions that we regulate.

17 Many stakeholders commented that people on our register would value more information on delegation and accountability, and we have produced some additional material on this which is available on the NMC website.

18 **Recommendation: The Council is recommended to approve the amended Code.**

Standards of proficiency for nursing associates

19 The Standards of proficiency are the minimum standards required to join the new nursing associate part of our register. They set out what all nursing associates should know and be able to do when they join the register. In common with other professions, nursing associates can acquire other knowledge and skills pre- and post-registration if supported to do so.

20 The Standards of proficiency for nursing associates are derived from the standards of proficiency for registered nurses. Council supported this design principle because it helps to show the synergies and the differences between the two roles, and makes it easy to identify the additional proficiencies required to progress from being a nursing associate to become a registered nurse via a nursing degree.

21 Our Standards of proficiency attracted a very high degree of

support across a number of important questions:

21.1 82 per cent of respondents agreed that the proposed Standards of proficiency for nursing associates set an appropriate level of knowledge and skill for all nursing associates at the point of registration.

21.2 70 per cent of respondents agree that they adequately distinguish the knowledge and skill expected of a nursing associate in comparison to what is expected from a registered nurse.

21.3 Furthermore, 74 per cent of respondents agreed that the Standards of proficiency for nursing associates, taken together with the new Standards of proficiency for registered nurses, help educators define the additional requirements for programmes that will enable progression to degree-level nursing.

21.4 75 per cent of respondents agreed that the Standards of proficiency for nursing associates are appropriate for a generic nursing associate role.

22 We also asked whether there were any additional elements that stakeholders felt needed to be included or removed from the Standards of proficiency and the skills annexe. Even though most respondents were of the view that nothing else needed to be included or removed, these questions generated the most comments and we analysed each one in turn to consider stakeholder views and whether any suggestions could usefully be incorporated.

23 As a result and following careful consideration of all the consultation comments, we have updated the Standards of proficiency. We have updated the wording to provide further clarity throughout and to align, where appropriate, to the final Standards of proficiency for registered nurses, which were published during the nursing associate consultation period.

24 The administering medicines section of the Standards received some comments, specifically in relation to the routes of administering injections, where some stakeholders felt that the intramuscular route injections (directly applied into a muscle) should be included and the intradermal route (situated or applied within the layers of the skin) be removed. We discussed this with a group of clinical and educational experts and have updated the Standards to include intramuscular and have removed intradermal (skills annexe reference - Annexe B, 10.5).

25 The nursing associate's role with regard to assessment also generated some comments, where stakeholders were seeking

further clarity on this. The Standards of proficiency include the skills that nursing associates will need to be able to input and contribute to assessment, such as monitoring, evaluation and specific assessment skills, however they do not include Standards relating to primary assessment.

26 Even though 75 per cent of respondents felt that the Standards of proficiency are appropriate for a generic nursing associate role, some felt that the Standards were too acute or adult focussed. Where specific examples were given of skills that could be included to address this, we have incorporated them within the Standards. This mainly relates to the communication and relationship management skills in Annexe A of the Standards of proficiency.

27 We received some views that venepuncture (process of obtaining intravenous access for the purpose of intravenous therapy or for blood sampling of venous blood) and cannulation (introduce a cannula or thin tube into (a vein or body cavity)) were skills that should be removed from the Standards of proficiency. Having considered these further and discussed with a group of clinical and educational experts, we have proposed that venepuncture remains within the skills annexe, as only a few people specifically expressed concerns about it. However, more people expressed concerns about cannulation and due to the complexity and length of time involved in training someone to cannulate and the view that this skill would not be required by all nursing associates, we have removed cannulation from the skills annexe (skills annexe reference - Annexe B, 1.3).

28 It is worth noting that the standards of proficiency set out what all nursing associates need to know and be able to do when they join the register. This does not mean that nursing associates are prohibited from doing things which are not in the standards of proficiency. There is nothing in the NMC's regulatory framework that prevents the acquisition of additional knowledge and skills, pre- or post-regulation. The same applies to nurses and midwives.

29 The updated Standards of proficiency for nursing associates are at Annexe 2.

30 **Recommendation: The Council is recommended to approve the Standards of proficiency for nursing associates.**

Education standards

31 All AEIs, and their practice partners need to meet the NMC's:

31.1 Standards framework for nursing and midwifery education

31.2 Standards for student supervision and assessment.

32 We asked stakeholders whether our standards for education and training (referred to in 25.1 and 25.2 above) should also apply to providers of nursing associate education.

33 91 per cent agreed that the Standards framework for nursing and midwifery education should apply to nursing associate programmes and 90 per cent agreed that the Standards for student supervision and assessment should apply to nursing associate programmes.

34 We will now review and update both the Standards for nursing and midwifery education and Standards for student supervision and assessment so that they reflect the regulation of pre-registration nursing associate programmes.

Standards for pre-registration nursing associate programmes

35 We also consulted on our proposed standards for pre-registration nursing associate programmes.

36 We asked questions on certain aspects of the standards that are specific to nursing associate programmes. In response to these questions we found that:

36.1 65 per cent agreed that a 50 per cent cap on the recognition of prior learning would be appropriate for applicants wanting to join a nursing associate programme.

36.2 Some respondents felt that this cap should be higher or removed, because some assistant practitioners will have completed programmes similar to nursing associate programmes. After careful review our decision is unchanged, because there is no group exemption we could safely apply to assistant practitioners, as their programmes are diverse in terms of content.

36.3 46 per cent agreed and 28 per cent disagreed that the cap for recognition of prior learning should not apply to registered nurses who want to join a nursing associate programme.

36.4 77 per cent agreed that nursing associate programmes should provide an equal balance of theory and practice learning.

36.5 77 per cent agreed that nursing associate pre-registration programmes include at least 2,300 protected theory and practice learning hours in total.

36.6 80 per cent agreed that the academic award associated

with a nursing associate programme should be a Foundation Degree. If Council approves Foundation Degree as the appropriate award, institutions applying for approval to run nursing associate programmes will require Foundation Degree-awarding powers, or have access to those powers through another Foundation Degree-awarding institution.

36.7 69 per cent agreed that the standard that specifies that 'students should be provided with learning experiences involving patients with diverse needs, across the lifespan, and in a variety of settings', is at the right level and the NMC does not need to be more prescriptive about how time should be spent. We will however provide some additional supporting information in this regard.

Protecting learning time on practice placements

37 While our standards are intended to be neutral as to the routes to qualification taken by students, we acknowledge that nursing associates are likely to be the first profession on our register for which apprenticeship is likely to be the most common route. The apprenticeship levy, which is therefore likely to be the principle funding route for nursing associate programmes, can only be spent on training costs and not on related costs incurred by host settings such as backfill. The NMC has been encouraged to consider the possible impact of supernumerary status on the take-up of nursing associate opportunities.

38 We asked two questions in the consultation focusing on how learning should be protected in practice and whether the same supernumerary requirement should apply to nursing associate pre-registration students, or whether we should permit other approaches that adequately safeguard patients and students. Both propositions received majority support. Overall 66 per cent agreed with supernumerary being a requirement for pre-registration nursing associate programmes. However, 62 per cent also agree that the NMC should permit a different approach to protecting learning in practice settings.

39 We set up a national task and finish group to explore approaches to protecting learning in practice and we propose two options that we believe can protect patient safety and student learning, which are:

39.1 Option A: Maintains the status quo and students are supernumerary when they are learning in practice.

39.2 Option B: Providers have discretion to demonstrate how they will protect sufficient learning time in practice. Of time spent in practice settings, only protected learning time can

count towards programme hours. There is no change to the requirement that all students must be adequately supervised when they are working towards proficiency. The same minimum programme hours apply to all students regardless of route.

40 Option B increases the onus on AEIs and partners to ensure that students benefit from appropriate learning opportunities, and on NMC quality assurance. In addition to scrutinising proposals at the point of approval we will conduct an evaluation of Option B starting in 2019.

41 Following the consultation analysis, the updated Standards for pre-registration nursing associate programmes are at Annexe 3. These include an updated standard covering protected learning time and Annexe 4 provides further background to this.

42 **Recommendation: The Council is recommended to approve the Standards for pre-registration nursing associate programmes.**

Core regulatory processes

43 The Department of Health and Social Care (DHSC) consulted on the same core regulatory processes applying to nurses, midwives and nursing associates. It is therefore proposed that we will apply the same guidance as for nurses and midwives relating to these approaches to education quality assurance, registration, revalidation and fitness to practise to nursing associates.

44 The consultation showed that:

44.1 93 per cent of respondents agreed that the English language requirements for nursing associates should be the same as they are for nurses and midwives

44.2 Over 90 per cent of respondents agreed that the same revalidation requirements for nurses and midwives should apply to nursing associates

44.3 69 per cent of respondents felt there were no implications of extending our fitness to practice approach to nursing associates and most of those that said that there were implications cited NMC resource and capacity implications rather than regulatory approach implications in their responses.

45 **Recommendation: The Council is recommended to approve the updating of our policies to reflect that our standards and guidance relating to registration, revalidation and fitness to practise will now apply to nursing associates.**

Next steps

46 Subject to Council's approval, we will publish the standards in early October 2018, so that programme approvals can begin.

47 We also intend to publish on our website a summary report on the outcome of the consultation in early October 2018.

48 There is a full communications plan for the publication of the standards.

Public protection implications:

49 The NMC agreed to regulate nursing associates because we believe we can enhance public protection by doing so. The principle test of our standards and guidance is that they should support us to meet our statutory duties for public protection and public confidence in the professions we regulate.

Resource implications:

50 The DHSC is meeting costs incurred by the NMC in setting up the regulation of nursing associates.

Equality and diversity implications:

51 The nursing associate programme is the subject of a full equality impact assessment which is monitored by our Nursing Associate Delivery Board, so that any unwarranted differential impacts can be identified and addressed.

Stakeholder engagement:

52 The paper details the extensive engagement associated with the development of these standards and guidance.

Risk implications:

53 There is a risk that if the standards and guidance are not approved, there will be a delay in programme approvals and the registration of the first cohort of nursing associate applicants. We have a statutory duty to open the new part of our register on 26 January 2019.

Legal implications:

54 We have a legal responsibility to publicly consult prior to approval of any amendments to our Order. To fulfil this obligation we consulted on our standards and associated guidance relating to our future approach to regulation between 9 April and 2 July 2018. Our legislation has been changed to allow us to regulate nursing associates and the standards and guidance presented for approval are aligned to our new powers and duties.

Item 8a: **Annexe 1**
NMC/18/80
26 September 2018

The Code
Professional standards of practice and behaviour for nurses, midwives and nursing associates

About us

The Nursing and Midwifery Council exists to protect the public. We do this by making sure that only those who meet our requirements are allowed to practise as a nurse or midwife in the UK, or a nursing associate in England. We take action if concerns are raised about whether a nurse, midwife or nursing associate is fit to practise.

It is against the law to claim to be, or to practise as, a nurse or midwife in the UK, or as a nursing associate in England, if you are not on the relevant part of our register.

It is also a criminal offence for anyone who, with intent to deceive, causes or permits someone else to falsely represent them as being on the register, or makes a false representation about them on being on the NMC register.

Publication date: 29 January 2015

Effective from: 31 March 2015

Updated to reflect the regulation of nursing associates: xx/xx/2018

A note on this version of the Code

All regulators review their Codes from time to time to make sure they continue to reflect public expectations. This new version of the Code is substantially similar to the 2015 version, but it has been updated to reflect our new responsibilities for the regulation of nursing associates. In joining the register, nursing associates will uphold the Code.

The current versions of our Code, standards and guidance can always be found on our website. Those on our register should make sure they are using the most up to date version of the Code.

For more information about the Code, please visit: www.nmc.org.uk/code

Introduction

The Code contains the professional standards that registered nurses, midwives and nursing associates[1] must uphold. Nurses, midwives and nursing associates must act in line with the Code, whether they are providing direct care to individuals, groups or communities or bringing their professional knowledge to bear on nursing[2] and midwifery practice in other roles, such as leadership, education, or research. The values and principles set out in the Code can be applied in a range of different practice settings, but they are not negotiable or discretionary.

Our role is to set the standards in the Code, but these are not just our standards. They are the standards that patients and members of the public tell us they expect from health professionals. They are the standards shown every day by those on our register.

When joining our register, and then renewing their registration, nurses, midwives and nursing associates commit to upholding these standards. This commitment to professional standards is fundamental to being part of a profession. We can take action if those on our register fail to uphold the Code. In serious cases, this can include removing them from the register.

The Code sets out common standards of conduct and behaviour for those on our register. This provides a clear, consistent and positive message to patients, service users and colleagues about what they can expect of those who provide nursing or midwifery care.

The professions we regulate have different knowledge and skills, set out in three distinct standards of proficiency. They can work in diverse contexts and have different levels of autonomy and responsibility. However, all of the professions we regulate exercise professional judgement and are accountable for their work.

Nurses, midwives and nursing associates uphold the Code within the limits of their competence. This means, for example, that while a nurse and nursing associate will play different roles in an aspect of care, they will both uphold the standards in the Code within the contribution they make to overall care. The professional commitment to work within one's competence is a key underpinning principle of the Code (see section 13) which, given the significance of its impact on public protection, should be upheld at all times.

In addition, nurses, midwives and nursing associates are expected to work within the limits of their competence, which may extend beyond the standards they demonstrated in order to join the register.

[1] Anyone practising as a registered nurse or midwife in the UK, or a nursing associate in England, has to be registered with us. The nursing associate role is being used only in England.
[2] We have used the phrase 'nursing' in this document to apply to the work of nurses and nursing associates. Nursing associates are a distinct profession with their own part of our register, but they are part of the nursing team.

The Code should be useful for everyone who cares about good nursing and midwifery.

- Patients and service users, and those who care for them, can use it to provide feedback to nurses, midwives and nursing associates about the care they receive.

- Those on our register can use it to promote safe and effective practice in their place of work.

- Employer organisations should support their staff in upholding the standards in their professional Code as part of providing the quality and safety expected by service users and regulators.

- Educators can use the Code to help students understand what it means to be a registered professional and how keeping to the Code helps to achieve that.

For the many committed and expert practitioners on our register, this Code should be seen as a way of reinforcing professionalism. Through revalidation, nurses, midwives and nursing associates provide evidence of their continued ability to practise safely and effectively. The Code is central in the revalidation process as a focus for professional reflection. This gives the Code significance in the professional life of those on our register, and raises its status and importance for employers.

The Code contains a series of statements that taken together signify what good practice by nurses, midwives and nursing associates looks like. It puts the interests of patients and service users first, is safe and effective, and promotes trust through professionalism.

Prioritise people

You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.

1. Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion

1.2 make sure you deliver the fundamentals of care effectively

1.3 avoid making assumptions and recognise diversity and individual choice

1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay

1.5 respect and uphold people's human rights

(The fundamentals of care include, but are not limited to, nutrition, hydration, bladder and bowel care, physical handling and making sure that those receiving care are kept in clean and hygienic conditions. It includes making sure that those receiving care have adequate access to nutrition and hydration, and making sure that you provide help to those who are not able to feed themselves or drink fluid unaided.)

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 work in partnership with people to make sure you deliver care effectively

2.2 recognise and respect the contribution that people can make to their own health and wellbeing

2.3 encourage and empower people to share in decisions about their treatment and care

2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care

2.5 respect, support and document a person's right to accept or refuse care and treatment

2.6 recognise when people are anxious or in distress and respond compassionately and politely

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

3.1 pay special attention to promoting wellbeing, preventing ill-health and meeting the changing health and care needs of people during all life stages

3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life

3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it

3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

4 Act in the best interests of people at all times

To achieve this, you must:

4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment

4.2 make sure that you get properly informed consent and document it before carrying out any action

4.3 keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process

4.4 tell colleagues, your manager and the person receiving care if you have a conscientious objection to a particular procedure and arrange for a suitably qualified colleague to take over responsibility for that person's care

(You can only make a 'conscientious objection' in limited circumstances. For more information, please visit our website at www.nmc-uk.org/standards.)

5 Respect people's right to privacy and confidentiality

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

To achieve this, you must:

5.1 respect a person's right to privacy in all aspects of their care

5.2 make sure that people are informed about how and why information is used and shared by those who will be providing care

5.3 respect that a person's right to privacy and confidentiality continues after they have died

5.4 share necessary information with other health and care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality

5.5 share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand

Practise effectively

You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay, to the best of your abilities, on the basis of best available evidence. You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.

6 Always practise in line with the best available evidence

To achieve this, you must:

6.1 make sure that any information or advice given is evidence-based including information relating to using any health and care products or services

6.2 maintain the knowledge and skills you need for safe and effective practice

7 Communicate clearly

To achieve this, you must:

7.1 use terms that people in your care, colleagues and the public can understand

7.2 take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs

7.3 use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs

7.4 check people's understanding from time to time to keep misunderstanding or mistakes to a minimum

7.5 be able to communicate clearly and effectively in English

8 Work co-operatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

8.4 work with colleagues to evaluate the quality of your work and that of the team

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

8.7 be supportive of colleagues who are encountering health or performance problems. However, this support must never compromise or be at the expense of patient or public safety

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.1 provide honest, accurate and constructive feedback to colleagues

9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

9.4 support students' and colleagues' learning to help them develop their professional competence and confidence

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

10.5 take all steps to make sure that records are kept securely

10.6 collect, treat and store all data and research findings appropriately

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions

11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care

11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard

12 Have in place an indemnity arrangement which provides appropriate cover for any practice you take on as a nurse, midwife or nursing associate in the United Kingdom

To achieve this, you must:

12.1 make sure that you have an appropriate indemnity arrangement in place relevant to your scope of practice

For more information, please visit our website at www.nmc.org.uk/indemnity.

Preserve safety

You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care

13.2 make a timely referral to another practitioner when any action, care or treatment is required

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

13.4 take account of your own personal safety as well as the safety of people in your care

13.5 complete the necessary training before carrying out a new role

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm.

14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

(The professional duty of candour is about openness and honesty when things go wrong. "Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress." Joint statement from the Chief Executives of statutory regulators of healthcare professionals)

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

15.1 only act in an emergency within the limits of your knowledge and competence

15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly

15.3 take account of your own safety, the safety of others and the availability of other options for providing care

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices

16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so

16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern

16.6 protect anyone you have management responsibility for from any harm, detriment, victimisation or unwarranted treatment after a concern is raised

For more information, please visit our website at www.nmc-uk.org/raisingconcerns.

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse.

17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information

17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines

18.4 take all steps to keep medicines stored securely

18.5 wherever possible, avoid prescribing for yourself or for anyone with whom you have a close personal relationship

Prescribing is not within the scope of practice of everyone on our register. Nursing associates don't prescribe, but they may supply, dispense and administer medicines. Nurses and midwives who have successfully completed a further qualification in prescribing and recorded it on our register are the only people on our register that can prescribe.

For more information, please visit our website at www.nmc.org.uk/standards.

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)

19.3 keep to and promote recommended practice in relation to controlling and preventing infection

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

(Human factors refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety – Health and Safety Executive. You can find more information at www.hse.gov.uk.)

Promote professionalism and trust

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people

20.4 keep to the laws of the country in which you are practising

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers

20.7 make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to

20.9 maintain the level of health you need to carry out your professional role

20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times

For more guidance on using social media and networking sites, please visit our website at www.nmc.org.uk/standards.

21 Uphold your position as a registered nurse, midwife or nursing associate

To achieve this, you must:

21.1 refuse all but the most trivial gifts, favours or hospitality as accepting them could be interpreted as an attempt to gain preferential treatment

21.2 never ask for or accept loans from anyone in your care or anyone close to them

21.3 act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with, including people in your care

21.4 make sure that any advertisements, publications or published material you produce or have produced for your professional services are accurate, responsible, ethical, do not mislead or exploit vulnerabilities and accurately reflect your relevant skills, experience and qualifications

21.5 never use your status as a registered professional to promote causes that are not related to health

21.6 cooperate with the media only when it is appropriate to do so, and then always protecting the confidentiality and dignity of people receiving treatment or care

22 Fulfil all registration requirements

To achieve this, you must:

22.1 keep to any reasonable requests so we can oversee the registration process

22.2 keep to our prescribed hours of practice and carry out continuing professional development activities

22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance

For more information, please visit our website at www.nmc.org.uk/standards.

23 Cooperate with all investigations and audits

This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register.

To achieve this, you must:

23.1 cooperate with any audits of training records, registration records or other relevant audits that we may want to carry out to make sure you are still fit to practise

23.2 tell both us and any employers as soon as you can about any caution or charge against you, or if you have received a conditional discharge in relation to, or have been found guilty of, a criminal offence (other than a protected caution or conviction)

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body.

23.4 tell us and your employers at the first reasonable opportunity if you are or have been disciplined by any regulatory or licensing organisation, including those who operate outside of the professional health and care environment

23.5 give your NMC Pin when any reasonable request for it is made

(When telling your employers, this includes telling (i) any person, body or organisation you are employed by, or intend to be employed by, as a nurse, midwife or nursing associate; and (ii) any person, body or organisation with whom you have an arrangement to provide services as a nurse, midwife or nursing associate.)

For more information, please visit our website at www.nmc.org.uk.

24 Respond to any complaints made against you professionally

To achieve this, you must:

24.1 never allow someone's complaint to affect the care that is provided to them

24.2 use all complaints as a form of feedback and an opportunity for reflection and learning to improve practice

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first

25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken

Throughout their career, all our registrants will have opportunities to demonstrate leadership qualities, regardless of whether or not they occupy formal leadership positions.

Item 8a: **Annexe 2**
NMC/18/80
26 September 2018

DRAFT

Standards of proficiency for nursing associates

Introduction

The standards of proficiency presented here represent the standards of knowledge and skills that a nursing associate will need to meet in order to be considered by the NMC as capable of safe and effective nursing associate practice. These standards have been designed to apply across all health and care settings.

The proficiencies serve a number of purposes:

- They set out for ***patients and the public*** what nursing associates know and can do when they join the NMC register.

- The standards help ***nursing associates*** by providing clarity about their role. Read alongside the nursing standards of proficiency, they demonstrate the synergies and differences between the two roles.

- For ***nurses and other health and care professionals***, the standards provide clarity on the knowledge and skills they can reasonably expect all nursing associates to have and this will help inform safe decisions about delegation.

- ***Employers*** understand what nursing associates can contribute to the health and wellbeing of patients and service users, and can make effective decisions about whether and how to use the role

- ***Educators*** must develop and deliver programmes that equip nursing associates with the skills, knowledge and behaviours needed to meet these standards of proficiency when they qualify.

Nursing associate is a new role being introduced into the health and care workforce in England from 2019[1]. It is a generic role (not defined by a field of nursing) but within the discipline of nursing. Nursing associates are intended to bridge a gap between health and care assistants, and registered nurses.

While the nursing associate role is new, it is particularly important that the public, health and care professionals, and employers can develop an understanding of what nursing associates know and can do.

Nursing associates are members of the nursing team, who have gained a Foundation Degree, typically involving two years of higher education. They are not nurses; nursing is a graduate entry profession and those joining the nursing part of the NMC register require a degree. Nurses also develop additional skills and knowledge within a specific field of nursing.

[1] The nursing associate role is being introduced and regulated in England from 2019. If other countries of the UK decide to use and regulate the role in future it will require a change to our legislation, and the updating of our standards.

Nursing associates are a new profession, accountable for their practice. These proficiencies set out what pre-registration training will equip nursing associates to know, and do. Once they are practising, nursing associates can undertake further education and training and demonstrate additional knowledge and skills, enhancing their competence as other registered professionals routinely do. The roles played by nursing associates will vary from setting to setting, depending on local clinical frameworks, and it may also be shaped by national guidance.

Nursing associates provide care for people of all ages and from different backgrounds, cultures and beliefs. They provide care for people who have mental, physical, cognitive and behavioural care needs, those living with dementia, the elderly and for people at the end of their life. They must be able to care for people in their own home, in the community or hospital or in any health care settings where their needs are supported and managed. They work in the context of continual change, challenging environments, different models of care delivery, shifting demographics, innovation and rapidly evolving technologies. Increasing integration of health and social care services will require nursing associates to play a proactive role in multidisciplinary teams.

We have designed these proficiencies to align with the latest standards of proficiency for nurses:

- To allow people to understand the differences between the two roles
- To enable education providers to facilitate educational progression from nursing associate to nurse
- To demonstrate how the nursing associate role can support the registered nurse, to allow registered nurses to deliver the NMC's enhanced "Future Nurse" standards of proficiency.

The outcome statements for each platform have been designed to apply across all health and care settings. At the point of registration, nursing associates are required to meet all outcome statements and to demonstrate an awareness of how requirements vary across different health and care settings. As the nursing associate role is generic, students may demonstrate proficiencies in any appropriate context, and there is no expectation that they must be demonstrated in every health and care setting.

In common with all of our regulatory standards and guidance, these proficiencies will be subject to periodic review. The current version of our proficiencies can always be found on our website.

Standards of proficiency for nursing associates

Platform 1: Being an accountable professional

Nursing associates act in the best interests of people, putting them first and providing nursing care that is person-centred, safe and compassionate. They act professionally at all times and use their knowledge and experience to make evidence based decisions and solve problems. They recognise and work within the limits of their competence and are responsible for their actions.

1. **Outcomes:** the outcomes set out below reflect the proficiencies for accountable practice that must be applied across all standards of proficiency for nursing associates, as described in platforms 2-6.

At the point of registration, the nursing associate will be able to:

1.1 understand and act in accordance with the Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates, and fulfil all registration requirements

1.2 understand and apply relevant legal, regulatory and governance requirements, policies, and ethical frameworks, including any mandatory reporting duties, to all areas of practice

1.3 understand the importance of courage and transparency and apply the Duty of Candour, recognising and reporting any situations, behaviours or errors that could result in poor care outcomes

1.4 demonstrate an understanding of, and the ability to, challenge or report discriminatory behaviour

1.5 understand the demands of professional practice and demonstrate how to recognise signs of vulnerability in themselves or their colleagues and the action required to minimise risks to health

1.6 understand the professional responsibility to adopt a healthy lifestyle to maintain the level of personal fitness and wellbeing required to meet people's needs for mental and physical care

1.7 describe the principles of research and how research findings are used to inform evidence-based practice

1.8 understand and explain the meaning of resilience and emotional intelligence, and their influence on an individual's ability to provide care

1.9 communicate effectively using a range of skills and strategies with colleagues and people at all stages of life and with a range of mental, physical, cognitive and behavioural health challenges

1.10 demonstrate the skills and abilities required to develop, manage and maintain appropriate relationships with people, their families, carers and colleagues

1.11 provide, promote, and where appropriate advocate for, non-discriminatory, person-centred and sensitive care at all times. Reflect on people's values and beliefs, diverse backgrounds, cultural characteristics, language requirements, needs and preferences, taking account of any need for adjustments

1.12 recognise and report any factors that may adversely impact safe and effective care provision

1.13 demonstrate the numeracy, literacy, digital and technological skills required to meet the needs of people in their care to ensure safe and effective practice

1.14 demonstrate the ability to keep complete, clear, accurate and timely records

1.15 take responsibility for continuous self-reflection, seeking and responding to support and feedback to develop professional knowledge and skills

1.16 act as an ambassador for their profession and promote public confidence in health and care services

1.17 safely demonstrate evidence based practice in all skills and procedures stated in Annexes A and B.

Platform 2: Promoting health and preventing ill health

Nursing associates play a role in supporting people to improve and maintain their mental, physical, behavioural health and wellbeing. They are actively involved in the prevention of and protection against disease and ill health, and engage in public health, community development, and in the reduction of health inequalities.

2. Outcomes: The proficiencies identified below will equip the newly registered nursing associate with the underpinning knowledge and skills required for their role in health promotion and protection and prevention of ill health.

At the point of registration, the nursing associate will be able to:

2.1 understand and apply the aims and principles of health promotion, protection and improvement and the prevention of ill health when engaging with people

2.2 promote preventive health behaviours and provide information to support people to make informed choices to improve their mental, physical, behavioural health and wellbeing

2.3 describe the principles of epidemiology, demography, genomics and how these may influence health and wellbeing outcomes

2.4 understand the factors that may lead to inequalities in health outcomes

2.5 understand the importance of early years and childhood experiences and the possible impact on life choices, mental, physical and behavioural health and wellbeing

2.6 understand and explain the contribution of social influences, health literacy, individual circumstances, behaviours and lifestyle choices to mental, physical and behavioural health outcomes

2.7 explain why health screening is important and identify those who are eligible for screening

2.8 promote health and prevent ill health by understanding the evidence base for immunisation, vaccination and herd immunity

2.9 protect health through understanding and applying the principles of infection prevention and control, including communicable disease surveillance and antimicrobial stewardship and resistance.

Platform 3: Provide and monitor care

Nursing associates provide compassionate, safe and effective care and support to people in a range of care settings. They monitor the condition and health needs of people within their care on a continual basis in partnership with people, families, and carers. They contribute to ongoing assessment and can recognise when it is necessary to refer to others for reassessment.

3. **Outcomes:** The proficiencies identified below will equip the newly registered nursing associate with the underpinning knowledge and skills required for their role in providing and monitoring care.

At the point of registration, the nursing associate will be able to:

3.1 demonstrate an understanding of human development from conception to death, to enable delivery of person-centred safe and effective care

3.2 demonstrate and apply knowledge of body systems and homeostasis, human anatomy and physiology, biology, genomics, pharmacology, social and behavioural sciences when delivering care

3.3 recognise and apply knowledge of commonly encountered mental, physical, behavioural and cognitive health conditions when delivering care

3.4 demonstrate the knowledge, communication and relationship management skills required to provide people, families and carers with accurate information that meets their needs before, during and after a range of interventions

3.5 work in partnership with people, to encourage shared decision making, in order to support individuals, their families and carers to manage their own care when appropriate

3.6 demonstrate the knowledge, skills and ability to perform a range of nursing procedures and manage devices, to meet people's need for safe, effective and person-centred care

3.7 demonstrate and apply an understanding of how and when to escalate to the appropriate professional for expert help and advice

3.8 demonstrate and apply an understanding of how people's needs for safety, dignity, privacy, comfort and sleep can be met

3.9 demonstrate the knowledge, skills and ability required to meet people's needs related to nutrition, hydration and bladder and bowel health

3.10 demonstrate the knowledge, skills and ability to act as required to meet people's needs related to mobility, hygiene, oral care, wound care and skin integrity

3.11 demonstrate the ability to recognise when a person's condition has improved or deteriorated by undertaking health monitoring. Interpret, promptly respond, share findings, and escalate as needed

3.12 demonstrate the knowledge and skills required to support people with commonly encountered symptoms including anxiety, confusion, discomfort and pain

3.13 demonstrate an understanding of how to deliver sensitive and compassionate end of life care to support people to plan for their end of life, giving information and support to people who are dying, their families and the bereaved. Provide care to the deceased

3.14 understand and act in line with any end of life decisions and orders, organ and tissue donation protocols, infection protocols, advanced planning decisions, living wills and lasting powers of attorney for health

3.15 understand the principles of safe and effective administration and optimisation of medicines in accordance with local and national policies

3.16 demonstrate the ability to recognise the effects of medicines, allergies, drug sensitivity, side effects, contraindications and adverse reactions

3.17 recognise the different ways by which medicines can be prescribed

3.18 demonstrate the ability to monitor the effectiveness of care in partnership with people, families and carers. Document progress and report outcomes

3.19 demonstrate an understanding of co-morbidities and the demands of meeting people's holistic needs when prioritising care

3.20 understand and apply the principles and processes for making reasonable adjustments

3.21 recognise how a person's capacity affects their ability to make decisions about their own care and to give or withhold consent

3.22 recognise when capacity has changed and understand where and how to seek guidance and support from others to ensure that the best interests of those receiving care are upheld

3.23 recognise people at risk of abuse, self-harm and/or suicidal ideation and the situations that may put them and others at risk

3.24 take personal responsibility to ensure that relevant information is shared according to local policy and appropriate immediate action is taken to provide adequate safeguarding and that concerns are escalated.

Platform 4: Working in teams

Nursing associates play an active role as members of interdisciplinary teams, collaborating and communicating effectively with nurses, a range of other health and care professionals and lay carers.

4. Outcomes: The proficiencies identified below will equip the newly registered nursing associate with the underpinning knowledge and skills required to understand and apply their role to work effectively as part of an interdisciplinary team.

At the point of registration, the nursing associate will be able to:

4.1 demonstrate an awareness of the roles, responsibilities and scope of practice of different members of the nursing and interdisciplinary team, and their own role within it

4.2 demonstrate an ability to support and motivate other members of the care team and interact confidently with them

4.3 understand and apply the principles of human factors and environmental factors when working in teams

4.4 demonstrate the ability to effectively and responsibly access, input, and apply information and data using a range of methods including digital technologies, and share appropriately within interdisciplinary teams

4.5 demonstrate an ability to prioritise and manage their own workload, and recognise where elements of care can safely be delegated to other colleagues, carers and family members

4.6 demonstrate the ability to monitor and review the quality of care delivered, providing challenge and constructive feedback, when an aspect of care has been delegated to others

4.7 support, supervise and act as a role model to nursing associate students, health care support workers and those new to care roles, review the quality of the care they provide, promoting reflection and providing constructive feedback

4.8 contribute to team reflection activities, to promote improvements in practice and services

4.9 discuss the influence of policy and political drivers that impact health and care provision.

Platform 5: Improving safety and quality of care

Nursing associates improve the quality of care by contributing to the continuous monitoring of people's experience of care. They identify risks to safety or experience and take appropriate action, putting the best interests, needs and preferences of people first.

5. Outcomes: The proficiencies identified below will equip the newly registered nursing associate with the underpinning knowledge and skills required for their role in contributing to risk monitoring and quality of care.

At the point of registration, the nursing associate will be able to:

5.1 understand and apply the principles of health and safety legislation and regulations and maintain safe work and care environments

5.2 participate in data collection to support audit activity, and contribute to the implementation of quality improvement strategies

5.3 accurately undertake risk assessments, using contemporary assessment tools

5.4 respond to and escalate potential hazards that may affect the safety of people

5.5 recognise when inadequate staffing levels impact on the ability to provide safe care and escalate concerns appropriately

5.6 understand and act in line with local and national organisational frameworks, legislation and regulations to report risks, and implement actions as instructed, following up and escalating as required

5.7 understand what constitutes a near miss, a serious adverse event, a critical incident and a major incident

5.8 understand when to seek appropriate advice to manage a risk and avoid compromising quality of care and health outcomes

5.9 recognise uncertainty, and demonstrate an awareness of strategies to develop resilience in themselves. Know how to seek support to help deal with uncertain situations

5.10 understand their own role and the roles of all other staff at different levels of experience and seniority, in the event of a major incident

Platform 6: Contributing to integrated care

Nursing associates contribute to the provision of care for people, including those with complex needs. They understand the roles of a range of professionals and carers from other organisations and settings who may be participating in the care of a person and their family, and their responsibilities in relation to communication and collaboration.

6. Outcomes: The proficiencies identified below will equip the newly registered nursing associate with the underpinning knowledge and skills required for their role in contributing to integrated care to meet the needs of people across organisations and settings.

At the point of registration, the nursing associate will be able to:

6.1 understand the roles of the different providers of health and care. Demonstrate the ability to work collaboratively and in partnership with professionals from different agencies in interdisciplinary teams

6.2 understand and explore the challenges of providing safe nursing care for people with complex co-morbidities and complex care needs

6.3 demonstrate an understanding of the complexities of providing mental, cognitive, behavioural and physical care needs across a wide range of integrated care settings

6.4 understand the principles and processes involved in supporting people and families with a range of care needs to maintain optimal independence and avoid unnecessary interventions and disruptions to their lives

6.5 identify when people need help to facilitate equitable access to care, support and escalate concerns appropriately

6.6 demonstrate an understanding of their own role and contribution when involved in the care of a person who is undergoing discharge or a transition of care between professionals, settings or services.

Annexe A: Communication and relationship management skills

Introduction

In order to meet the proficiency outcomes outlined in the main body of this document, nursing associates must be able to demonstrate the communication and relationship management skills described in this annexe at the point of registration.

The ability to communicate effectively, with sensitivity and compassion, and to manage relationships with people is central to the provision of high quality person-centred care. These competencies must be demonstrated in practice settings and adapted to meet the needs of people across their lifespan. Nursing associates need a diverse range of communication skills and strategies to ensure that individuals, their families and carers are supported to be actively involved in their own care wherever appropriate, and that they are kept informed and well prepared. It will be important for nursing associates to demonstrate cultural awareness when caring for people and to ensure that the needs, priorities, expertise and preferences of people are always valued and taken into account.

Where people have special communication needs or a disability, it is essential that nursing associates make reasonable adjustments. This means they'll be able to provide and share information in a way that promotes good health and health outcomes and does not prevent people from having equal access to the highest quality of care.

The skills listed below are those that all nursing associates are expected to demonstrate at the point of registration.

At the point of registration, the nursing associate will be able to safely demonstrate the following skills:

1. Underpinning communication skills for providing and monitoring care:

1.1 actively listen, recognise and respond to verbal and non-verbal cues

1.2 use prompts and positive verbal and non-verbal reinforcement

1.3 use appropriate non-verbal communication including touch, eye contact and personal space

1.4 make appropriate use of open and closed questioning

1.5 speak clearly and accurately

1.6 use caring conversation techniques

1.7 check understanding and use clarification techniques

1.8 be aware of the possibility of own unconscious bias in communication encounters

1.9 write accurate, clear, legible records and documentation

1.10 clearly record digital information and data

1.11 provide clear verbal, digital or written information and instructions when sharing information, delegating or handing over responsibility for care

1.12 recognise the need for translator services and material

1.13 use age appropriate communication techniques.

2. Communication skills for supporting people to prevent ill health and manage their health challenges

2.1 effectively share information and check understanding about:

- preventative health behaviours that help people to make lifestyle choices and improve their own health and wellbeing
- a range of common conditions including: anxiety, depression, memory loss, diabetes, dementia, respiratory disease, cardiac disease, neurological disease, cancer, skin problems, immune deficiencies, psychosis, stroke and arthritis in accordance with care plans

2.2 clearly and confidently explain to the individual and family how their lifestyle choices may influence their health. This includes the impact of common health risk behaviours including smoking, diet, sexual practice, alcohol and substance use

2.3 use appropriate materials, making reasonable adjustments where appropriate to support people's understanding of what may have caused their health condition and the implications of their care and treatment

2.4 use repetition and positive reinforcement strategies

2.5 recognise and accommodate sensory impairments during all communications

2.6 support and monitor the use of personal communication aids

2.7 address and respond to people's questions, recognising when to refer to others in order to provide accurate responses

2.8 identify the need for and manage a range of alternative communication techniques

2.9 engage in difficult conversations with support from others, helping people who are feeling emotionally or physically vulnerable or in distress, conveying compassion and sensitivity.

3. Communication skills and approaches for providing therapeutic interventions

3.1 identify the need for and use appropriate approaches to develop therapeutic relationships with people

3.2 demonstrate the use of a variety of effective communication strategies:
- reassurance and affirmation
- de-escalation strategies and techniques
- distraction and diversion strategies
- positive behaviour support approaches.

4. Communication skills for working in professional teams

Demonstrate effective skills when working in teams through:

4.1 active listening when receiving feedback and when dealing with team members' concerns and anxieties

4.2 timely and appropriate escalation

4.3 being a calm presence when exposed to situations involving conflict

4.4 being assertive when required

4.5 using de-escalation strategies and techniques when dealing with conflict.

5. Demonstrate effective supervision skills by providing:

5.1 clear instructions and explanations when supervising others

5.2 clear instructions and checking understanding when delegating care responsibilities to others

5.3 clear constructive feedback in relation to care delivered by others

5.4 encouragement to colleagues that helps them to reflect on their practice.

Annexe B: Procedures to be undertaken by the nursing associate

Introduction

In order to meet the proficiency outcomes outlined in the main body of this document, nursing associates must be able to carry out the procedures described in this annexe at the point of their registration. Nursing associates are required to demonstrate an awareness of how requirements for procedures may vary across different health and care settings. As the nursing associate role is generic, students may demonstrate the ability to carry out procedures in any appropriate context, and there is no expectation that this must be demonstrated in every health and care setting. Ideally students will demonstrate skills in a practice setting, but where necessary some procedures may be demonstrated through simulation.

Nursing associates are expected to apply evidence based best practice across all procedures. The ability to carry out these procedures, safely, effectively, with sensitivity and compassion (while demonstrating the communication and relationship management skills described in Annexe A) is crucial to the provision of person-centred care. These procedures must be demonstrated with an awareness of variations required for different practice settings and for people across their lifespan. They must be carried out in a way that reflects cultural awareness and ensures that the needs, priorities, expertise and preferences of people are always valued and taken into account.

At the point of registration, the nursing associate will be able to safely demonstrate the following procedures:

Part 1: Procedures to enable effective monitoring of a person's condition

1. Demonstrate effective approaches to monitoring signs and symptoms of physical, mental, cognitive, behavioural and emotional distress, deterioration and improvement:

1.1 accurately measure weight and height, calculate body mass index and recognise healthy ranges and clinically significant low/high readings

1.2 use manual techniques and devices to take, record and interpret vital signs including temperature, pulse, respiration (TPR), blood pressure (BP) and pulse oximetry in order to identify signs of improvement, deterioration or concern

1.3 undertake venepuncture and routine ECG recording

1.4 measure and interpret blood glucose levels

1.5 collect and observe sputum, urine, stool and vomit specimens, interpreting findings and reporting as appropriate

1.6 recognise and escalate signs of all forms of abuse

1.7 recognise and escalate signs of self-harm and/or suicidal ideation

1.8 undertake and interpret neurological observations

1.9 recognise signs of mental and emotional distress including agitation, or vulnerability

1.10 administer basic mental health first aid

1.11 recognise emergency situations and administer basic physical first aid, including basic life support.

Part 2: Procedures for provision of person-centred nursing care

2. Provide support in meeting the needs of people in relation to rest, sleep, comfort and the maintenance of dignity:

2.1 observe and monitor comfort and pain levels and rest and sleep patterns

2.2 use appropriate bed-making techniques, including those required for people who are unconscious or who have limited mobility

2.3 use appropriate positioning and pressure relieving techniques

2.4 take appropriate action to ensure privacy and dignity at all times

2.5 appropriate action to reduce or minimise pain or discomfort

2.6 support people to reduce fatigue, minimise insomnia and take appropriate rest.

3. Provide care and support with hygiene and the maintenance of skin integrity:

3.1 observe and reassess skin and hygiene status using contemporary approaches to determine the need for support and ongoing intervention.

3.2 identify the need for and provide appropriate assistance with washing, bathing, shaving and dressing

3.3 identify the need for and provide appropriate oral, dental, eye and nail care and suggest to others when an onward referral is needed

3.4 prevent and manage skin breakdown through appropriate use of products

3.5 Identify and manage skin irritations and rashes

3.6 monitor wounds and undertake wound care using appropriate evidence-based techniques.

4. Provide support with nutrition and hydration:

4.1 use contemporary nutritional assessment tools

4.2 assist with feeding and drinking and use appropriate feeding and drinking aids

4.3 record fluid intake and output to identify signs of dehydration or fluid retention and escalate as necessary

4.4 support the delivery of artificial nutrition and hydration using oral and enteral routes.

5. Provide support with maintaining bladder and bowel health:

5.1 observe and monitor the level of urinary and bowel continence to determine the need for ongoing support and intervention, the level of independence and self-management of care that an individual can manage

5.2 assist with toileting, maintaining dignity and privacy and use appropriate continence products

5.3 care for and manage catheters for all genders

5.4 recognise bladder and bowel patterns to identify and respond to incontinence, constipation, diarrhoea and urinary and faecal retention.

6. Provide support with mobility and safety:

6.1 use appropriate risk assessment tools to determine the ongoing need for support and intervention, the level of independence and self-care that an individual can manage

6.2 use appropriate assessment tools to determine, manage and escalate the ongoing risk of falls

6.3 use a range of contemporary moving and handling techniques and mobility aids

6.4 use appropriate moving and handling equipment to support people with impaired mobility.

7. Provide support with respiratory care:

7.1 manage the administration of oxygen using a range of routes and approaches

7.2 take and be able to identify normal peak flow and oximetry measurements

7.3 use appropriate nasal and oral suctioning techniques

7.4 manage inhalation, humidifier and nebuliser devices.

8. Preventing and managing infection:

8.1 observe and respond rapidly to potential infection risks using best practice guidelines

8.2 use standard precautions protocols

8.3 use aseptic, non-touch techniques

8.4 use appropriate personal protection equipment

8.5 implement isolation procedures

8.6 use hand hygiene techniques

8.7 safely decontaminate equipment and environment

8.8 safely handle waste, laundry and sharps.

9. Meeting needs for care and support at the end of life:

9.1 recognise and take immediate steps to respond appropriately to uncontrolled symptoms and signs of distress including pain, nausea, thirst, constipation, restlessness, agitation, anxiety and depression

9.2 review preferences and care priorities of the dying person and their family and carers, and ensure changes are communicated as appropriate

9.3 provide care for the deceased person and the bereaved respecting cultural requirements and protocols.

10. Procedural competencies required for administering medicines safely:

10.1 continually assess people receiving care and their ongoing ability to self-administer their own medications. Know when and how to escalate any concerns

10.2 undertake accurate drug calculations for a range of medications

10.3 exercise professional accountability in ensuring the safe administration of medicines to those receiving care

10.4 administer medication via oral, topical and inhalation routes

10.5 administer injections using subcutaneous and intramuscular routes and manage injection equipment

10.6 administer and monitor medications using enteral equipment

10.7 administer enemas and suppositories

10.8 manage and monitor effectiveness of symptom relief medication

10.9 recognise and respond to adverse or abnormal reactions to medications, and when and how to escalate any concerns

10.10 undertake safe storage, transportation and disposal of medicinal products.

Glossary

Abuse: is something that may harm another person, or endanger their life, or violate their rights. The person responsible for the abuse may be doing this on purpose or may not realise the harm that they are doing. The type of abuse may be emotional, physical, sexual, psychological, material or financial, or may be due to neglect.

Candour: being open and honest with patients when things go wrong.

Cognitive: The mental processes of perception, memory, judgment, and reasoning.

Co-morbidities: the presence of one or more additional diseases or disorders that occur with a primary disease or disorder.

Contraindications: a condition or factor that serves as a reason to withhold a certain medical treatment due to the harm that it would cause the patient.

Demography: the study of statistics such as births, deaths, income, or the incidence of disease, which illustrate the changing structure of human populations.

Evidence based person-centred care/nursing care: making sure that any care and treatment is given to people, by looking at what research has shown to be most effective. The judgment and experience of the nurse and the views of the person should also be taken into account when choosing which treatment is most likely to be successful for an individual patient.

Genomics: branch of molecular biology concerned with the structure, function, evolution, and mapping of genomes.

Health literacy: the degree to which individuals can obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Human factors: environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety.

Intervention: any investigations, procedures, or treatments given to a person.

People: individuals or groups who receive services from nurses and midwives, healthy and sick people, parents, children, families, carers, representatives, also including educators and students and other within and outside the learning environment.

Person-centred: an approach where the person is at the centre of the decision making processes and the design of their care needs, their nursing care and treatment plan.

Reflection: to carefully consider actions or decisions and learn from them.

Vulnerable people: those who at any age are at a higher risk of harm than others. Vulnerability might be in relation to a personal characteristic or a situation. The type of harm may be emotional, physical, sexual, psychological, material or financial, or may be due to neglect.

Item 8a: **Annexe 3**
NMC/18/80
26 September 2018

Nursing & Midwifery Council

DRAFT

Standards for pre-registration nursing associate programmes

Introduction

Our *Standards for pre-registration nursing associate programmes* set out the legal requirements, entry requirements, availability of recognition of prior learning, length of programme, methods of assessment and information on the award for all pre-registration nursing associate education programmes.

Overall responsibility for the day-to-day management of the quality of any educational programme lies with an approved education institution (AEI) in partnership with health and care settings that offer practice experience to nursing associate students.

Standards for pre-registration nursing associate programmes follow the student journey and are grouped under the following five headings:

1 **Selection, admission and progression:** standards about an applicant's suitability for, and continued participation in, a pre-registration nursing associate programme

2 **Curriculum:** standards for the content, delivery and evaluation of the pre-registration nursing associate education programme

3 **Practice learning:** standards specific to pre-registration learning for nursing associates that takes place in practice settings

4 **Supervision and assessment:** standards for safe and effective supervision and assessment for pre-registration nursing associate education programmes

5 **Qualification to be awarded:** standards which state the award and information for the NMC register.

1. Selection, admission and progression

Approved education institutions together with practice learning partners must:

1.1 confirm on entry to the programme that students:

- 1.1.1 demonstrate values in accordance with *the Code*[1]
- 1.1.2 have capability to learn behaviours in accordance with *the Code*
- 1.1.3 have capability to develop numeracy skills required to meet programme outcomes
- 1.1.4 can demonstrate proficiency in English language[2]
- 1.1.5 have capability in literacy to meet programme outcomes
- 1.1.6 have capability for digital and technological literacy to meet programme outcomes

1.2 ensure students' heath and character allows for safe and effective practice on entering the programme, throughout the programme and when submitting the supporting declaration of health and good character in line with the NMC's health and character decision-making guidance. This includes satisfactory occupational health assessment and criminal record checks

1.3 ensure students are fully informed of the requirement to declare immediately any cautions or convictions, pending charges or adverse determinations made by other regulators, professional bodies and educational establishments and that any declarations are dealt with promptly, fairly and lawfully

1.4 ensure that the registered nurse or registered nursing associate responsible for directing the educational programme or their designated registered nurse substitute or designated registered nursing associate substitute, are able to provide supporting declarations of health and character for students who have completed a pre-registration nursing associate programme

1.5 permit recognition of prior learning that is capable of being mapped to the *Standards of proficiency for nursing associates* and programme outcomes, up to a maximum of 50% of the programme. This maximum limit of 50% does not apply to applicants to pre-registration nursing associate programmes who are currently a NMC registered nurse without restrictions on their practice, and

1.6 provide support where required to students throughout the programme in continuously developing their abilities in numeracy, literacy, digital and technological literacy to meet programme outcomes

[1] https://www.nmc.org.uk/standards/code/
[2] https://www.nmc.org.uk/registration/joining-the-register/english-language-requirements

2. Curriculum

Approved education institutions together with practice learning partners must:

2.1 ensure that programmes comply with the *NMC Standards framework for nursing and midwifery education*

2.2 comply with the NMC *Standards for student supervision and assessment*

2.3 ensure that all programme learning outcomes reflect the *Standards of proficiency for nursing associates*

2.4 design and deliver a programme that supports students and provides an appropriate breadth of experience for a non-field specific nursing associate programme, across the lifespan and in a variety of settings

2.5 set out the general and professional content necessary to meet the *Standards of proficiency for nursing associates* and programme outcomes

2.6 ensure that the programme hours[3] and programme length are:

- 2.6.1 sufficient to allow the students to be able to meet the *Standards of proficiency for nursing associates*,
- 2.6.2 no less than 50 per cent of the minimum programme hours required of nursing degree programmes, currently set under Article 31(3) of Directive 2005/36/EC (4,600 hours)
- 2.6.3 consonant with the award of a Foundation degree (typically 2 years)

2.7 ensure the curriculum provides an equal balance of theory and practice learning using a range of learning and teaching strategies, and

2.8 ensure nursing associate programmes which form part of an integrated programme meet the nursing associate requirements and nursing associate proficiencies.

3. Practice learning

Approved education institutions together with practice learning partners must:

3.1 provide practice learning opportunities that allow students to develop and meet the *Standards of proficiency for nursing associates* to deliver safe and effective care, to a diverse range of people, across the lifespan and in a variety of settings[4]

[3] 'Programme hours' are hours protected for learning, in theory and practice. Hours which are not protected for learning, in which students are in effect working in their substantive place of work, do not count towards programme hours.

[4] Nursing associate students are not required to have placements in each field of nursing, but should, through their education programme, benefit from experience of children and adults, and patients/service users with mental health conditions and learning disabilities, and understand the most significant factors to be aware of when providing care to different types of service user.

3.2 ensure that students experience the variety of practice expected of nursing associates to meet the holistic needs of people of all ages

3.3 ensure technology enhanced and simulation-based learning opportunities are used effectively and proportionately to support learning and assessment

3.4 take account of students' individual needs and personal circumstances when allocating their practice learning including making reasonable adjustments for students with disabilities, and

3.5 ensure that nursing associate students have protected learning time[5] in line with one of the following two options:

3.5.1 Option A: nursing associate students are supernumerary when they are learning in practice

3.5.2 Option B: nursing associate students, via work-placed learning routes:

3.5.2.1 are released for a minimum of 20 per cent of the programme for academic study[6]

3.5.2.2 are released for a minimum of 20 per cent of the programme time, which is assured protected learning time in external practice placements, enabling them to develop the breadth of experience required for a generic role, and

3.5.2.3 for the remainder of the required programme hours, protected learning time must be assured.

4. Supervision and assessment

Approved education institutions together with practice learning partners must:

4.1 ensure that, support, supervision, learning and assessment provided complies with the NMC *Standards framework for nursing and midwifery education*

4.2 ensure that support, supervision, learning and assessment provided complies with the *NMC Standards for student supervision and assessment*

4.3 ensure they inform the NMC of the name of the registered nurse or registered nursing associate responsible for directing the education programme

4.4 provide students with feedback throughout the programme to support their development

4.5 ensure throughout the programme that students meet the *Standards of proficiency for nursing associates*

4.6 ensure that all programmes include a health numeracy assessment related to nursing associate proficiencies and calculation of medicines which must be passed with a score of 100%

[5] Protected learning time is designated time in which students are supported to learn. All students are appropriately supervised until they have demonstrated proficiency in aspects of care. Supernumerary status is one approach to protected learning time.

[6] The 20 per cent specified here is not the total sum of theoretical learning students will need to undertake, please see standard 2.7 which requires equal weighting of theory and practice in the curriculum

4.7 assess students to confirm proficiency in preparation for professional practice as a nursing associate

4.8 ensure that there is equal weighting in the assessment of theory and practice, and

4.9 ensure that all proficiencies are recorded in an ongoing record of achievement which must demonstrate the achievement of proficiencies and skills as set out in *Standards of proficiency for nursing associates*

5. Qualification to be awarded

Approved education institutions together with practice learning partners must:

5.1 ensure that the minimum award for a nursing associate programme is a Foundation Degree of the Regulated Qualifications Framework (England), which is typically two years in length, and

5.2 notify students during the programme that they have five years in which to register their award with the NMC. In the event of a student failing to register their qualification within five years they will have to undertake additional education and training or gain such experience as is specified in our standards in order to register their award

Item 8a: **Annexe 4**
NMC/18/80
26 September 2018

Background note on protected learning time in pre-registration nursing associate programmes

1 The NMC has been in dialogue with the Department for Health and Social Care (DHSC) and NHS Employers regarding our requirement that students on NMC pre-registration programmes are supernumerary when they are learning in practice settings. There has been an Education Select Committee inquiry regarding barriers to the take up of apprenticeships and correspondence between the NMC and Ministers in the Department for Education (DfE) and DHSC. There are soundly-based concerns about whether employers will invest in nursing associate apprenticeships if they are perceived as too costly. The apprenticeship levy can only be used to fund training costs, not for wider capacity-building in a setting that hosts students, or for backfill.

2 This matters because, unlike nursing, for nursing associates the apprenticeship route is conceived from the outset as the principle route by which people will train to enter the new profession.

3 For this reason we asked two questions about supernumerary status in our nursing associate consultation. We asked whether the same supernumerary requirement should apply to nursing associate pre-registration students, or whether we should permit other approaches that adequately safeguard patients and students.

4 Both propositions received majority support. Overall 66 per cent agreed with supernumerary being a requirement for pre-registration nursing associate programmes. However, 62 per cent also agree that the NMC should permit a different approach to protecting learning in practice settings.

5 As part of our consultation engagement, we set up a task and finish group which met four times between May and August to explore our approach to protecting learning in practice. The group included representatives from employers, education providers, Health Education England (HEE), NHS Employers and DHSC.

Option A: Maintain supernumerary status

6 Many stakeholders support the removal of the requirement of supernumerary status altogether, which they suggest is in keeping with our move to outcomes-focused quality assurance of education. Those with a research background in work-based learning supported the view we should not place an artificial divide between ‘working’ and ‘learning’. They point out that other regulators do not get into the contractual status of trainees when they are learning in practice.

7 Conversely, others observe that in a hard-pressed health and care system, there were risks that without the NMC setting standards in this area students may not get sufficient learning opportunities. This was some of the early feedback from the test site students, although HEE now has measures in place to make sure all students get access to the required placement learning hours. It was also acknowledged that the NMC has recently overhauled its approach to education

quality assurance and that this was an inopportune moment to pursue wholesale change.

Option B: Define protected learning time

8 We have therefore developed a second option for AEIs and their practice partners, Option B in the nursing associate pre-registration programme standards (Annexe 3). Under Option B we are silent on supernumerary status and it is for providers to demonstrate how they will protect a defined amount of time to be spent learning in practice. Of time spent in practice settings, only protected learning time can count towards programme hours.

9 Option B places a greater onus on NMC quality assurance to scrutinise how learning time will be protected. It also places a greater onus on AEIs and their practice placement partners to define and monitor protected learning time, making sure that they have processes in place to evidence protected learning time and identify and address any issues arising.

10 Para 3.5 of Annexe 3 sets out the proposed programme standard. With our task and finish group we have developed guidance on Option B to sit below the standard. This guidance covers:

10.1 Releasing students for academic learning and external placements

10.2 Examples of activities that could contribute to protected learning time

10.3 What the NMC will look for when approving programmes via Option B

11 In common with supernumerary students, learners engaging in protected learning time will need to be supervised while they work towards achieving competence, and confidence.

12 If approved, Option B will only be available for pre-registration nursing associate programmes; supernumerary status will continue to be a requirement for pre-registration nursing and midwifery programmes (where apprenticeship remains a minority route to the register).

13 We propose to evaluate the impact of this option in order that we can be sure there are no unintended consequences for patient safety, student learning and equality of opportunity.

Item 8b
NMC/18/80
26 September 2018

Council

Nursing associate fees

Action: For decision

Issue: This paper seeks Council's agreement to amend the Nursing and Midwifery Council (Fees) Rules 2004 so as to include the fees for nursing associates.

Core regulatory function: All regulatory functions

Strategic priority: Strategic priority 1: Effective regulation
Strategic priority 4: An effective organisation

Decision required: The Council is recommended to:

- approve the proposed fees for nursing associates (paragraph 10)
- make the Nursing and Midwifery Council (Fees) (Amendment) Rules 2018 (paragraph 11).

Annexes: The following annexes are attached to this paper:

- Annexe 1: Draft Nursing and Midwifery Council (Fees) (Amendment) Rules 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 To introduce fees for nursing associates we need to make changes to the Nursing and Midwifery Council (Fees) Rules 2004 (Fees Rules). Our legislation requires us to consult before determining or varying our fees[1].

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 two specific groups of 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 Northern Ireland, Scotland or Wales, 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.

4 At its meeting in July 2018, Council reviewed a paper for information (Item 12 NMC/18/61 25 July 2018) which provided an update on the consultation and an overview of the findings. Council members were also provided with a draft of the consultation response. Council is now asked to take a formal decision on the fees for nursing associates. If Council approves the proposed fees, Council is then asked to make the Nursing and Midwifery Council (Fees)(Amendment) Rules 2018 (attached at Annexe 1).

Four country factors:

5 We regulate nurses and midwives across the UK, but we will only regulate nursing associates in England. This means that applicants to the nursing associate part of the register who trained in Northern Ireland, Scotland or Wales will not have a qualification from an NMC approved provider of nursing associate education. Therefore, we will need to evaluate the comparability of their qualification to determine whether they meet our standards.

Discussion:

6 As discussed at the previous Council meeting in July, the majority of respondents to the consultation were supportive of the NMC's

[1] Article 7(3) and Article 47(3) set out our duty to consult.

proposals.

7 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.

8 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 Royal College of Nursing (RCN), Unite and Unison.

9 At the July meeting, Council noted that the consultation proposed that the fee structure should mirror that of nurses and midwives - as the cost for regulation was the same - and there was no reason to change the approach in light of the responses to the consultation. The Council is now asked to formally approve the fee structure for nursing associates as set out in the consultation and make the Nursing and Midwifery Council (Fees)(Amendment) Rules 2018.

10 Recommendation: The Council is recommended to approve the proposed fees for nursing associates.

11 Recommendation: The Council is recommended to make the Nursing and Midwifery Council (Fees)(Amendment) Rules 2018.

Next steps

12 If Council approves the proposed fees for nursing associates and makes the fees rules contained in Annexe 1, these rules will be incorporated into a Statutory Instrument. The Statutory Instrument will then 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.

13 We will be aiming for the Privy Council to approve the Statutory Instrument in October 2018. 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 on 28 January 2019.

14 Our report in response to the consultation (which Council reviewed in draft in July) will be published by mid-October.

Public protection implications:

15 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 total costs of regulating the professions on our register.

Resource implications:	16	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:	17	The majority of respondents to the consultation 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, race, etc.).
Stakeholder engagement:	18	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 members of the Nursing Associate External Stakeholder Group (which includes representatives from professional associations and unions).
Risk implications:	19	In order to join our register, nursing associates will be required to pay a fee. The fees for nursing associates must be included in the Nursing and Midwifery Council (Fees) Rules 2004 and this is contingent on Council approving the proposed fees.
Legal implications:	20	The NMC has a statutory duty to consult on fees. This duty was met by the public consultation which ran from 4 December 2018 to 26 February 2018.
	21	Subject to Council agreeing the proposed fees and making the rules a Fees Rules Amendment Order will be used to amend the Nursing and Midwifery Council (Fees) Rules 2004.

Item 8b: **Annexe 1**
NMC/18/80
26 September 2018

Note: This draft is still subject to DHSC approval and may be subject to technical amendments.

THE NURSING AND MIDWIFERY COUNCIL (FEES) (AMENDMENT) RULES 2018

The Nursing and Midwifery Council makes the following Rules in exercise of the powers conferred by articles 7(1), 7(2)(c) and 47(2) of the Nursing and Midwifery Order 2001(**a**).

The Nursing and Midwifery Council has consulted in accordance with articles 7(3) and 47(3) of that Order.

Citation and commencement

1. These Rules may be cited as the Nursing and Midwifery Council (Fees) (Amendment) Rules 2018 and come into force on 28th January 2019.

Amendment to the Nursing and Midwifery Council (Fees) Rules 2004

2. In the table in rule 3 (fees) of the Nursing and Midwifery Council (Fees) Rules 2004(**b**)—

(a) in the entry of column (2) of row (a), for "(e) or (f)" substitute "(dd), (e) or (f) or article 13A";

(b) in the entry of column (2) of row (c), for "or (d)" substitute ", (d) or (dd)".

Given under the common seal of the Nursing and Midwifery Council this [xxx] day of [xxx] 2018.

L.S.

Philip Graf
Chair
Sue Killen
Interim Chief Executive and Registrar

(**a**) S.I. 2002/253 as amended by S.I. 2018/838; there are other amending instruments but none is relevant.
(**b**) Scheduled to S.I. 2004/1654, as amended by S.I. 2005/3353, S.I. 2007/1885, and 3101, S.I. 2011/2297, S.I. 2012/3026 and S.I. 2014/3139.

Item 9
NMC/18/81
26 September 2018

Council

Gosport Independent Panel report – next steps

Action: For discussion.

Issue: To provide an update on our progress in response to the Gosport Independent Panel's report.

Core regulatory function: All regulatory functions.

Strategic priority: All strategic priorities.

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 Gosport Independent Panel, which was set up to address concerns raised by families about the care of their relatives at Gosport War Memorial Hospital and the subsequent investigations into their deaths, published its final report on 20 June 2018.

2 On 25 July, the Council considered and discussed the report and its findings, during which the Council paid tribute to the families who fought for 20 years to understand what happened to their loved ones at Gosport and apologised for the way we let the families down.

3 At its meeting, the Council asked that the Executive provide further updates on progress we have made to review learning from the report, and to take forward any related regulatory actions.

Four country factors:

4 The report and its lessons apply to all of our work across all four countries.

Discussion:

Improving the way we communicate

5 We recognise that the way we communicated with families was not acceptable and that there is much more we need to do to improve. When the report was published we wrote to families involved whom we had dealt with in the past and apologised for the role we played, and committed to keeping them up to date with our work to respond to the report. Since writing to the families we have had ongoing communication with some of them and will keep the families updated as we move forward.

6 We have also written to Bishop James Jones, Chair of the Independent Panel, setting out our commitment to ensuring that the lessons identified in the report are reflected in our work to make sure patients, families and the public are front and centre in the way we consider the fitness to practise of our registrants, as well as how we approach our communication with them.

7 Following the last Council meeting we have also met with Professor Deborah Sturdy OBE, a senior nurse and member of the Gosport Independent Panel, to discuss the findings and our next steps.

8 We are in regular contact with the Department of Health and Social Care about its response to the report. We understand that the Department will be meeting with the affected families on 16 October 2018 to discuss its planned next steps. We will continue to work closely with the Department and other stakeholders to ensure a coordinated approach to next steps as far as possible.

Applying the learning

9 We recognise that the report has implications not just for regulators

but for nurses and midwives too. As such, subject to the views of Council, we are proposing to bring together a group of nurses to review the findings with us, identify what the key learning is for the profession, and consider how we can best support and communicate it. We will engage with the Chief Nursing Officers, professional bodies, and other nursing leaders before we start the work.

10 As part of our response we will also be reviewing our "What the Code means for patients" document and talking to stakeholders about how we can better publicise it amongst service user groups and others.

11 Following the publication of the report we have been reviewing the content to determine whether any further regulatory action is required. A full update on the progress of this work is included in the confidential Council papers.

12 On 27 July 2018 it was announced that the Head of Serious Crime for Kent and Essex police would lead the next stage of the police assessment of the events at Gosport War Memorial Hospital. This work started in September 2018. We have established contact with the police team and will ensure we remain in close communication with them as the work progresses.

Public protection implications:

13 The issues identified in the report clearly posed a risk to public protection at the time. An update on whether any regulatory action is required is provided as part of the confidential Council papers.

Resource implications:

14 There are no resource implications at this stage.

Equality and diversity implications:

15 None.

Stakeholder engagement:

16 We are committed to engaging effectively with patients and the public as we take forward actions arising from the report.

17 A full programme of engagement is being been developed in response to this and the Professional Standards Authority's Lessons Learned Review that focuses on improving the patient and public voice.

Risk implications:

18 None.

Legal implications:

19 None.

Item 10
NMC/18/82
26 September 2018

Council

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

Action: For discussion.

Issue: Provides an update on progress made in taking forward work to address the Lessons Learned Review findings.

Core regulatory function: All regulatory functions.

Strategic priority: All strategic priorities.

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 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 (FtP) at Furness General Hospital. The Council apologised unreservedly to the families for not listening to them, not acting on credible evidence and for the multiple missed opportunities.

2 The Council committed to addressing all of the lessons identified in the review and asked the Executive to come back with a programme of work that would seek to do this. On 25 July 2018, the Council discussed and agreed the programme of work to take forward the lessons identified.

3 Council asked that the Executive report back on progress on an ongoing basis.

Four country factors:

4 Not applicable for this paper.

Discussion:

5 Since the Council's last meeting in July 2018, we have continued to take forward the programme of work at pace, focusing on the two key lessons identified in the review, that of improving how we communicate and engage with patients, families and the public and being open and transparent in our work.

6 We have established a programme board to oversee the work, led by the Director of Registration and Revalidation. Work streams, which reflect the priorities agreed by the Council in July 2018, have been established and milestones and budgets are being agreed. An update on milestones and budget is included as part of the Performance and Risk report on the agenda and this update will become a standing part of that report.

7 We have continued to work closely with some family members, hearing from them about their experiences and getting their input into how we ensure that the voices of patients, families and the public are reflected in all we do going forward.

8 We have also updated the Health and Social Care Select Committee on our progress in taking forward our actions.

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

Supporting the public through the Public Support Service

9 Work to set up the Public Support Service (PSS), which will lead our work to embed a person-centred approach in the organisation, has continued at pace. An update on this work can be found elsewhere

on the agenda.

A new strategic direction for Fitness to Practise

10 Following Council approval in July 2018, we have published the new strategic direction for fitness to practise. Updated guidance for colleagues and panel members was launched on 31 August 2018, incorporating the strategic policy principles. Our new approach:

10.1 puts people at the center of how we work.

10.2 contributes to a just culture in health and social care.

10.3 supports nurses and midwives to practise safely and professionally.

11 More information about progress is included in the Performance and Risk report on the agenda.

Better understanding the people we are here to serve

12 We recognise that we need to reach out to the people we serve and those we regulate so that we can truly understand what they expect from regulation. As part of our new approach, we are commissioning some research to better understand what people think our role should be and why. This research will give us useful insights that will form the basis of our strategy and communications going forward.

13 We are currently in the process of procuring an agency to undertake the research and hope to report to Council on the findings early in the new year.

Improving the way we communicate with people every day

14 We have started to review our correspondence and letters to make sure they are clear, empathetic and offer the right level of support. We are focusing initially on two priority areas, FtP and Registration and Revalidation. The correspondence review of FtP will be completed by November 2018 and Registration and Revalidation by the end of 2018. Tone of Voice training for all FtP colleagues will be completed by the end of October 2018. We will start training for all other directorates in January 2019.

15 We recognise that we have not done enough to engage with service user groups, patients and their families over the years. As part of improving our relationships and insight we are developing a programme of events with these groups that will run throughout the autumn. We are also considering how we can involve Council in these and other events so that they too are able to hear firsthand, the experiences of service users.

Improving our approach to transparency

Being open, approachable and helpful

16 We have started work on introducing a new approach to handling enquiries, information requests and corporate complaints with the presumption of transparency at its core.

17 Since the last Council meeting in July 2018, we have expanded the role of the corporate complaints team, increased the resources of the team and made the following improvements:

17.1 Dealing with complaints in a more efficient and customer focussed way through first line resolution of the issues. This means that the complainants' concerns are resolved much quicker.

17.2 Bringing complaints received from MPs into the corporate complaints process. This has already resulted in improvements in how quickly we are responding to these complaints and addressing the issues raised.

17.3 Initial review of how enquiries come into the organisation and the scope of the proposed new enquiries function.

17.4 Starting the process of reviewing how we deal with information requests.

17.5 Starting work to coordinate the learning from complaints with the learning from customer feedback.

Treating people with empathy and respect – our values and behaviours

18 We recognise that changing values and behaviours across the organisation will take time. We are planning to use our employee conference in November 2018 as a key event to talk to employees about embedding our values and behaviours and how we will move forward as an organisation.

Other priorities

Handling evidence in our fitness to practise cases

19 We have commissioned an independent audit to review the way we handled a piece of evidence in the FtP cases. The PSA review found no documentary record of it being in our possession between 2010 and 2016 and identified possible inconsistencies in our explanation of what happened. The audit will focus on our systems and processes in order to identify learning and opportunities for improvement.

Public protection implications:	20	The issues identified in the report clearly posed a risk to public protection. We recognise that we must work hard to ensure that we maintain public confidence in us as a regulator.
Resource implications:	21	Additional resources will be required and the forecast costs for these have been reflected in the Performance and Risk report.
Equality and diversity implications:	22	We recognise we need to engage on our future plans as widely as 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:	23	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:	24	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:	25	All changes we make will be discussed with our legal team to ensure they remain in line with our statutory obligations.

Item 11
NMC/18/83
26 September 2018

Council

Public Support Service

Action: For discussion.

Issue: To update the Council on the development and implementation of the Public Support Strategy.

Core regulatory function: Fitness to practise.
Supporting functions.

Strategic priority: Strategic priority 1: Effective regulation.
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.

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Context:

1 Following the Lessons Learned report, the Public Support Service (PSS) is putting patients, families, carers and the public at the heart of the way we operate and the support we offer. The PSS will support people who are involved in our cases to ensure they are protected, valued, cared for, respected and held as important partners throughout the fitness to practise (FtP) process.

2 Following consultation and approval by Council, the first priority within our new FtP strategy is taking a person-centred approach. The introduction of the PSS 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.

Four country factors:

3 The service will be equally provided in all four countries.

Discussion

4 The PSS is committed to putting patients, families, and members of the public at the centre of everything that we do. As the reports about our part in responding to the tragic events at Morecambe Bay and at Gosport War Memorial Hospital show, there are many ways we need to change and improve what we do.

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

6 To provide direction to this work the Head of PSS has developed a strategy. The strategy explains what we mean by a person-centred approach to FtP and what the drivers are for it. It sets out seven priorities for implementing and sustaining this new approach across FtP, which are:

6.1 Ensure that the voice of patients, families and the public is heard in FtP.

6.2 Co-produce a set of person-centred principles.

6.3 A focus on safeguarding.

6.4 A systematic process for identifying people who need support.

6.5 Useful and accessible information available to people every step of the FtP process.

6.6 Training to make sure our staff, panel members, representatives and case presenters understand and feel confident to deliver a person-centred approach to FtP.

6.7 Seek and act on feedback to constantly improve what we do.

7 Activity so far has included:

7.1 The appointments of the Head of PSS, the Public Support Manager and Patient Meetings Adviser. The recruitment of remaining team members is underway.

7.2 A steering group including external and internal partners will guide the implementation of the PSS, challenge our thinking, further develop under-pinning principles and hold us to account for delivery and impact. The first meeting of this group is scheduled for 2 October 2018.

7.3 Support provided to 35 patients and families connected with existing cases and advice and communications for engagement with other complex multi-family cases.

7.4 Feedback sought from patients, families and the public who have been in contact with the PSS to help improve the development of the service. Including input to the PSS strategy, the new web pages and involvement in the steering group.

7.5 The establishment of the PSS Network comprising a group of 60 FtP colleagues who ensure public support is provided effectively across all teams.

7.6 Colleagues and panel member engagement in the development of the PSS strategy.

7.7 The launch of a dedicated area of the website for patients, families and the public including details for help and support from us and sign-posting to other support organisations and a film to help witnesses https://www.nmc.org.uk/concerns-nurses-midwives/support-for-patients-families-and-public/.

7.8 Colleagues from the PSS Network have been trained in mental health awareness, learning from deaths and person-centred approaches.

7.9 We commenced introduction of a needs assessment to ensure we offer appropriate levels of support to people at the earliest point of contact and throughout the time a person is in touch with us.

8 Next steps include:

8.1 Commencing a pilot of patient and family meetings at the start and conclusion of an investigation in October 2018.

8.2 Work to explore the value and impact of patient and family experience in FtP, including the power of stories to enhance our understanding. An initial paper has been discussed at our policy review group on 7 September 2018. The focus of discussion was patients, families and members of the public: understanding the regulatory value of their voices in FtP proceedings. The general principle was fully accepted with the next stage as further work to map out what this means across the FtP process and for a further paper to be presented at the next meeting of the group in November 2018.

8.3 Continuation of the training programme for colleagues including, safeguarding and handling conversations with vulnerable people (October 2018), learning disability awareness (November 2018).

8.4 Further development of our public facing information (from October to December 2018) and work to raise our profile with patient networks and advocacy groups (from November 2018 to July 2019).

8.5 Access to specialist advocacy support for people with mental health needs, people living with a learning disability and people who have been affected by sexual abuse (from November 2018).

8.6 Access to independent, emotional support service for witnesses (from January 2019).

9 The main way we will measure the impact of what we do is by what the people who matter most tell us. We expect to see an improvement in the feedback we receive from patients, families, and members of the public.

10 At this early stage, we anticipate seeing some differences in the way cases progress through FtP:

10.1 By providing better information to people in advance about what we can do and opportunities for issues to be resolved by others, we expect to see a reduction in the proportion of concerns raised with us by patients, families, and members of the public.

10.2 By better engaging and supporting people who raise concerns with us, we expect to see an increase in the proportion of concerns raised by patients, families, and members of the public progressing for investigation.

Public protection implications:

11 Ensuring we hear the patient/family input and support them appropriately to engage throughout our process will improve public protection.

Resource implications:

12 The Executive Board have signed off the business case, allocation of £200k additional resources in 2018–2019 to be funded by underspend in FtP (including recurrent costs), any additional future requirements will be identified as part of business planning and budgeting process.

Equality and diversity implications:

13 EDI assessment including compliance with the Equality Act 2010 and other relevant legislation in Northern Ireland, and the Human Rights Act 1998. The service will assist in making sure we make reasonable adjustments for people who need them and build on our Equality Diversity and Inclusion strategic aim to 'build trust and confidence of service users, nurses and midwives and others that share protected characteristics by showing understanding of their needs and preferences'. The delivery of the PSS will align to our equality, diversity, and inclusion objectives. To achieve this, we aim to:

13.1 Remove unnecessary barriers in how people access our services, resulting in equal protection for all groups.

13.2 Ensure there are no barriers (on the basis of protected characteristics) to accessing our services.

13.3 Ensure that our customers will not have different outcomes from using our services because of their protected characteristics.

13.4 Ensure that the EDI lead is a member of the Steering Group.

Stakeholder engagement:

14 Stakeholder engagement is embedded throughout and key to the effective development and delivery of the PSS. To guide, support and challenge us we are engaging a range of external stakeholders in the PSS steering group. See paragraph 8.2 in this paper for more information.

Risk implications:

15 There are a number of risks associated with the delivery of this work, specifically:

15.1 The PSS will be seen as a small team of experts rather than integral to the operation and delivery of core activity. This is being dealt with by making it clear that public support is everyone's job. To help improve confidence and skills to achieve this we have set up of the PSS Network (see

paragraphs 8.3–8.6 above) and have a focus on staff training.

15.2 That under pressure to deliver, the PSS grows too quickly creating a lack of firm foundations, robust process and procedure and the ability to build and sustain a new area of knowledge and expertise across the organisation. To address this we are taking a phased approach introducing new ways of working through pilots that will be evaluated before rolling out as business as usual.

15.3 That undue expectation is placed on the ability of the PSS to deliver organisation-wide improvements. A strategy and clear action plan and timeline have been developed and signed off by the Executive Board to support the delivery of the PSS. This will remain under review to reflect organisation-wide needs.

Legal implications: 16 None.

Item 12
NMC/18/84
26 September 2018

Council

Midwifery update

Action: For discussion.

Issue: Provides an update on midwifery matters.

Core regulatory function: Education and Standards

Strategic priority: Effective regulation

Decision required: None

Annexes: The following annexe is attached to this paper:

- Annexe 1: Terms of reference and membership of the Midwifery Panel

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 which includes, 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 issues.

Discussion:

Midwifery Panel

3 The Midwifery Panel last met on the 19 July 2018.

4 At this meeting the Panel approved its amended terms of reference (see annexe 1) following the decision at the last meeting, to take on the role of overseeing progress and assessing the draft future midwifery standards, as requested by the Council. The membership of the Midwifery Panel was also reviewed and midwifery representation was increased.

5 Following the departure of the former Chief Executive and Chair of the Panel, an independent chair with chairing experience and a knowledge of healthcare regulation is being sought for the Panel. The Chairman and Interim Chief Executive will liaise with members of the Panel to confirm a new chair.

6 The Panel considered the Lessons Learned review, which was published in May 2018. The Panel discussed a midwifery-focused communication and engagement plan for the coming months.

7 The NMC's senior midwifery adviser updated the Panel on her work and engagements over the previous three months.

External midwifery news

Perinatal Mortality Surveillance Report for Births in 2016

8 On 15 June 2018, MMBRACE – UK published a Perinatal Mortality Surveillance Report for births in 2016, within the UK and the Crown Dependencies.

9 This report will be considered in the development of the new midwifery proficiencies.

Healthcare workforce statistics: England March 2018

10 On 23 August 2018, NHS Digital published the Healthcare Workforce Statistics for March 2018, which stated that the number of full time

equivalent staff working for the NHS in England had increased by 1.6 percent since March 2017.

11 The report details that the number of hospital and community health services (HCHS) nurses and health visitors fell by 148, from 285,900 to 285,700. The number of nurses in general practice increased by 400 from 15,500 to 15,900. The number of HCHS midwives increased by 200, from 21,600 to 21,800.

12 The full report can be found at https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/may-2018.

Maternal Request Caesarean

13 In August 2018 Birthrights published new research concerning the treatment of women who request a caesarean section.The results of a nationwide Freedom of Information Information Act request show that the majority of Trusts in the UK make the process of requesting a caesarean section lengthy, difficult or inconsistent.

14 The full report can be read at http://www.birthrights.org.uk/wordpress/wp-content/uploads/2018/08/Final-Birthrights-MRCS-Report-2108.pdf.

15 This report will be considered during the development of the new midwifery proficiencies.

External consultations – August 2018

16 We responded to Skills for Health's consultation on the draft standards for an apprenticeship route to becoming a midwife.

17 We provided feedback to Royal College of Obstetricians and Gynaecologists consultation on a new core curriculum for obstetricians and gynaecologists.

Update on the future midwife standards

18 Over the next few months the future midwife project team will focus on preparing the draft proficiencies for November 2018 when we will ask the Council for approval to go out to consultation in February 2019. This will involve carrying out a regulatory and legal review of the draft proficiencies to ensure that they meet our core design principles.

19 Alongside the development of the new proficiencies, a UK-wide reference group, chaired by Professor Gwendolen Bradshaw, began meeting in July 2018 to start developing the draft midwifery programme standards. The group has communicated regularly over August 2018 to prepare a final pre-consultation draft for the Council's consideration in November 2018, ready for consultation in February 2019.

Future midwife External Affairs activity

20 Since the Council last met, we have worked with the External Affairs team to continue with the second phase of our future midwife engagement. This phase has come to a close, and all feedback will be used to inform the drafting of the proficiencies and the programme standards.

21 In June and July 2018, as part of the future midwife phase two engagement, we held workshops in Antrim, Edinburgh, Swansea and Birmingham. We asked 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.

22 These were all organised with the support of 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 to seek additional views.

23 In each location we offered the option of an informal drop-in session at a local maternity unit, to maximise the opportunity for clinical midwives to speak to us about the future midwife project, and the work of the NMC more generally. We held successful sessions in Antrim Hospital, Birmingham Women and Children's Hospital, Singleton Hospital and a breastfeeding group in Swansea.

24 The Council previously commented that our engagement to date has been too heavily focused on midwives and we undertook to extend engagement with other groups such as other professionals, advocacy groups, women, and families, including representation on the TLG. In response, we held a forum in July 2018 with a mix of clinical midwives, educators, multi-disciplinary professionals and advocacy groups. We also held a roundtable in July 2018 with a mix of multi-disciplinary professionals. We've increased the number of meetings held with advocacy groups, and met with a breastfeeding group in Antrim in July 2018.

25 The roundtable was with multi-disciplinary professional groups who work with midwives and who have been under-represented in our engagement to date. They were asked to discuss and feedback on what midwives need to know at the point of registration.

26 We also held a large workshop-style forum event for 40 people in July 2018, with a range of key senior stakeholders. This provided a means of sharing, and gathering feedback on, the draft proficiencies. Representatives included commissioners, midwifery educators, CNO representatives, Heads/Directors of Midwifery, Lead midwives for

Education, selected Royal Colleges and midwifery/maternity focused advocacy groups.

27 We have continued our programme of one-to-one meetings with advocacy groups, and organisations representing women and families. We met with a number of these groups throughout July and August 2018.

28 We also plan 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.

29 In August 2018, we held a successful Twitter chat with #WeMidwives, an online community for midwives. Professor Mary Renfrew, Donna Ockenden and Jacqui Williams all took part in the chat, with hundreds of messages being sent over the scheduled hour.

30 As appropriate, we continue to post information about our engagement on social media. For example, during recent workshops, we asked for views on the questions being discussed. Responses were shared with the future midwife project team.

Midwifery strategic engagement

31 The External Affairs team are working with colleagues across the organisation on midwifery matters more generally. They have started a strategic programme of engagement, and have a range of communications and engagement activity planned over the coming months.

32 At the end of August 2018, we focused on a week of external activity specifically for midwifery.

33 We have reviewed and updated our midwifery website content, using the expertise of our midwifery advisers. This included uploading and promoting a new future midwife video, made up of interviews with midwives from around the country. Midwives in the film raised a number of requirements for the future midwife including support of continuity of carer schemes, personal attributes and complexity of care.

34 In August 2018, we published a new blog from Donna Ockenden, Senior Midwifery Adviser to the Chief Executive, outlining her experiences from a recent visit and discussing revalidation.

35 Also in August 2018, we sent an email to all midwives on the register, updating them on our midwifery work and the future midwife project, highlighting how they can get involved.

36 The positive feedback received during the future midwife engagement activity reflects what Donna Ockenden, Senior Midwifery Adviser to the Chief Executive, has experienced from her visits to maternity

departments across the UK. Over the coming months Donna will be visiting midwives in Edinburgh and London, and we will share the outcomes from these on social media and via our website.

37 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 representative bodies, over the coming months we aim to facilitate focus groups with seldom-heard groups, particularly those representing the voices of women and families.

38 We are planning to hold a Twitter chat with women and families within the next couple of months, working in partnership with an online forum such as Mumsnet or Netmums.

39 We are planning a midwifery listening event for October 2018 in London.

Public protection implications: 40 None directly arising from this report.

Resource implications: 41 None directly arising from this report.

Equality and diversity implications: 42 We are tracking the diversity of engagement to date and will be targeting specific groups that are currently underrepresented.

Stakeholder engagement: 43 This is covered in the body of the report.

Risk implications: 44 No specific risk implications arising from this report. Risks relating to development of the future midwife standards are captured through the programme.

Legal implications: 45 None arising from this paper.

NMC Midwifery Panel Terms of Reference

Remit

1 The purpose of the Midwifery Panel is to provide the NMC with authoritative high-level advice about midwifery and maternity issues to enhance the NMC's primary role of protecting the public, including:

1.1 advice on changes in statutory regulation and the effectiveness of the transition to new arrangements.

1.2 strategic input into policy or regulatory proposals affecting midwifery, or maternity services, or satisfies itself that such input has been secured.

1.3 overseeing progress and providing assurance on the delivery of the future midwife education standards and standards of proficiency.

2 To provide a forum for invited leading midwifery and lay figures to exchange information and intelligence; and for the development of strategic thinking on all aspects of the future approach to midwifery regulation.

3 The Panel has no decision-making powers.

Membership

4 The membership of the Panel is determined by the Chair and will include expertise from the midwifery community, professional leaders, and lay input.

Mode of Working

5 Formal meetings of the Panel will normally take place on a quarterly basis.

6 In addition to its regular meetings, Panel members may be called upon to provide input individually or in small groups.

7 Members will receive regular email updates on midwifery developments from an NMC perspective.

8 Discussions at the Panel will be reflected in the standing item on midwifery matters on the Council's agenda.

Approved by the Panel and the Chief Executive and Registrar on 19 July 2018.

Current Midwifery Panel Members

- Jane Cummings, Chief Nursing Officer for England
- Professor Jean White, Chief Nursing Officer for Wales
- Professor Mary Renfrew, University of Dundee
- Professor Charlotte McArdle, Chief Nursing Officer for Northern Ireland
- Ann Holmes, Chief Midwifery Advisor and Associate Chief Nursing Officer for the Scottish Government
- Cath Broderick, Lay member
- Gill Walton, Chief Executive, Royal College of Midwives
- Geraldine Walters, Director of Education, Standards and Policy, NMC
- Janice Sigsworth, Chair of the Shelford Group Chief Nurses Sub-Group
- Professor Jacqueline Dunkley-Bent, Professor of Midwifery, NHS England
- Donna Ockenden, Senior Midwifery Adviser, NMC
- Leigh Kendall, Maternity campaigner and communications expert
- Lord Willis of Knaresborough, Member of the House of Lords
- Logan Van Lessen, Consultant Midwife (Public Health)
- Professor Tracy Humphrey, Chair of the Council of Deans for Health UK Future of Midwifery Group
- Nicky Clark, Chair of Lead Midwife for Education Strategic Reference Group
- Sascha Wells, Maternity Improvement Advisor, NHS Improvement
- Maxine Spencer, Director of Midwifery, St Thomas' Hospital
- Anne Wright CBE, Lay member, NMC Council
- Lorna Tinsley, Registrant member, NMC Council

Item 14
NMC/18/86
26 September 2018

Council

Investment proposals

Action: For decision.

Issue: Revision of the investment strategy and setting up an Investment sub-Committee.

Core regulatory function: Supporting functions.

Strategic priority: Strategic priority 4: An effective organisation.

Decision required: The Council is asked to:

- endorse the outline of the proposed revised Investment Strategy;
- agree to set up an Investment Sub-Committee and approve the amendments to the Council's Standing Orders and Scheme of Delegation including the draft terms of reference for the Investment Sub-Committee (**annexe 1**).

Annexes: The following annexe is attached to this paper:

- Annexe 1: Amendments to the Council's Standing Orders and draft terms of reference of the Investment Sub-Committee.

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 Our investment policy, approved by the Council in November 2016, is as follows:

1.1 "investments in the form of cash deposits are maintained only in appropriately credit rated banks or building societies regulated by the Prudential Regulation Authority[1];

1.2 no individual bank or building society shall exceed an investment of 40%[2] of available funds;

1.3 the maximum period for cash funds to be invested is 12 months;

1.4 investment in property will be for the primary purpose of meeting a business need, but will also be considered from an investment perspective."

2 At its seminar in January 2018, the Council discussed the case for designing a revised investment strategy. This would allow the NMC to invest a portion of its funds in non-cash portfolios, moving away from the current position where our funds (typically about £80 million) are held in short term cash deposits.

3 Our approach of investing only in short term cash deposits reduces as far as practicable the risk of capital losses. Any investment in equities carries a risk of capital loss. However, it is generally recognised that, over the long term, equities are the best performing class of investments, whereas investments in cash will not keep pace with inflation and will therefore lose value in real terms.

4 Council asked to see proposals for a revised investment strategy, which would allow some funds to be invested in non-cash portfolios as the best way of protecting the value of money provided to us by our registrants.

5 Our external investment advisors have helped us develop the draft principles, allocation proposals and suggested management arrangements as set out in this paper.

6 It is proposed that the Council set up an Investment Sub-Committee to advise further on development of the strategy and then oversee implementation of the strategy on behalf of the Council.

7 The Council has the power to do anything which appears to it to be necessary or expedient for the purpose of, or in connection with, the

[1] In approving the policy in November 2016, Council stipulated that the "appropriate" threshold credit rating should be defined. This is addressed in the proposed revision in paragraph 13.1 below

[2] In November 2016, Council commented that efforts should be made to further reduce the 40% limit. The proposed revision of the policy does not reduce the 40% limit, because the absolute value of the exposure to any one bank will be significantly reduced under the new policy of investing in equities, funds and bonds as well as bank deposits.

performance of its functions, including power to invest (Schedule 1, Part 1, paragraph 15 (1) NMC Order 2001). As a Charity, the Council has power to invest through the Trustee Act 2000, which confers a general power of investment on charity trustees.

8 These proposals are consistent with the Charity Commission's guidance on investments[3], the Treasury's guidance on Managing Public Money, and our reserves policy.

9 Capital gains and dividend income are non-taxable due to our charitable status.

Four country factors:

8 Not applicable for this paper.

Discussion:

Outline of proposed revised investment strategy

9 Following discussion at the seminar in January 2018, at the Executive Board in May 2018, and with our investment advisers, a proposed revised investment strategy is outlined below. If Council approves the establishment of an Investment Sub-Committee the Sub-Committee will keep the strategy under review and make recommendations to the Council on suggested future amendments, in line with its terms of reference.

10 The proposed high level financial objective is to: "maintain the value, in real terms, of our cash and investments overall, whilst maintaining sufficient cash to meet our needs for operations and planned development projects".

11 The proposed overall appetite for investment risk is "cautious to open"[4] for the overall portfolio including cash.

12 This approach implies that a high level of security of our capital is a priority. Whilst recognising that investment values will change, we would feel uncomfortable if our investments rose and fell in value very quickly and would not expect a drop of more than 10 per cent in the overall value of the portfolio over any 12 month period. Nevertheless, if we proceed with the proposal to switch substantial investable funds out of cash, the risk of capital losses cannot be excluded.

13 Based on advice from our investment advisers, our proposed

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/581814/CC14_new.pdf

[4] HM Treasury's guidance on risk management includes a five point scale for risk appetite: Averse; Minimalist; Cautious; Open; Hungry. "Cautious" is defined as "Preference for safe options that have a low degree of residual risk and may only have limited potential for reward". "Open" is defined as "Willing to consider all options and choose the one that is most likely to result in successful delivery while also providing an acceptable level of reward".

approach is to split our investable funds into three sections:

13.1 cash needs (with a five year horizon). This would include what we keep in a current account for day to day needs, and rolling fixed term deposits of up to 24 months (up from 12 months in the current policy). Our risk appetite for this section of the portfolio would be "minimalist". To reduce "counter-party risk" – that is, the risk of one of the institutions going out of business - balances will be held only with UK registered financial institutions, with no more than 40% by value of this section of the overall portfolio being held under any one banking licence.. We propose that the long term credit ratings for the institutions we place deposits with should be at least A from Standard and Poors and A3 from Moodys[5];

13.2 medium term, low risk investments, representing a "cautious" risk appetite that should provide a higher return than cash deposits over a five to ten year horizon. The purpose being to achieve an average growth of inflation plus one percent after fees - but still offering low risk of losing significant capital value. These could be liquidated in the short term (14 days) if needed. It would reflect possible medium term expenditure, providing a middle ground between cash and the long term portfolio, which could be accessed if needed to fund projects or investments;

13.3 longer term investments, which we would expect to hold for at least ten years, representing an "open" risk appetite where we would expect average annual growth of inflation plus two percent. These investments could also be liquidated within 14 days, but access would be avoided except in an emergency.

14 The need for liquidity means that investment property – meaning property that is not occupied by the NMC and is held for rental income and/or capital appreciation – is not considered an appropriate category for us.

15 Our initial assessment indicates that the split between the three funds, based on our current cash holdings might be about £25/25/30 million across the cash/medium term/longer term categories. This reflects a cautious approach to reducing our current cash holdings. This would be revisited by the proposed Investment Sub-Committee at the time the new approach is implemented, and kept under review thereafter.

16 As a regulator and a charity with the objective of protecting,

[5] The risk level of bank deposits and bonds is assessed by credit ratings agencies. The three main agencies are Standard & Poor's, Moody's and Fitch. They use similar scales, ranging from AAA, which is the judged to be the lowest risk of default, to C. Instruments rated BBB- or higher by S&P or Baa3 or higher by Moody's are referred to as "investment grade" – that is, deemed suitable for investment by banks.

promoting and maintaining the health, safety and wellbeing of the public, it may be appropriate for our equity investments to be subject to ethical considerations. For example, we may choose to exclude investments in companies who are significantly involved in tobacco, alcohol or gambling. Any ethical investment policy will be for the Investment Sub-Committee to commission and make proposals for approval by the full Council.

Arrangements to manage and monitor funds

Use of advisers and managers

17 We propose that the short term cash holdings section of the portfolio will be managed internally by the Resources Directorate. This is because managing fixed term deposits within a Minimalist risk appetite is technically relatively straightforward and within our internal capability, and can only provide low returns. Therefore we think external investment advice is unnecessary for this part of the portfolio, and would be unlikely to increase the net financial return.

18 We propose that the medium and long term funds will be managed by one or possibly two independent investment managers. Charity law requires that trustees must take and consider advice from someone experienced in investment matters before making investments and when reviewing them. Trustees may decide not to take external advice if they have sufficient experience within the charity. We have Council members with investment management experience, but given the size of the portfolio and the time commitment required to manage it, we think it is appropriate to appoint external investment managers.

19 The development of these proposals has been assisted by our independent investment advisors. The Investment Sub-Committee may wish to retain independent investment advisors after the investment portfolio becomes operational, to help the Sub-Committee manage the performance of the investment managers. Alternatively the Sub-Committee may conclude that the experience of Sub-Committee members and/or the measurability of investment performance and the existence of established investment performance benchmarks means that retaining investment advisors is not necessary.

20 For investment managers and advisers, we will need to insist on full transparency on fees and charges.

Governance and establishing an Investment Sub-Committee

21 Oversight of investments, the performance of the investment managers and review of the investment strategy are important elements of the responsibilities of the trustees of any charity. We suggest that there should be a detailed review annually, with a high

level review at the six month period in between, taking reports from investment manager(s) and, if appropriate, an independent investment adviser.

22 These reviews would be performed by the Investment Sub-Committee, which would in turn provide updates to Council. Establishing an Investment Sub-Committee would enable greater focus on oversight of this area than would be the case if reports were simply made to and discussed by the full Council.

23 Draft terms of reference for an Investment Sub-Committee are attached at **annexe 1**, together with the necessary amendments to the Council's Standing orders and Scheme of Delegation.

24 **Recommendation: The Council is recommended to agree to set up an Investment Sub-Committee and to approve the amendments to the Standing Orders and Scheme of Delegation at annexe 1, including the Draft terms of reference for the Investment Sub-Committee.**

Next steps

25 If Council agrees in principle to the outlined revised investment strategy, and agrees to establish an Investment Sub-Committee, we propose that the Executive should develop proposals for the procurement of investment managers to present to the Sub-Committee. If the Investment Sub-Committee decides to retain independent investment advisers to help manage the performance of the investment managers, the Executive would also support the procurement of the advisers.

26 The procurement of investment managers will need to be undertaken via a route to market that complies with the Public Contracts Regulations. If no suitable framework agreement exists, this will take a minimum of six months.

27 In parallel with the procurement, the Executive would further develop the investment strategy for consideration by the Sub-Committee.

28 The Sub-Committee would then make recommendations to Council to approve the revised investment strategy.

Public protection implications: 29 None.

Resource implications: 30 Discussions and advice to date are expected to cost up to £15,000. For the next stages, we will need to tender for investment manager(s) to manage the long term investment funds. We will demand complete transparency on fees. All returns sought in the

discussion above are net of fees.

Equality and diversity implications:	31	None.
Stakeholder engagement:	32	None required.
Risk implications:	33	The proposed new investment strategy will expose us to the risk of capital losses on our investments. A significant fall in the value of our investments also carries reputational risks. Stakeholders are likely to have an asymmetric view of risk; that is, they may see more disbenefit in a given percentage downward movement that they see benefit in the same percentage upward movement.
	34	Risks will be mitigated by working in conjunction with our existing investment advisors and new investment managers to be tendered for. Regular reporting to Council will provide the relevant oversight of the investment performance.
Legal implications:	35	None.

Amendments to the Council's Scheme of Delegation

The following changes are proposed to the Council's Standing Orders and Scheme of Delegation

Amendment 1: Council Standing Orders, Annexe 1, Scheme of Delegation, Discretionary Committees - add new paragraph as follows:-

The Investment Sub-Committee

The Investment Sub-Committee's remit is to advise the Council on its investment strategy and to oversee and monitor implementation of the strategy, reporting progress regularly to the Council. The Committee has delegated authority from the Council to appoint such investment managers and/or advisers, as required and to take such decisions as are appropriate to ensure implementation of the Council's investment strategy.

Amendment 2: Council Standing Orders, Annexe 2, Terms of Reference of Committees add new Annexe as follows:-

Annexe 2e: Terms of reference of the Investment Sub- Committee

1. The Investment Sub-Committee is established by the Council under Article 3 (12) of the Nursing and Midwifery Order 2001.

Remit

2. The Council is responsible for determining the investment strategy, risk appetite and target returns on the advice of the Sub-Committee.

3. The remit of the Sub-Committee is to oversee implementation of the Council's investment strategy; determine the allocation and movement of funds in accordance with the investment strategy; and monitor the Council's investment portfolio. Decision-making and implementation of the investment strategy is delegated to the Investment Sub-Committee.

Responsibilities

4. In particular, the Sub-Committee has the following responsibilities:

4.1. Keep the investment strategy under review, taking into consideration factors such as legislative, financial and economic changes, and ethical considerations; and make recommendations to the Council for changes, as necessary.

4.2. Oversee implementation of the investment strategy and monitor risks.

4.3. Appoint external Investment fund Managers, including deciding the number of fund managers to be used, the proportion of assets managed by each manager, their mandates and associated fees.

4.4. Set asset allocation parameters, based on advice from fund managers and/or external advisers, and monitor the actual asset allocations chosen by the fund manager, to ensure consistency with the policy. Where more than one fund manager is appointed, the Sub-Committee will also monitor the aggregate asset allocation to ensure it provides sufficient diversification to reduce the risk of capital and/or revenue loss.

4.5. Meet regularly with Investment Fund managers and monitor the performance of each against agreed objectives by means of regular review of the investment results and other information, including corporate governance activities, policies and exercising of voting rights of the investment fund managers.

4.6. Appoint independent Investment Advisers, as necessary, and approve associated fees.

4.7. Report to the Council on the Committee's work, escalating issues or risks as required. Provide an annual report to the Council which includes investment performance in comparison to relevant benchmarks (either directly or via investment experts); and risks within the investment strategy and the appropriateness of mitigations put in place to address those risks. A summary of investment performance will be reported to the Council as part of the normal reporting of financial performance by the Director of Resources.

Membership and operation

5. The Sub-Committee will operate in accordance with the Standing Orders (made by the Council under Article 12 Schedule 1 of the Nursing and Midwifery Order 2001), except where the operations below are different.

6. The Chair of the Council will determine the membership of the Sub-Committee. Membership will comprise at least three Council members and include at least one lay and one registrant member The Chair of the Council will appoint a Chair of the Sub-Committee from amongst the Council members. The membership will be reviewed from time to time.

7. The Sub-Committee, with the consent of the Chair of the Council, may co-opt or appoint suitably qualified independent members with extensive investment expertise. Independent members will be expected to act as full members of the Committee, whilst recognising that that they are not Council members or trustees and that in the event of a vote, only Council members of the Committee would be entitled to vote.

8. The Sub-Committee shall meet at least twice a year, or when directed by the Council, or determined by the Sub-Committee Chair.

The terms of reference of the Investment Sub-Committee were adopted by the Council on DD MMMM 2018.

Item 15
NMC/18/87
26 September 2018

Council

Our work with employers and other regulators

Action: For discussion.

Issue: To update the Council on the work of the Employer Link Service (ELS) and Regulatory Intelligence Unit (RIU) in 2017–2018.

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: None.

Annexes: The following annexe is attached to this paper:

- Annexe 1: Initial assessment of benefits.
- Annexe 2: Our work with employers and other regulators 2018–2019.

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 annual report at Annexe 2 provides an update on the work of our Employer Link Service (ELS) and Regulatory Intelligence Unit (RIU) in 2017–2018.

Four country factors:

2 The ELS covers all four countries and the detailed coverage of its work in 2017–2018 is detailed in figure 1 of the annual report.

Discussion and options appraisal:

3 The ELS is in its third year of operation. The highlights of its work over the last year include:

3.1 Improving the way we share data with other regulators and organisations responsible for quality and safety across the UK;

3.2 Consistently positive feedback from users of the ELS advice line on the value of the service, and strong appreciation of the learning sets our regulation advisers provide to employers;

3.3 Setting up of the RIU to improve understanding of our data and that gathered from external sources, to enable an intelligence driven approach to our work with employers; and

3.4 The introduction of a new coding framework into the case management system to better assess risk to patient safety.

4 The initial ELS business case, prepared with external advice in 2014, identified a range of quantifiable and wider benefits. Progress against these measures is summarised in Annexe 1.

5 Our assessment is that we are delivering the wider benefits. Demonstrating delivery of the quantifiable benefits is more difficult:

5.1 The proportion of referrals from employers closed at the screening and investigation stages has increased, rather than decreased, since ELS was set up. In the same period, we have made very significant changes across fitness to practise (including placing much greater emphasis on remediation and insight) that influence the closure rates.

5.2 The median ages of cases at the decision points has reduced since ELS was set up. In the same period, we have made significant changes across fitness to practise (including introducing Case Examiners in 2015 and significant legislative changes in 2017) which means it is difficult to isolate the impact of ELS.

6 We plan to undertake a more detailed evaluation of the impact of the

service in 2020.

Public protection implications:	7	Our ELS is primarily driven by the need to protect the public, by ensuring that employers make appropriate and timely referrals and by contributing to local intelligence networks including work with other regulators.
	8	The primary objective of the RIU is to analyse information relating to patient safety issues and to ensure that appropriate regulatory action is taken where necessary.
Resource implications:	9	The resources for ELS are covered within existing budgets.
Equality and diversity implications:	10	None.
Stakeholder engagement:	11	This paper sets out all engagement with employers and other stakeholders undertaken by ELS in 2017–2018. During the year, the RIU team met with the intelligence units at the systems regulators across all four counties.
Risk implications:	12	None.
Legal implications:	13	None.

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Initial assessment of benefits

Quantifiable Benefits	
1A - Reducing the number of cases from employer referrals closed at screening that shouldn't enter the system	The proportion of referrals from employers closed at screening in the last three financial years is: • 2015–2016: 21% • 2016–2017: 33% • 2017–2018: 33% The proportion of referrals from employers closed by the Investigating Committee / Case Examiners in the last three financial years is: • 2015–2016: 46% • 2016–2017: 40% • 2017–2018: 60%
1B – Reducing the number of cases from employer referrals closed at Investing Committee that should not enter the system	
2A - % reduction of the average life of all cases at the screening stage	The median age of cases at the screening decision point at the end of the last three financial years is: • March 2016: 6 weeks • March 2017: 4 weeks • March 2018: 4 weeks The median age of cases at the Case Examiner decision point at the end of the last three financial years is: • March 2016: 54 weeks • March 2017: 59 weeks • March 2018: 43 weeks The median age of cases at the Adjudication decision point at the end of the last three financial years is: • March 2016: 85 weeks • March 2017: 81 weeks • March 2018: 75 weeks
2B - % reduction of the average life of all cases at the investigations stage	
2C - % reduction of the average life of all cases at the adjudication stage	

Wider Range of Benefits	
1. Increased patient safety through early intervention and better supervision	ELS has begun to establish strong relationships with employers, leading to improved sharing of potential FtPconcerns at the pre-referral stage. As the work of the RIU develops there will be greater emphasis on sharing emerging trends and issues with other regulators; as well earlier interventions with employers to address identified risks.
2. Responding adaequately to the Francis report and enhancing the reputation of the NMC	ELS has made good progress in building improved external stakeholder relationships – particularly with employers. Further work is planned in the coming year to improve the guidance to employers on making effective referrals, as well as advising them on good practice in delivering local action, so that more cases can be adequately resolved upstream of the FtP process.
3. Enhanced communication and feedback	The ELS regulation advisers have been well positioned to communicate important NMC messages and developments including the FtP strategy the new Education Standards and Code Of Practice and changes in registration and revalidation. This engagement now needs to be extended to a wider group of employers, particularly in the adult social care and independent sectors.
4. Getting closer to employer and registrant issues	ELS's engagement with employers has provided an important channel of two way communication on FtP issues as well as a means of escalating progress on sepcific cases. In the coming year more work will be focused on understanding concerns of midwives and nurses affected by the FtP process and where relevant, feedback these concerns to employers so that they and the NMC are able to support them more effectively.
5. Supporting the environment for revalidation	ELS has supported the introduction of revalidation through the by communicating and explaining key changes to employers. The RIU will also be supporting the Registration and Revalidation Directorate on the development and data requirements for its evolving assurance matrix.
6. Appropriateness of referrals and	The role of the ELS regulation advisers has been

timeliness of investigation	strongly praised by employers in providing good advice on potential referrals This work will be strengthened in the coming year with revised employer guidance.

Item 15: **Annexe 2**
NMC/18/87
26 September 2018

Nursing and Midwifery Council

Our work with employers and other regulators in 2017-2018

Contents

Introduction

1 We set up the employer link service (ELS) and regulatory intelligence unit (RIU) after the Mid Staffordshire NHS Foundation Trust Public Inquiry published its report in February 2013. In it, Robert Francis QC made a specific recommendation for us to address the 'regulatory gap' between the systems regulator and the professional regulators.

2 Recommendation 232 stated that we should consider providing support and guidance locally for employers and others with concerns about nurses and midwives. The need to identify and act on local concerns in the light of recent high-profile incidents, such as Morecambe Bay, means that health regulators need mechanisms for engaging locally and working with employers and other regulators.

3 Other factors that led us to set up the ELS and RIU included the need to address the growing number of referrals, the time taken to resolve cases and the need to identify and act on local concerns.

4 In 2016-2017 we established a centrally based team of six ELS regulation advisers to cover the four countries. Regulation advisers are senior enough to build confidence with nurse directors, have strong relationship skills, expert fitness to practise knowledge and regulatory expertise so they can deal effectively with individual cases.

5 Advisers look after geographical areas while we maintain the principle of having a centrally based resource. The geographical split is now: south west England, south east England, London, east England, Midlands, Wales, north west England, north east England, east Scotland, west Scotland and Northern Ireland. This approach has worked well and employers have welcomed it. It ensures good coverage across the UK.

6 We have been able to gain a deeper understanding of local health economies and environments in which nurses and midwives practice, build more effective regulatory relationships with directors of nursing and heads of midwifery on a one-to-one basis, and develop relationships with our counterparts in the four systems regulators (Care Quality Commission, Healthcare Improvement Scotland, Health Inspectorate Wales and the Regulation & Quality Improvement Authority in Northern Ireland) as well as professional regulators such as the GMC. This improves collaboration and intelligence sharing.

7 By establishing the RIU and continuing to develop the ELS we are seeking to strengthen our relationships with employers and other regulators so that we:

7.1 have better links to directors of nursing, heads of midwifery and other regulators to support two-way exchange of information about nurses and midwives of concern

7.2 improve our understanding of our data and get better access to local information about nurses and midwives who might pose a professional regulatory risk

7.3 identify themes and trends to feedback to employers. This includes information about fitness to practise outcomes, so they can take action to reduce unnecessary referrals and/or manage issues more effectively locally

7.4 improve knowledge among directors of nursing, heads of midwifery and other regulators of our referral thresholds and fitness to practise process

7.5 have a way to share our data about nurses and midwives whose practice might pose a regulatory risk, including geographical trends

7.6 can design and deliver tailored learning sets for employers and appropriate stakeholders to address issues arising from intelligence and data analysis

7.7 can benchmark referral activity by organisation to identify changes in referral patterns and allegation types that might indicate a regulatory intervention may be necessary.

8 Developing more effective relationships with stakeholders, especially employers, is a good way of positively influencing the number and quality of appropriate referrals. It is also a means of encouraging feedback from employers to inform service improvement initiatives internally.

Intelligence model and data improvement

9 ELS has continued to develop effective regulatory relationships with employers building on the progress made last year. This year we established an RIU that works with ELS to enable a more targeted approach to our engagement with employers.

10 We agreed an intelligence model based on the National Intelligence Model (NIM). The model is used by police forces and other healthcare regulators. The NIM is a well-established and recognised model which provides a standardised approach to gathering, coordinating and disseminating intelligence. Using a standardised approach across regulators makes it easier to share information between regulators. We also recruited a small team of intelligence analysts and have established a cross-directorate intelligence coordination group to consider and coordinate responses to the concerns identified by the RIU.

11 We designed and introduced a case risk assessment coding frame which we have integrated into our case management system. The new risk assessment codes will enable analysis of the levels of harm to patients associated with each FtP case. The case owner completes a case risk assessment each time they receive new information about the case or when the case moves between FtP stages. The new risk codes include harm resulting in patient death, serious harm to patient, potential for serious harm, serious harm to self and risk of repetition.

Working with independent sector employers

12 We are working with the system regulators to improve patient safety in the independent sector by training care home managers about fitness to practise. In 2017-2018, we worked with the systems regulator in Northern Ireland to devise and deliver learning events for new care home managers. The events in Northern

Ireland were well received so we are looking to run similar events with the system regulators in Scotland and Wales. Due to the size of the sector in England, we will evaluate the effectiveness of the sessions before deciding on whether we should begin to consider a strategy for delivering similar sessions across England.

Sharing information with others

13 We have also improved the way we share our data with other organisations responsible for quality and safety, to better understand the wider health system. We increased the number of times we shared information with other regulators and bodies by 75 percent, from 133 times in 2016-2017 to 233 times in 2017-2018. We are also now sharing quarterly reports of aggregated FtP data associated with all NHS and Health and Social Care (HSC) providers, and with the system regulators in Northern Ireland, Scotland and Wales. We provide similar reports to the system regulator in England, on request, to inform their pre-inspection processes. The new reports include the recently implemented allegation codes, and fitness to practise outcomes. In future we will also include the new risk assessment levels of harm codes.

14 During 2017-2018, we took part in a cross regulator working group to produce an information and intelligence sharing protocol. This will allow any of the signatory organisations to call meetings between appropriate healthcare regulators to share information at a much earlier stage than current arrangements allow. A pilot of the 'emerging concerns' protocol took place in north London and this worked well. This has been seen as a very positive development of collaboration by both by systems and professional healthcare regulators. The final draft of the protocol was approved by the Health and Social Care Regulators Forum (HSCRF) in May.

15 We agreed a new memorandum of understanding (MoU) with Regulation and Quality Improvement Authority (RQIA) in Northern Ireland and a joint working protocol with Care Quality Commission in England. We now have MoUs with:

15.1 Healthcare Improvement Scotland (HIS)

15.2 Disclosure and Barring Service (DBS)

15.3 Scottish Public Services Ombudsman (SPSO)

15.4 Health and Social Services Department of the States of Jersey (HSSD)

15.5 CQC

15.6 Healthcare Inspectorate Wales (HIW/AGIC)

15.7 NHS Education for Scotland (NES)

15.8 Care Inspectorate

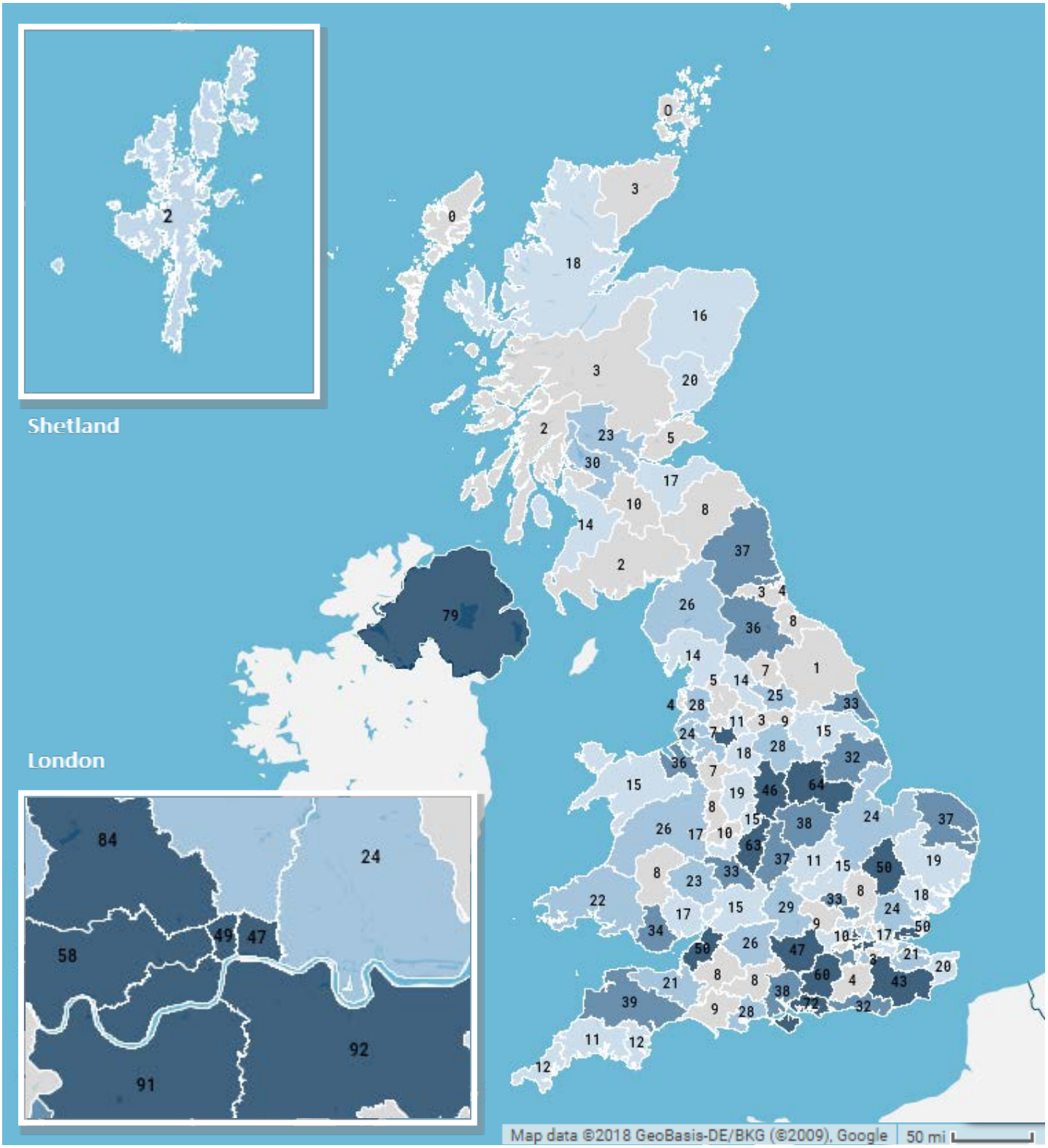
15.9 RQIA

16 We are currently in the process of reviewing our MoU with Healthcare Improvement Scotland and we are working towards agreeing one with Healthcare Safety Investigation Branch (HSIB) and Social Care Wales.

Our work with employers and other regulators across the four countries

17 The map below includes all advice line calls, learning sessions, one to one employer meetings and intelligence sharing forums.

Figure 1 – Four country coverage of ELS in 2017-2018



Whistleblowing concerns

18 The Public Interest Disclosure (Prescribed Persons) Order 2014 lists organisations and individuals a worker can approach outside of their workplace to report suspected or known wrongdoing. As a regulator, we are one such organisation. When raising a concern, a worker may qualify for certain employment rights in the same way as if they had raised the issue with their employer. This is called a ‘protected disclosure’. Our role is not to decide whether the individual blowing the whistle to us qualifies for protection in the law. Our role is to decide whether we ‘reasonably believe’ a concern raised to us constitutes whistleblowing in the context of our role as a prescribed person, and to take any appropriate action through our existing processes.

19 From 1 April 2017 a further legal duty came into force to produce an annual report on the action we take as a result of whistleblowing disclosures made to us. The report also sets out how these disclosures help us to achieve our statutory objectives.

20 In 2017-2018, the RIU agreed and embedded processes for managing and reporting on whistleblowing disclosures. We assessed 371 pieces of information against the whistleblowing criteria during 2017-2018, 60 of which we believe are qualifying disclosures. Where relevant we shared these with our fitness to practise team and other regulators or organisations.

21 We are working with the other health professional regulators to design and produce a joint whistleblowing report for publication. The report will set out the outcomes of our whistleblowing assessments against the criteria and the action taken. It will be published before October 2018.

How we deal with regulatory concerns

22 Below are some examples of regulatory concerns managed by ELS and RIU in 2017-2018:

Case study one: Concerns raised through our whistleblowing processes

We received an email from a nurse who was concerned that the system for reallocating staff in her hospital was unsafe, as it didn't properly take account that staff may be acting outside their scope of practice, or might not have had the right training.

The nurse was also concerned that vulnerable patients were being left in theatre while the nursing staff needed to help with work on other wards. She also highlighted examples of inadequate training and occasions when managers failed to listen to staff concerns.

We worked with the nurse to get more information so we could take issues forward with the employer's executive board. The employer confirmed that they had finished an investigation into a number of incidents and that they were implementing several recommendations. The nurse confirmed that, since the NMC became involved, she had noticed changes including more training, and the introduction of new processes including risk assessments and incident reporting.

The nurse said:

"Your assistance has not just impacted on the problems we were experiencing in theatres. It was a much larger concern, that I have only just recently recognised. I honestly don't believe without your help this could have such a positive outcome".

Case study two: Concerns about medication errors and bullying

We had two anonymous letters from an individual concerned about medication errors, some which were life threatening. The letters alleged that managers were failing to manage these errors appropriately. They also raised concerns about how managers treated staff, including allegations of bullying, and questioned the use of resources.

The same provider received an ‘inadequate’ rating by the system regulator after an inspection. The system regulator’s report found that staff were not always competent and skilled in treating the vulnerable patients in their care. It also found that safeguarding concerns were not being investigated fully and incident forms were not being completed when something went wrong. We monitored this closely as the system regulator checked compliance against recommendations in their report.

We wanted to make sure we had all the relevant information about any nurses or midwives involved in the incidents so we contacted the employer. It told us that it had dismissed two nurse managers for gross misconduct as there were findings of dishonesty and lack of accountability for dealing with safety issues. We advised the employer to refer the nurses to us so we could investigate potential fitness to practise concerns. The employer also told us that they had made significant changes since the inspection, particularly around appropriate escalation of issues, and managers having oversight and accountability for these. These issues are currently being dealt with through the FtP process.

Case study three: Concerns about a learning environment

A source of intelligence indicated that there were concerns relating to bullying and harassment at a healthcare provider. We wanted to understand whether the concerns related to any nurses or midwives, so we contacted the employer to get more information.

After talking to the director of nursing, we were satisfied that she had no concerns around the fitness to practise of any nurses or midwives. However we asked the employer to give us a copy of the investigation report that highlighted that some staff treated students inappropriately in front of patients. The report also mentioned that nearly half of staff reported bullying problems and some experienced harassment. Staff interviewed for the report highlighted concerns about colleagues in positions of trust who were not behaving appropriately towards students.

While this information assured us that nurses and midwives were not involved, we shared the information with our education and standards team so they could get in touch with any universities who place student nurses with this employer. We also shared it with the appropriate systems regulator.

Performance

In 2017-2018, ELS handled more than 1,500 calls with employers and other stakeholders, and met with employers and other key stakeholders almost 900 times.

The top themes of that engagement were:

- advice on making referrals (n=740)
- two way information and intelligence sharing (n=105)
- general advice on fitness to practise or discussions about individual cases (n=45)

23 ELS provides a referral advice line for employers. The advice line helps employers to decide whether a referral is necessary so that we can stop inappropriate referrals. It also gives employers advice on the information we need to so a referral can move through fitness to practise efficiently.

24 During 2017-2018 we had 740 calls about referrals. We 'advised to refer' 433 times. We advised 241 callers that the nurse or midwife they were considering referring did not currently meet the referral threshold. We gave other advice in the remaining 66 calls. This early intervention improves employers' understanding of thresholds and fitness to practise and reduces the resources we spend cases that more appropriately require local action.

25 When surveyed, most callers were very positive about the advice we provided with 98 percent saying they were satisfied or very satisfied with the adviser's knowledge, 99 percent saying they would call again, and 100 percent stating that we helped them fully or partially with their query.

Chart 1: ELS advice line (258 responses received)

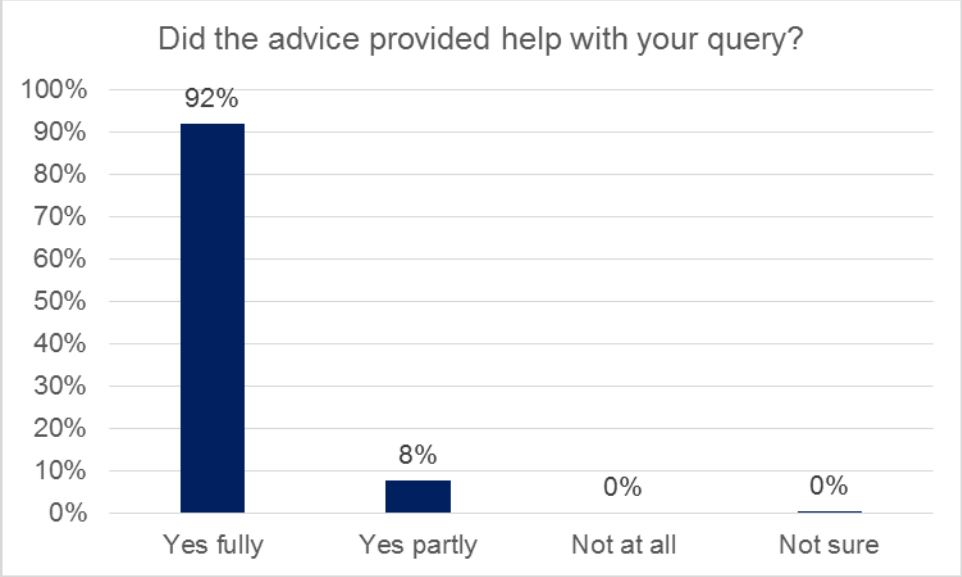


Chart 2: ELS advice line (258 responses received)

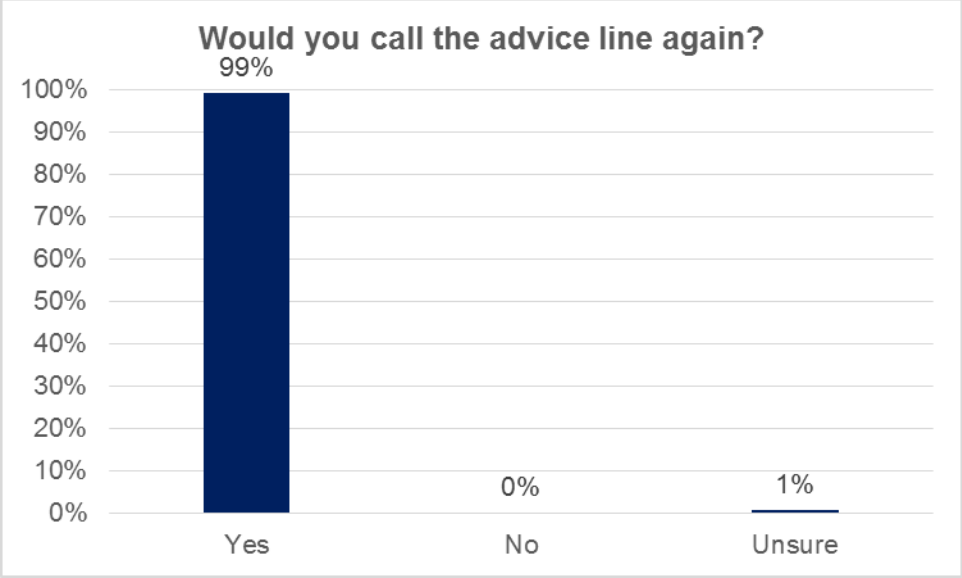
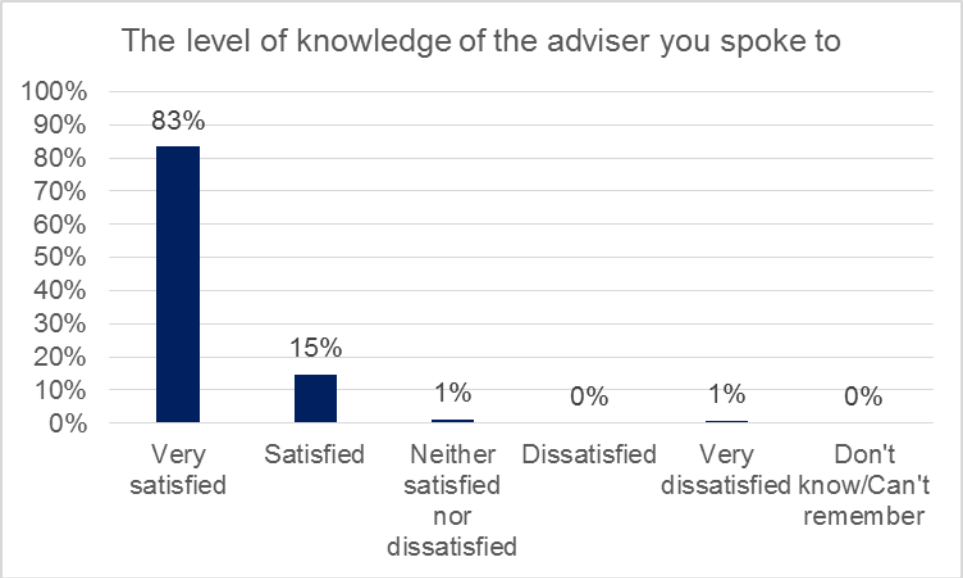


Chart 3: ELS advice line (258 responses received)



Learning sets for employers

26 ELS provides learning sets for employers. In 2017-2018 they focused on fitness to practise and understanding referral thresholds. The learning sets range from small sessions with directors of nursing and executive management teams to larger sessions with up to 100 attendees including nurses and midwives of varying seniority and fields of practice. A recent example was a learning set provided to 350 nursing and midwifery students about fitness to practise and the importance of adhering to our standards and the Code.

27 Learning sets give us an opportunity to engage with larger audiences and build understanding of our referral thresholds as another way of reducing unnecessary referrals. They are extremely well received. Between 97 and 100 percent of participants agree or strongly agree that:

27.1 the practical scenarios helped them understand the concepts discussed,

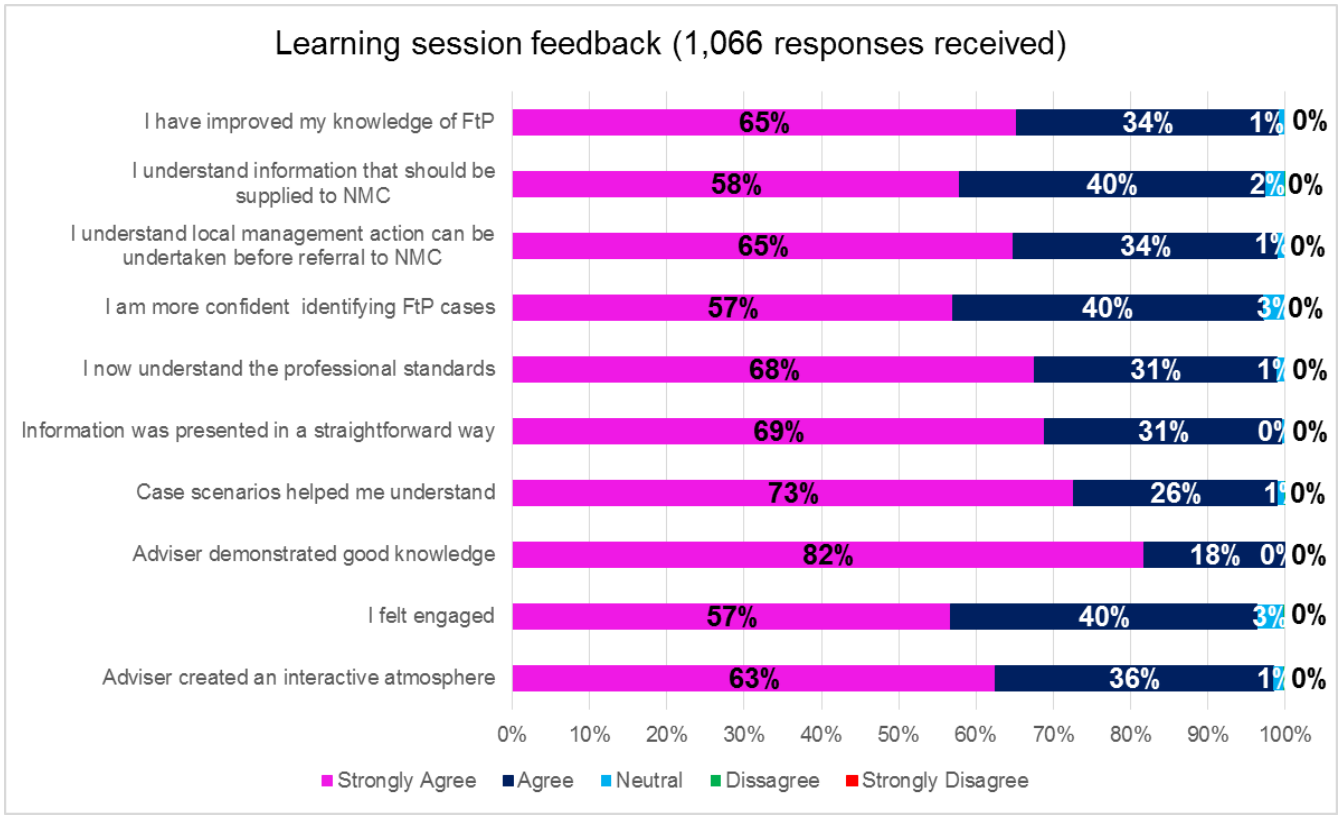
27.2 they understand that local management action can be taken before considering making a referral

27.3 they felt more confident in identifying cases that should be referred to the NMC

27.4 they understood the information needed by the NMC to support a referral

27.5 they had improved their knowledge of the principles of fitness to practise

27.6 they recognise and understand the professional standards that should be met by nurses and midwives.


Learning session feedback (1,066 responses received)
I have improved my knowledge of FtP
65%
34%
1%
0%
I understand information that should be supplied to NMC
58%
40%
2%
0%
I understand local management action can be undertaken before referral to NMC
65%
34%
1%
0%
I am more confident identifying FtP cases
57%
40%
3%
0%
I now understand the professional standards
68%
31%
1%
0%
Information was presented in a straightforward way
69%
31%
0%
0%
Case scenarios helped me understand
73%
26%
1%
0%
Adviser demonstrated good knowledge
82%
18%
0%
0%
I felt engaged
57%
40%
3%
0%
Adviser created an interactive atmosphere
63%
36%
1%
0%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Strongly Agree
Agree
Neutral
Dissagree
Strongly Disagree

Future plans and Lessons learned review

28 By continuing to focus on intelligence in 2018-2019, we hope to gain new insights into our work, helping us to be more effective, transparent and proportionate. We are going to focus on improving how we report on fitness to practise themes, which will inform the public and professions of our work, and reduce the time taken responding to ad hoc queries.

29 We will widen and further strengthen our regulatory relationships with employers to build understanding of our regulatory responsibilities, and the fitness to practise strategy. We will focus on supporting effective local action by employers. We continue to work towards achieving strong relationships with key stakeholders including trusts, boards and the systems regulators.

30 As recommended in the Professional Standards Authority's Lessons learned review, we have reviewed our resources and are expanding the team by recruiting two more regulation advisers and two more intelligence analysts. These roles will mean that we will be able to reduce the number of employers per regulation adviser and expand our reach in the independent and the voluntary sectors. We will also continue promoting the work of the employer link service and the regulatory intelligence unit to the rest of the organisation as recommended.

31 We will continue to build our regulatory intelligence capability to develop a data driven approach. This will help us to proactively manage regulatory concerns and inform our regulatory decision making. To do this, we will need to procure the systems and tools that will significantly expand our analytical capability. We will also improve our joint working across all of our data functions so we can better use all of our data. We will improve and expand our employer codes to include independent sector employers in Scotland and Northern Ireland.

32 We will continue working with system regulators, healthcare professional regulators and other relevant oversight bodies to share information so settings that we can identify the settings that pose the most risk in relation to nursing and midwifery care and take appropriate action at the earliest possible stage.

33 The RIU will improve our understanding of what we know about our regulated professions, from our own data and that of others. This will make sure the way we regulate focuses on identifying areas of concern and preventing harm by pooling information and aligning regulatory activity. We plan to move RIU towards a more intelligence led approach to regulation. We are beginning to use intelligence drawn from data, analysis, research and horizon-scanning to improve the way we work.

34 Understanding what our own data tells us, and making good use of what others know, are central to regulation. Along with other regulators, we are rethinking the significance of our overarching purpose and how intelligence can help us to achieve our aims. We know that intelligence will help us respond better to regulatory concerns and we hope that, in the future, better intelligence will allow us to understand risk-factors for poor practice and use these to anticipate and avoid its impact on service users.

Item 16
NMC/18/88
26 September 2018

Council

Annual equality, diversity and inclusion report 2017–2018

Action: For discussion.

Issue: This paper presents the NMC's equality diversity and inclusion annual report 2017–2018.

Core regulatory function: All regulatory functions.
Supporting 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: Equality diversity and inclusion 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 This is the sixth annual equality, diversity and inclusion (EDI) report. It covers the period of April 2017 to March 2018.

2 This report is divided into two sections. Section one is an overview of the achievements against the *Equality Diversity and Inclusion Strategy 2015–2020.* Section two presents a summary of the diversity data about the nurses and midwives on our register, including fitness to practise data.

3 The full diversity data set will be made available and published by Winter 2018.

Four country factors:

4 We ensure that we comply with the equality legislative requirements across the four Countries where these differ.

Discussion

5 In November 2017, the Council considered the *Annual Equality and Diversity Report 2016–2017* and strategic action plan 2017–2020. The action plan showed how the organisation would implement our EDI aims.

6 The Council requested that this year's annual EDI report should contain more analysis of the data presented in the report. This additional analysis is presented as a summary in the beginning of section 2.

7 Some notable achievements from this year's report include:

7.1 Improving the diversity data we hold about nurses, midwives and our panellists.

7.2 Increasing our engagement with diverse stakeholders.

7.3 Ongoing equality impact assessments of our regulatory policy work, for example the FtP Strategy, Overseas review and Nursing Associates programme.

8 The Professional Standards Authority (PSA) is consulting on the Standards of Good Regulation. It proposes to introduce a specific standard on EDI to ensure regulators understand the diversity of their registrants and that their processes do not disadvantage people with protected characteristics. This annual EDI report will support the NMC in reporting against this standard if implemented in the future.

9 The next step would be to publish the report on the NMC website in the autumn, with a version in Welsh.

Public protection

10 Good practice on EDI and compliance with equalities legislation is not separate from good regulation. This report demonstrates how we

implications:		protect the public with consideration of equality, diversity and inclusion.
Resource implications:	11	Costs of producing this report in English and translating the report into Welsh are met from within the existing budget.
Equality and diversity implications:	12	The publication of these reports demonstrates the activities the NMC is undertaking to meet compliance with the Equality Act 2010 and the relevant legislation in Northern Ireland.
Stakeholder engagement:	13	We have engaged with diverse external stakeholder groups. Information about our stakeholder engagement is contained in the report.
Risk implications:	14	We have identified a risk of failure to embed equality and diversity in the regulatory and operational functions of the NMC and non-compliance with the Welsh language standards. This report helps us manage that risk by demonstrating how we have mitigated against that risk during the reporting period and provide information to help us identify appropriate mitigating actions.
Legal implications:	15	The annual report is one of the mechanisms in place to demonstrate the NMC's compliance with the Equality Act 2010 and relevant legislation in Northern Ireland.

Item 16: **Annexe 1**
NMC/18/88
26 September 2018

Nursing Midwifery Council

Annual equality, diversity and inclusion report 2017–2018

Foreword

I'm very pleased to introduce this report. We're passionate about diversity and inclusion and we're committed to putting equality, diversity and inclusion (EDI) at the heart of everything we do. Our commitment to EDI is reflected in our values of fairness, transparency and people.

2018 is an important year as we celebrate the 70th anniversary of the NHS. 1948 was also the year that the ship the Empire Windrush docked in Tilbury bringing nearly 500 Caribbean people to the UK, one of the first large groups of immigrants who became known as the Windrush generation. Over the last 70 years the NHS has relied on talent and workforce from around the world, including the Windrush generation, with ethnic minorities making up a fifth of its workers.

Today 202 nationalities are represented in the NHS workforce. We regulate nurses and midwives that work in all settings, but we acknowledge the significance of this particular milestone as so many of our nurses and midwives work in the NHS.

This annual report presents our actions and improvements across the year, our performance against our strategic aims and how we met our legal requirements. The report presents data about diversity to meet our legal requirements, and also supports our values by helping us be more transparent. The report focuses on the nurses and midwives we regulate. Our annual workforce report contains the data relating to our colleagues' diversity.

I'm proud of what we have achieved over the past year and the fact that we are able to share more data and analysis in this report than we could in previous years. We'll continue to gather and share more data as we move forward. There are some challenges, but also many opportunities for improvement that we hope to progress.

It is clear from the data in this annual report that nurses and midwives are very diverse. How we regulate now and in the future, must be very mindful of this.

Emma Broadbent
Director of Registration and Revalidation

Contents

Introduction

This is the sixth EDI annual report for the Nursing and Midwifery Council (NMC). It's divided into two sections. Section one is an overview of the achievements against the EDI strategic aims as taken from the *Strategy 2015–2020.* Section two presents a summary of the diversity data about the nurses and midwives on our register, including fitness to practise data.

About us

The NMC is the independent professional regulator for nurses and midwives across the United Kingdom. We exist to protect the public. Our regulatory responsibilities are to:

- maintain a register of all nurses and midwives who meet the requirements for registration in the UK
- set standards for education, training, conduct and performance so that nurses and midwives are able to deliver high-quality healthcare consistently throughout their careers
- take action to deal with individuals whose integrity or ability to provide safe care is questioned, so that the public can have confidence in the quality and standards of care provided by nurses and midwives.

Why do we produce this report?

We publish this report to promote best practice in EDI and to be transparent about how we are meeting our EDI aims and objectives. We want to put EDI at the heart of everything we do and are proud to demonstrate our achievements, while being open about the areas we find challenging. This report provides access to information about all the EDI work at the NMC, to assure our diverse stakeholders that we are actively considering their needs in our work.

We're bound by the Equality Act 2010. We're named in schedule 19 of the Act as being subject to the public-sector equality duty (PSED). The PSED states that we must, in the exercise of our functions, have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and those who do not
- foster good relations between people who share a protected characteristic and those who do not.

The PSED covers the nine protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

The Equality Act 2010 doesn't apply to Northern Ireland, where the equalities legislation is spread across several orders and regulations and has some differences to the rest of the UK. For example, Section 75 of the Northern Ireland Act 1998 also includes consideration of 'political opinion' as an equality category.

We believe that the best way to demonstrate our compliance with the Equality Act 2010 and other relevant legislation is by publishing our activities in this annual report.

What has happened in nursing and midwifery regulation?

After changes to our legislation, we're now the regulator in law for nursing associates – the new health and care role designed as a bridge between unregulated health care assistants and registered nurses. A driving force for this new role was to widen access to education to allow more people to potentially join the profession. We'll begin collecting diversity data in relation to this new profession from early 2019 when the first nursing associates begin to join our register.

In November 2017 we made changes to our registration processes, and expanded the types of evidence that we accept from overseas nurses and midwives in order to demonstrate their English language capability. This is part of our ongoing review of the overseas process with a clear aim of making that process more proportionate and flexible for candidates.

Earlier this year, Council also agreed the new nursing proficiencies, education and training standards, standards for supervision and assessment in practice, and prescribing standards, all of which were equality impact assessed, including wide stakeholder engagement, and targeted involvement of seldom heard groups.

The changing political landscape, in particular the potential implications of Brexit may impact on the diversity of the register because five percent of nurses and midwives registered with us were first registered in an European Economic Area (EEA) country. We are monitoring the position with regard to EEA nurses and midwives closely and reporting separately on those numbers.

Section 1: Achievements against our aims

What is our EDI strategy?

We value the diversity of the nurses and midwives on our register, our employees and the wider community we serve. We want this diversity to be reflected in everything we do. Our Council approved the *Strategy 2015–2020: Dynamic regulation for a changing world* in June 2014, which contains our aims to:

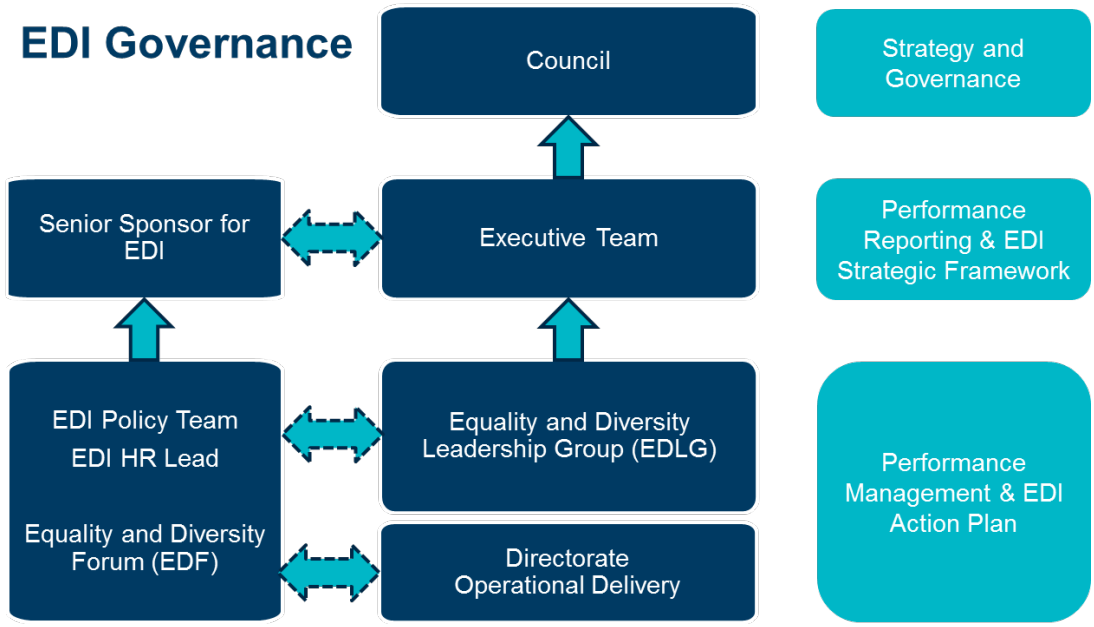
- Place promoting equality, diversity and inclusion at the heart of what we do.
- Comply with equality and human rights legislation by ensuring our regulatory processes are fair, consistent and non-discriminatory.
- Be a good employer – aspire to have a workforce that reflects the diversity of the communities in which we operate at all levels of our organisation.
- Use our influence to promote wider improvements in equality, diversity and inclusion practice.
- Build the trust and confidence of service users, nurses and midwives and others that share protected characteristics by showing understanding of their needs and preferences and challenging discrimination where evidence comes to our attention.
- Evaluate and, as needed, address equality issues raised by our work.
- Collect evidence that helps us know we are fair and consistent – working to enhance the quality and extent of EDI data about our registrants through their careers.
- Ensure that new entrants to the register are equipped to practise effectively in diverse and global environments.
- Set out our expectations that nurses and midwives challenge discrimination in their practice, are mindful of difference and show respect to all patients, service users and colleagues.
- Pursue diversity in those applying to become Council, committee and panel members.
- Be recognised as an organisation that upholds best practice in equality, diversity and inclusion, including meeting recognised sector standards.

How are we delivering the strategy?

Our EDI approach is the **NMC EDI strategic framework**, a delivery plan that was approved by the Executive Team in September 2016. The framework grouped delivery into five areas: leadership, policy, communication, evidence and people (Diagram 1). The framework sets out how we will continue to pursue our strategic EDI aims, best practice approaches and how we will meet the PSED.

The framework includes a governance structure (Diagram 1). This is how we manage the performance of EDI in the organisation against our strategy.

Diagram 1



A key part of monitoring delivery of the framework is an **EDI action plan.** This provides directorate level accountability to ensure delivery of the EDI aims and priorities. We revise the plan annually and our Equality and Diversity Leadership Group (EDLG) monitors it quarterly. The EDLG reviews progress against the directorate level plans.

We also developed an overarching **strategic EDI action plan** that we presented to Council in November 2017. It's a high-level plan of the activities, outputs, measures and desired outcomes for each strategic aim. The table in *Annexe 1: Progress against the strategic EDI aims 2015-20*, shows how this plan has moved forward in the 2017–2018 reporting period.

The recruitment of a Senior Equality and Diversity Policy Officer will support the delivery of the EDI Strategic Action Plan. By March 2018 the NMC EDI team consisted of an Equality and Diversity Policy Manager, a Senior Equality and Diversity Policy Officer and an EDI Lead in the People and Organisational Development Directorate.

The Executive Team and the EDLG will continue to provide assurance by monitoring our EDI activities.

In addition, the quarterly Equality and Diversity Forum (EDF) is open to all employees for sharing EDI best practice, communicating across directorates and raising EDI concerns. A member of the EDF attends every EDLG meeting to report key updates.

Key EDI activities in 2017–2018

In this section we focus on some of the key achievements and challenges in this reporting year.

Our data
Our EDI aim 7 is to 'Collect evidence that helps us know we are fair and consistent - working to enhance the quality and extent of EDI data about our registrants through their careers'. This continues to be a priority.

As nurses and midwives update their information on NMC Online and through revalidation we're creating a richer picture. For example, some early analysis of new information about place of practice indicates that there are some differences in ethnicity and gender in certain areas of practice, including proportionately more men than women in mental health settings. We'll have a fuller picture in 2019 when everyone has revalidated.

In 2018 we published *The NMC register*, our first annual registration report. It reported on data by the protected characteristics of age and gender. The data in this report supplements *The NMC register*. We also published our annual Revalidation report in July 2018 which analyses the revalidation outcomes by protected characteristic.

Our fitness to practise panellists
Over the course of the reporting year we've collected diversity data from all current panel members. For the first time we can see the difference in representation between our register and the panel members appointed to the Fitness to Practise and Investigating Committees. The results show that there are significant differences in ethnicity, for example a higher percentage of panellists identifying as white compared to the proportion on the register (Table 01), as well as a higher proportion of older groups in our age profile (Table 02).

Table 01: Fitness to practise panellists by ethnic group

Ethnic group	Number	%	Register	Population[1]
Asian - Indian	5	1.6%	3.0%	2.8%
Asian - Pakistani	1	0.3%	0.5%	1.3%
Asian - Bangladeshi	1	0.3%	0.1%	0.5%
Asian - Chinese	2	0.6%	0.3%	0.6%
Asian - other background	2	0.6%	3.8%	1.5%
Black African	1	0.3%	6.1%	1.5%
Black Caribbean	7	2.2%	1.4%	1.1%
Black - other background	-	-	0.2%	0.4%

[1] England and Wales working population- usual residents aged 16 to 74 in employment; 2011 Census

White and Asian	3	0.9%	0.3%	0.4%
White and black African	-	-	0.9%	0.2%
White and black Caribbean	-	-	0.4%	0.5%
Mixed - other background	4	1.3%	0.3%	0.4%
White - English/Welsh/Scottish/ Northern Irish	264	83.5%	67.7%	81.4%
White - Irish	-	-	1.9%	1.0%
White - Gypsy or Irish Traveller	-	-	<0.1%	0.1%
White - other background	4	1.3%	4.5%	5.7%
Any other ethnic group	4	1.3%	0.9%	0.6%
Unknown/prefer not to say	18	5.7%	7.6%	-
Total	316	100%	100%	100%

Table 02: Fitness to practise panellists by age group

	Number	%	Register	Population[2]
20-29	2	0.6%	13.6%	19.5%
30-39	15	4.7%	21.5%	19.1%
40-49	48	15.2%	27.1%	19.6%
50-59	137	43.4%	29.0%	19.4%
Over 60	104	32.9%	8.7%	22.3%
Unknown/prefer not to say	10	3.2%	-	-
Total	316	100%	100%	100%

We launched a recruitment campaign focused on addressing the underrepresentation in these areas. The campaign had a strong emphasis on our organisational values of fairness, transparency and people, and used digital media to reach and appeal to a wider applicant base. We've been tracking the diversity data throughout process and there have been no indications of significant disadvantage for any particular group.

[2] Based on working age population 16-74; UK Population by age group 2016; Office of National Statistics; March 2018

We've also given unconscious bias training to all panel members, case examiners, the Case Examiner Quality team and to employees who directly support panel members in our hearings. We did this to ensure proceedings are better supported and to give assurance that all our hearings are fair.

Equality Impact Assessments (EQIAs)
One of our key areas of work is supporting employees to systematically review their work through an EDI lens using an Equality Impact Assessment (EQIA). EQIAs provide a detailed analysis of the impact of our work on protected and other vulnerable groups. To ensure consistency and encourage employees to embed EDI in their planning early on in their projects, we launched a new EQIA toolkit internally with in-depth guidance, advice on equality legislation, examples of barriers certain groups face, and templates.

Major programmes of work are conducting equality impact assessments and will be regularly updated as the programmes are delivered. For example, the Education programme, which delivered the new education standards, had a design principle for consultation that specified the standards must promote equality and diversity. The programme created a consultation assimilation team with the sole focus of EDI. It assessed whether this design principle had been met and how to integrate the EDI related consultation feedback into the standards. One example of how this approach lead to change was the action to include more information about reasonable adjustments in the supporting guidance.

Disproportionate outcomes on the basis of ethnicity
We published *The Progress and Outcomes of Black and Minority Ethnic (BME) Nurses and Midwives through the Nursing and Midwifery Council's Fitness to Practise Process* research into disproportionate outcomes for ethnic minority nurses and midwives was published in April 2017. The research showed that a disproportionate number of BME nurses and midwives go through the full fitness to practise process, mainly because they are more likely to be referred by employers, and that employer referrals are more likely to progress to a full hearing. We acknowledge that fairness, equality and patient safety are closely linked.

This research feeds into several of our projects. It has influenced our new approach to fitness to practise (it's one of the reasons EDI has been identified in a key regulatory outcome). The regulation advisers in the employee liaison service have shared themes from the research with directors of nursing and other employers.

In November 2017 we held a follow up meeting with the stakeholder group that advised the development of the research. We're committed to do further research into the experiences of ethnic minority nurses, midwives and nursing associates next year when we have more data. We also continue to meet with partners and stakeholders, such as NHS Improvement, to look at ways of addressing the issue.

Stakeholder engagement
We aim to reach diverse organisations so that their expertise and views can inform our work. In the reporting period our engagement included:

- the BME CNO Strategic Advisory Group (England)
- the Nigerian Nurses Association
- Mencap
- Challenging Behaviour Foundation
- Young Mothers.

It's important that we continue to build good relationships with a range of stakeholders who can engage with our work at an early stage. In 2018–2019 we will expand on our stakeholder engagement to reach a wider range of experiences and viewpoints.

Next steps 2018–2019

Our Corporate Plan for 2018-19 says that we will continue engaging with our stakeholders to make sure we understand patient and public perspectives and equality, diversity, and inclusion in our work. We also state that we will continue to fulfil our commitments to equality, diversity and inclusion as set out in our strategic framework.

Using our EDI Strategic Framework, we have identified the following EDI priorities for the organisation in 2018–2019.

- Continue to improve the quality of the diversity data we hold.
- Implement our reasonable adjustments policy for customers.
- Raise awareness of gender identity and how it affects the service we provide.
- Reduce disproportionately negative outcomes for ethnic minority nurses, midwives and staff.
- Build the capability of employees to comply with equalities legislation.
- Embed equality impact assessments into our project and operational processes.

We will continue to embed the EDI framework – to ensure that EDI is at the heart of everything we do: communications, evidence, people, policy and leadership. This means EDI will be a key part in all our programmes of work and in our plan to develop our internal systems and processes. Using this evidence-based approach we'll seek to prioritise and measure how effective we are in achieving our EDI aims.

We're striving to actively manage EDI as part of our core business using evidence to prioritise our activities in this area. Examples of some activities we expect to deliver by March 2019 include:

- updating NMC online diversity monitoring categories in line with best practice
- delivering trans awareness training for front line employees
- updating our EDI intranet and internet pages
- delivering unconscious bias training for all managers
- agreeing high level measures for monitoring EDI progress
- embedding equality impact assessment guidance and templates into all project activities and process reviews.

- reviewing registration and FtP processes for trans nurses, midwives and nursing associates
- delivering equality impact assessments of the Fitness to Practise strategy, nursing associate implementation and the overseas programme.
- launching an internal EDI strategy in line with the people strategy (see our workforce plan).

The Professional Standards Authority (PSA), which reports on our performance each year, is consulting on its Standards of Good Regulation. It is considering introducing a specific standard on EDI to ensure regulators understand the diversity of the people they regulate, and that their processes do not disadvantage people with protected characteristics. We support the PSA's intention to raise the profile of EDI and will work with them to support this goal and align any new reporting requirements into our EDI framework.

Section 2: Summary of the data

Council and committee members

Our Council is made up of twelve members: six lay people and six nurses and midwives, from England, Northern Ireland, Scotland and Wales, all appointed by the Privy Council. The Council has an Audit Committee; Remuneration Committee; and an Appointments Board to support it in its role. Appointments Board members are not members of the Council. Diversity data is collected when a member is appointed to the Council or the Appointments Board.

There were 17 members in office on 31 March 2018: 12 Council members and five members of the Appointments Board. Of the 17 members, 12 identify as female. All members identify as heterosexual. Two members identify as disabled, with one preferring not to say. Sixteen members identify as white with one member from a BME background. In terms of age, all members are in the age categories over 40. Nine members identify as Christian and eight as having no beliefs.

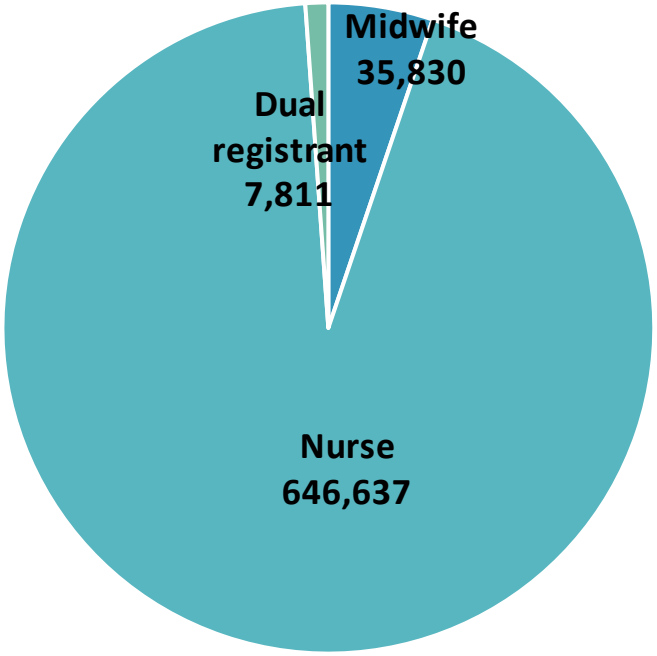
Nurses and midwives

This section provides a narrative summary of the diversity data that we hold about nurses and midwives on the register and in our fitness to practise processes. We hold and analyse data by age, disability, ethnicity, gender, gender identity, religion and belief and sexual orientation. In this year's report we have picked out the data that appears to be notable or of interest.

In presenting the data in this report we've rounded percentages up to the nearest whole number or one decimal place. In a small number of cases this means the data may add up to slightly over/under 100 percent.

In some instances our data presents small numbers for some groups that could lead to individuals being identified, or we have data that could be considered sensitive. In these cases that information has not been presented or smaller categories have been collapsed into bigger categories.

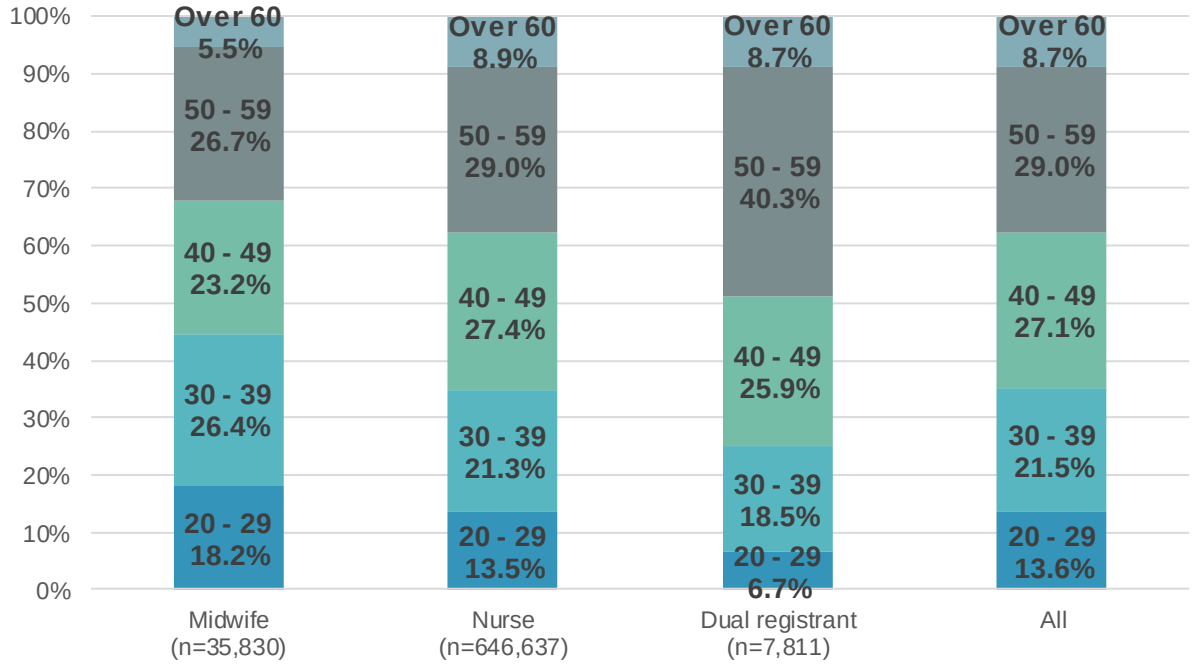
Chart 01: Breakdown of nurses, midwives and dual registrants on the register as at 31 March 2018



What does our data tell us about nurses and midwives on the register?

Looking at the registration data, some notable differences are that midwives are a younger group than the nurse group, while people with dual registration (that is, people who are registered as both a nurse *and* a midwife) are the oldest group (40.3 percent of these are in the 50-59 age group) [Chart 02]. The number of dual registrants has decreased by 9.3 percent since last year (from 8,614 to 7,811) which is a marked difference. This may be due to the fact that we are encouraging them only to renew the registration type(s) which they are currently using when they revalidate.

Chart 02: Age groups of nurses, midwives and dual registrants



The population of midwives is younger than the population of nurses and dual registrants with 18.2 percent in the 20-29 age group compared with 13.5 percent for nurses and 6.7 percent for dual registrant. Dual registrants have proportionately more people in the 50-59 age group at 40.3 percent. This is likely to be due to the longer time it takes be qualified as both a nurse and midwife.

Table 03: Disability of nurses, midwives and dual registrants

	2017 midwife	2018 midwife	2017 nurse	2018 nurse	2017 dual	2018 dual	2017 all	2018 all
No	27,098	31,599	497,601	560,423	6,602	6,777	**531,301**	**598,799**
Yes	1,704	1,394	33,345	25,378	334	263	**35,383**	**27,035**
Unknown	5,752	2,837	116,659	60,836	1,678	771	**124,089**	**64,444**
Total	**34,554**	**35,830**	**647,605**	**646,637**	**8,614**	**7,811**	**690,773**	**690,278**

Compared to last year's report there have been significant increases in the number of nurses and midwives that have completed the disability information, with the number of people in the unknown category reducing from 124,089 in 2017 to 64,444 in 2018 [table 03]. It appears that there were more people previously in the unknown category that were not disabled (the percentages and numbers of nurses and midwives that have identified as disabled have reduced in all registration types). The number of people that identify as having a disability has decreased considerably from 35,383 in the 2017 report to 27,035 in the 2018 report – Chart 03 below shows that the proportion of people that identify as having a disability has reduced from 5.1 to 3.9 percent.

Chart 03: Disability of nurses, midwives and dual registrants

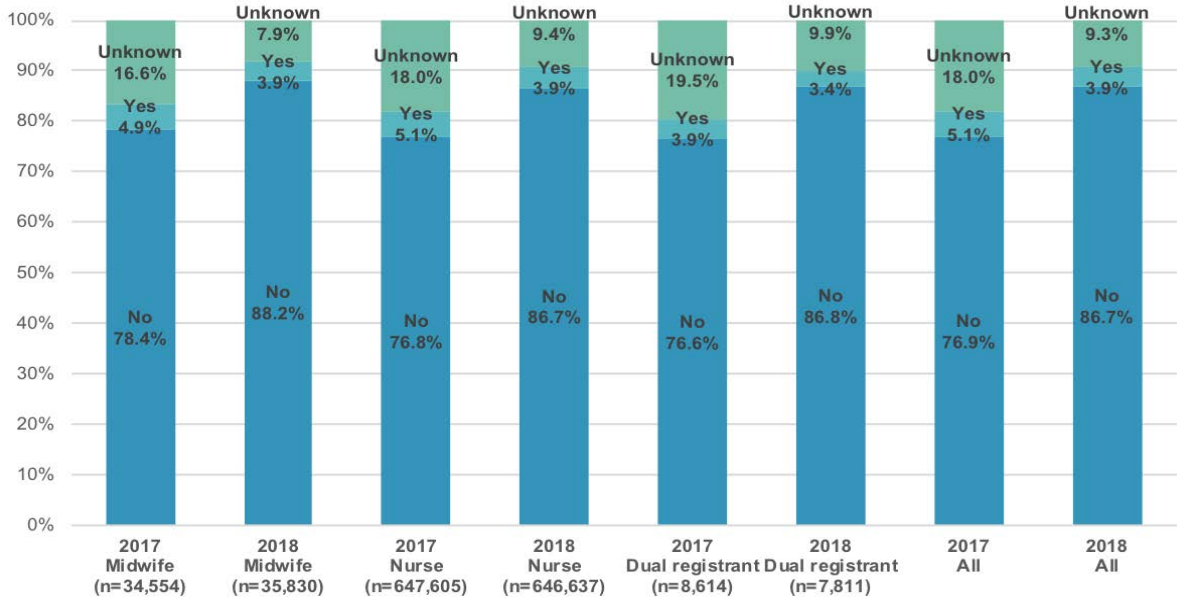


Table 04: Ethnic groups on the register (numbers)

	Midwife	Nurse	Dual	Total
Asian - Asian - Indian	197	20,676	66	20,939
Asian - Asian - Pakistani	150	3,030	22	3,202
Asian - Asian - Bangladeshi	45	794	5	844
Asian - Asian - Chinese	100	2,170	43	2,313
Asian - other background	112	25,993	48	26,153
Black African	679	40,433	1,050	42,162
Black Caribbean	583	8,841	308	9,732
Black - other background	40	1,506	22	1,568
Mixed - white and Asian	119	1,896	25	2,040
Mixed - white and black African	61	1,750	24	1,835
Mixed - white and black Caribbean	380	5,838	64	6,282
Mixed - other background	132	2,465	31	2,628
White - English/Welsh/Scottish/Northern Irish	28,778	433,622	4,718	467,118
White - Irish	655	12,454	268	13,377

White - Gypsy or Irish Traveller	11	269	6	286
White - other background	1,501	29,347	423	31,271
Any other ethnic group	143	5,704	35	5,882
Prefer not to say	358	12,416	132	12,906
Unknown	1,786	37,433	521	39,740
Total	35,830	646,637	7,811	690,278

Table 05: Ethnic groups on the register (percentages)

	Midwife	Nurse	Dual	Total
Asian - Asian - Indian	0.5%	3.2%	0.8%	3.0%
Asian - Asian - Pakistani	0.4%	0.5%	0.3%	0.5%
Asian - Asian - Bangladeshi	0.1%	0.1%	0.1%	0.1%
Asian - Asian - Chinese	0.3%	0.3%	0.6%	0.3%
Asian - other background	0.3%	4.0%	0.6%	3.8%
Black African	1.9%	6.3%	13.4%	6.1%
Black Caribbean	1.6%	1.4%	3.9%	1.4%
Black - other background	0.1%	0.2%	0.3%	0.2%
Mixed - white and Asian	0.3%	0.3%	0.3%	0.3%
Mixed - white and black African	0.2%	0.3%	0.3%	0.3%
Mixed - white and black Caribbean	1.1%	0.9%	0.8%	0.9%
Mixed - other background	0.4%	0.4%	0.4%	0.4%
White - English/Welsh/Scottish/Northern Irish	80.3%	67.1%	60.4%	67.7%
White - Irish	1.8%	1.9%	3.4%	1.9%
White - Gypsy or Irish Traveller	0.0%	0.0%	0.1%	0.0%
White - other background	4.2%	4.5%	5.4%	4.5%
Any other ethnic group	0.4%	0.9%	0.4%	0.9%

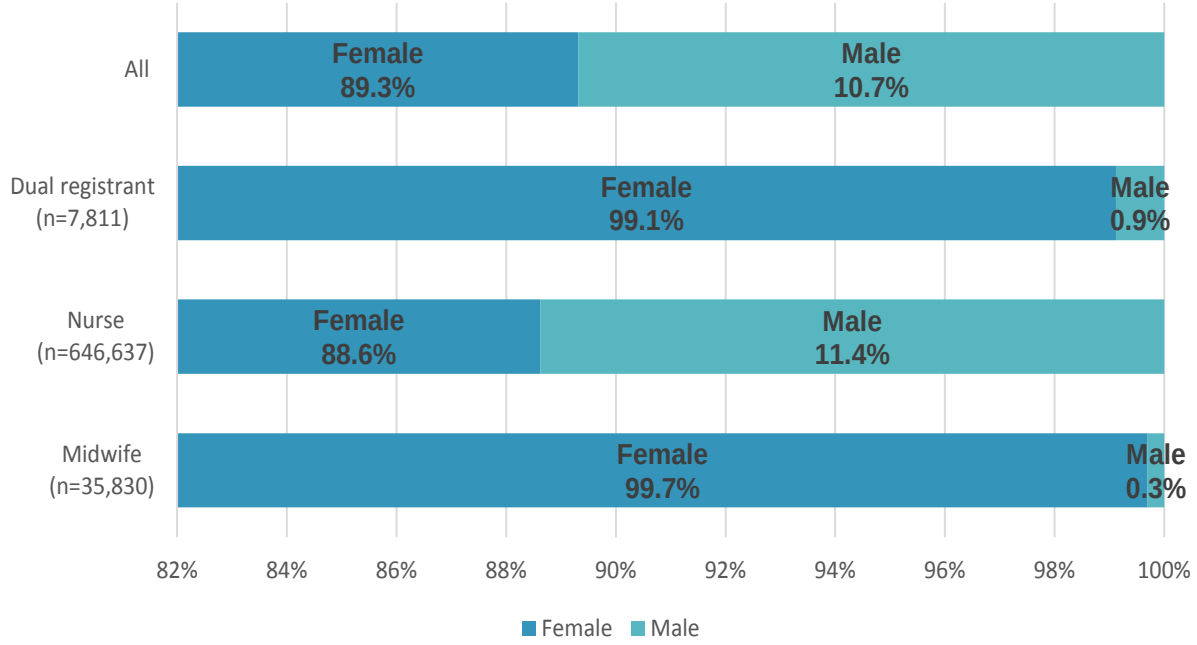
	Midwife	Nurse	Dual	Total
Prefer not to say	1.0%	1.9%	1.7%	1.9%
Unknown	5.0%	5.8%	6.7%	5.8%
Total	100%	100%	100%	100%

The data shows that nurses are more ethnically diverse than midwives, and those dual registrants are the most ethnically diverse group of all [tables 04 and 05]. Almost all ethnic groups have increased in both number and proportion in the last year as the number of 'unknowns' has decreased. For example the percentage of dual registrants that identify as 'white – English/Welsh/Scottish/Northern Irish/British' increased in all registration types from 2016/2017 to 2017/2018; midwives from 72.8 percent to 80.3 percent; nurses from 61.1 percent to 67.1 percent; and dual registration from 55.5 percent to 60.4 percent.

In this report we are publishing for the first time the data from nurses and midwives who answered the question, 'does your gender identity completely match the sex you were registered with at birth?' Of all nurses and midwives, 3,789 answered no to this question, 0.5 percent. 13.2 percent are unknown.

Looking at religion or belief, notable differences include 30.1 percent of midwives that say they have no religion or belief as compared with 22.1 percent of nurses and 15.3 percent of those with dual registration. Also, 54.8 percent of midwives identify as Christian as compared with 59.8 percent of nurses and 67.8 percent of those with dual registration.

Chart 04: Gender on the register



The chart above shows that there are significant differences in the gender breakdown between the registration types. Midwives are 99.7 percent female compared with 88.6 percent of nurses and 99.1 percent of those with dual registration.

On sexual orientation the differences between the professions are that 0.6 percent of midwives identify as gay or lesbian as compared with 1.7 percent of nurses and 0.8 percent of those with dual registration. There are few differences from last year's report, except that as can be expected all groups have increased in numbers as the number of 'unknowns' decreases.

What does our data tell us about fitness to practise outcomes?

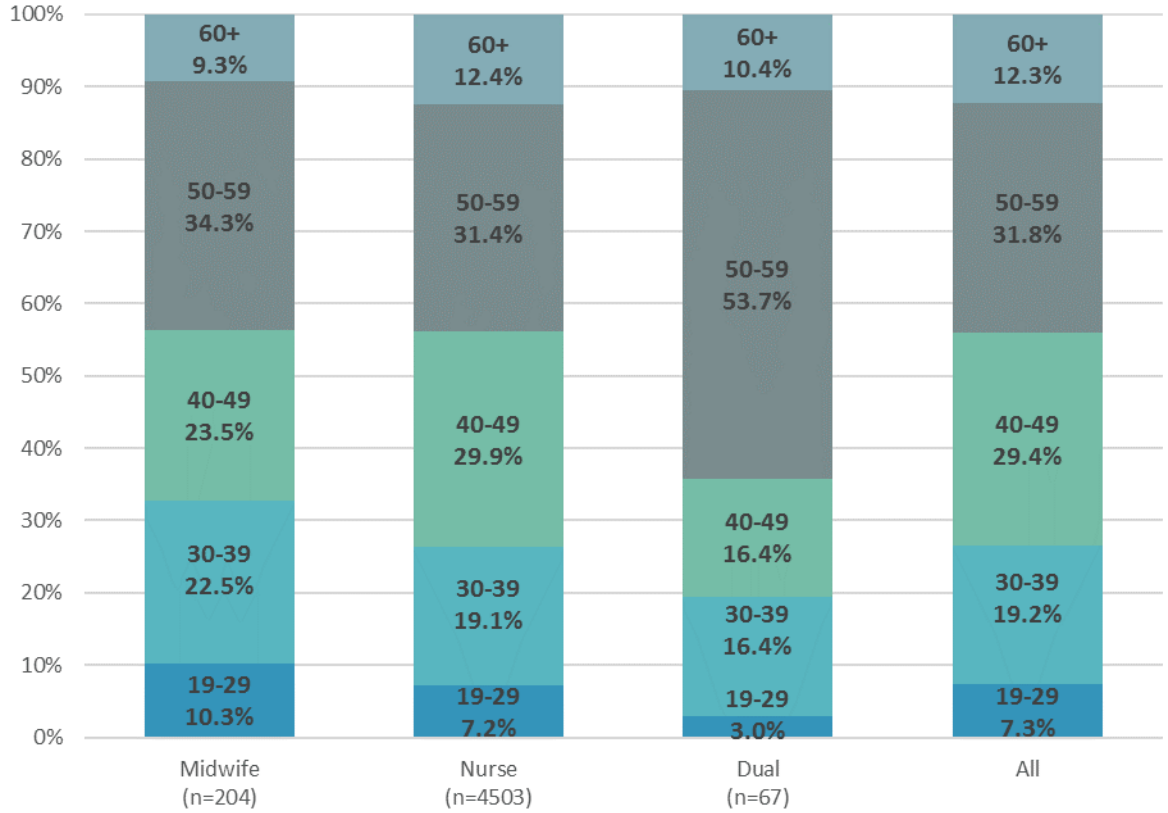
In this section we are only making comparisons with the register where there are relatively large groups. If the numbers by registration type are small we will not make a comparison.

Some trends follow through all the sections. For example, for gender we know from the 'new concerns' section that men make up a higher proportion of people who are referred to fitness to practise. They are more likely to be referred to fitness to practise than would be expected given their proportion on the register. At case examiner stage, they are more likely to get a 'case to answer' decision than women. They are more likely to get an interim suspension order than women and at hearing stage they are more likely to be struck off the register than women.

New concerns

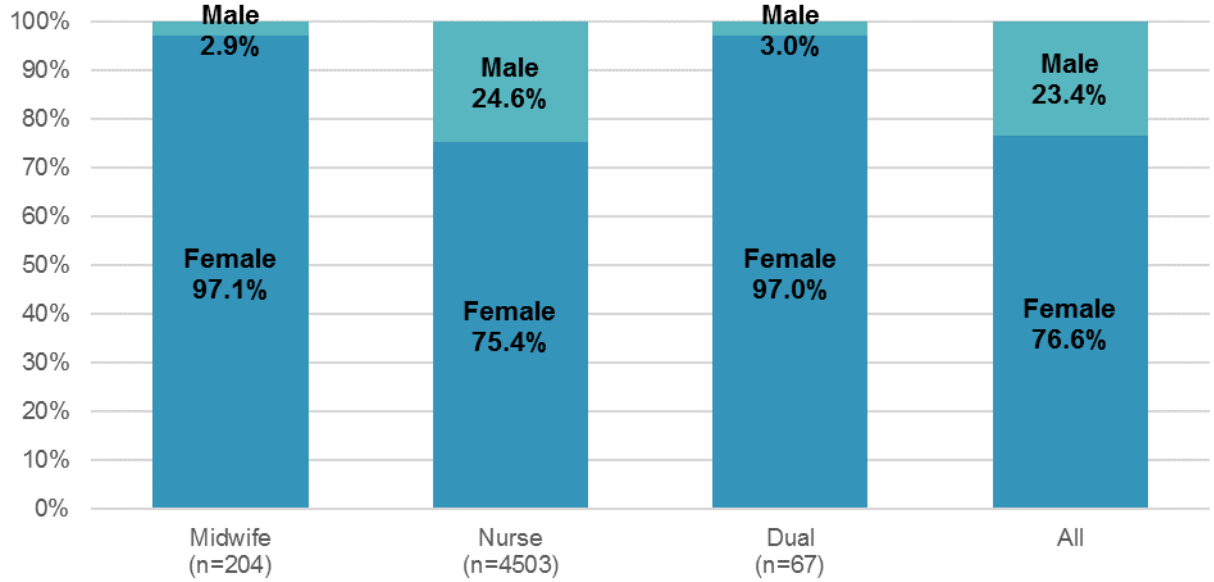
This section details the diversity data for the 4,778 new concerns where we opened a between April 2017 and March 2018. In the same period four new concerns were raised about individuals that were not on our register at the time of the referral (but may have previously been on the register). These four individuals are not reported in the tables broken down by registration type. The figures in this report are in line with the figures in our annual fitness to practise report 2017–2018 which reports on number of referrals as a whole, not by individual. This means there may be more than one referral for an individual and that individual may present in the data more than once.

Chart 05: New concerns by age group



Comparing everyone on our register (Chart 02) to the data on new concerns we can see that nurses and midwives being referred are more likely to come from older age groups. For example, the 19-29 age group made up 10.3 percent of new concerns compared to being 18.2 percent of the register and nurses aged 19-29 made up of 7.2 percent of new concerns compared to being 13.5 percent of the register. Conversely 34.3 percent of new concerns raised about midwives were for the 50-59 age group compared with being only 26.7 percent of the register and 53.7 percent of dual registrants compared with being only 40.3 percent of the register.

Chart 06: New concerns by gender



Overall, 23.4 percent of new concerns were for men, compared with being 10.7 percent on the register. Across all registration types there are proportionately more men being referred than women.

Last year was the first year that we reported fitness to practise outcomes by ethnicity broken down into all 18+1[3] of the 2001 census categories. The proportion of 'unknown' ethnicity has decreased from 14.6 percent of new concerns in 2016–2017 to 7.8 percent of new concerns in 2017–2018, this has led to the numbers for other groups going up.

Table 06: New concerns by ethnic group

	Midwife	%	Nurse	%	Dual	%	All	%
Asian - Indian	1	0.5%	113	2.5%	1	1.5%	115	2.4%
Asian - Pakistani	2	1.0%	26	0.6%	1	1.5%	29	0.6%
Asian - Bangladeshi	-	-	9	0.2%	-	-	9	0.2%
Asian - Chinese	-	-	11	0.2%	2	3.0%	13	0.3%
Asian - other background	-	-	143	3.2%	-	-	143	3.0%
Black African	8	3.9%	574	12.7%	18	26.9%	600	12.6%
Black Caribbean	4	2.0%	79	1.8%	4	6.0%	87	1.8%
Black - other background	-	-	23	0.5%	-	-	23	0.5%
White and Asian	-	-	13	0.3%	-	-	13	0.3%
White and black African	1	0.5%	28	0.6%	1	1.5%	30	0.6%
White and black Caribbean	7	3.4%	53	1.2%	1	1.5%	61	1.3%
Mixed - other background	3	1.5%	21	0.5%	-	-	24	0.5%

[3] In the ONS census there are 5 broad categories (white, Asian, black, mixed, other), with a number of subcategories, making a total of 18 choices plus the one 'prefer not to say' option.

	Midwife	%	Nurse	%	Dual	%	All	%
White - English/ Welsh/ Scottish/ Northern Irish	151	74.0%	2,537	56.3%	26	38.8%	2,714	56.8%
White - Irish	0	-	51	1.1%	1	1.5%	52	1.1%
White - other background	5	2.5%	271	6.0%	2	3.0%	278	5.8%
Any other ethnic group	3	1.5%	66	1.5%	2	3.0%	71	1.5%
Prefer not to say	3	1.5%	135	3.0%	1	1.5%	139	2.9%
Unknown	16	7.8%	350	7.8%	7	10.4%	373	7.8%
Total	**204**	**100%**	**4,503**	**100%**	**67**	**100%**	**4,774**	**100%**

This year's data (Table 06) is echoing the findings in *The Progress and Outcomes of Black and Minority Ethnic (BME) Nurses and Midwives through the Nursing and Midwifery Council's Fitness to Practise Process* that people of white British ethnicity are proportionately less likely to be referred than expected given their proportions on the register (Table 02). People of black African ethnicity are more likely to be referred (than expected given their proportion on the register). The other ethnic groups are too small to make valid comparisons.

People of black African ethnicity made up 3.9 percent of all referrals for midwives (they are 1.9 percent of the register). For nurses, there were a disproportionately higher percentage of referrals for the black African ethnic group at 12.7 percent compared to being 6.3 percent of the register. The black African ethnic group also made up a large percentage of dual registrant referrals at 26.9 percent (18 out of all 67 new concerns for dual registrants). On the register, 13.4 percent of dual registrants are black African. For the ethnic group of white - English/Welsh/Scottish/Northern Irish/ British, they were 74 percent of referrals of midwives compared with 80.3 percent on the register and for dual registrants they were 38.8 percent of referrals compared with 60.4 percent on the register.

Table 07: New concerns by sexual orientation

	Midwife	Nurse	Dual	All
Bisexual	0.5%	0.9%	-	0.9%
Gay or lesbian	1.0%	3.0%	1.5%	2.8%
Heterosexual or straight	84.8%	80.7%	83.6%	80.9%
Prefer not to say	5.9%	7.6%	4.5%	7.5%
Unknown	7.8%	7.8%	10.4%	7.8%
Total	**100%**	**100%**	**100%**	**100%**

For sexual orientation 80.7 percent of referrals were for nurses that are heterosexual/straight compared to 85.3 percent on the register. This difference may be related to the fact that there was a higher proportion of unknowns and prefer not to say for sexual orientation in the new concerns (15.3 percent) compared to the register (12.4 percent).

Interim orders

This section on interim orders (IOs) compare the differences between whether a nurse or midwife has received an Interim conditions of practice order, interim suspension order or if it was decided that an IO was not necessary.

Table 08: Interim orders by age group

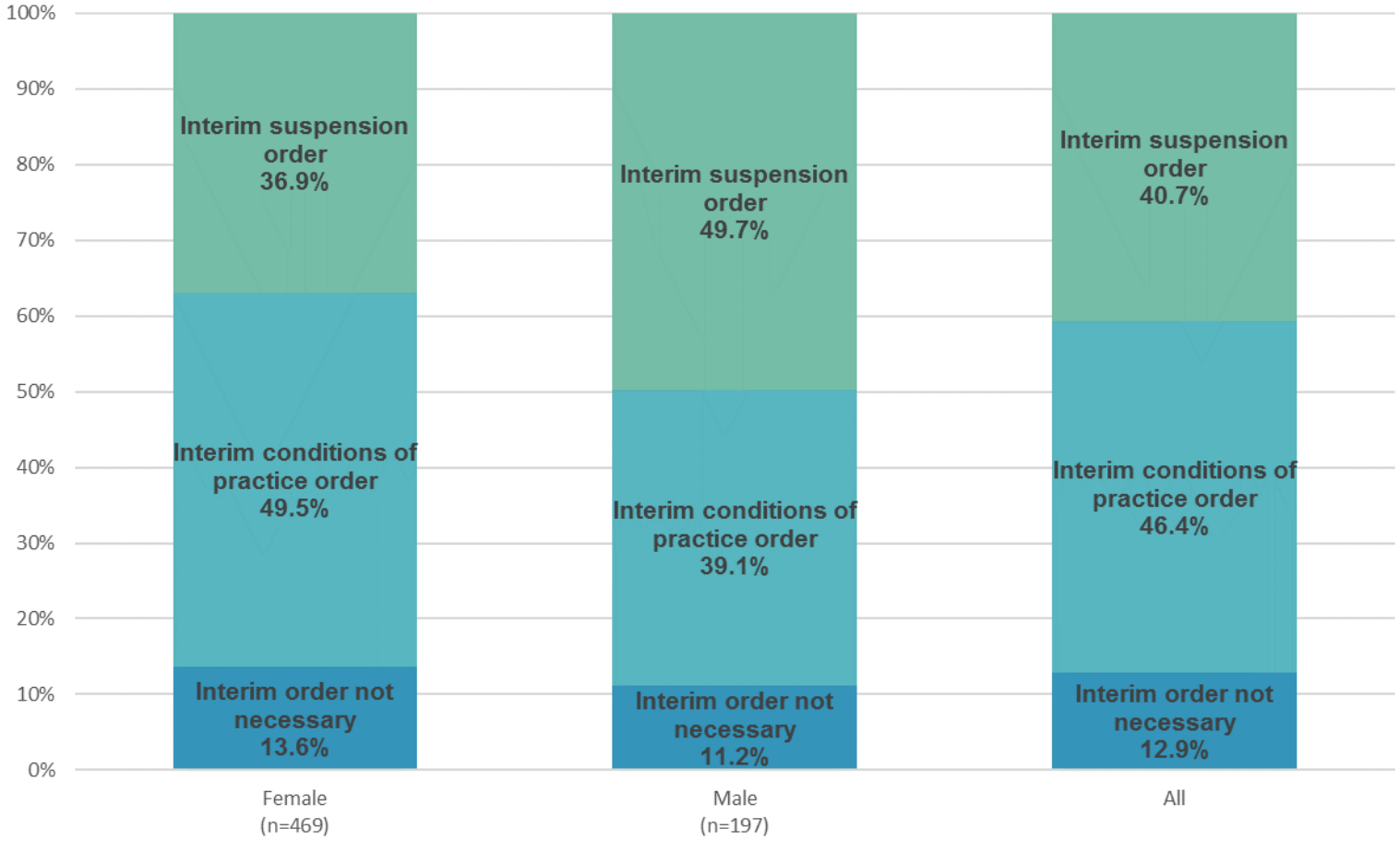
	19 - 29	%	30 - 39	%	40-49	%	50 - 59	%	Over 60	%	Total	%
Interim conditions of practice order	23	48.9%	56	47.5%	92	48.4%	95	43.6%	43	46.2%	309	**46.4%**
Interim order not necessary	3	6.4%	16	13.6%	26	13.7%	23	10.6%	18	19.4%	86	**12.9%**
Interim suspension order	21	44.7%	46	39.0%	72	37.9%	100	45.9%	32	34.4%	271	**40.7%**
Total	**47**	**100%**	**118**	**100%**	**190**	**100%**	**218**	**100%**	**93**	**100%**	**666**	**100%**

The table above shows there were a higher percentage of decisions that an IO was not necessary for people aged 60 and over compared with younger groups. The table below shows that this was also the case for those in the black and Asian ethnic groups compared with the other ethnic groups. This table shows the higher level ethnic categories as the numbers in the lower level categories are too small to report.

Table 09: Interim orders by ethnic group

	Asian	%	Black	%	Mixed	%	White	%	Other	%	Prefer not to say	%	Unknown	%	Total	%
Interim conditions of practice order	22	50.0%	50	48.1%	27	47.4%	153	46.9%	7	50.0%	10	58.8%	40	38.5%	**309**	**46.4%**
Interim order not necessary	7	15.9%	19	18.3%	8	14.0%	39	12.0%	2	14.3%	3	17.6%	8	7.7%	**86**	**12.9%**
Interim suspension order	15	34.1%	35	33.7%	22	38.6%	134	41.1%	5	35.7%	4	23.5%	56	53.8%	**271**	**40.7%**
Total	**44**	**100%**	**104**	**100%**	**57**	**100%**	**326**	**100%**	**14**	**100%**	**17**	**100%**	**104**	**100%**	**666**	**100%**

Chart 07: Interim orders by gender



The chart above shows that men are more likely to receive an interim suspension order, whereas women are more likely to receive a conditions of practice order. Of the 666 IO decisions being made 30 percent were for male nurses and midwives this is significantly higher than the 11 percent of men on the overall register of nurses and midwives.

Case examiner decisions

During a fitness to practise investigation, we gather evidence that is needed to make a full assessment to the allegations. At the end of the investigation, the case examiners review all the evidence and decide one of the following:

- No case to answer (NCTA)
- Case to answer (CTA) referred to a hearing
- Advice
- Warning
- Undertakings

The data in this section has not been separated into registration type to prevent individuals being identified by the small numbers. The percentages are column percentages – they show for each demographic group what percentage were NCTA, advice, warnings, undertakings and CTA.

Across the fitness to practise outcomes data, people with 'unknown' protected characteristics appear to have higher proportions of more severe outcomes and/or sanctions. This could be because people who do not engage with the fitness to practise process are both most likely to have more severe outcomes and be the least likely to complete their diversity data on NMC Online.

Table 10: Case examiner decisions by age group

Decisions	19-29	%	30-39	%	40-49	%	50-59	%	Over 60	%	Total	%
NCTA	57	50.9%	206	53.4%	344	55.7%	457	58.3%	206	61.7%	**1,270**	**56.8%**
Advice	1	0.9%	10	2.6%	5	0.8%	5	0.6%	3	0.9%	**24**	**1.1%**
Warning	5	4.5%	22	5.7%	25	4.0%	30	3.8%	11	3.3%	**93**	**4.2%**
Undertakings	1	0.9%	5	1.3%	6	1.0%	12	1.5%	4	1.2%	**28**	**1.3%**
CTA	48	42.9%	143	37.0%	238	38.5%	280	35.7%	110	32.9%	**819**	**36.7%**
Total	**112**	**100%**	**386**	**100%**	**618**	**100%**	**784**	**100%**	**334**	**100%**	**2,234**	**100%**

The older the age group, the smaller the proportion that have a CTA. Of all the decisions made about the 19-29 age group 42.9 percent of decisions led to NCTA compared with 32.9 percent of all decisions about the over 60 age group.

Table 11: Case examiner decisions by disability

Decision	No	%	Yes	%	Prefer not to say	%	Unknown	%	Total	%
NCTA	1,043	61.0%	80	51.0%	63	54.8%	84	33.5%	**1,270**	**56.8%**
Advice	17	1.0%	3	1.9%	0	0.0%	4	1.6%	**24**	**1.1%**
Warning	78	4.6%	4	2.5%	4	3.5%	7	2.8%	**93**	**4.2%**
Undertakings	20	1.2%	2	1.3%	1	0.9%	5	2.0%	**28**	**1.3%**
CTA	553	32.3%	68	43.3%	47	40.9%	151	60.2%	**819**	**36.7%**
Total	**1,711**	**100%**	**157**	**100%**	**115**	**100.0%**	**251**	**100.%**	**2,234**	**100%**

The table above shows that disabled nurses and midwives have a higher proportion of CTA decisions than people without a disability (43.3 percent for people with a disability vs. 32.3 percent for people without a disability). Also the proportion of people with ‘unknown’ disability status who have a CTA is high at 60.2 percent.

Table 12: Case examiner decisions by ethnicity

Decision	Asian	%	Black	%	Mixed	%	White	%	Any other ethnic group	%	Prefer not to say / unknown	%	Total	%
NCTA	129	65.2%	240	64.7%	31	52.5%	732	58.1%	18	62.1%	120	37.7%	**1,270**	**56.8%**
Advice	0	0.0%	2	0.5%	0	0.0%	18	1.4%	0	0.0%	4	1.3%	**24**	**1.1%**
Warning	6	3.0%	13	3.5%	6	10.2%	57	4.5%	2	6.9%	9	2.8%	**93**	**4.2%**
Undertakings	3	1.5%	5	1.3%	1	1.7%	14	1.1%	0	0.0%	5	1.6%	**28**	**1.3%**
CTA	60	30.3%	111	29.9%	21	35.6%	438	34.8%	9	31.0%	180	56.6%	**819**	**36.7%**
Total	**198**	**100%**	**371**	**100%**	**59**	**100%**	**1,259**	**100%**	**29**	**100%**	**318**	**100%**	**2,234**	**100%**

Nurses and midwives in the black (29.9 percent) and Asian (30.3 percent) group categories had a lower proportion of CTA decisions than those in the mixed (35.6 percent) and white (34.8 percent) ethnic groups. It is important to note that the groups have very different sizes, for example there are only 59 in the mixed ethnic group, compared to 1,259 in the white ethnic group.

The case examiner decisions for the ethnic groups with the largest numbers of cases from the lower level 18+1 ethnic group categories are presented in the table below. The ethnic groups that seem to have proportionately more NCTA decisions are Asian Indian (69.2 percent of all decisions about the Asian Indian ethnic group) and black African (64.7 percent of all decisions made about black African ethnic group). Of the nurses and midwives that we do not know their ethnic group (the unknowns) 33.6 percent of decisions were NCTA as compared with the relatively high 60 percent CTA decisions.

Table 13: Case examiner decisions for the ethnic group categories with more than 50 cases

Decision	Asian - Indian	%	Asian - other	%	Black African	%	White - English/ Welsh/ Scottish/ Northern Irish	%	White - other	%	Prefer not to say	%	Unknown	%	Total	%
NCTA	63	69.2%	45	57.7%	211	64.7%	655	58.8%	70	55.6%	36	52.9%	84	33.6%	**1270**	**56.8%**
Advice	0	0.0%	0	0.0%	1	0.3%	16	1.4%	1	0.8%	0	0.0%	4	1.6%	**24**	**1.1%**
Warning	3	3.3%	3	3.8%	11	3.4%	53	4.8%	2	1.6%	2	2.9%	7	2.8%	**93**	**4.2%**
Undertakings	0	0.0%	3	3.8%	2	0.6%	12	1.1%	2	1.6%	0	0.0%	5	2.0%	**28**	**1.3%**
CTA	25	27.5%	27	34.6%	101	31.0%	377	33.9%	51	40.5%	30	44.1%	150	60.0%	**819**	**36.7%**
Total	**91**	**100%**	**78**	**100%**	**326**	**100%**	**1113**	**100%**	**126**	**100%**	**68**	**100%**	**250**	**100%**	**2234**	**100%**

Chart 08: Case examiner decisions by gender

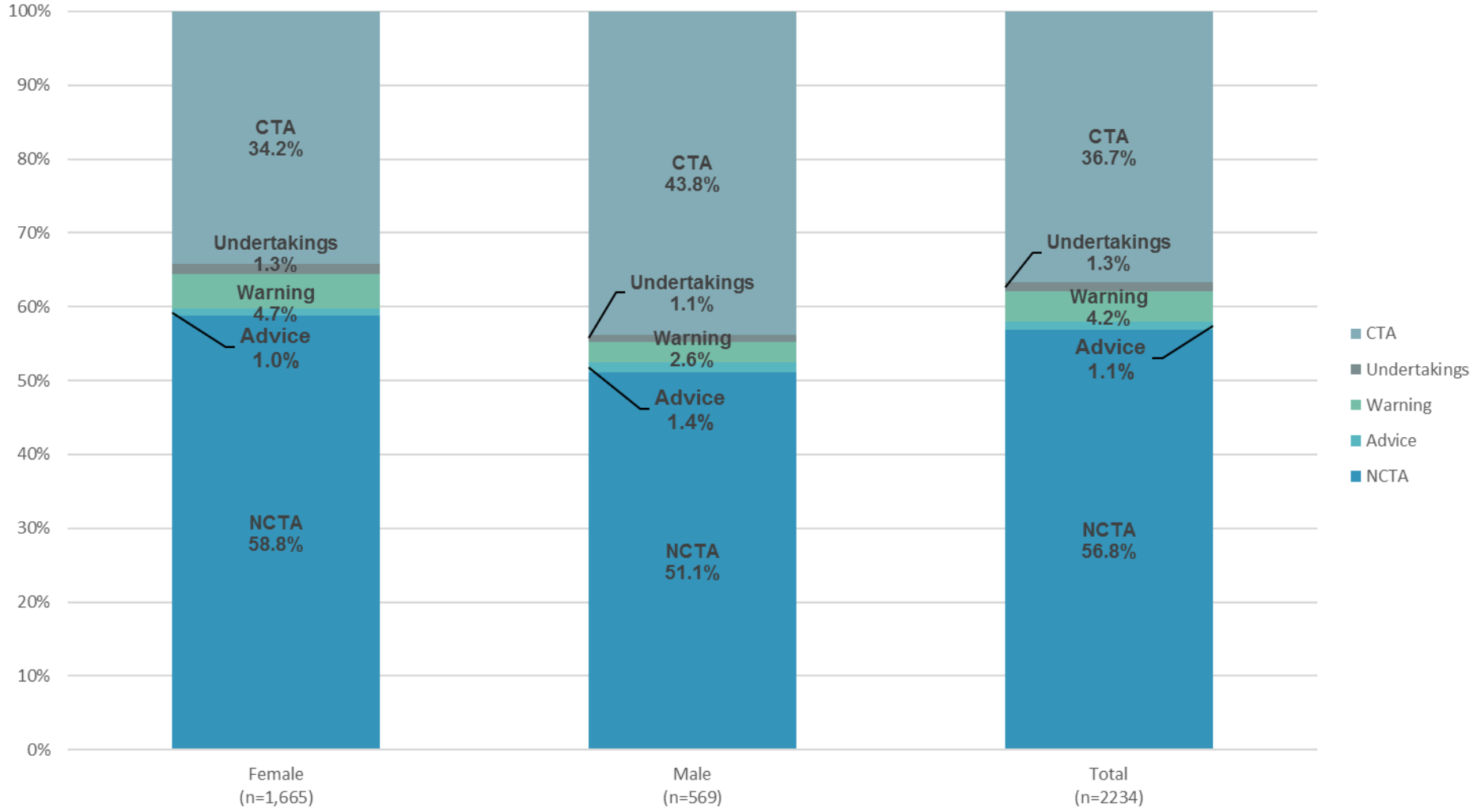


Chart 08 above shows that women have a smaller proportion of CTAs than men (34.2 percent of decisions for women vs. 43.8 percent of decisions for men).

Hearings

Some of the diversity data that we hold about nurses and midwives that go to hearings is sensitive data and cannot be published in this report. For the same reason the data in this section is not divided into nurse, midwife and dual registration. The sanctions that the panels determine are listed below. Go to the Sanctions we can impose pages on our website for more information.

Sanctions	Abbreviation
Facts not proved	FNP
Fitness to practise not impaired	FTPNI
Caution order	CO
Conditions of practice order	CPO
Suspension order	SO
Striking off order	SOO

Table 14: Hearing outcome by age group

Outcome	19-29	%	30-39	%	40-49	%	50-59	%	Over 60	%	Total	Total
FNP	0	-	0	-	1	0.5%	3	0.7%	2	1.2%	**6**	**0.4%**
FTPNI	5	10.0%	43	21.6%	74	37.2%	104	22.7%	52	30.6%	**278**	**23.1%**
CO	6	12.0%	19	9.5%	33	16.6%	57	12.4%	14	8.2%	**129**	**10.7%**
CPO	11	22.0%	32	16.1%	43	21.6%	58	12.6%	21	12.4%	**165**	**13.7%**
SO	18	36.0%	67	33.7%	102	51.3%	137	29.8%	48	28.2%	**372**	**30.8%**
SOO	10	20.0%	38	19.1%	76	38.2%	100	21.8%	33	19.4%	**257**	**21.3%**
Total	**50**	**100%**	**199**	**100%**	**329**	**100%**	**459**	**100%**	**170**	**100.0%**	**1,207**	**100.0%**

People aged 60 and over were more likely to be found to **not** have their fitness to practise impaired (30.6 percent of outcomes for this age group vs. 10.0 percent of outcomes for the 19-29 age group.) They were also less likely to have caution orders, conditions of practice orders or suspension orders than the younger age groups.

Table 15: Hearing outcome by disability

	No	%	Yes	%	Prefer not to say	%	Unknown	%	Total	Total
FNP	3	0.4%	0	0.0%	1	1.9%	1	0.4%	**5**	**0.4%**
FTPNI	221	27.4%	19	16.5%	19	35.8%	20	8.7%	**279**	**23.1%**
CO	105	13.0%	7	6.1%	6	11.3%	11	4.8%	**129**	**10.7%**
CPO	105	13.0%	24	20.9%	5	9.4%	31	13.4%	**165**	**13.7%**
SO	231	28.6%	44	38.3%	9	17.0%	88	38.1%	**372**	**30.8%**
SOO	143	17.7%	21	18.3%	13	24.5%	80	34.6%	**257**	**21.3%**
Total	**808**	**100%**	**115**	**100%**	**53**	**100%**	**231**	**100%**	**1,207**	**100%**

Table 15 shows that disabled nurses and midwives were more likely to have a conditions of practice (20.9 percent compared to 13 percent for non-disabled people) and suspension order (38.3 percent compared with 28.6 percent for non-disabled people) and non-disabled people had proportionately more decisions that their fitness was not impaired (27.4 percent compared with 16.5 percent for disabled people) and given caution orders (13 percent compared with 6.1 percent for non-disabled people).

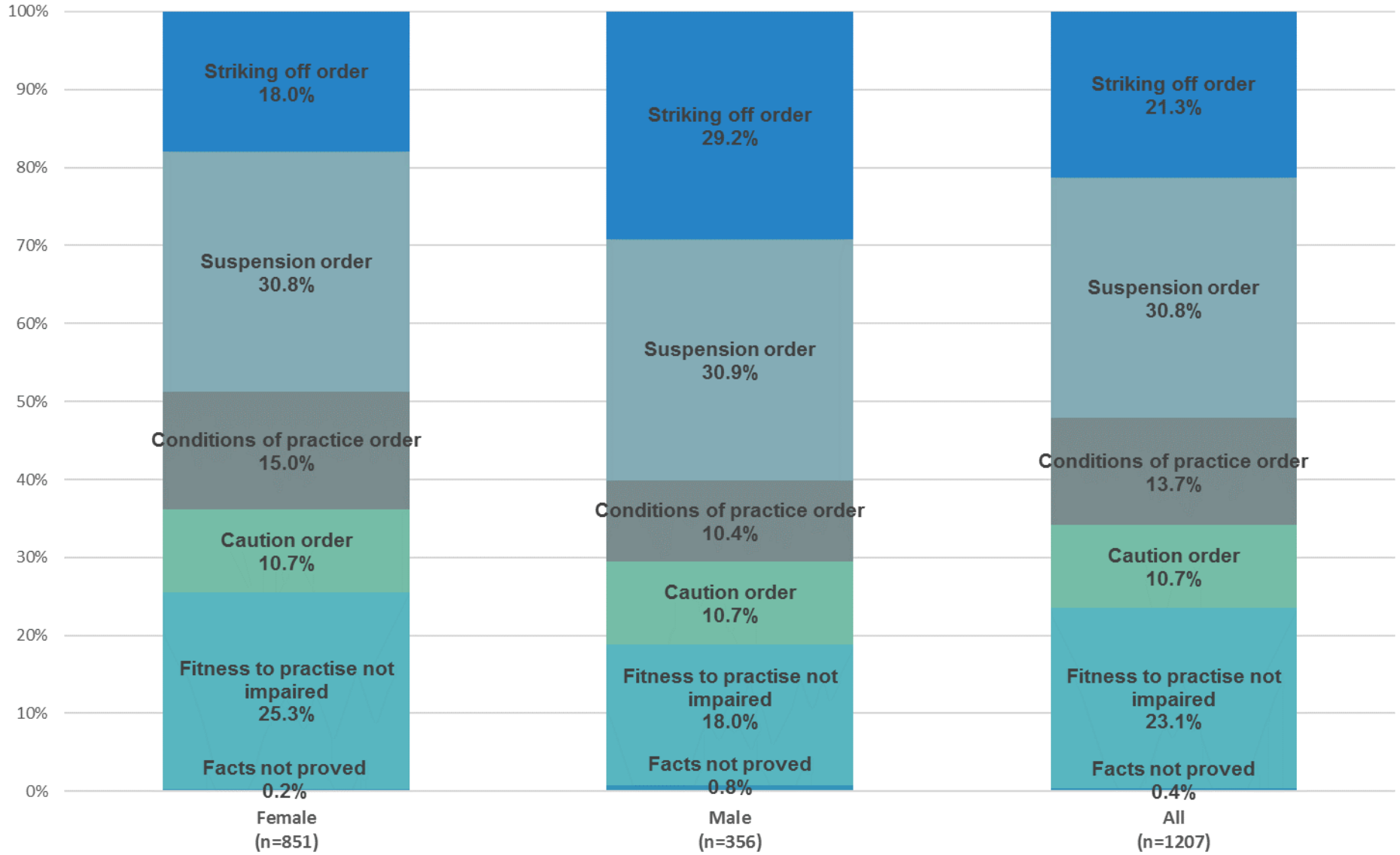
Table 16: Hearing outcome by ethnicity
This chart shows the four ethnic groups that had more than 50 cases going through the hearings stage of FtP. These are from the lower level 18+1 ethnic group categories.

	Black African	%	White - English/ Welsh/ Scottish/ Northern Irish/ British	%	White - other background	%	Unknown	%	All	%
FNP	1	0.6%	1	0.2%	0	0.0%	1	0.4%	**5**	**0.4%**
FTPNI	60	35.1%	136	24.4%	14	19.7%	20	8.7%	**279**	**23.1%**
CO	20	11.7%	71	12.7%	9	12.7%	11	4.8%	**129**	**10.7%**
CPO	19	11.1%	78	14.0%	6	8.5%	31	13.5%	**165**	**13.7%**
SO	44	25.7%	167	29.9%	28	39.4%	87	38.0%	**372**	**30.8%**
SOO	27	15.8%	105	18.8%	14	19.7%	79	34.5%	**257**	**21.3%**
Total	**171**	**100%**	**558**	**100%**	**71**	**100%**	**229**	**100%**	**1207**	**100%**

People of black African ethnicity have a higher proportion of ‘Fitness to practise not impaired’ outcomes than people who are white British or white other. They have correspondingly fewer suspension orders. 35.1 percent (60 out of 171) of decisions for black African registrants were ‘fitness to practise not impaired’. 24.4 percent (136 out of 558) decisions for white British registrants were ‘fitness to practise not impaired’ (Table 16).

There were a disproportionately higher number of cases where male nurses and midwives received striking off orders. 29.2 percent of men have a striking off order compared to 18.0 percent of women (Chart 09). At the same time, we know from the ‘new concerns’ section that men make up a higher proportion of people who are referred to FtP.

Chart 09: Hearing outcome by gender



Annexe 1: Progress against the strategic EDI aims 2015–2020

The EDI progress of the NMC is reported below against the strategic aims that are part of the Strategy 2015–2020. This table provides a status update against the plan that was presented to Council in November 2017.

	EDI Strategic Aims	Objectives	Measures	Current status
1	Place promoting equality, diversity and inclusion at the heart of what we do.	To embed EDI into governance, business planning and performance monitoring systems.	• Business plans contain relevant EDI activities. • EDI exceptions reported to the Executive Team. EDI action plan updated quarterly by EDLG.	The EDI Framework was agreed by the Executive Team in September 2016. We continue to communicate the EDI Framework across the organisation through regular face to face briefings with leaders and teams. The EDLG have quarterly meetings to monitor the status of the annual EDI annual action plan. We recruited a Senior E&D Policy Officer to support the implementation of the EDI Framework. We continue to produce this annual EDI report and the Welsh language report to demonstrate our progress.
2	Comply with equality and human rights legislation by ensuring our regulatory processes are fair, consistent and non-discriminatory.	a) To revise systems, information and guidance for employees to ensure compliance with discrimination law, and relevant equalities	• EDI and EQIAs are discussed in meeting minutes of NMC boards. • Surveys show employee awareness of EQIAs and EDI increased. • EQIAs are developed and monitored for NMC policies and projects. • Non-mandatory EDI training courses are well attended.	We revised the equality impact assessment (EQIA) guidance and templates. We held EQIA workshops for key programmes of work including the Education Programme, Nursing Associate and FtP Strategy. EQIA guidance, templates and training includes Welsh language compliance. Completion of equality and diversity training (e-learning and face to face) is mandatory for all new starters and all employees must repeat the e-learning every two years. Welsh language awareness is included in EDI mandatory training.

	EDI Strategic Aims	Objectives	Measures	Current status
		legislation. b) Compliance with the Welsh Language Scheme to be integrated into activities about equality impact assessment (EQIA) and EDI best practice.		EDI mandatory training attendance from 1st April 2017 – 31 March 2018: • Face to face training. 215 eligible employees joined the organisation and 183 attended face to face E&D training. 85 percent attended. • E-learning completions were 95 percent In addition, we have inserted an EDI section in our face-to-face induction training to make employees aware of our EDI commitments and expectations from the start of their employment with us.
3	Be a good employer. Aspire to have a workforce that reflects the diversity of the communities in which we operate at all levels of our organisation.	a) To take actions as part of workforce planning to achieve a workforce that is meaningfully diverse (as expected when compared with appropriate comparator populations and related to job role). b) To review EDI training provision for	• a) The workforce is more proportionate by protected characteristic at each pay grade (as expected). • a/b) Employees survey results (broken down by directorate) show: equal perceptions of fairness when analysed by protected characteristic; an increased number of Employees know the EDI objectives; and an increased number of employees that know where to go for EDI support.	We published the gender pay gap report and conducted analysis of pay grades in one directorate by ethnicity. In addition to mandatory training the EDI team run face-to-face EDI briefings for senior managers and teams. For example, equality impact assessment workshops, trans awareness, the history of black history month and briefings about Reasonable Adjustment compliance for disabled customers for the Fitness to Practise Senior Management Team. We commissioned unconscious bias training for all managers to roll out in 2018–19. In our 2017 employee survey, of the employees that responded: • 88 percent said their manager treats them fairly (up from 83 percent last year). • 93 percent said they understood EDI and where it is relevant to their role. • 87 percent were aware of the Valuing Diversity Policy

	EDI Strategic Aims	Objectives	Measures	Current status
		employees to be role specific. To deliver tailored training for all employees, panelists and Council members.	• b) EDI training by role is mapped and monitored by role.	(down from 92 percent last year). • 74 percent said the NMC is an inclusive place to work and 18 percent were unsure. • 72 percent agreed that there is a real commitment at the NMC to continue to improve performance on EDI. In addition to the employee survey results above, we conduced further analysis of workforce data to understand better what factors have led to disproportionate representation of certain groups by protected characteristic in grades/teams. A new employee LGBT+ network was launched in 2017 and a new employee Cultural Network was launched in January 2018. We recruited a new post of EDI Lead in HR to take forward our EDI activities as an employer as part of the People Strategy. This is in addition to the work that the EDI Policy Team do to support regulatory EDI compliance.
4	Use our influence to promote wider improvements in equality, diversity and inclusion practice.	a) To identify within our regulatory role where we can make improvements to EDI externally. b) To publish data about differences in outcomes for	• Research commissioned and engagement monitoring with diverse stakeholders. • Data reports are produced and published in time, broken down by protected characteristic. • Education QA reports contain information about EDI practice in AEIs and other institutions.	In April 2017 we published research that looked at the differences by ethnicity, gender and country in new concerns raised and fitness to practice outcomes. The findings of the research were communicated widely to employers and a further meeting was held in November 2017 with the advisory group who informed the design of the research. The agreed next steps of that meeting were: • for all bodies to continue to share research, findings and best practice; • for the NMC to continue to involve and communicate with the advisory group members in relation to relevant developments such as the FtP Strategy;

	EDI Strategic Aims	Objectives	Measures	Current status
		different groups going through our regulatory processes e.g. revalidation and FtP data. c) To ensure EDI compliance considered by bodies which we regulate and procure contracts to (e.g. AEIs)	• Contracts contain EDI compliance and best practice requirements. • Evaluations of contracts monitor if EDI requirements have been met.	• to explore the possibility of expanding future research to analyse outcomes for nurses and midwives on the basis of additional protected characteristics such as age; • to repeat this analysis in 2019 when we have richer data about nurses and midwives, e.g. where they are practising, as well as a greater percentage of diversity data. to continue to communicate the findings of the research to external stakeholders and • use the research internally to discuss the impact on our regulatory role e.g. in our FtP Strategy consultation. Our procurement tender processes and contracts specify that businesses we have contracts with must comply with equalities legislation. We consulted with our Test of Competence suppliers about how to standardise the EDI considerations of each test site. We held a workshop with the provider sites to explore potential areas of concern and improvements. This was followed by a questionnaire completed by all sites to determine further support the NMC can provide to the test sites on EDI best practice.
5	Build the trust and confidence of service users, registrants and others that share protected	a) To create systems to effectively engage with diverse stakeholders. b) NMC publications, meetings,	• Our engagement lists have an increased number of diverse stakeholders. • Feedback from engagement events shows diverse representatives feel engaged.	We have been working to improve EDI within external affairs in line with a new EDI external affairs strategy for inclusive communications and engagement. We produced guidance for employees running events and engaging with diverse stakeholders. We have been building relationships with the organisations who represent a diverse range of groups. For example, for our work to

<table>
<tr><th></th><th>EDI Strategic Aims</th><th>Objectives</th><th>Measures</th><th>Current status</th></tr>
<tr><td></td><td>characteristics. By showing understanding of their needs and preferences and challenging discrimination where evidence comes to our attention.</td><td>correspondence and consultations are accessible and available in alternative formats when requested and reasonable.
c) The internal and external communications are updated to include relevant EDI information. E.g. social media engagement with diverse nurses and midwives.</td><td>• Increased number of meetings with external groups/individuals that represent diverse views.
• Our website and external communications contain up to date EDI information and are accessible by external benchmark standards.</td><td>develop new standards of education for midwives, we have been engaging with charities representing young women, people who have experienced domestic violence, refugees and asylum seekers, LGBT+ people, people living with HIV, and Gypsies, Roma and Travellers.

We have also attended meetings of the CNO (England) BME Strategic Advisory Group and invited their members to respond to our consultations on the Education Framework.

During our consultation on our new education standards, we worked with a learning disability charity to hold an event. Around 20 people with learning disabilities attended to share their views on the future of nursing education.

During our consultations on education, nursing associates and fitness to practise, we have contracted external companies to gather the views of underrepresented groups including people with learning disabilities, younger people and older people.

Our NMC consultations also monitor responses by protected characteristic, which has enabled us to do targeted engagement with underrepresented groups such as learning disabled and traveller groups. For example, we know that the nursing associate fees consultation had the following breakdown of respondents:

<table>
<tr><td>Gender</td><td>Number</td><td>Percentage</td></tr>
<tr><td>Female</td><td>446</td><td>54</td></tr>
<tr><td>Male</td><td>127</td><td>15</td></tr>
<tr><td>Non-binary</td><td>3</td><td><1</td></tr>
</table>
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	EDI Strategic Aims	Objectives	Measures	Current status

Not stated	256	31

Organisations that responded to the consultation that said they officially represents views of nurses/ midwives and/or public that share the following protected characteristics:

	Number	Percentage
Older	13	42
Ethnic minorities	13	42
Younger	12	39
Gender	12	39
Disabled	11	35
Religion or belief	11	35
Lesbian, Gay and Bisexual	10	32
Transgender	9	29
Pregnancy/maternity	9	29
Not stated	15	48

By carrying out continuous equality assessments of our processes and systems, we were able to identify areas where we could improve our processes for certain groups. An EDI review of our registration and revalidation processes identified that we could make improvements to our communications for disabled and trans service users. This led to sensitivity training and awareness raising activities for front line employees.

We have also been working to improve our understanding of equality, diversity and inclusion issues by attending internal and external training and events. For example, in November 2017 we attended a workshop on reducing health inequalities amongst

	EDI Strategic Aims	Objectives	Measures	Current status
				groups such as homeless people, sex workers and vulnerable migrants.
6	Evaluate and as needed address, equality issues raised by our work.	To improve our understanding of how our activities, functions and services impact on diverse groups and take action to eliminate unlawful discrimination.	• All external consultations have EQIA summaries published. • Monitoring of the number of EQIAs, workshops and meetings. • Evaluation reports and EDI review documents that show EDI considerations and recommendations for improvement.	We published an EQIA summary with the Education Standards and nursing associate (NA) fees consultation. We held EQIA workshops with the employees that were involved with the development of both the Education Standards and the NA programme. Our registration and revalidation function had an EDI review to look at gaps in their EDI regulatory role. This is part of our ongoing equality impact reviews, based on prioritised areas of potential concern. This was translated into prioritised actions in their business plan, for example trans awareness training for customer facing employees. Formal evaluations for Revalidation and the test of competence for overseas nurses and midwives included looking at different outcomes for nurses and midwives by protected characteristics as well as perceptions of fairness. Through the evidence stream of our EDI Strategic Framework we identified the following EDI priorities for the organisation in 2018-19 to: • Continue to improve the quality of the diversity data we hold; • Implement our reasonable adjustments policy for customers; • Raise awareness of gender identity and how it affects the service we provide; • Reduce disproportionately negative outcomes for ethnic

<table>
<tr><th></th><th>EDI Strategic Aims</th><th>Objectives</th><th>Measures</th><th>Current status</th></tr>
<tr><td></td><td></td><td></td><td></td><td>minority nurses, midwives and staff;
• Build the capability of employees to be compliant with equalities legislation;
• Embed equality impact assessments into our project and operational processes.</td></tr>
<tr><td>7</td><td>Collect evidence that helps us know we are fair and consistent. Working to enhance the quality and extent of E&D data about our registrants through their careers.</td><td>a) To collect, analyse and publish data about the diversity of nurses and midwives on our register.
b) We understand where our functions impact on different groups of nurses and midwives.</td><td>• Reduce ‘unknown’ percentage of diversity data of nurses and midwives.
• Research and evaluation reports compare outcomes for different groups of nurses and midwives on the basis of protected characteristic.</td><td>During the reporting period we commissioned the following research and evaluations that looked at our regulatory outcomes but also at differences between patients, public and registrants by protected characteristic. The figures below show the improvements to the percentage of diversity data we hold about nurses and midwives on the register:

<table><tr><td>Protected characteristic</td><td>Mar-17</td><td>Mar-18</td></tr><tr><td>Age</td><td>100%</td><td>100%</td></tr><tr><td>Gender</td><td>100%</td><td>100%</td></tr><tr><td>Ethnicity</td><td>83%</td><td>94%</td></tr><tr><td>Disability</td><td>80%</td><td>90%</td></tr><tr><td>Religion or belief</td><td>64%</td><td>71%</td></tr><tr><td>Sexual orientation</td><td>83%</td><td>94%</td></tr><tr><td>Marital Status</td><td>83%</td><td>94%</td></tr><tr><td>Gender identity</td><td>70%</td><td>89%</td></tr></table>
This is the first year that we are publishing the gender identity of the nurses and midwives on the register. There are 3,789 nurses and midwives on the register that say their gender identity does not completely match the sex they were registered with at birth, equivalent to 0.5 percent of the register.</td></tr>
<tr><td>8</td><td>Ensure that new entrants</td><td>a) Standards for nurses and</td><td>• increased engagement events for those involved</td><td>During our engagement for the revision of the education standards we recognised the need to improve information about</td></tr>
</table>

	EDI Strategic Aims	Objectives	Measures	Current status
	to the register are equipped to practise effectively in diverse and global environments.	midwives entering the register contain relevant information about the equality diversity and inclusion requirements. b) QA of education and assessment institutions look at compliance with PSED.	in the education/ assessment of nurses, midwives coming onto the register • more communications and guidance about EDI expectations. • QA reports show where bodies have considered EDI.	supporting students with diverse needs, which led to clearer information on the expectations of education providers to support disabled students Our newly published standards for pre-registration nursing programmes contain the following text: 'Approved education institutions (AEIs) together with practice learning partners must take account of students' individual needs and personal circumstances when allocating their practice learning including making reasonable adjustments for students with disabilities'. Our interaction with AEIs in Wales highlighted our need to be continuously aware of the needs of Welsh language speaking patients, nurses and midwives. We have planned for an EDI question in our QA feedback from AEIs in the next reporting year. We conducted an EDI questionnaire of all our Test of Competence providers to share their best practice of the EDI and ensure consistency in access to the sites and fair assessment processes.
9	Set out our expectations that nurses and midwives challenge discriminatio n in their practice, are mindful of difference and show	Our standards, the Code and FtP guidance contain EDI requirements for how nurses and midwives should practise without discrimination against diverse	• Standards and guidance documents contain relevant EDI requirements.	Our consultation questions for the revision of the Education Standards asked a specific question about EDI. The EQIA of the Education Programme included engagement with diverse groups. In our consultations and engagement, we received feedback that the language in the standards should be explicit in what is expected of nurses and midwives. Our new *Future nurse: Standards of proficiency for registered nurses* contain the following words 'at the point of registration, the registered nurse will be able to demonstrate an understanding of, and the ability to challenge, discriminatory behaviour'.

	EDI Strategic Aims	Objectives	Measures	Current status
	respect to all patients, service users and colleagues.	service users and with an understanding of health inequalities.		FtP allegation codes were updated to include discrimination against service users and colleagues.
10	Pursue diversity in those applying to become Council, committee and panel members.	For our Council and committee members and panellists to reflect the diverse nurses and midwives on the register and the diverse patients and public.	• The diversity data of applicants, shortlisted and appointments to Council and FtP panelist posts by protected characteristic is proportionate in comparison with a relevant pool of people e.g. FtP registrant panellists to have similar makeup to the makeup of the register.	We held two recruitment campaigns for Council and committee members during 2017–2018. One was for a new Chair of Council who took office on 1 May 2018. The other was for a new Chair and two new members of the Appointments Board. Both recruitment exercises were equality impact assessed. Our search and advertising strategies were designed to encourage applications from candidates from underrepresented groups and we promoted the vacancies to key stakeholder groups. During the reporting period the FtP Panel recruitment was commissioned to an external partner with the specific criteria of providing a diverse applicant pool by protected characteristic. The diversity profile of the current pool of panelists is available in section 2 of this report.
11	Be recognised as an organisation that upholds best practice in equality, diversity and inclusion, including through	To promote NMC EDI activities externally.	• Completed external benchmarks and assessments. Improvements annually. • More feedback from employees and external stakeholders (in surveys and meetings) about perception of NMC.	We have good connections with the other healthcare regulators, such as the General Medical Council and General Pharmaceutical Council, and learn from each other's insights and research. The EDI leads from each regulator have a forum where we discuss best practice. We completed the Stonewall Workplace Equality Index (WEI) benchmark in 2018. Our overall score was 30.5 marks out of a possible 200. The sector average for health and social care is 60 marks. This gave us an immediate push to raise awareness of LGBT+ equality by hosting events and increasing communications

	EDI Strategic Aims	Objectives	Measures	Current status
	meeting recognised sector standards.			about LGBT+ equality during LGBT History Month. For example, talks by Schools Out, the National Aids Trust and trans health and justice campaigner Christine Burns. We completed the Social Mobility Employer Index and will receive the result in the next reporting period. We improved our Employee Engagement Survey questions and had the following results: • My manager treats me fairly and with respect Agree 88% Neutral 9% Disagree 3% (2016 83% 11% 6%) • I understand equality diversity and inclusion and where it is relevant to my role Agree 93% Neutral 5% Disagree 1% • I am aware of the NMC's Valuing Diversity Policy Agree 87% Neutral 9% Disagree 4% (2016 92% 5% 3%) • In my experience, the NMC is an inclusive place to work Agree 74% Neutral 18% Disagree 8% • There is real commitment at the NMC to continuing to improve performance on equality, diversity and inclusion Agree 72% Neutral 19% Disagree 9% In the next reporting year, we will complete the Stonewall WEI, Social Mobility Employer Index and the Business in the Community (BITC) Race Index.

Item 17
NMC/18/89
26 September 2018

Council

Welsh language scheme monitoring report 1 April 2017–31 March 2018

Action: For decision.

Issue: This paper presents the NMC's Welsh language scheme monitoring report 1 April 2017–31 March 2018 for approval by Council.

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: The Council is asked to approve the Welsh language scheme monitoring report 1 April 2017–31 March 2018 for submission to the Welsh Language Commissioner (paragraph 7).

Annexes: The following annexe is attached to this paper:

- Annexe 1: The Welsh language scheme monitoring report 1 April 2017–31 March 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 The NMC, as a public body that exercises statutory functions in Wales, is subject to the Welsh Language Act 1993 which requires us to:

1.1 Establish the principle that the English and Welsh languages should be treated on a basis of equality in the conduct of public business.

1.2 Facilitate the use of the Welsh language.

2 In 2011, the Welsh government introduced the Welsh Language Measure, which granted the Welsh language official status in Wales and established the Office of the Welsh Language Commissioner.

3 Our Welsh language scheme was prepared in accordance with the Welsh Language Act 1993. It was approved by the Welsh Language Board in accordance with section 14(1) of the Welsh Language Act 1993 on 19 January 2011.

Four country factors:

4 This report is of particular relevance to Wales and Welsh speakers.

Discussion

5 This is our sixth Welsh language scheme annual report covering the period 1 April 2017 to 31 March 2018.

6 After the report has been discussed it will be translated into Welsh and submitted to the Commissioner by 1 October 2018.

7 **Recommendation: The Council is asked to approve the Welsh language scheme monitoring report 1 April 2017–31 March 2018 for submission to the Welsh Language Commissioner.**

Public protection implications:

8 This report does not have any implications for public protection.

Resource implications:

9 Resource implications arising from this report relate to the compilation, translation and publication of the report, which are covered within current resources.

Equality and diversity implications:

10 Welsh language considerations are included in our equality impact assessment toolkit and will continually be reviewed to ensure that in all of our work we uphold the commitments we have made in our Scheme.

Stakeholder engagement:

11 The report includes information about how Welsh language speakers

were engaged in our organisational activities in the reporting period.

Risk implications:	12	None.
Legal implications:	13	We are now compliant with the scheme and there are no legal implications.

Item 17: **Annexe 1**
NMC/18/89
26 September 2018

Nursing & Midwifery Council

The Welsh language scheme monitoring report

1 April 2017–31 March 2018

Introduction

Our role

We exist to protect the public by regulating nurses and midwives in the UK. We do this by setting standards of education, training, practice and behaviour so that nurses and midwives can deliver high quality healthcare throughout their careers.

We maintain a register of nurses and midwives who meet these standards, and we have clear and transparent processes to investigate nurses and midwives who fall short of our standards.

Corporate commitment

Members of the Council, the Executive team and all employees play a part in delivering our Welsh language scheme.

- The Council is responsible for setting our overall strategy.
- The Executive team is responsible for implementing our strategy and for setting internal policies and business plans that support the delivery of the Welsh language scheme.
- The Director of Registration and Revalidation is responsible for the Policy and Legislation team and the Equality Diversity and Inclusion (EDI) team; and therefore has overall responsibility for the delivery of the Welsh language scheme.
- The Policy and Legislation team are responsible for monitoring legislative change and the impact on our business planning in relation to compliance with the Welsh Language Act 1993.
- The Equality and Diversity team (based in the Policy team) are responsible for driving forward Welsh language awareness and supporting individual action owners and our employees to comply with our Welsh language scheme.

Welsh language scheme progress

In accordance with Section 21 of the Welsh Language Act 1993, we will treat Welsh and English equally in the conduct of public business and the administration of justice in Wales, as far as is appropriate in the circumstances and reasonably practicable. Our Welsh language scheme was approved by the Welsh Language Board in January 2011.

The aim of the annual monitoring report is to summarise our progress in

implementing our Welsh language scheme during the period 1 April 2017 to 31 March 2018. A summary report (based on questions from the Welsh Language Commissioner's Office) is set out in Annexe 1.

We recognise that it's important that we continue to focus on the Welsh language scheme to help us to achieve our aims. We'll continue to engage with the Welsh Language Commissioner to help inform and develop our approach.

Our regulatory engagement in Wales depends on the nature of the policy or project. For corporate change programmes we ensure we hold engagement events across the UK, informing devolved governments where appropriate. For example:

- Events as part of our work to develop the future nurse standards.
- We have kept the Welsh government updated on our work to begin regulating nursing associates in England. We primarily update them via the Chief Nursing Officer.
- We responded to the Welsh government's consultation on nurse staffing levels in 2017.
- Our consultation in 2017 regarding the English language standards for overseas nurses received responses from Healthcare Inspectorate Wales and NHS Wales.
- Our current work on our review of the Overseas process includes an event in Cardiff and other engagement with Welsh representatives.

Welsh language standards

Over the past couple of years we've provided detailed feedback to the Welsh government on its proposals for Welsh language standards, which were intended to replace our Welsh language scheme. We also liaised with other healthcare regulators to discuss the potential implications of any new standards. However, following consultation, in June 2018 the Welsh government announced that it won't introduce sub-legislation to bring more bodies under Welsh language standards. Instead, it will prioritise a new bill to promote growth in the number of people who speak and use the Welsh language.

Our Welsh language scheme therefore remains in force and we'll continue to comply with the commitments in our scheme and submit an annual report to the Welsh Language Commissioner.

We're committed to Welsh language equality and will continue to work with the Welsh government, the professional regulators and the Professional Standards Authority to ensure any future statutory standards are targeted, reasonable and proportionate.

Welsh Language Commissioner's regulatory work 2018–19

In responding to this year's request for information we also considered the letter we received from the Commissioner dated 3 May 2018 setting out the proposed regulatory work the Commissioner will take forward in 2018–19. This included setting out the self-regulatory steps organisations can take to ensure they comply with the duties and how they can increase opportunities for people to use Welsh language. We completed the checklist sent by the Commissioner while compiling this report and will ensure the advice is taken into account going forward. For example:

- We haven't previously published our annual report but will publish this report this year and in the future.

Key actions for the next year

Over the next year, we'll continue to focus our efforts on:

- continuing to raise the profile of the Welsh language scheme across the organisation to ensure employees are fully aware of what is required under and why.

- monitoring the timeline for the implementation of any proposed new standards from the Welsh Language Commissioner.

- using the *Self-regulation: guidance for organisations* to see if there is best practice we can take forward.

Annexe 1: Summary report of the implementation of the Welsh language scheme from 1 April 2017 to 31 March 2018

Policy impact assessment	
Number and percentage of policies (including those that were reviewed or revised) where consideration was given to the effects the policy would have on the use of the Welsh language.	1. Education change programme 2. Nursing associate fees policy 3. Nursing associate regulatory approach policy 4. Overseas policy 5. English language policy 6. Fitness to practise strategy All policies have equality impact assessments which include consideration of the effects the policy on the use of the Welsh language.
Example of an assessment deemed to have an impact on the use of the Welsh language and details of how the policy was amended as a result.	Our education change programme included the following set of standards: 1. Standards framework for nursing and midwifery education 2. Standards for student supervision and assessment 3. Standards for pre-registration nursing programmes 4. Standards of proficiency for registered nurses This programme of change took place from 2016–2018. An equality impact, including a Welsh language impact assessment, was conducted at several stages of the programme. As part of the formative engagement and pre-consultation and consultation we held events in Wales. We printed copies of all documents were available in Welsh and participants were encouraged to engage with us in Welsh if they preferred. Four country experts, including from Wales were part of our subject matter expert (SME) group whom we worked with closely in the pre and post-consultation assimilation and drafting stage. A wide variety of stakeholders from the four countries of the UK responded to our consultation. 1,932 individuals and organisations responded to consultation one on the new education standards and 706 organisations and individuals responded to consultation two on prescribing and medicines management.

<table>
<tr><td></td><td>We also received a response from the Welsh Language Commissioner which we have taken into consideration when the standards were refined following consultation.

In fact Wales, NI and Scotland were statistically over-represented in their responses to the consultation as compared to England. The following table was generated by Why Research, the external research agency which analysed our consultation responses.

<table>
<tr><th></th><th>Proportion from our register</th><th>Proportion responding to consult 1</th><th>Net difference (% points)</th></tr>
<tr><td>England</td><td>78.9%</td><td>71.0%</td><td>-7.9%</td></tr>
<tr><td>Scotland</td><td>10.0%</td><td>14.0%</td><td>+4.0%</td></tr>
<tr><td>Wales</td><td>5.2%</td><td>7.0%</td><td>+1.8%</td></tr>
<tr><td>N. Ireland</td><td>3.5%</td><td>7.0%</td><td>+3.5%</td></tr>
<tr><td>Non-UK</td><td>2.4%</td><td>2.0%</td><td>-0.4%</td></tr>
</table>

All the five sets of standards are now available on our website, including Welsh versions. Following publication of the standards we have now progressed into implementation stage. This includes engaging with four country stakeholders with implementation events planned for autumn. We have also commenced work on supporting information for our new standards for student supervision and assessment and have subject matter experts from the four countries of UK. At a recent NMC event on practice assessment documentation (PAD) we had presentations from different PAD best practice including Wales. The engagement will form part of our next phase of work on implementation and this also includes engagement with all four countries at a strategic level.

One key action we have taken as a result of our Welsh language impact assessment and engagement was including a question in our survey of all Approved Education Institutions to determine if they provide courses in the Welsh language.</td></tr>
<tr><td>Publications</td><td></td></tr>
<tr><td>Number of publications</td><td>2827</td></tr>
</table>

available to the public	
Number of publications available to the public in Welsh	128 This is in line with our Welsh language scheme that says information aimed at patients and members of the public will be available in English and Welsh. Standards, guidance and other technical or specialised material aimed at professionals and not directly at the public is published in English. However we offer a translation into Welsh on request. In addition to what we set out in the scheme we translate materials when we engage with the Welsh speaking public e.g. our consultation materials and documents for engagement events in Wales.
Complaints	
Number of all complaints received about the conduct of practitioners in Wales	264 referrals were received regarding nurses and midwives with a registered address in Wales.
Number of complaints received in Welsh about the conduct of practitioners in Wales	We received no referrals in Welsh during 2017–18.
Number of complaints received related to the Council's compliance with its Welsh language scheme	We received no complaints about the operation of the Welsh language scheme in the reporting period 2017–18.
Website	
Percentage of the organization's website that is available in Welsh	Less than 1%. The main website features an 'About us' page in Welsh, accessed through a 'Cymraeg' button in the navigation bar. This page draws together key information about us as a regulator. As stated above this is in line with our Welsh language scheme that says information aimed at patients and members of the public will be available in English and Welsh. Standards, guidance and other technical or specialised material aimed at professionals and not directly at the public is published in English. We offer a

	translation into Welsh on request. In addition to what we set out in the scheme we translate materials when we engage with the Welsh speaking public e.g. our consulation materials and documents for engagement events in Wales.
Evidence relating to any plans to improve or increase the Welsh Language provision on the website	We continue to offer the Browsealoud function on the website, which enables users to translate the whole site into Welsh, either to read or listen to (using Google translate). Future policy consultations will have Welsh versions available. All core documents are available in Welsh.
Evidence relating to the process used to ensure that existing content, updates and new content, complies with the requirements of the Welsh language scheme (if the process is different to that reported in 2016-17)	We continue to review existing website content to ensure compliance with our policy of ensuring all significant documents are available in Welsh. These documents always sit alongside the English language versions.
Promotion of Welsh language services	
Information about methods used to promote the organisation's Welsh language services and evidence of any subsequent increase in the public's use of the services.	The link to the Welsh language page is prominent on the homepage of our website. There is a clear link, in Welsh, to the page on our commitment to the Welsh language scheme, which sits under 'About us'. We respond to requests for information and resources to be available in different formats but have received none for availability in Welsh by email nor has our contact centre received any requests for a Welsh language speaker. We would, however, respond to any demand. **NMC Council meeting in Wales** The Council held its meetings and a range of stakeholder events in Wales from 22–24 May 2017. We took a number of steps to ensure that the needs of speakers of the Welsh language were accommodated in the stakeholder events and at the public Council meeting. Including: • sending invitations to the meeting and stakeholder events in

<table>
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<td>
both Welsh and English.
• asking people in advance what their Welsh language needs were.
• publishing all materials for the Council meeting in both Welsh and English (both online and hard copies available on the day).
• offering live interpretation at the Council meeting.
• seeking feedback through surveys (in English and Welsh).

In addition, each of the surveys for feedback included a specific question on our approach to the Welsh language scheme:

Are you satisfied with the approach to communicating with speakers of the Welsh language at these meetings?’ The responses in each case were ‘Yes; No; Not applicable.’ The combined result for all surveys were:

<table>
<tr><td>Yes</td><td>68</td></tr>
<tr><td>Not applicable</td><td>43</td></tr>
<tr><td>Blank</td><td>15</td></tr>
<tr><td>No</td><td>1</td></tr>
<tr><td>Yes and No</td><td>1</td></tr>
<tr><td>Total</td><td>128</td></tr>
</table>
The majority of responses (111 out of 128) therefore were either satisfied with our approach to the Welsh language or said it was ‘not applicable to them’. A further 15 questionnaires were left blank.

One respondent replying to the ‘Nursing and Midwifery in action in Wales’ survey selected the ‘no’ response, however they gave no further explanation as to why they were not satisfied with our approach to the Welsh language.
</td>
</tr>
<tr>
<td>Information about methods used to assess the quality of the organisation’s Welsh language services (e.g. by assessing the experience of existing/ potential service users)</td>
<td>See above section about how we monitored consulation responses to the Education Programme.</td>
</tr>
</table>

Fitness to practise cases	
Number of hearings held in Wales	We held 77 substantive events and 73 non substantive events (130 substantive cases and 89 non substantive cases were considered at these events).
Number of hearings where a request was made by the witness to speak in Welsh	0. There were no requests made by a witness to speak Welsh.
Number of hearings in which evidence was presented in Welsh.	0. There were no hearings in which evidence was presented in Welsh.
Language awareness training	
Number and percentage of the organisation's new staff (i.e. new since 1 April 2017) that received Welsh language awareness training.	All new starters' complete mandatory equality diversity and inclusion e-learning and face-to-face training that includes Welsh language awareness. EDI training attendance from 1st April 2017 – 31 March 2018: 215 eligible staff joined the organisation and 183 attended face-to-face E&D training = 85% attended. EDI training attendance from 1st April 2014 – 18th June 2018: 632 staff attended E&D training between these dates. We do not hold data about training attendance before 2014 and Welsh language awareness was not included as part of the E&D training course before Summer 2016 – it is now included in all the E&D training sessions after a review.
Number and percentage of the organisation's entire workforce that has received Welsh language awareness training since the training was introduced.	Our equality diversity and inclusion (EDI) e-learning contains awareness raising about our Welsh Language Scheme. All employees must complete the equality diversity and inclusion e-learning every two years. EDI e-learning completions from 1st April 2017 – 31 March 2018: 95% (this includes new starters). Our learning portal has the following resources available to employees: • e-Learning course - This module is designed to raise awareness of the Welsh language and is aimed at anyone interested in the history of Welsh, from past to present day

	• Welsh Surface languages – Online resources to learning Welsh online • BBC learning Welsh - Learning guides and online videos. We have bespoke equality impact assessment workshops for policy employees that include Welsh language assessment. In the reporting period we held three workshops.

Item 18
NMC/18/90
26 September 2018

Council

Annual Health and Safety and Security Report 2017–2018

Action: For discussion.

Issue: Provides assurance on the NMC's health, safety and security arrangements and information on activity.

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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Context:

1 In terms of health, safety and security the NMC is a relatively low-risk environment. However, it is still important that the Council monitor the extent to which we have formal policies, guidance and procedures in place, assuring the health, safety and welfare of our employees, contractors and visitors.

2 This annual report outlines how we ensure compliance with health and safety requirements and our security arrangements and the assurance available to the Council.

Four country factors:

3 Not applicable for this paper.

Discussion

Sources of assurance

4 The following arrangements are in place:

4.1 A Health and Safety Steering Group (HSSG), chaired by the Head of Estates under the Director of Resources, with membership drawn from across the organisation. Over the period the HSSG has met twice. Relevant changes to legislation or guidelines were discussed in the HSSG's meetings. No revisions were required to the NMC policy.

4.2 Mandatory e-learning on health and safety for all staff.

4.3 Training for statutory responsibilities and further training for specific roles.

4.4 A Health and Safety policy. The policy statement was reviewed and signed November 2017 by [?].

4.5 A Health and Safety guide for staff which was reviewed, revised and reissued in December 2017.

4.6 Sufficient numbers of trained first aiders and fire wardens at all sites, including refresher courses as necessary.

4.7 Fire Risks Assessments (FRAs) in place for all NMC buildings with evacuation testing and weekly fire alarm tests.

4.8 Regular incident reporting.

4.9 A programme of planned preventative maintenance to the mechanical and electrical plant and associated infrastructure, fire alarm, CCTV and access control systems.

Reviews during the year

5 The Health and Safety guide was reviewed and revised to ensure that it was up to date with the latest relevant legislation and good

practice. This includes guidance for staff and managers' with regards to lone working and 'young persons' working with the organisation, for example during youth placement. The guide will be included in induction packs for new starters, as well as being promoted to all staff through Insider Weekly and on iNet as a news item.

6 Following the Grenfell fire incident, the Fire Risk Assessments were reviewed for each NMC site. A new Fire Risk Assessment was undertaken at 23 Portland Place, which confirmed that there were no immediate or major issues found with regards to the building. For multi-tenanted buildings assurance was sought and confirmed from the respective Landlords. A separate additional paper was written for the September 2017 Council meeting.

Training

7 The main focus of health and safety training in the year was on continuing to improve rates of compliance with the mandatory e-learning. Compliance is now consistently above 90 percent.

8 Refresher and new training continues to be provided to fire wardens and first aiders across all sites, which includes defibrillator training to first aiders.

9 Health and safety also includes consideration of staff welfare and 'well-being'. Please see actions undertaken below: Priority outcomes (paragraphs 14–19).

Incident reporting

10 During the year 1 April 2017 to 31 March 2018 there were five reported health and safety incidents and one near miss, across all sites. The incidents were minor and no trends or common causes were identified.

11 There were no Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations 2013 (RIDDOR) incidents that required reporting to the Health and Safety Executive (HSE).

12 There was an alleged terrorist incident near Oxford Street Underground station in November 2018, which turned out to be a false alarm. Two members of the public were given shelter in 23 Portland Place and the building went into 'lockdown' until the incident was confirmed to be over.

13 During the period of continuous hot weather starting in April 2018 through to July 2018, mains water pressure issues were experienced to the general locality around 23 Portland Place. On three occasions this led to the loss of water to the toilet and washing facilities for the building. For health and staff welfare reasons we had to enact our business continuity plans, where in the afternoon of the occurrences we relocated the Call Centre operation to One Kemble Street while

enacting agile working for general staff, either from other NMC locations or home. To alleviate any future issues we have now installed secondary pumps and a reservoir tank in the basement alongside the main water tanks in the roof.

Progress against priorities set for 2017–2018

14 We committed to keep security under review for all our buildings/venues and to appoint a security contractor to provide guarding at our hearing venues.

14.1 *Outcome: Additional access control points installed to the first floor at 23 Portland Place to secure the area of the Council Chamber and Cherry meeting room.*

14.2 *'Run Hide Tell' anti-terrorism poster and staff communication campaign run across all sites. At 23 Portland Place new links formed with the BBC, Langham's Hotel, Facebook and the Police Area Ward Panel. Lockdown procedure guidelines in place for all buildings.*

14.3 *Following a procurement tender process a security contractor was appointed to undertake guard services at each of our hearing venues.*

15 We committed to keep our business continuity arrangements under review, undertake business continuity exercises and learn any necessary lessons from these exercises.

15.1 *Outcome: Policy and business arrangements in place. Training and exercises undertaken with the Emergency Response teams (ERTs) and strategic senior level Incident Management Team (IMT).*

16 We continued our ongoing planned maintenance programme at 23 Portland Place to maintain health and safety compliance of 23 Portland Place and an ambient office environment.

16.1 *Outcome: A structured maintenance+ regime is in place which meant that the building continued to operate during three area wide electrical power supply failure spikes.*

17 We committed to ensuring that directorate representation is maintained across all areas of the business to the HSSG.

17.1 *Outcome: new members recruited for the HSSG.*

18 We also worked with the Employee Forum (EF) to inform future well-being initiatives. This is linked with the broader People Strategy for the organisation and is led by Learning and Organisational Development.

18.1 *Actions implemented in 2017–2018, following input from the EF, include initiatives around:*

18.2 *Mental Health:*

18.2.1 We publicised the purpose and benefits of the Employee Assistance Programme.

18.2.2 We trained first aiders in a mental health programme to offer support for staff who need assistance.

18.3 *Healthy eating:*

18.3.1 We trialed monthly fruit baskets from January – March 2018 with positive feedback received.

18.3.2 Healthy snack options were implemented in vending machines and healthy eating posters were made available across all locations.

18.4 *Leadership:*

18.4.1 An attendance management module was rolled out to all first line managers with a view of adopting an effective and supportive attendance management approach.

19 We worked to increase the awareness and reporting of 'near misses' to help in the prevention of accidents and other incidents.

19.1 *Outcome: Raising awareness was undertaken through advertising on the NMC intranet and poster campaign. There are future plans to increase the level of reporting.*

Priorities for 2018–2019

20 In addition to regular monitoring of incidents and accidents, and maintaining oversight of any changes to legislative requirements, priorities for health and safety for the coming year are:

20.1 To keep security under review for all our buildings/venues.

20.2 To undertake business continuity training and exercises and take forward any necessary lessons from these exercises.

20.3 To continue with the ongoing planned maintenance programme at 23 Portland Place to maintain health and safety compliance of 23 Portland Place and an ambient office environment.

20.4 To increase health, safety and security awareness and the

reporting of ‘near misses’.

20.5 To continue working with Learning and Organisational Development to promote well-being:

20.5.1 Well-being actions to be prioritised with Employee Forum representatives during 2018–2019

20.5.2 Updated Sickness Absence Policy to be implemented.

20.5.3 A new Occupational Health provider to be procured.

Public protection implications:	21	None.
Resource implications:	22	There are no material resource implications. Health and safety requirements, such as training, are built into normal revenue budgets.
Equality and diversity implications:	23	Estates/Facilities staff undertake workplace Display Screen Equipment assessments, as necessary. Staff can be referred to Occupational Heath, in conjunction with People and Organisational Development (POD), as required.
	24	Personal Emergency Evacuation Plans (PEEPS) are undertaken where there is less abled or disabled persons.
Stakeholder engagement:	25	Not Applicable.
Risk implications:	26	This report provides assurance that we have measures in place to address health, safety and security risks.
Legal implications:	27	Policies and guidance notes are reviewed and updated for compliance with any new legislation or best practice.

Item 19
NMC/18/91
26 September 2018

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 performance and risk at August 2018;
- note and comment on the additional reports;
- consider whether it wishes to add any comments to our response to the PSA consultation on Standards of Good Regulation (paragraph 16).

Annexes: The following annexes are attached to this paper:

- Annexe 1: Performance and risk report.
- Annexe 2: Additional reports.
- Annexe 3: Response to the PSA's consultation on Standards of Good Regulation.

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 performance and risk report is provided at Annexe 1 and includes corporate financial performance, non-financial performance, and our corporate risk position to August 2018.

2 Annexe 2 provides more detailed reports on the implementation of the new Fitness to Practise (FtP) strategic direction and a review of the impact of the legislative changes introduced during 2017.

3 Annexe 3 provides our response to the Professional Standards Authority (PSA) consultation into the standards of good regulation.

Four country factors:

4 Four country factors are taken into account in considering our risks and through our operational performance.

Discussion:

Performance against our 2018–2019 corporate business plan

Corporate Commitments

5 The progress of corporate commitments is reported quarterly, with the next Council update at quarter two due in November 2018.

6 Quarter one status showed that nine of our 11 commitments were on track, with delays experienced within the Education Programme and Modernisation of Technology Services (MOTS) programme. We also predicted re-phasing of activities needed to deliver our Overseas Programme.

7 Financial indicators year to date show that we expect the pace of programme delivery to increase with some additional agreed spend during this financial year. As anticipated, activity has been re-phased for the Overseas Programme and the Education Programme. Although some activities will move into the 2019–2020 delivery period, we do not expect this to significantly impact the overall expected outcomes of these programmes.

8 In July 2018, we agreed a new strategic programme to deliver the recommendations outlined in the PSA's Lessons Learned report. This joins the other seven strategic programmes outlined in our 2018–2019 business plan.

Corporate KPIs

9 Performance of all five of our corporate KPIs remains strong and above target. These include timeframes for registrations, interim orders and progression of FtP cases within 15 months. These are detailed in Annexe 1.

Financial performance against 2018–2019 corporate budget

10 Detailed financial performance commentary is provided at Annexe 1.

11 Key points are:

11.1 Since April 2018, we have recorded a surplus of £5.0 million compared to a £2.8 million deficit at the same point last year. This is due to a combination of factors including higher than expected income, combined with expenditure that is £3.6 million (10%) below budget, due to lower than planned spend on FtP adjudication hearings, rescheduled Estates maintenance work, and lower than anticipated spend on certain projects as a result of re-phasing of activity.

11.2 By March 2019, we expect spend across business as usual (BAU) and programmes and projects to be £89.0 million, which is £1.5 million (2%) below budget, of which £1.3 million is within BAU budgets.

11.3 A key driver for this forecast is the expectation that programme delivery will accelerate significantly in the remainder of the year. Spend on programmes in the first five months of the year is £2.7 million. This compares to forecast spend of £13 million for the full year.

11.4 Our quarter two forecast will enable us to provide a more detailed assessment which we will report on in November 2018.

Corporate Risk Position

12 Our corporate risk position is largely unchanged since July (Annexe 1, section 5).

12.1 **Meeting external expectations**: We are taking the PSA's recommendations very seriously, and are acting to meet the high expectations that people have of the NMC. We have put in place our Lessons Learned programme and building capacity in our newly formed Public Support Service so that we can better support the public.

12.2 **Workforce**: Following the July 2018 Council meeting, we have reviewed our priorities and the capacity and resource challenges they present. We concluded that none of the existing priority programmes should be paused or deferred, and that there is sufficient capacity to deliver.

12.3 In the medium term we are implementing a business planning cycle that will take a longer term view at both corporate and operational objectives which will aid us to plan for and manage capacity pressure to points. In the longer term our People Strategy will continue to build on putting people at the heart of what we do.

12.4 **ICT failures:** We continue to manage ICT risks associated

with system failures and cyber security. In the short term we have taken corrective action to avoid failures or put in place contingency plans for when things might go wrong. In the medium term we will reduce ICT risks through our Modernisation of Technology Services (MOTS) programme which will replace core and legacy systems and build a stable platform for our data and processing.

Additional Reports

13 Annexe 2 provides additional reports covering implementation of our new FtP strategic direction and an assessment of the impact on FtP of the legislative changes (section 60) introduced in 2017, including additional means of disposing of FtP cases.

Response to the PSA consultation of the Standards of Good Regulation

14 We submitted our response to the PSA consultation on revising the Standards of Good Regulation by the PSA's deadline on the understanding that Council would have the opportunity to review and submit any additional comments at a later stage. The response is attached at Annexe 3.

15 **Recommendation: The Council is asked to consider whether it wishes to add any further comments to the response already submitted.**

Public protection implications

16 Public protection implications are considered when reviewing performance and the factors behind poor or good performance.

Resource implications:

17 Performance and Risk Reporting are a corporate requirement and are resourced from within BAU budgets with no additional cost attached. No external resources have been used to produce this report.

Equality and diversity implications:

18 Equality and diversity implications are considered in reviewing our performance and risks.

Stakeholder engagement:

19 Not applicable.

Risk implications:

20 The impact of risks is assessed and rated within our corporate risk register.

Legal implications:

21 None.

Item 19: **Annexe 1**
NMC/18/91
26 September 2018

NMC Performance and Risk Report for 2018–2019

Report period: June 2018 – August 2018

Contents

Section 1: Performance against Income and Expenditure

a. Current status at August 2018

Year to Date Income and Expenditure at August 2018	Current status
Income (August actual: £37.2 million / 3% over budget)	Green
Expenditure (August actual: £32.4 million / 10% under budget)	Amber

b. Forecast status at 31 March 2019

Full Year Forecast Income and Expenditure	31 March 2019 Status
Income (Forecast: £88.7 million / 3% over budget)	Green
Expenditure (Forecast: £89.0 million / 2% below budget). Some risk of underspend exists within programme and project expenditure if delivery of activity does not keep pace with expected plans for the remainder of the year.	Green
Deficit: (Forecast: £0.3 million deficit / a reduction of £3.8 million deficit)	Green

c. Actuals to 31 August 2018. Forecast to 31 March 2019

Nursing and Midwifery Council Financial Monitoring Report

	Year-to-date August 2018				Full Year			
Income	Actual £'m	Budget £'m	Var. £'m	Var. %	Forecast £'m	Budget £'m	Var. £'m	Var. %
Total Income	**37.2**	**36.3**	**0.9**	3%	**88.7**	**86.4**	**2.3**	**3%**
Expenditure								
Directorates								
Fitness to Practise	15.0	16.0	1.0	6%	38.2	38.2	0.0	0%
Resources	3.7	4.0	0.3	7%	9.1	9.7	0.6	7%
Technology and Business Innovation	2.7	2.9	0.2	7%	6.6	7.0	0.4	6%
Registration and Revalidation	2.5	2.6	0.1	5%	6.4	6.6	0.2	2%
OCCE	1.2	1.2	0.0	0%	3.2	3.1	(0.1)	(4%)
Education and Standards	1.0	1.3	0.2	18%	2.9	3.0	0.2	6%
People & Organisational Development	1.0	1.1	0.1	9%	2.6	2.6	0.0	0%
External Affairs	0.5	0.6	0.1	20%	1.5	1.5	0.0	0%
Total Directorates - BAU	**27.6**	**29.7**	**2.1**	**7%**	**70.3**	**71.7**	**1.3**	**2%**
Programmes & Projects								
Modernisation of Technology Services	0.5	0.6	0.1	11%	3.5	3.5	0.0	0%
Nursing Associates	0.8	1.5	0.7	46%	2.7	2.7	0.0	1%
Education Programme	0.5	0.9	0.4	46%	1.7	1.7	0.0	0%
Overseas Programme	0.2	0.4	0.1	38%	1.0	1.4	0.4	31%
Lessons Learned Programme	0.0	0.0	0.0	100%	1.2	1.2	0.0	0%
Accommodation Project	0.0	0.0	0.0	0%	1.0	1.0	0.0	0%
FtP Change Strategy	0.3	0.5	0.2	39%	0.9	0.9	0.0	0%
People Strategy	0.0	0.2	0.2	85%	0.5	0.5	0.0	0%
Other Projects	0.3	0.3	0.0	10%	0.3	0.3	0.0	0%
Strategic Projects Reserve	0.0	0.0	0.0	0%	0.2	0.2	0.0	0%
Total Programmes/Projects	**2.7**	**4.2**	**1.6**	**37%**	**13.2**	**13.4**	**0.2**	**1%**
Corporate								
Depreciation	1.2	1.1	(0.1)	(5%)	2.7	2.7	0.0	1%
PSA Fee	0.7	0.7	0.0	4%	1.8	1.8	0.0	2%
Other	0.0	0.1	0.0	30%	0.2	0.2	0.0	0%
Contingency	0.0	0.0	0.0	0%	0.8	0.8	0.0	0%
Total Corporate/Central	**2.0**	**1.9**	**(0.1)**	**(5%)**	**5.4**	**5.4**	**0.0**	**0%**
Total Expenditure	**32.3**	**35.9**	**3.6**	**10%**	**89.0**	**90.5**	**1.5**	**2%**
Surplus/(Deficit)	**5.0**	**0.4**	**4.5**		**(0.3)**	**(4.1)**	**3.8**	

Available Free Reserves (Actuarial Basis)	**28.5**	**23.5**	**5.0**	**21%**	**24.7**	**18.3**	**6.5**	**35%**
Available Free Reserves (Cash Committed Basis)	**30.3**	**25.3**	**5.0**	**20%**	**26.5**	**20.1**	**6.5**	**32%**

Notes:

1. Where totals and variances do not calculate exactly this is due to rounding.
2. The overall approved budget has moved from £89 million as set out in the July report to £90.5 million as above. This is due to Council approving a budget of £1 million for the Accommodation programme in July and agreeing to bring forward £0.5 million for the MOTs programme from

2019-2020. Both amounts were anticipated at the time the budget was discussed in March 2018 but were not, at that point, formally included in the budget.

3. Budgeted costs, primarily for programmes and projects, include elements that may be classified as capital in our published financial statements. This is typically major development of new IT software and building refurbishment. Items classified as capital will reduce expenditure reported in the financial statements in 2018-2019, but will not affect Available Free Reserves.

4. Nursing associates (NA): budgeted and actual income includes refunds from the Department for Health and Social Care. These match exactly the actual programme costs for NAs shown above. This treatment – of showing NA income and costs separately – is in line with their treatment in the audited financial statements. At the time budgets were set in March, these amounts were netted off.

5. 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 full financial statements. This will reflect the annual payment of £1.2 million to reduce the pension deficit and may result in an increase or decrease in costs.

d. Balance Sheet at 31 August 2018

BALANCE SHEET	Mar-18	Aug-18	Change	Change
	£'m	£'m	£'m	(%)
Fixed Assets				
Tangible Assets	18.9	17.9	(1.0)	(5%)
Current Assets				
Cash	16.7	16.1	(0.6)	(3%)
Debtors	4.1	3.3	(0.7)	(18%)
Investments	65.5	65.6	0.1	0%
Total Current Assets	**86.3**	**85.0**	**(1.2)**	**(1%)**
Total Assets	**105.2**	**103.0**	**(2.2)**	**(2%)**
Current Liabilities				
Creditors	(50.4)	(36.4)	14.0	28%
Provisions	(0.5)	(0.5)	0.0	0%
Total Current Liabilities	**(50.9)**	**(36.8)**	**14.0**	**28%**
Non-current liabilities				
Creditors	(0.5)	(7.7)	(7.3)	(1,495%)
Provisions	(1.0)	(1.1)	(0.1)	(10%)
Total Non-current Liabilities	**(1.4)**	**(8.8)**	**(7.3)**	**(510%)**
Total Liabilities	**(52.3)**	**(45.6)**	**6.7**	**13%**
Net Assets (excl pension liability)	**52.9**	**57.3**	**4.5**	**8%**
Pension Liability	(11.7)	(11.2)	0.5	5%
Total Net Assets	**41.2**	**46.2**	**5.0**	**12%**
Total Reserves	**41.2**	**46.2**	**5.0**	**12%**

Notes:

1. The movement of £14.0 million 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

2018-2019 Corporate Budget

Budget reconciliation

Overview of budget changes:

	March 2018 £'m	Change £'m	July 2018 £'m	Change £'m	Budget at period 5 £'m
Budgeted Income for year	83.7	+2.7	86.4		86.4
Budgeted total spend for year	83.3	+2.7 +3.0	89.0	+0.5 +1.0	90.5
Surplus/(deficit)	0.4	(3.0)	(2.6)	(1.5)	(4.1)

The Council has taken a number of decisions since March that have marginally affected the corporate budget and business plan presented to the Council in March 2018. Changes are:

- £2.7m added to income and expenditure to reflect the refund from DHSC and the associated costs with the NA programme. In the budget discussed at 30 March 2018, income and expenditure had been netted off to nil for NA. The treatment adopted here mirrors the annual audited financial statements.
- Additional budget of £3.5m for the Modernisation of Technology Services programme (indicatively agreed at £3.0 million before July), and £1.0 million for Accommodation Programme (total £4.4 million) have been added to budgeted expenditure following approval by Council. Both amounts were anticipated at the time of the budget discussion in March 2018, but not formally included at that point.

e. Detailed financial commentary

Year to date financial position

Overview: NMC's financial position remains stable. Year-to-date (YTD), we have recorded a surplus of £5.0 million compared to a £2.8 million deficit at the same point last year. This is due to a combination of factors including higher than expected income, combined with lower than planned spend on FtP adjudication hearings, rescheduled Estates maintenance work and lower than anticipated spend on certain projects as a result of re-phasing of activity.

	YTD Actual at August 18 £'m	YTD Budget at August 18 £'m	Variance to budget %
Income	37.2	36.3	3% above
Expenditure	32.4	35.9	10% below

Income:

- **YTD**: Income is £0.9 million higher than budget, reflecting the view of register volumes when the budget was set. Recent data suggests a flatter trend in overall register volumes. We have reflected this in the forecast. Other, smaller sources of income are also higher than planned. We will continue to track fluctuations.
- **Full year expectations**: are £88.7 million and 3% (£2.3 million) above budget, and whilst we are refining our forecasting, these are only estimates.

Expenditure:

- **YTD:** Spend across Business As Usual (BAU) and Programmes and Projects is £3.6 million (10%) below budget. Key factors are lower than anticipated adjudications in FtP and project slippage.
- **Full year expectations:** We expect spend across BAU and Programmes and Projects to be £89.0 million, 2% (£1.5 million) below budget. This is largely driven by £1.3 million of underspends from within BAU across a number of budgets.
- **Risks:** Risks within BAU spend are tolerable. Underspends are spread across a number of Directorates, and we do not believe delivery will be adversely be impacted as a result. Forecast spend against programme and project budget may prove optimistic as delivery is weighted towards the latter part of the year. A larger proportion of underspend is possible if there is any re-phasing of activity.

Expenditure on business as usual activities

YTD spend on BAU is £2.1 million (7%) below budget but expected to reduce to £1.3m below budget by year-end.

Underspends are being redeployed towards actions in response to the Lessons Learned recommendations and to speed up FtP investigations.

Underspends:

- **Fitness to Practise (FtP):** (Spend on FtP accounts for over 50% of our BAU budget)
  - **YTD spend:** there are £1.0 million of underspends (6% of budget). This is primarily due to fewer cases at adjudication resulting in less hearings taking place than planned.
  - **Full year expectations:** we anticipate 140 fewer hearings this year compared to the 966 originally planned (a reduction of 14%). This will reduce budgeted spend. This is in part due to a backlog in the number of investigations in progress. Redeployment of funds within FtP will mean that FtP's overall expenditure forecast will remain within budget.
  - **Redeployment of funds:** Part of the £1.0 million underspend will be redeployed to investigations to reduce the caseload, with the other part invested to help implement the PSA Lessons Learned recommendations.
  - **Risk**: One implication of fewer hearings this year may be that there are more during 2019–2020. The associated impact on expenditure could be offset through improvements we are piloting as part of the FtP Strategy.
- **Other Directorate underspends:**
  - **YTD spend:** there were a total £1.1 million of combined underspends across six of our other directorates. Items of note: re-phasing of planned estates maintenance spend within Resources, lower staff costs resulting from vacancies within Technology and Business Innovation, and reduced Quality Assurance activity within Education and Standards.
  - **Full year expectations:** we anticipate total underspends of £1.3 million (2%) by March 2019. These are largely due to the reasons noted above.
  - **Risks**: Delayed activities will be taken forward into next year's budget and the risks arising from the delays remain tolerable for 2018-2019.

Expenditure on Strategic Programmes and Projects

YTD expenditure on Strategic Programmes and Projects, including Nursing Associates, is £1.6 million (37%) below budget. This is due to the phasing of project activities starting later in the year than originally planned.

We currently anticipate that through the year we will use the majority of available budget to deliver programme and project objectives within the 2018-2019 corporate plan. This excludes the Overseas Programme, which is forecasting to deliver early in 2019-2020 due to a re-phasing of a number of activities.

- **The Lessons Learned programme:** is anticipated to cost £1.6m during 2018-2019. Funding has been sourced from our Contingency Fund (£1.2m), and from an expected underspend in FTP BAU (£0.4m). A financial reporting and accountability framework has been created to facilitate robust monitoring and ensure transparency.

  Activities within the overall Lessons Learned programme that were already part of our FtP workplan prior to the PSA's report, for example the Public Support Service, are currently

budgeted for and recorded within FTP BAU. From November, we will report the overall spend on the programme against the overall £1.6m budget.

Other activities that were planned additionally in response to the PSA's report are budgeted for and recorded on the programme budget line. Internal staff time is not being recharged against Lessons Learned so is not part of the £1.6m budget or part of recorded actual costs.

Thirteen workstreams have been identified within the programme. Budgets totalling £0.4m have been allocated to three of those: the Public Support Service (£0.2m), improving access to clinical advice (£0.1m), and the work on new sources of assurance (£0.1m). The remaining £1.2m of the programme budget is held centrally while the activities within the workstreams are planned and costed. That planning work will continue into quarter three.

- **Modernisation of Technology Services (MOTS) programme:** In July 2018, Council approved the full business case for the programme including spend of £3.5m in 2018-2019 (slightly higher than the £3m anticipated in March 2018). The additional £0.5 million will be budget taken from our reserves. We expect that the budget to be spent in full. The forecast currently includes £0.5m for the NA elements of the programme. As previously advised, discussions are ongoing with the DHSC about specific additional costs attributable to NA.

- **Education Programme**: Work to consult on "future midwife", "return to practice" and post registration evaluation will commence later than was initially planned and contributes to the YTD underspend of £0.4 million. Activity is expected to significantly increase over the remaining months with the anticipated full year spend and delivery of programme objectives to be in line with plan.

- **Overseas Programme**: YTD spend is £0.1m below budget due to re-phasing of activities into the second half of the year. The project activity plan was adjusted to defer £0.4 million of the £1.4 million current year budget into 2019–2020. This is due to rescheduling the full implementation of the 'Future Nurse' route into July 2019. We expect to deliver the overall programme outcomes in line with our plans.

- **Nursing Associates**: Despite YTD underspends of £0.7 million due to the phasing of activities, we expect to spend the full year budget of £2.7 million by March 2019 with no adverse impact on our overall objectives. As agreed by the Council, full costs of the NA programme are to be met by funding from the DHSC.

Use of Strategic Programmes and Projects Reserve:
The Council established a reserve of £0.5 million in March 2018, in addition to our funding for programmes and projects, to account for any unforeseen events. 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.

Corporate Expenditure
The Executive has so far accessed £1.5 million of the £2.3 million contingency fund, with £0.8 million still available to support any further unplanned pressures. The £1.5 million has been used for the Lessons Learned programme, 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.

Section 2: Performance against the corporate business plan

2.1. Corporate KPIs

a. Current Status at August 2018

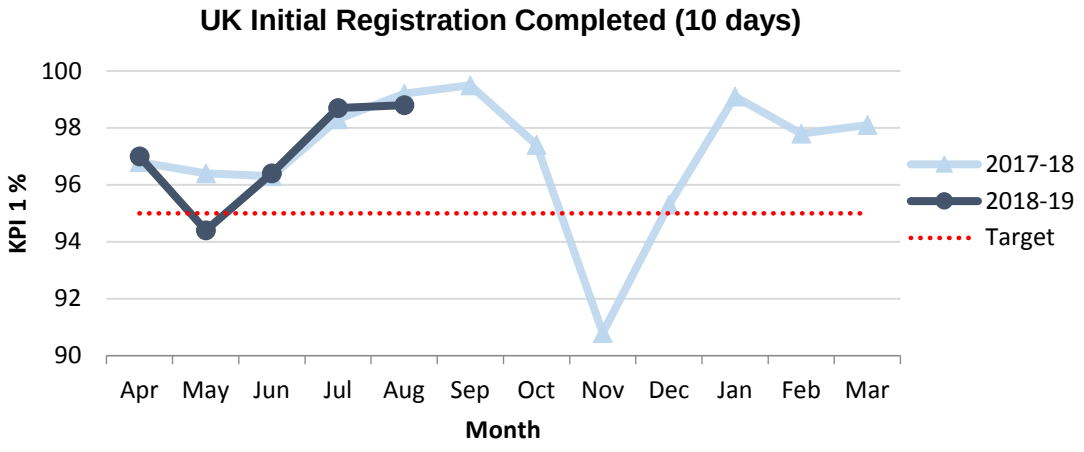
5 Currently above target	0 Marginally below target	0 Significantly below target

b. Detailed Commentary

Progress against corporate KPIs	Current Status
Registrations and Revalidation	
KPI 1: Percentage of UK initial registration applications completed within 10 days. **Target**: 95%	**Green**

Result:

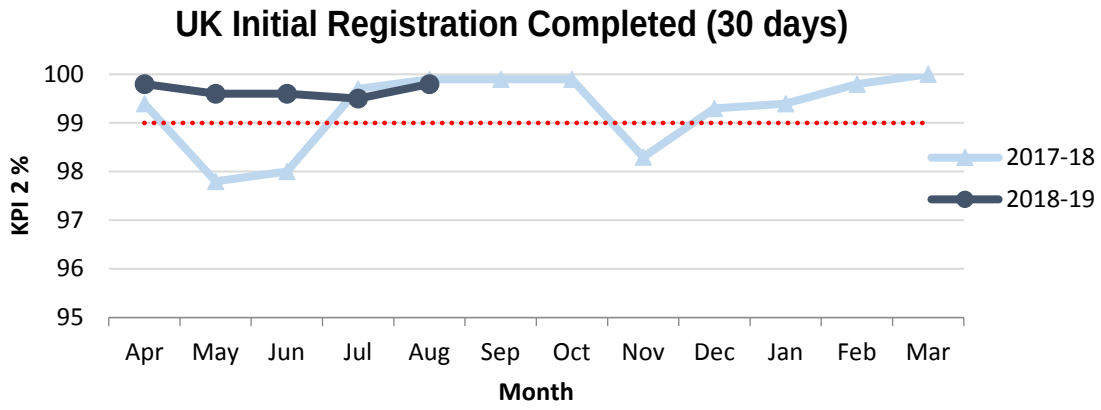
- Strong performance continues. Except for May, each month of 2018-2019 has exceeded target.
- Compared to the same period last year our trend follows the same pattern as 2017-2018.
- Improvements to systems and processes this year are expected to support delivery of performance during the annual September / October peak.



Progress against corporate KPIs	Current Status
KPI 2: Percentage of UK initial registration applications completed within 30 days. **Target:** 99%	**Green**

Result:

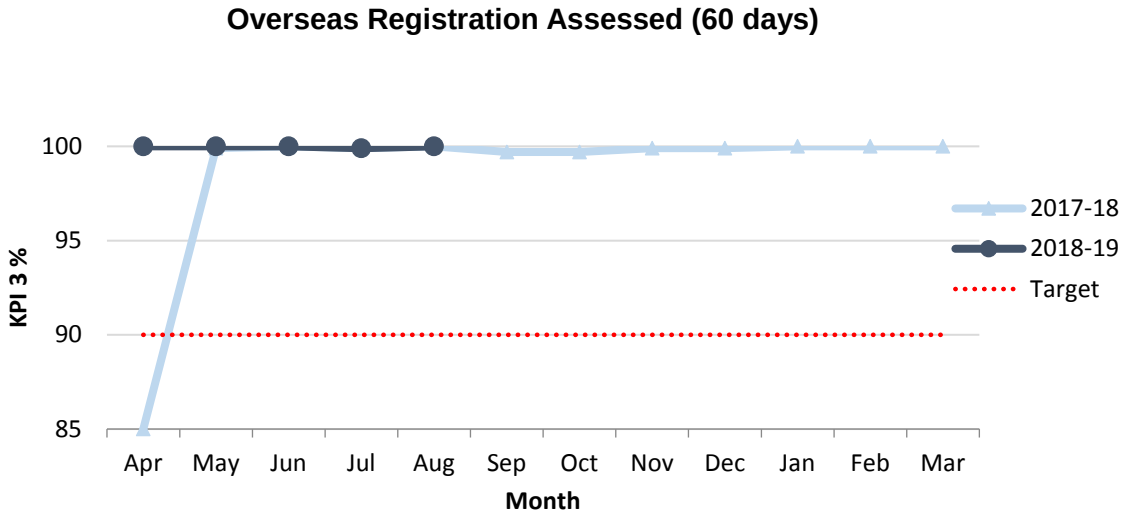
- Strong performance continues. Each month of 2018-2019 has exceeded target.
- Compared to the same period last year our trend has remained above target and flatter compared to 2018-2019.



KPI 3: Percentage of EU/Overseas registration applications assessed within 60 days. **Target:** 90%	**Green**

Result:

- Strong performance continues. Each month of 2018-2019 has exceeded target.
- Compared to the same period last year our trend follows the same pattern as 2017-2018.



Progress against corporate KPIs	Current Status

Fitness to Practise

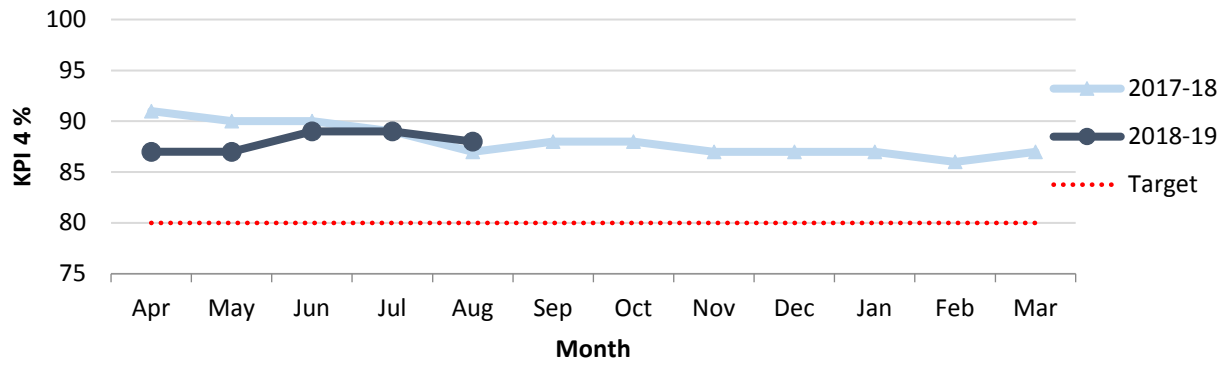
KPI 4: Percentage of interim orders (IOs) imposed within 28 days of opening the case (12-month rolling average). **Target:** 80%

Green

Result:

- Strong performance continues. Each month of 2018-2019 has exceeded target.

Orders within 28 days of opening case



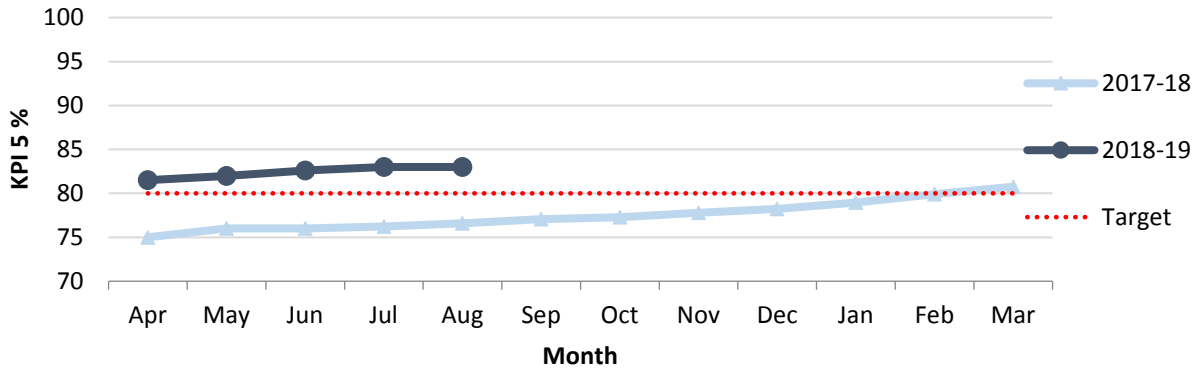
KPI 5: Percentage of FtP cases concluded within 15 months of being opened (12-month rolling average). **Target:** 80%

Green

Result:

- Strong performance continues. Each month of 2018-2019 has exceeded target.
- Compared to the same period last year our trend shows that have continued to maintain our position above target.

FtP Cases concluded within 15 months*



12 month rolling average

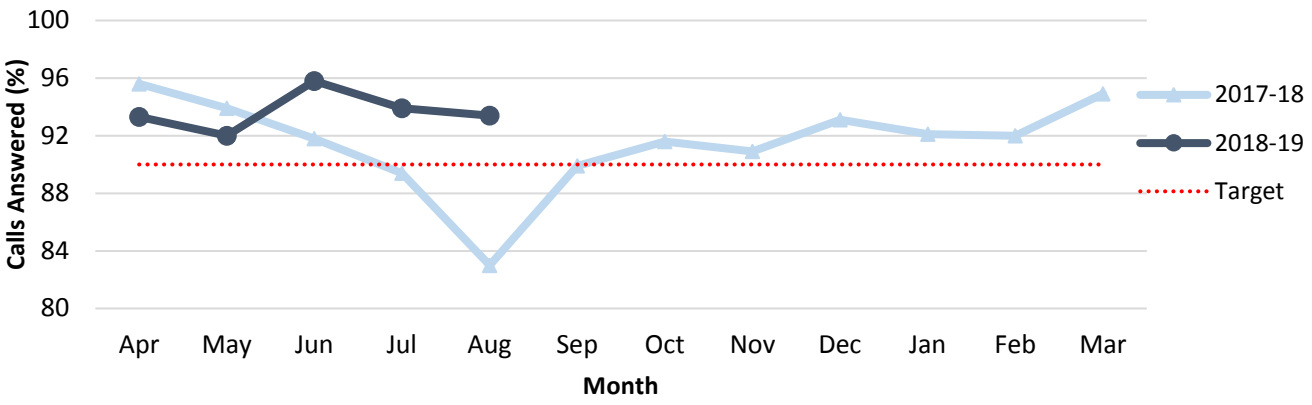
Section 3: Call centre

Registrations and Revalidation Service Measures	Current status
Measure: Call centre - % of calls answered. **Target:** 90%	**Green**

Result: 93.6% (YTD Average)

- Strong performance continues. Each month of 2018-2019 has exceeded target.
- Compared to the same period last year our trend shows a pattern of smaller dips during the summer months.
- The numbers of calls are in decline based on year on year comparison, with an average decline of 12%. This is positive as it is largely due to ongoing improvements to enable registrants to self-serve, reducing the overall number of calls we receive. Call duration has increased compared to the same period in 2017 by 8 seconds per call.

Registration Call Centre - calls answered



Section 4: People

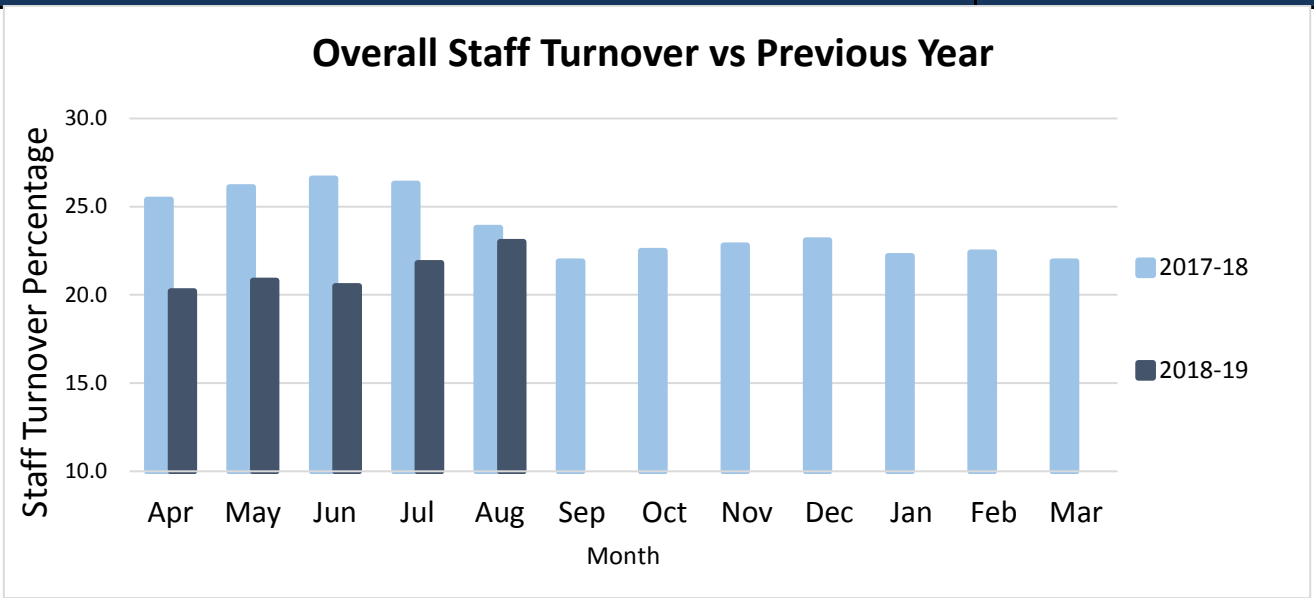
People Measures	

Measure 1: Overall staff turnover (12 month rolling). **Target:** Reduce

August 2018: 23.0%

- **YTD**: Turnover has been significantly lower than in 2017-2018, except for an increase in July and August.
- **Trend:** Compared to August 2017, turnover has decreased by 0.7%.

People Measures

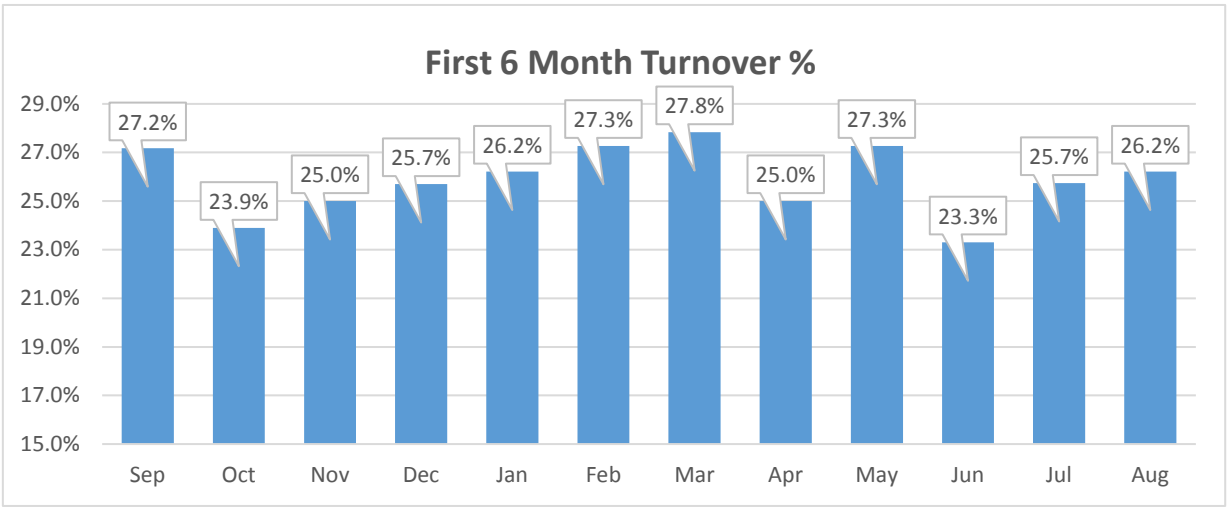


Measure 2: Staff turnover of leavers within 6 months of joining.
Target – reduce.

Results: 26.2% of new starters left within their first 6 months of service as at August 2018, up from 23.3% in June 2018.

It is too early to draw conclusions from the interventions taken by management as they take time to implement and bed in. Changes made include improving how we recruit and induct new joiners. We will monitor impact over the coming 6–12 months and outcomes should 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;



Section 5: Corporate Risks

This risk summary reflects events and changes to NMC's corporate risk register for the period of April to June 2018.

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
Risk 1: Risk that we fail maintain an accurate register of people who meet our standards	High impact, low likelihood ◀▶
In place: • Revalidation ensures the details of registrants are kept up to date and that their fitness to practice is confirmed. • 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, complaints, and assurance controls. **Planned:** • Data and systems work to improve robustness. • Review of Overseas registrations process via Overseas programme. • Updated guidance to Higher Education Institutions. • Modernisation of Technology Service programme to replace core systems. • Risk based Quality Assurance of education providers.	
Risk 2: Risk that we fail to take appropriate action to address a regulatory concern	High impact, low likelihood ◀▶
In place: • Existing FtP, Registrations and Education policies and processes. • Monitoring of FtP timeliness pathway. • New powers for case examiner disposals to manage cases more quickly and effectively. • Collaboration and data sharing with external stakeholders and partners. • Routine information sharing regarding processes and risk internally. **Planned:** • Investment on Lessons Learned programme to deliver PSA lessons learned recommendations. • Establishment of Public Support Service.	

Detailed Summary	Current Rating
• FtP change programme to deliver process and cost efficiencies. • Regulatory Intelligence Unit to continue developing trend analysis capability. • Process improvements between FtP and Registrations to ensure accuracy of the register.	
Risk 3: Risk that we fail to recruit and retain an adequately skilled and engaged workforce (permanent and temporary staff, contractors, and third parties)	High impact, probable likelihood ◀▶
In place: • Targeted recruitment and procurement of specialist advertising partner. • Creation of focused People Directorate. • HR policies, procedures and L&D. • Leadership development programme. • Annual staff engagement survey. • Updated appraisal format. • People strategy with three-year plan covering attraction, recruitment, retention and reward. **Planned:** • Continuous improvement of NMC employer brand to attract and retain staff. • Staff capacity improvement plan to relieve current capacity / capability pressure points. • HR policies review. • Pay envelope analysis to develop options for strengthening pay staff and reward. • Employee engagement action plan.	
Risk 4: Risk that we fail to prevent or recover from adverse infrastructure incidents, data loss, or legal and compliance breaches	High impact, possible likelihood ◀▶
In place: • Business Impact Assessments to understand resource requirements in the event of infrastructure incidents. • Training and desktop exercises. • Insurance cover for cyber security threats. • Technical controls. • Oversight provided by Information Governance and Security Board. • Information security risk register. • NMC policies and procedures. **Planned:** • Review of business continuity plan. • IT Infrastructure disaster recovery test. • Investment in addressing cyber vulnerabilities. • Improvement plan to resolve weaknesses in HR controls, contracting and procurement.	

Detailed Summary	Current Rating
Risk 5: Risk that we fail to meet expectations, influence key external stakeholders or respond to changes in the external environment	High impact, probable likelihood ◀▶
In place: • Investment in External Affairs directorate to focus on managing external stakeholders. • NMC Chair role increased to deliver more focused external stakeholder activities. • Brexit working group. • CEO leads on major external changes. **Planned:** • Annual review of organisational design and governance structures. • Strategy refresh led by NMC chair. • Lessons Learned programme to deliver PSA lessons learned recommendations.	
Risk 6: 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 ◀▶
In place: • Management plan for systems failures. • External review of failures and updated escalation plan. • Penetration and vulnerability testing. **Planned:** • Investment plan to resolve cyber risks. • IT infrastructure disaster recovery test. • Full penetration testing. • Modernisation of Technology Services. • Plan to improve cyber and other vulnerabilities.	
Risk 7: Risk that we fail to deliver our corporate plan and commitments leading to reputational damage	Medium impact, possible likelihood ◀▶
In place: • Budgets, establishment control, contingency fund, financial business partnering. • Corporate KPIs with clear target expectations. • Bi-monthly performance and financial monitoring at Council. • Corporate oversight via Portfolio Management Office. • Continuous Improvement projects identified. • Procurement improvement plan. • Recruitment of interim CEO and interim Director of Resources.	

Detailed Summary	Current Rating

Planned:

- Maturing financial business partnering function to provide more challenge.
- Improved performance monitoring, linking financial and non-financial reporting.
- Strengthening benefit definition and monitoring within strategic programmes.
- Corporate CI training across the organisation.
- Risk oversight and improvement work.

Section 6: Operational Performance

Fitness to Practise

Performance Summary

1. At the start of July 2018, our overall caseload was 3,139. In the two months to the end of August, overall caseload has decreased to 3,054 (2.7%).

2. Screening caseload increased to 753 during the first quarter. In the two months to the end of August, it has decreased to 674 (10%) and is now back on track. Case examiner and adjudication caseloads remain on track.

3. We have reported on low output at investigations previously. It remains an issue, and the investigations caseload has increased and is currently at 1,795. As previously reported, we are working with external advisers to improve performance, focusing on three areas: getting the early stages of the investigation right; improving employee skills mix; improving retention. We have put in place three initiatives to further support the teams:

    - Sending more cases for investigation by external firms
    - Setting up a new team to focus on completing older cases
    - Training colleagues in other parts of the directorate so they can assist with completing investigations

4. Although we expect to start seeing improvements in output in quarter three, there are likely to be more cases than planned in the investigations caseload at the end of the year.

Notes on the FtP dashboard (following page)

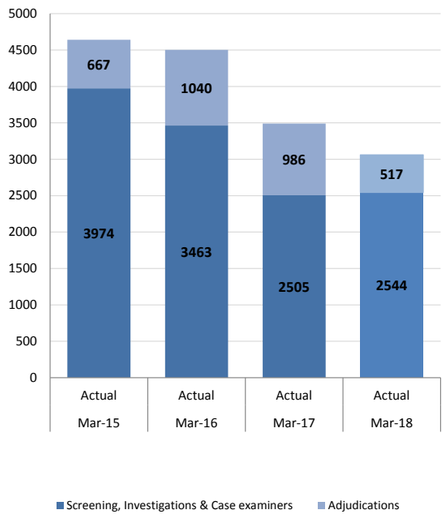
1. Graph A1 shows the historical caseload data for comparison. Caseload has reduced significantly over the last three years.

2. Graph A2 shows the caseload forecast for 2018–2019. We expect the caseload to be broadly stable during the year.

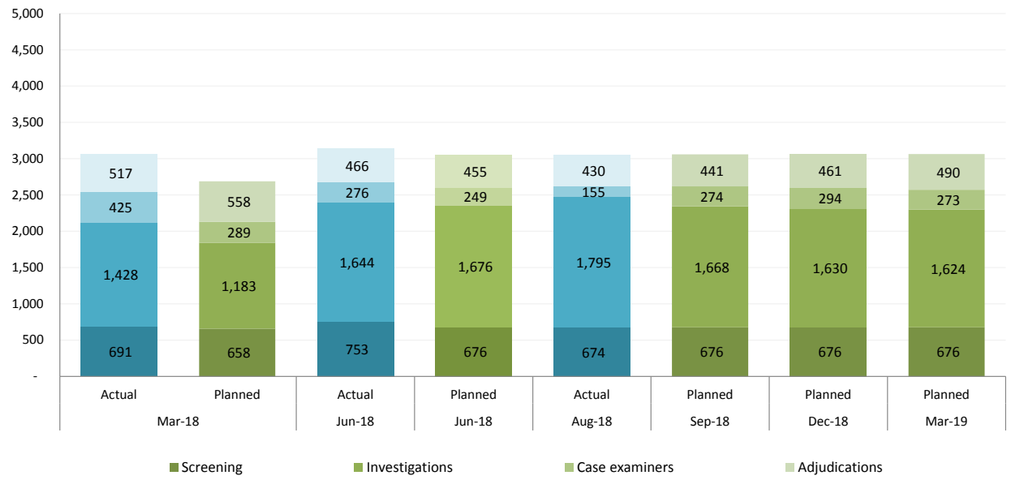
Performance Summary
3. Graph A3 shows the referral rate, which remains slightly under our maximum capacity of 500 referrals / month. 4. Graphs B1 to B3 show the median ages of cases in the caseload and at the key decision points. 5. Graphs C1, C2, C3, and C4 reflect the ages of the cases at each stage 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. Achieving the timeliness pathway is largely dependent on improving output at the investigation stage.

FtP performance dashboard August 2018

A1 Historic caseload

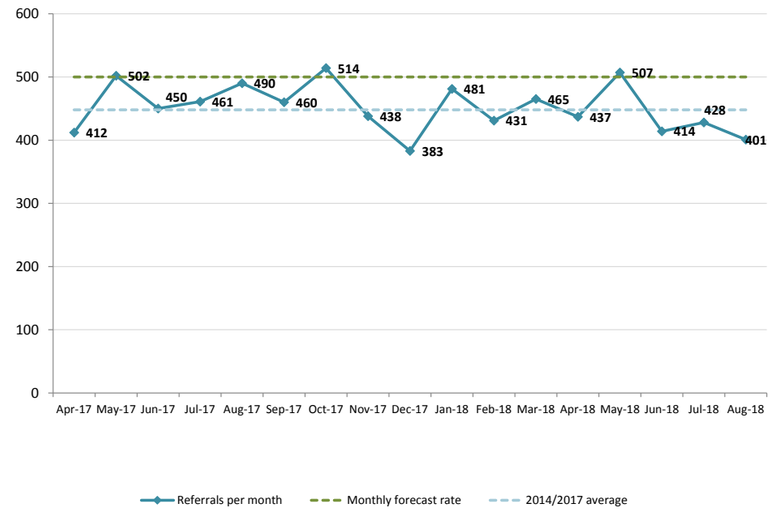


A2 FtP caseload

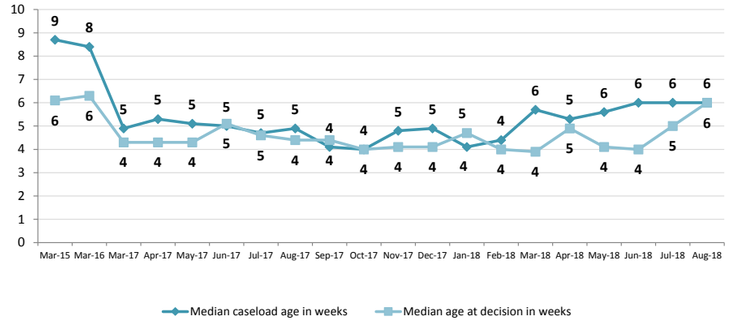


Note: The Case Examiner and Investigation caseloads have been realigned to better reflect the operational handover point between the two case stages. Case Examiners has decreased and Investigations has increased when compared to prior year reports.

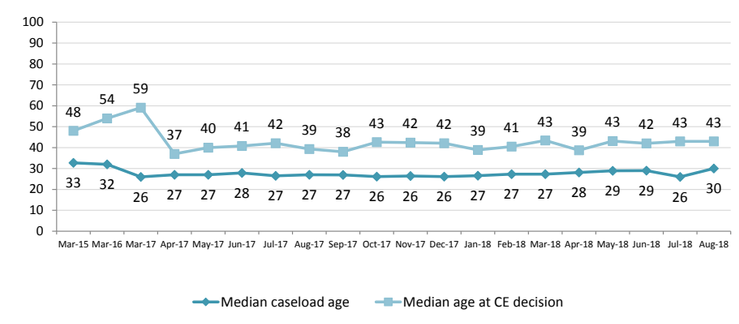
A3 New referrals



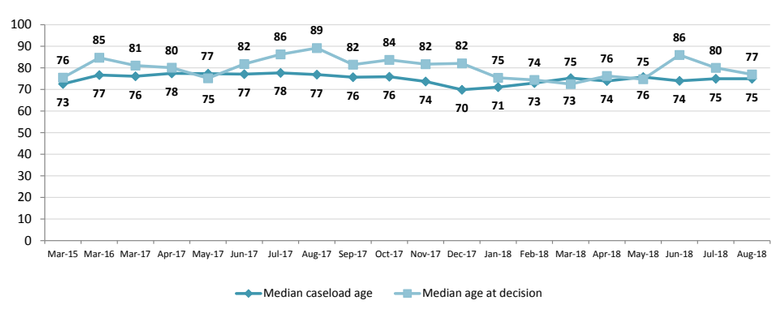
B1 Median age at Screening



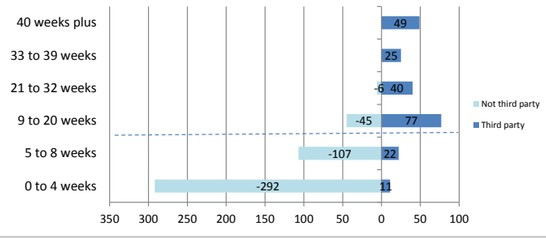
B2 Median age at Investigations and Case Examiners



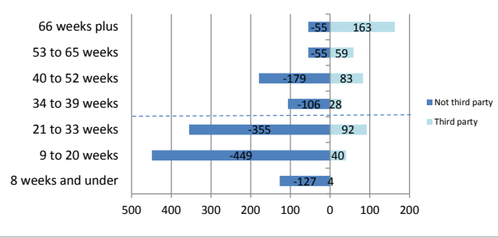
B3 Median age at Adjudications



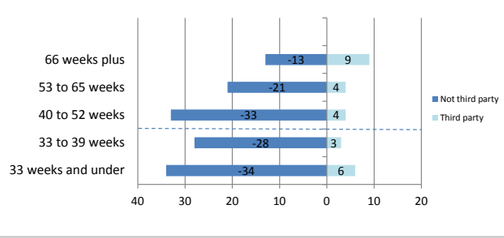
C1 Screening caseload



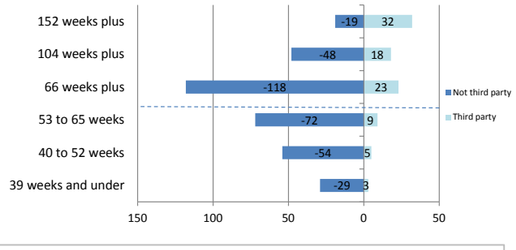
C2 Investigations caseload



C3 Case Examiner caseload



C4 Adjudication caseload



Caseload Movement Summary June 2018

Opening caseload 3,151	401 cases received	479 cases closed	3,054 Closing caseload

Glossary

A. Performance Traffic Light Definitions

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)

	Income	Expenditure	Actions
Red	2% or more below budget	• 2% or more over budget • 10% or more under budget	• 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	• 1-2% over budget • 5-10% under budget	• 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	• Less than 5% under budget	No action

C. Corporate Risk Traffic Light Definitions

(Applies to section 5)

Red	• High likelihood with high impact
Amber	• Medium to low likelihood but high impact • High likelihood but moderate to minor impact
Green	• Low likelihood but moderate to minor impact • High likelihood but minor to insignificant impact

D. Programme Traffic Light Definitions

Red	Progress between 1% - 49% against milestones or benefits

Amber	Progress between 50% - 79% against milestones or benefits
Green	Progress between 80% - 100% against milestones or benefits

Additional Reports

1. Fitness to Practise strategic direction update

1 Following Council approval in July 2018, we have published the new strategic direction for fitness to practise. Updated guidance for colleagues and panel members was launched on 31 August 2018, incorporating the strategic policy principles. The updated guidance includes the new approach to resolving cases at meetings rather than hearings unless there is a material dispute.

2 In September and October 2018, we start piloting operational improvements in the following key areas:

2.1 Better information and support for the public – we are piloting personal calls to people who raise concerns with us about a nurse or a midwife.

2.2 Closer working with employers – we are piloting co-produced information to support employers in deciding when and how to refer something to us.

2.3 Taking account of context – we are piloting a tool for assessing the context in which incidents occur, which has been developed for us by external advisers, working with stakeholders.

3 Enabling nurses and midwives to remediate – we are piloting tailored advice for nurses, midwives, and their employers about steps they can take to make sure that things that went wrong do not happen again.

3.1 Making best use of hearings – we are piloting 'statements of case' on cases that are referred for adjudication, which will set out in detail our position on the case and the expected outcome and will provide a basis for narrowing down areas of material dispute.

4 The pilots are planned to run for six months. Once we have evaluated the outcomes, we will plan full implementation from 2019–2020.

5 On 10 September 2018, we introduced an online form for referrals from members of the public. We will be doing the same for employers later in this financial year.

6 A Continuous Improvement strategy and plan for FtP are in place. Staff have been trained and have started the work on the following initiatives (with key deliverable due dates):

6.1 Effective completion of listed hearings: November 2018.

6.2 Improved management of physical case material: December 2018.

6.3 Publishing Voluntary Removal application decisions with reasons: February 2019.

7 The strategic change programme is currently within budget.

2. Review of the impact of the legislative (section 60) changes introduced in 2017

1 In March and July 2017, we successfully introduced significant changes to our legislation. We have now assessed the impact of these changes after one full year of operation.

2 Set out below is our assessment of the three changes which had the most operational impact. They were:

2.1 Removal of statutory supervision of midwives.

2.2 New Case Examiner powers.

2.3 Reducing the frequency of mandatory reviews of interim orders.

3 We also introduced other changes to modernise and simplify our processes:

3.1 Replacing the Health Committee and the Conduct and Competence Committee with a single Fitness to Practise Committee.

3.2 New discretionary powers for panels to review orders in some cases.

3.3 Removing the requirement to hold hearings in the country of the midwife or nurse's registered address.

3.4 New powers for the Courts to vary interim orders.

4 These changes have been successfully implemented. There are no particular issues to draw to the Council's attention. We will continue to monitor their operation through our normal quality management and assurance processes.

Statutory supervision of midwives

5 In March 2017, statutory supervision of midwives was taken out of our legislation to remove the conflict between the professional and regulatory aspects of supervision. This placed regulation of midwives on the same footing as nurses.

6 During the transition period we worked with stakeholders to ensure employers were well placed to handle concerns about midwives directly.

7 Our data shows that, in the 17 months from April 2017 to July 2018, there has been:

7.1 No change in the referral rate.

7.2 No material change in the Screening closure rate.

8 There does not appear to have been any impact on referrals about midwives reaching us, or on how we deal with them at the early stages of our process.

9 Our experience is that midwifery cases raise more complex clinical issues. For that reason, all midwifery cases are initially assessed by our high profile and complex cases team and assigned to senior investigators with access to clinical advice and expertise.

Case Examiner powers

10 In July 2017, we introduced new powers for Case Examiners to agree undertakings and to issue warnings and advice, in addition to their powers to refer cases for adjudication or to close them with no regulatory action.

11 Case Examiners and investigators were comprehensively trained on the new powers prior to implementation. We also made operational changes to be more open with nurses and midwives from the outset about the regulatory concerns we are investigating and to encourage greater engagement throughout the investigation.

12 Case Examiners are successfully exercising the new powers as a matter of routine. We introduced enhanced quality assurance following the introduction of the new powers, which have not identified any substantive issues with the quality of decision-making. In the first year of operation, we did not receive any requests for us to review the Case Examiners' use of the new powers.

13 Table 1 below compares our planning assumptions with the actual decisions taken by Case Examiners in the period August 2017 to July 2018.

Table 1

Case Examiner decision	Planning assumption proportion of decisions	Actual proportion of decisions
Refer for adjudication	42%	34%
Undertakings offered	5%	3%
Warnings issued	11%	6%
Advice issued	6%	1%
No further action	36%	55%

14 Of particular note is the increase in the proportion of no further action findings. We conducted a sample audit of cases considered by the Case Examiners before and after the new powers were introduced. The findings demonstrate better engagement with registrants and more evidence of effective remediation being presented to the Case Examiners. As a result, more cases are being closed on the basis that there is no longer a significant risk that the registrant's fitness to practise is currently impaired.

15 The reduction in hearings and associated costs was expected to lead to an expected cost saving of approximately £1.7M between July 2017 and July 2018. We calculate that we actually saved over £2M during the period.

Frequency of interim order review hearings

16 The mandated time limit for hearings to review interim orders was extended from three to six months. Early reviews of interim orders can still be arranged at the registrant's request or where new evidence comes to light which means that the order may need to be varied. The change has been successfully implemented and we have not identified any operational issues.

17 This change has lessened the burden on nurses and midwives and delivered a reduction in costs. We expected a cost saving of £0.9M in year from April 2017 and July 2018. We have calculated the actual saving to be closer to £1.2M.

Item 19: **Annexe 3**
NMC/18/91
26 September 2018

The Nursing and Midwifery Council's response to the Professional Standards Authority's consultation on 'A review of the Standards of Good Regulation'

About us

1 We exist to protect the public by regulating nurses and midwives in the UK. We do this by setting standards of education, training, practice and behaviour so that nurses and midwives can deliver high quality healthcare throughout their careers.

2 We maintain a register of nurses and midwives who meet these standards, and we have clear and transparent processes to investigate nurses and midwives who fall short of our standards. From 2019, we will also regulate the new profession of nursing associate.

3 We responded to the Professional Standards Authority's ('the Authority') consultation last year on potential changes to the Standards of Good Regulation (SoGR), and we welcome this further opportunity to comment on the proposed individual SoGR. Our response consists of two parts, an initial part where we outline our overarching views and rationale for these, and a second part where we provide our views on the individual SoGR.

Our views on the Standards of Good Regulation

Structure of the Standards of Good Regulation

4 We welcome the Authority's ambition of rationalising the SoGR, for these to be structured thematically, and for them to be flexible enough to allow for innovation while maintaining transparency and public protection (2.1 of the consultation document). Such an approach is helpful in principle as a number of our aims and approaches are shared across our regulatory functions. Therefore we agree with the assessment that the suggested approach could reduce duplication and potentially reduce the regulatory burden on professional regulators. We are concerned however that these aspirations have not been achieved with the final set of proposed Standards and that this is potentially a missed opportunity to make some fundamental changes to the new SoGR.

5 We also agree with the approach that the Principles of Good Regulation should form the basis for assessing performance and that such an approach would help foster consistency (1.6 of the consultation document).

6 We recognise that this is ambitious and would potentially be more difficult to assess than input based measurements designed around processes. To overcome this it would be helpful to consider and establish what the characteristics of good outcomes look like. In our view this would allow for a framework focused on maintaining public protection, flexible enough to allow professional regulators to be innovative and proactive, and which will foster further cooperation to identify and share best practice. Additionally, it would place professional regulators in a position

where they would be able to adjust and accommodate for situations arising from a changing healthcare landscape and future challenges and demands.

7 As highlighted in our response last year, studies into regulatory performance have demonstrated the advantage of measuring outcomes as opposed to inputs in determining and improving regulatory effectiveness.[1]Such an outcome focussed approach is not limited to the sphere of professional regulation and has already been accepted across the wider healthcare sector and beyond. We encourage the Authority to consider such an outcome focussed approach and how the SoGR can be deployed to promote best practice. This model has already been adopted across the UK, for example by the Care Quality Commission (CQC), the Financial Conduct Authority and the Scottish Care Inspectorate. We are working towards moving our own regulatory model to this outcomes measured approach.

8 Our overarching concern in this area is that we believe that the SoGR should be outcome focussed, be qualitative in scope, and assess the approach of professional regulators to maintaining public protection overall. We also believe standards should designed in such a way as to encourage learning from mistakes and facilitate sharing of best practice.

Our views on the General Standards

9 We have concerns about the general standards (Standard 1-5) to the extent that these are primarily about policies, processes and inputs. It is difficult to see how the Authority will be able to define what good performance looks like in each of these five areas and even more difficult to see how any assessment could be fair, objective and evidence based. We are also concerned that there is a significant degree of duplication between some of these new general standards and the function-specific standards which follow, for example the need to provide accurate and accessible information about our register, which appears in standards 1 and 10, and the new standard 3 about diversity which in our view should be an essential part of maintaining up to date regulatory standards addressed in standards 6-9.

10 We are therefore unpersuaded of the value of introducing the five new general standards and would be concerned that these will divert the focus of both the Authority and regulators from delivering our core regulatory functions.

11 Good governance is important to ensure healthy well-functioning organisations but it is not a regulatory function. Ensuring good governance is the business of each regulator's Council and they are directly accountable for this to Parliament and the public. In the case of the NMC, as a charity, we are also accountable to the Charity Commission and the Office of the Scottish Charity Regulator. As a matter of good governance we already undertake annual reviews of the effectiveness of our Council and abide by good corporate standards such as the Cabinet Office Code of Corporate Governance and the Charity Governance Code. We are additionally

[1] '*Measuring Regulatory Performance: evaluating the impact of regulation and regulatory policy*', Cary Coglianese, Organisation for Economic Co-operation and Development (OECD), Expert Paper No. 1, August 2012 - http://www.oecd.org/gov/regulatory-policy/1_coglianese%20web.pdf

subject to both internal and external audit and the Authority has oversight of Council appointments. We do not see the need or the added benefit that we or the public would gain from the Authority seeking to extend its activity in these areas.

12 We are concerned that reaching a fair assessment against each of these new general standards could require extensive scrutiny and review of almost every aspect of the work of each regulator's Council, plus involve additional documentation which could be disproportionate and out of step with right touch regulation. This would create a significant additional burden on regulators, as well as significant additional work for the Authority. This raises questions around how this would be funded and potential additional costs for regulators through the levy, the largest proportion of which is met by the NMC's registrants' fees.

Measurement and assessment

13 We welcome the Authority's ambition in rationalising the SoGR with the objective of making these less burdensome. As we have highlighted previously, we do not believe that the 'met/not met' approach is the most beneficial measurement.

14 We encourage the Authority to take into consideration the individual context in which the professional regulators operate. This includes difference and limitations in the legislative frameworks and requirements of the regulators, the regulatory powers of the regulators, the regulatory approaches taken by the regulators, and the availability of Department of Health and Social Care (DHSC) and parliamentary time and resources to address structural and other issues.

15 Additionally, we believe that a linear 'met/not met' decision based largely on quantitative process derived data is no longer appropriate. The healthcare environment is complex, fast paced, changing and diverse. The professional regulators therefore face different challenges and take necessarily diverse approaches for different reasons, aiming to achieve different objectives, measured against different sets of criteria.

16 Linked with this is that a number of the draft SoGR are wide in scope and include a number of elements. An example of this is draft SoGR 16 which currently reads: "The regulator ensures that all decisions are made in accordance with its processes, are proportionate, consistent and fair, take account of the statutory objectives, the regulator's standards and the relevant case law and prioritise patient and service user safety." A potential consequence of this approach is that it would be possible for a professional regulator to be considered to have met all but one of the elements of this SoGR, and would then be considered to have 'not met' the full SoGR. Even though an accompanying narrative section would be helpful and provide valuable context, this would in our view be a disproportionate outcome.

17 We encourage the Authority to consider adopting a CQC type of approach towards measurement and assessment. The approach adopted by the CQC in assessing health and social care services includes a more nuanced rating ranging across 'Outstanding, 'Good', 'Requires improvement' to 'Inadequate' and each rating is broken down into key questions and key lines of enquiry which creates an outcome

focussed approach depending on the sector being assessed.[2] This approach has proven effective as a flexible assessment framework but also provides consistency and allows the CQC to focus on areas that matter most. We feel the framework is easily understandable for the public highlighting what good care looks like and a useful tool for increasing the public voice and responding to their needs, along with being an effective tool for providing accountability and enabling improvement.

18 Such an outcomes focussed approach has also been embraced by other regulators across the UK, for example by the Scottish Care Inspectorate. In its role the Care Inspectorate assess registered care services in Scotland and look at a number of areas, including staffing and the management. Each area of the service is graded from 1 to 6 with 6 being excellent. The Care Inspectorate also has a focus on supporting improvement in care, including by providing guidance and sharing best practise.[3] Such an approach is aligned with the Scottish Government's 'Scottish Regulators' Strategic Code of Practice'.[4]

19 Adopting a similar approach would require the Authority to revisit how it engages with the professional regulators to gather information, focussing more on qualitative measurements and the impact of regulators' approaches, linked back to public protection. However, we feel the potential added value of this approach to public protection and effective oversight is significantly greater. This approach is also currently adopted by a number of commercial and public sector service providers such as the National Audit Office at a reasonable cost to public sector bodies. Typically, such approaches use existing material such as internal and external audits, and therefore we anticipate that it would be a cost effective approach which would not adversely affect the professional regulator levy.

20 In July 2018 our Council considered and discussed the Authority's Lessons Learned Review of the NMC's handling of concerns about midwives' fitness to practise at Furness General Hospital. In addition to this the Gosport Independent Inquiry Report was published in June 2018 and themes in that report resonate with the key findings in the Lessons Learned review. In response to the Lessons Learned Review we have adopted a programme of work to address the findings and to ensure that patients and families are at the heart of what we do. We will be reporting to Council and the Authority on an ongoing basis as we deliver our programme of work.

21 Going forwards we believe that more outcome focused SoGR, centred on transparency and good practice, would be helpful in supporting improvement - such as our response to the Lessons Learned Review - and supporting regulators to share best practice and maintain public protection.

22 We also believe that the Authority can play a greater role in encouraging shared learning and best practice between regulators by making information available which allows benchmarking of performance, and by facilitating shared learning outside of the annual reviews, for example supporting regulators more to raise issues and share best practice throughout the year. We are strongly in favour of such a proactive approach and believe this would help maintain public protection as it would

[2] https://www.cqc.org.uk/what-we-do/how-we-do-our-job/ratings
[3] http://www.careinspectorate.com/index.php/about-us
[4] https://www.gov.scot/resource/0046/00467429.pdf

allow regulators and the Authority to work in closer cooperation to identify potential issues and act in a timely manner. We have submitted detailed responses to the consultation questions.

NMC
September 2018

Item 21
NMC/18/93
26 September 2018

Council

Chair's action taken since the last meeting of the Council

Action:	For information.
Issue:	Reports action taken by the Chair of the Council since 25 July 2018 under delegated powers in accordance with Standing Orders. There has been one Chair's action for approval to appoint Robert Allan as a partner member of the Appointments Board from 1 October 2018 to 30 September 2021.
Core regulatory function:	Supporting functions.
Strategic priority:	Strategic priority 4: An effective organisation.
Decision required:	None.
Annexe:	The following annexe is attached to this report: • Annexe 1: Chair's action – Appointment of Robert Allan as a partner member of the Appointments Board from 1 October 2018 to 30 September 2021.
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.

Secretary: Fionnuala Gill
Phone: 020 7681 5842
fionnuala.gill@nmc-uk.org

Item 21: **Annexe 1**
NMC/18/93
26 September 2018

Chair's Action

Under NMC Standing Orders, the Chair of the Council has power to authorise action on minor, non-contentious or urgent matters falling under the authority of the Council (Scheme of Delegation, paragraph 4.6). Such actions shall be recorded in writing and passed to the Secretary who maintains a record of all authorisations made under this paragraph. The Chair is required to report in writing, for information, to each Council meeting the authorisations which have been made since the preceding Council meeting.

Each Chair's action must set out full details of the action that the Chair is requested to authorise on behalf of the Council.

Requested by:	**Date:**
Secretary to the Council	6 September 2018

Appointment to the Appointments Board

The Chair is asked to appoint Robert Allan as a partner member of the Appointments Board from 1 October 2018 to 30 September 2021 in accordance with section 4.2 of the Standing Orders.

The basis for the recommendation is set out in the supporting paper at Annexe 1.

Signed  (Chair)

Date 6 September 2018

Chair's Action: **Annexe 1**
07/2018
6 September 2018

Appointment to the Appointments Board

Action: For decision.

Issue: Appointment of a partner member to the Appointments Board.

Core regulatory function: Supporting functions.

Strategic priority: Strategic priority 4: An effective organisation.

Decision required: The Chair is asked to appoint Robert Allan as a partner member of the Appointments Board, as recommended by the Chair of the Selection Panel, from 1 October 2018 to 30 September 2021.

Annexes: The following annexe is attached to this paper:

Appendix 1: Candidate information and report from the Chair of the Selection Panel.

Not included for Council.

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

Author: Mary Anne Poxton
Phone: 020 7681 5440
maryanne.poxton@nmc-uk.org

Lorna Tinsley
Chair of the Selection Panel

Context:

1 The Council established the Appointments Board as a Discretionary Committee to assist the Council in connection with the exercise of any function or process relating to the appointment of Panel Members and Legal Assessors.

2 In accordance with Standing Orders, the Board comprises a Chair and four members, all of whom are lay, partner members. The Board currently has a vacancy following a recent resignation.

3 From December 2017 to February 2018, an open competitive recruitment process was undertaken to fill three vacancies on the Board. As part of that process, a further candidate was assessed as suitable for appointment and placed on a reserve list for 12 months to be considered should a future vacancy arise.

Four country factors:

4 Not applicable for this paper.

Discussion:

5 The candidate was contacted and it was confirmed that he had a continued interest in the role. A discussion was therefore arranged with the Chair of the original Selection Panel, Lorna Tinsley, to assess the candidate's continued suitability and availability to fulfil the role. The Chair of the Selection Panel has recommended the candidate be appointed.

6 The Secretariat has revisited and updated the conflicts of interest and due diligence checks undertaken at the time of the original process. No issues of concern have been identified.

Terms of Appointment

7 Appointment of partner members to Discretionary Committees of the Council is governed by section 4.2 of the Standing Orders.

8 The normative principle adopted by the Council is that appointments should be for a period of 3 years. The appointment will be effective from 1 October 2018 to 30 September 2021 with the possibility of reappointment for a further term, subject to satisfactory performance.

9 **Recommendation: The Chair is asked to appoint Robert Allan as a member of the Appointments Board, as recommended by the Chair of the Selection Panel, from 1 October 2018 to 30 September 2021.**

10 Subject to the recommendation being accepted, a formal appointment letter will be sent and induction arranged.

Public protection implications:	11	None.
Resource implications:	12	Allowances and expenses for partner members are provided for within the Governance budget.
Equality and diversity implications:	13	Efforts were made through the advertising process for the original recruitment campaign to attract as wide and diverse a pool of candidates as possible.
	14	All recommendations for appointment, or to be placed on the reserve list, were based on merit alone.
Stakeholder engagement:	15	Not applicable.
Risk implications:	16	None.
Legal implications:	17	The Chair has delegated authority to appoint Chairs and members of the committees under Annexe 1, section 4 of the Standing Orders.

Item 22
NMC/18/94
26 September 2018

Council

Council meeting dates 2019–2020

Action: For information.

Issue: Provides the Council meeting dates for 2019–2020.

Core regulatory function: Supporting functions.

Strategic priority: Strategic priority 4: An effective organisation.

Decision required: None.

Annexes: The following annexe is attached to this paper:

- Annexe 1: Council meeting dates 2019–2020.

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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Item 22: **Annexe 1**
NMC/18/94
26 September 2018

Council meeting dates

April 2019–March 2020

April 2019	Seminar	Tuesday 30 April
May 2019	Seminar	Tuesday 21 May
	Meetings	Wednesday 22 May
June 2019	Seminar	Tuesday 11 June
July 2019	Seminar	Tuesday 2 July
	Meetings	Wednesday 3 July
	Seminar	Wednesday 24 July
September 2019	Seminar	Tuesday 17 or 24 September (TBC)
	Meetings	Wednesday 18 or 25 September (TBC)
October 2019	Seminar	Tuesday 29 October
November 2019	Seminar	Tuesday 26 November
	Meetings	Wednesday 27 November
January 2020	Seminar	Tuesday 28 January
	Meetings	Wednesday 29 January
February 2020	Seminar	Tuesday 25 February
March 2020	Seminar	Tuesday 24 March
	Meetings	Wednesday 25 March