Nursing & Midwifery Council

Harry Cayton
Chief Executive
Professional Standards Authority for Health and Social Care
157-197 Buckingham Palace Road
London
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3 December 2012

Dear Harry,

I am pleased to enclose the NMC's submission to the annual performance review 2012-2013.

We hope the submission reflects the transformational change now underway to put the interests of patients and the public firmly at the forefront of all we do.

We recognise that there is a long way to go. But we believe that we can point to progress on two fronts:

- In beginning the substantial task of turning the NMC into a modern, efficient and effective regulator.
- In the protection we offer the public, through the improvements that are starting to be seen in fitness to practise, registration and education. We know we need to intensify our efforts to build on these promising foundations.

Much of our effort in the past year has had to be on getting the basics right. Firstly by refocusing on our statutory purpose of protecting the public and then starting to build the capacity and capability to do that.

This has meant some difficult decisions and recognition both for ourselves and some of our partners that our past efforts have at times been misdirected. The difference now is that we recognise our weaknesses and are either taking steps to address them or have a clear plan for how to put things right.

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Our substantial programme to bring about the necessary change identified by the Strategic Review in leadership, governance, culture and delivery is now well underway. We do not underestimate the scale of the challenge we face in making such wide-ranging and substantial changes across all aspects of our work. We agree with your expectation that it may take two to three years before the reality matches the vision we have set ourselves: to become a respected and high performing regulator which has the confidence of patients and the public.

The finishing line may be some way off, but some significant milestones have already been reached.

Together with our new Chair and leadership team, we are taking steps to transform the culture of the organisation into one where openness, integrity and learning are valued and where staff are empowered to deliver proportionate, patient focused regulation and high quality customer services. Changing longstanding behaviours does not happen overnight. But our new competency based approach to selection and appointment of staff represents a step in the right direction. We have also begun, with our professional stakeholders, to delineate more clearly our respective roles and responsibilities to help us all protect the public more effectively.

Council's recent decision to increase the registration fee and accept a grant from the Department of Health, mean we can start to rectify past underinvestment in both our fitness to practise function and critical infrastructure.

Nevertheless, the financial challenges remain significant. We need to focus relentlessly on ensuring we deliver our regulatory responsibilities in the most cost effective and efficient way. We are pleased that, as planned, we are on track to bring 80% of investigations in-house by the end of this year to both improve the quality of our investigations and secure efficiencies.

We have restructured the way we do business. In reducing from seven to four directorates, we can ensure that delivery of our front line regulatory functions is effectively resourced and enabled. The funding we have secured has supported a major recruitment drive to increase staffing levels within fitness to practise. This should start to bring down the unacceptably high caseloads about which you rightly expressed concern in the last performance review, concerns which Council shared.

It will also help us maintain momentum in speeding up investigations – we have seen a welcome 6 months sliced off average investigation times in recent months; progress cases to final outcomes more quickly by increasing significantly the number of hearings we hold each day and meet our target to clear our historic caseload, already halved, by autumn 2013.

The funding will help too, in supporting the much needed stabilisation of our outdated IT systems. In turn, that provides the platform for us to implement our longer term ICT strategy to help us do business more efficiently and move towards realising our ambition to increase on-line registration services.

Underpinning all of the above, are the steps we are taking to strengthen our governance, business planning and project management, including through ensuring that decisions are transparent, well-informed and evidence based. Council's ability to scrutinise and challenge performance has been enhanced by the development of tools such as the Balanced Scorecard. This is supported by the considerable efforts being made to improve the quality and use of management information at all levels and to learn from adverse events to drive continuous improvement and create a learning culture. We have now advertised for a senior manager to lead our quality assurance function in Corporate Governance with responsibility for quality assurance across the NMC and for managing risk.

The performance review process rightly focuses on how well we deliver our regulatory functions. Inevitably, the changes described above and the priority we must give to Fitness to Practise, has impacted on our capacity to progress other issues as quickly as we might like. For example, as I indicated in my evidence to the Health Committee recently, we have had to push back our plans to introduce revalidation. However, I am confident that we can get our systems in the right order and our standards at the right level to roll out the start of revalidation in 2015.

As you know, we have undertaken a considerable programme of work this year to reconcile the information on the Registration system (WISER) and the Fitness to Practise Case Management System (CMS). We were pleased that a recent external review found that the work has substantially addressed all historical discrepancies and that the current procedures give confidence that any future discrepancies will be dealt with efficiently and effectively. I will forward a copy of the final report once it has been seen by our Audit Committee.

I should also mention that, as indicated in our submission, we have identified some gaps in our registration processes and policies and are carrying out an urgent review, focusing initially on overseas applications.

Finally, we need to correct the data we submitted last year for cases concluded in 2011-2012. The figure we provided only reflected cases resulting in a sanction (650). The final number (including those where no impairment was found) was 753, as published in our Fitness to Practise Annual Report 2011-2012. We plan to undertake a thorough review of our fitness to practise data.

I am sure that in considering our progress this year the substantial effort we are investing in transforming the NMC into a regulator which deserves the respect and confidence of patients, the public and stakeholders will be given appropriate weight.

Yours sincerely

Jackie Smith
Chief Executive and Registrar

Enclosure

Evidence submission: Nursing and Midwifery Council

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Performance Review

Evidence Template

Introduction

1 Our fundamental purpose is to protect the public. To deliver that purpose we must focus all our efforts and resources on delivering our core regulatory functions.

2 Our aim is to continue to transform the NMC into a modern, economic, efficient and effective regulator which puts the interests of patients and the public first. We have developed and are implementing a substantial programme of change to achieve this over the next two to three years.

3 Our change programme is intended to help us improve all aspects of how we regulate nurses and midwives. It has been shaped by:

- 3.1 CHRE's strategic review findings and recommendations[1] .
- 3.2 CHRE's performance review findings[2] and the principles of right touch regulation[3].
- 3.3 Our corporate plan and priorities which have refocused our work on our core regulatory functions and other internal and external recommendations.
- 3.4 The need to address the substantial workload in Fitness to Practise arising from the significant increase in referrals experienced in the previous two years.
- 3.5 The financial challenges we face, including the need for a recovery plan to achieve a sustainable level of reserves[4].

4 As part of our change programme we have:

- 4.1 Strengthened our leadership with the appointment of a new Chair and substantive Chief Executive and Registrar.
- 4.2 Begun to stabilise our financial position. We:
  - 4.2.1 Rebased our budget using more robust and realistic assumptions of the anticipated workload and the requisite resources to achieve the improvements in our fitness to practise function needed to protect the public.
  - 4.2.2 Subjected our financial modelling and assumptions to external testing[5].
  - 4.2.3 Accepted a grant from the Department of Health (£20m) to support achievement of fitness to practise improvements and have increased our annual registration fee to £100 (from £76) with effect from 1 February 2013 for the next two years, subject to an annual review.

4.2.4 Co-opted a financial adviser onto Council.

4.3 Developed plans to address the significant risk posed by our current IT systems, in order to stabilise these in the short to medium term and realise our longer term ICT strategy. Council has allocated £2.542m in financial years 2012-2014 for the stabilisation plan.

4.4 Begun to strengthen governance by:

4.4.1 Improving the information available to Council on which to reach decisions and scrutinise performance including:

4.4.1.1 Monthly reports of the Chief Executive and Registrar on progress against our objectives.

4.4.1.2 A balanced scorecard of performance measures relating to delivery of our regulatory functions and complaints.

4.4.1.3 Progress reports on the change management programme delivery plan.

4.4.1.4 Detailed monthly Fitness to Practise performance reports.

4.4.1.5 More robust financial monitoring information.

4.4.1.6 Clearer and more focused articulation of the risks.

4.4.2 Increased Council oversight of financial management and fitness to practise, through two Council sub-groups tasked to scrutinise these areas on a monthly basis. In October, Council decided to reconstitute these groups as formal Council committees and to establish a further committee to provide oversight of Education[6].

4.4.3 Improved transparency and accountability by:

4.4.3.1 Ensuring that Council considers and decides issues in public except where confidentiality can be justified against stringent criteria.

4.4.3.2 Reinstating public questions at Council meetings.

4.4.3.3 Publishing our risk register which is subject to review by Council in open meetings.

4.4.4 Establishing a Directors Group to support the Chief Executive and Registrar in managing operational performance and exercising the decision making delegated by Council.

4.5 Reassessed all existing and planned work programmes:

4.5.1 Work streams not deemed essential to delivery of our core regulatory functions have been revised or discontinued.

4.5.2 Programmes which were not of pressing priority have been delayed or deferred.

4.5.3 Protecting the public is now central to our approach and the litmus test against which all current or proposed work is measured.

4.5.4 Begun to embed proportionality and right touch regulation across our work, for example in our approach to standards development and education quality assurance.

4.6 Restructured the organisation (reducing from seven to four directorates[7]) to focus on, and improve delivery of, our core regulatory functions and undertaken a major reorganisation within, and substantial recruitment to, Fitness to Practise. The restructure has inevitably impacted upon staff turnover levels and we recognise the journey to be travelled for the NMC to become an “employer of choice.”

4.7 Begun to tackle cultural and behavioural issues within the organisation, characterised by CHRE as "resigned resilience"[8], including through:

4.7.1 A process of reappointment of staff at all levels within the new structure. This has resulted in a healthy mixture of current staff and external recruits being appointed.

4.7.2 Introducing new behavioural competencies against which everyone can be assessed. These competencies have started to be used in recruitment and will be incorporated into the appraisal process in 2013.

4.7.3 Introducing "new ways of working" and the approval and implementation of a new Human Resources and Organisational Development strategy. A recognition scheme reinforcing the new behaviours has been rolled out and has had excellent take up.

4.7.4 A "pulse" survey of staff to measure current staff engagement is planned for January 2013 and the results will be acted upon.

4.7.5 Improving internal communications, leadership visibility and transparency. For example, through the Chief Executive’s Staff Forums, weekly Chief Executive walkabouts and weekly Director briefings to staff.

4.7.6 Staff have been involved in commenting on the HR and OD strategy and have done excellent work on helping revise the vision for the organisation.

4.8 Begun to:

4.8.1 Refocus on putting the patient and public interest at the heart of our work.

4.8.2 Clarify with key stakeholders, partners, nurses and midwives our respective roles and responsibilities in response to CHRE’s recommendations.

4.8.3 Develop an Engagement strategy which Council will consider in January 2013. This will make proposals for how we engage with all those with an interest in our work, including patients and the public and seek to develop ways of measuring the impact of that engagement.

4.9 Begun to apply accepted programme management principles in a systematic way to the range of programmes and projects which will be delivered under the umbrella of the wider change management programme.

5 It is against this backcloth of substantial change that progress on the performance issues identified by CHRE should be viewed.

Response to last year's performance review

- **What consideration have you given to issues raised in the previous year's performance review report including the adoption of any good practice identified in that report**?

6 Council considered the performance review report in July 2012 and approved plans to address the issues identified by CHRE as part of the wider change management programme described above (paragraph 4)[9] .

- **How have you addressed the areas for improvement identified in your individual performance review report?**

7 We are now clearly focused on our core purpose of protecting the public and on delivery of our core regulatory functions.

8 Our change management programme is designed to address:

8.1 CHRE strategic review recommendations including tackling the cultural changes needed to address the issues of "resigned resilience" and have a clearer dialogue with stakeholders on our role.

8.2 CHRE performance review recommendations.

8.3 Health Committee recommendations

8.4 Learning from other sources such as internal or external audit, serious event reviews, security incidents and complaints, as well as from other regulators.

9 The current position in relation to the specific concerns identified in the performance review is set out below. More detailed information on each is provided in response to the questions raised by CHRE in the relevant regulatory sections.

10 Registration: accuracy of the register.

10.1 We are satisfied that we are managing the weakness identified in our register resulting from the separate IT systems used for registration (WISER) and fitness to practise case management (CMS) and believe that all associated public protection issues have been addressed.

10.1.1 An extensive programme of work has been completed to reconcile all historical discrepancies identified between the WISER and CMS systems. We continue to run daily checks and fix discrepancies immediately.

10.1.2 Scrutiny of all corrective action is undertaken by a cross-directorate experts group.

10.1.3 A solution is being built into our proposed IT stabilisation plan, currently being finalised. This will also be addressed in our longer term IT strategy.

10.1.4 Standard operating procedures have been introduced in Fitness to Practise (FtP). Registration staff provide training to those FtP staff involved in updating the register with fitness to practise outcomes.

10.1.5 Clear governance has now been introduced to determine appropriate decision making at senior levels.

10.2 An internal quality assurance audit has been undertaken followed by an independent audit by the NMC's external auditors. The report of the external auditors found that the controls and processes we have put in place are adequate and are being followed by staff members[10].

11 Registration: publishing information about those suspended or struck off the register online.

11.1 We are on track to introduce this from January 2013.

11.1.1 Council took a decision in principle in January 2012 to make information about those who have been suspended or struck off accessible to those searching the online register. We consulted stakeholders during the summer on how to implement this in practical terms.

11.1.2 Implementation had to await completion of the work to reconcile the information held on our separate registration and fitness to practise systems (see paragraph 10.1 above).

11.1.3 Council considered the outcomes of the consultation in October 2012 and approved implementation from January 2013[11].

12 Fitness to practise.

12.1 We have:

12.1.1 Developed a draft Fitness to Practise strategy setting out our aims and objectives covering the period September 2012 to March 2015. This is now providing FtP staff with a clear picture of what they are aiming for and driving activity within Fitness to Practise.

12.1.2 Produced an improvement programme to deliver the draft strategy. As recommended by CHRE[12], this brings together in one place the multiple projects and initiatives already in train or planned to address the weaknesses in our fitness to practise functions.

12.1.3 Started to address the significant past underinvestment in our Fitness to practise function as recognised by CHRE[13]. Following the funding decisions described above (paragraph 4.2), we have been able to allocate additional resources to increase our fitness to practise activities. This includes being able to increase hearings activity and recruit substantial numbers of additional staff to support the increased levels of activity needed to deliver the FtP improvement programme.

12.1.4 Made substantial progress in tackling our historic caseload (that is cases received before January 2011). This has now been halved and we are on target to conclude all outstanding historic cases in autumn 2013.

12.1.5 Begun to see improvements in the three top priorities agreed with the Department of Health and CHRE in November 2011:

12.1.5.1 Improving the timeliness of case progression: we have reduced the time taken for investigations by some six months and for adjudications by some two months.

12.1.5.2 Improving the quality of customer service: we are now sending over 97% of decision letters out within 5 days.

12.1.5.3 Improving the quality and consistency of decision-making: we have seen this recognised in two recent appeals.

12.1.6 Strengthened oversight and scrutiny of progress through the work of the Council Fitness to Practise Action Plan Group. This has helped drive substantial improvements in the scope and quality of management data being produced to enable progress to be tracked and blockages in case progression to be identified and tackled.

12.1.7 Reported progress monthly to CHRE since January 2012. In August 2012, CHRE advised that reporting was only required on an exception basis in future.

13 Education: assuring continuing fitness to practise/revalidation.

13.1 In our evidence to the Health Committee[14], we advised that due to the wider challenges we face, that we would not now introduce revalidation before 2015.

13.2 Council considered a position report and proposed next steps in developing our revalidation strategy in November 2012.[15] As that report makes clear, we have continued to make progress but recognise that there is significant work still to do. Council is keen to ensure active oversight of this work going forward, including the development of a series of options for future consultation.

14 Public consultation.

14.1 We have responded to the criticisms made by CHRE last year and have adhered to Cabinet Office good practice guidance in all public consultation exercises undertaken this year. For example:

14.1.1 Our consultation on the introduction of fitness to practise case management tools and consensual disposal[16].

14.1.2 Our consultation on the proposed increase in fees[17].

14.2 Council will consider a proposed engagement strategy in January 2013. The strategy will embed the revised Cabinet Office good practice principles on consultation.

14.3 We have developed internal staff guidance on consultation which reflects good practice. For example, our use of "easy read" materials in consulting on our proposed equality objectives earlier this year[18].

- **Where has your performance improved since last year (in addition to the points raised above)?**

15 Our change programme is intended to deliver a step change in performance across all our regulatory functions.

16 We have:

16.1 Begun to ensure that our decision-making at all levels is informed by evidence that public and patient safety is safeguarded or enhanced by our actions.

16.2 Started to embed the principles of right touch regulation[19] in our approach to all existing and planned work.

16.3 Begun to revitalise our engagement with patients and the public to ensure that the patient voice is heard in every aspect of our work. Council discussed its approach in November 2012[20] and is clear about the importance of ensuring that we listen actively to patients and the public and that our work achieves measurable outcomes. Steps already taken include:

16.3.1 Setting up a new Patient and Public Engagement Forum in August 2012. The Forum comprises patient representative groups, advocacy organisations and health charities but is also open to interested members of the public. It meets quarterly and action points are captured for business planning processes. Progress is fed back to the group adopting a 'you said: we did' approach.

16.3.2 Introducing a new monthly public newsletter from the end of October 2012. We hope this will help raise public awareness of our work and what the public and patients can expect of us and the professions we regulate. We include a summary of our fitness to practise activity and the action we take to protect the public as well as updates on our work and details about events or consultations to encourage participation.

16.3.3 Making all the information and documentation we provide more accessible, for example by subjecting it to scrutiny by bodies such as the “Plain English Campaign.”

- **What areas for concern have you identified in each of the four functions and how have these been addressed?**

17 Although our performance in the registration function has improved significantly this year in terms of processing times and customer service we have identified gaps in some of our processes which may present a risk. As a result we are undertaking a review of registration policy and processes starting with the process for overseas applications.

18 We have continued to advocate for regulators to be allowed to check the language skills of EU nurses and midwives systematically. A good command of English is part of the essential skills required to provide good quality care. We have taken the opportunity presented by the current review of the EU Qualifications Directive[21] to raise this subject with EU and UK lawmakers.

19 In the meantime, we continue to engage with employers to highlight their responsibilities to ensure that their staff possess the necessary language skills to communicate with patients and other members of the care team. We have written to all employers reminding them of this and highlighted it in articles in our e-newsletters for employers. We are also exploring with the Department of Health the legality of requiring applicants to pass a test before gaining registration where we have serious doubts about their language proficiency.

- **What areas of good practice have you identified in each of the four functions?**

20 Enhancement of our ability to safeguard the public and patients through the significant improvements introduced in Screening to ensure that serious cases or those posing a risk to patient or public safety are expedited and the introduction of our case assessment tool to help us determine the urgency and complexity of cases.

21 Improvements in customer service delivered to registrants through the sustained focus being given to this in Registrations including our customer surveys and dissemination of feedback to staff to help encourage continuous improvements.

22 The quarterly monitoring of Local Supervising Authorities which has proved a useful early warning system and which is used on a risk based approach to follow up areas of potential concern.

Responding to change, learning and information

- **Where relevant, how has/will learning from the following five areas be/en taken into account in each of the functions:**
  - **other areas of your work (such as fitness to practise, policy development or quality assurance of educational institutions)**

23 We recognise that we can do more to capture information and learning systematically across the organisation to improve delivery of our core regulatory functions:

23.1 Our new Evidence and Research Team has a brief to develop a strategic evidence-led approach to our work including identifying learning and good practice from inside and outside the organisation. A key future focus will be work to make more effective use of the considerable data we hold to inform work across our regulatory functions. For example, using Fitness to Practise (FtP) data to inform future standards development or quality assurance work.

23.2 Our new ways of working include an emphasis on openness and sharing of relevant information across the organisation and joint and cross-functional working to deliver results. Concrete examples of this are:

23.2.1 The joint work by ICT, Registrations and FtP staff to resolve the register reconciliation issue (see paragraph 10 above). As a result all new FtP staff now receive induction and training from Registration staff.

23.2.2 The sharing internally of information and learning from extraordinary review activity between teams involved in midwifery supervision and education quality assurance, as well as external collaborative work with systems regulators.

23.2.3 Council's decision to explore the scope for a more joined-up approach to our quality assurance work (see paragraph 101 below) by testing the possibility of combining quality assurance provision for Local Supervising Authorities and education.

23.2.4 Developing, under the guidance of the Audit Committee, a coherent policy to capture and implement learning from serious event reviews, security incidents, data breaches, freedom of information requests and organisational complaints and compliments.

- **organisational complaints**

24 We introduced a new corporate complaints process from April 2012. The new process was a refinement of our previous approach and we now have a single route - the Chief Executive's Office -for all complaints received across the organisation.

25 This has improved customer service by:

25.1 Providing a single contact point for complaints. Information on complaints is now centrally logged and the Chief Executive and director team are sighted on all complaints received by the organisation.

25.2 Enabling us to respond quickly when it is clear that something is going wrong. For example, following an increase in complaints from registrants they had not received registration renewal packs, we identified that the problem related to our postal service providers and acted promptly to resolve the situation.

25.3 Highlighting issues that require us to change our processes, policies or documentation. For example, feedback from registrants indicated confusion about the wording of parts of our Notification of Practice (NoP) forms. As a result of the feedback we amended the wording of the forms to clarify the documentation requested from registrants.

26 Council scrutinises performance in complaint handling closely including:

26.1 Monthly, through the Balanced Scorecard, which includes an assessment of the timeliness of our response to complaints.

26.2 Quarterly, on the number and nature of complaints received.

27 The Directors' Group also receives detailed management information about complaints on a monthly basis to enable emerging trends to be identified and acted upon. At these meetings, individual directors are asked to review all complaints where issues, or potential learning points, have been identified to consider the most appropriate course of action.

28 We continue to work on ensuring that learning from complaints is transferred throughout the organisation. This is being taken forward as part of the work requested by the Audit Committee referred to above (paragraph 23.2.4). We are also seeking to capture learning from positive feedback and have started to collect this more systematically so that good practice can be shared.

- **the outcomes of CHRE's/the Authority's work such as the cost efficiency and effectiveness review of health professional regulation project and the appointments to regulators' councils project**

29 Cost efficiency and effectiveness review.

29.1 We contributed to the CHRE's work and welcomed this as a step forward. Directors will be considering the report in detail later this year. The project has given useful impetus to work among the regulators to benchmark activities, practices and processes for example in Finance and Registration. We are actively participating in a number of such fora.

29.2 We are considering the findings of the report both in relation to the NMC and other regulators. The report's currency has been affected by the significant changes to our income and internal resource allocation compared to the financial year used in the review (2010-2011).

30 Appointment of Council members.

30.1 We contributed to CHRE's consultation on its proposals.

30.2 The NMC Council will be reconstituted on 1 May 2013[22]. Our proposed process for appointing a reconstituted Council takes account of the principles and standards produced by CHRE[23].

30.3 We engaged early with CHRE in taking forward our process for appointments to ensure we properly understood the requirements for the selection process and to learn from CHRE's experience of piloting its arrangements with other regulators.

– **feedback from stakeholders from the four UK countries**

31 We recognise the importance of ensuring both that our regulatory approach is informed by the views and feedback of all those who have an interest in our work and that we demonstrate how we have taken account of those views in reaching decisions. We describe above (paragraph 16.3) our efforts to take account of feedback from patients, the public and service users. Our response here is therefore focused on how we take account of feedback from our professional stakeholders.

31.1 We have sought to reinvigorate our engagement with stakeholders, including the four Chief Nursing Officers, professional bodies and unions, NHS employers, educators, quality assurance reviewers, educational institutions and bodies such as Health Education England, Nursing Education Scotland and the Northern Ireland Practice and Education Council (NIPEC) and other key partners and organisations. The Chair has made building constructive relationships with stakeholders an early priority.

31.2 We have begun to work with stakeholders to clarify respective roles and responsibilities, as recommended by CHRE[24]. Our engagement with stakeholders over our plans to withdraw our professional advice service has been a useful starting point for working through these issues in practice (see paragraph 68 below).

31.3 As indicated (paragraph 4.8.3 above), we are developing an Engagement strategy which Council will consider in January 2013. This will help to define more clearly how views and feedback from stakeholders is used to inform our work. As a first step we now systematically capture and disseminate internally the outcomes and actions from the wide range of engagements which staff are involved in to ensure that this feeds into development of our work.

31.4 We seek to engage with nurses and midwives, employers and educators more widely through our regular e-newsletters and through social media. For example:

31.4.1 We hosted a panel discussion as part of Social Media Week in September 2012 on how healthcare regulators can better engage with patients and the public[25] and undertook a joint presentation with the Health and Care Professions Council on social media at the Scottish Government and UK health care regulators conference[26].

31.4.2 Directors have been interviewed on twitter.

31.4.3 The live tweeting of the October Council meeting which considered the proposed fee increase. This enabled registrants and others with a keen interest to stay in close touch with the discussions. Given the level of interest, we also tweeted the November Council meeting and look set to continue this practice.

31.5 We have followed through on Council's commitment to consider the issues and concerns raised by nurses and midwives regarding the fee rise and Council is considering proposals on how to build this into the annual review of the fees[27].

31.6 We continue to be represented at, and participate in, key conferences and events organised by stakeholders to gather feedback and information where this can demonstrably support delivery of our core regulatory functions. For example, we contributed to the recent annual conference organised by the Scottish Government in conjunction with professional healthcare regulators. As part of the conference we led two workshops, one jointly with HCPC on the impact of social media, and the other seeking views on our approach to revalidation. We also used the opportunity to meet with senior registrants and civil servants from the devolved administrations.

- **public policy programme reports from the four UK countries**

32 We continue to monitor policy initiatives across the four countries to identify the implications for nursing and midwifery relevant to our regulatory role and to respond to consultations as appropriate. For example, we have engaged with the Northern Ireland Practice and Education Council (NIPEC) to inform a recent review by the Northern Ireland government.

33 We are aware of the continuing divergence in policy and developments particularly around education and commissioning issues and are engaging closely with partners and stakeholders to ensure that we have a good understanding of the picture.

34 We are monitoring proposals around the inclusion in the Care and Support Bill of a possible duty on professional regulators to co-operate with Health Education England and Local Education Training Boards.

- **How have you addressed information, (other than formal fitness to practise complaints), which you may have received from other sources on possible failures in performance of organisations or individuals?**

35 Where we become aware of possible failures in performance from other sources, we:

35.1 Collate all relevant information held within the NMC, including from Education and Local Supervising Authority (LSA) quality assurance work, fitness to practise and registrations (such as information on lapsed registrations) and triangulate this to form a view on the risks presented to public safety and the commensurate level of response. This might be to monitor the situation, refocus activity already planned or take other appropriate action. As detailed above (paragraph 31), in relation to education or training issues we now use clear risk based criteria to determine our response.

35.2 Engage, where appropriate, with other regulators to share such information and ascertain whether joint regulatory action may be needed (see paragraph 39.3 below). A key aim for the future is to establish sound operational frameworks to exchange information appropriately with other professional and system regulators.

35.3 Continue to use our powers under Article 22(6) to open fitness to practise cases, where appropriate, in the absence of an external referral.

36 Jointly with the General Medical Council (GMC), we issued a statement in August 2012, reminding doctors and nurses of their professional values in response to a series of high profile examples of patients, particularly older people and those with learning disabilities, being neglected[28].

- **How have you responded to changes in regulation or forthcoming changes in regulation for example those imposed by the Health and Social Care Act 2012?**

37 We continue to engage with the Law Commissions as they develop their proposals on the future of health care regulation including through the health care regulators' Chief Executives' Steering Group.

38 We are engaging with the various new bodies in the reconfigured health care landscape resulting from the Health and Social Care Act 2012 both nationally and locally, such as Healthwatch England, Health Education England and Local Education Training Boards. We are engaging with the UK Public Health Register (UKPHR), the Health Visitors Professional Group and the Public Health Workforce Advisory Group (Regulation) along with other health regulators.

Liaison with other bodies

- **How have you worked with service regulators, other regulatory bodies or other bodies with shared interests to:**
  - **ensure that relevant intelligence is shared (within legislative requirements) on individuals or organisations**

39 We have systems in place to share issues and concerns with other regulators:

39.1 We notify the Care Quality Commission (CQC) of all cases where we discover a nurse or midwife has continued to work with lapsed registration. We have recently taken steps to ensure that where this comes to light in a fitness to practise case (rather than registration renewal), we will similarly notify CQC.

39.2 We refer concerns raised with us but which are not within our remit directly to the CQC or another regulatory body where appropriate.

39.3 We engage with CQC, Monitor and other relevant authorities, as appropriate. We participate in risk summits called where concerns or failings have been identified in relation to a care setting to determine the further scrutiny and/or action or support required to tackle the issues either by individual regulators or jointly. Our work in relation to University Hospitals Morecambe Bay NHS Foundation Trust is an example[29].

40 We are represented on the National Quality Board and are contributing to the current exercise to identify information which should be shared with Quality Surveillance Groups.

41 We are already identifying the learning which has already emerged during the course of the Mid Staffordshire NHS Foundation Trust Inquiry. Council was updated in September 2012 on the action we had already taken and our preparations for publication of the report. A key focus of the Francis Inquiry has been around failures of communication between regulators in relation to care settings where there is cause for concern. We have initiated joint work with other regulators to tackle these issues (see paragraph 42 below).

- **ensure that cross regulatory learning is shared?**

42 In September 2012, the NMC convened a meeting on partnership working with the GMC and the CQC to share thinking and identify improvements to information sharing. Further meetings of this partnership forum are planned and potential areas for future working include: induction and training; information sharing; development of a shared vision of good practice and relationships with the wider inter-regulatory group.

43 In addition to regular bilateral engagement across all levels and functions with other healthcare regulators such as the GMC, Health and Care Professions Council and General Dental Council, we continue to participate in a range of cross-regulatory fora and networks to ensure learning is shared and good practice disseminated including:

43.1 The Health Professional Regulators' Learning Circle on Patient and Public Engagement. This has helped inform our approach to our own reinvigorated Patient Engagement Forum. We have also shared our work with the GMC who are currently looking at how to involve patients in their new governance structures.

43.2 Registration benchmarking group - this helped to develop our thinking on the development of improved management information for registrations (see paragraph 145.2 below).

43.3 Registration customer service network.

43.4 Revalidation inter-regulatory group

43.5 Education inter-regulatory group.

Guidance and standards

First standard	Standards of competence and conduct reflect up-to-date practice and legislation. They prioritise patient and service user safety and patient and service user centred care.
Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 44 As described above (Overview, paragraphs 2 to 5), the NMC is embarked on a considerable programme of change designed to deliver improvements in delivery of all our regulatory functions. This includes putting patients and the service users at the heart of our work including in our work to develop and maintain guidance and standards. Our new Public and Patient Engagement Forum (see paragraph 16.3.1 above) will be one of the key channels we will use to help us achieve this. 45 A key output of our change programme, has been the reorganisation of how we deliver our work. We have now combined all our core regulatory functions, except for fitness to practise, within a single directorate to help development of a joined up and seamless approach to our regulatory work. The directorate's work includes: 45.1 Standards and guidance. 45.2 Education and training. 45.3 Registration. 46 We are developing a Registration and Standards strategy for 2013 to 2015 to set out our aims and objectives for our work in this areas and what success will look like. The strategy will inform our business planning for 2013-2015 and will be considered by Council in January 2013, alongside those for our Fitness to Practise and supporting functions. In relation to our work on Standards and Guidance, we anticipate that the strategy will include a focus on: 46.1 Developing agreed definitions and purposes for regulatory standards. 46.2 Ensuring standards are developed consistently using a clear methodology for standards development and evaluation. 46.3 Establishing clear priorities for standards developments and evaluation. 47 Our work on Guidance and Standards has been particularly affected by the wider context described above. As part of the refocusing of our work on our core regulatory functions, we undertook a comprehensive reassessment of our work in line with our corporate objectives (see paragraph 4.5 above) which resulted in various work programmes being paused, reconfigured or stopped completely. 48 Through this exercise, we identified a need to re-evaluate our approach to the development of policy, standards and guidance to make patient and public protection central to our approach and to reflect 'right touch' principles. 49 We have continued to build on our quarterly monitoring process for Local Supervising Authorities introduced in 2011-2012 and this

continues to provide a useful and timely way of ensuring we are alert to developments on the ground which may affect the health and well-being of women and their babies.

b) What progress has been made on:

- **The publication of the revised *Midwife Rules and Standards*?**

50 Council made the Midwives Rules in September 2012[30] and approved the new Standards and Guidance which underpin the rules in October 2012[31]. It is expected that the rules will be laid in Parliament shortly to come into force in early 2013.

51 In finalising the new Midwives Rules, Standards and Guidance, we have ensured that they focus more explicitly on our regulatory role and reflect the principles of 'right touch' regulation, as well as taking account of the responses received to the two major public consultations previously conducted and the views of our Midwifery Committee. In particular, the new Rules and Standards seek to reduce the regulatory burden and achieve a more proportionate, public centred approach.

52 We will:

52.1 Publish the new Midwives Rules, Standards and Guidance on our website.

52.2 Send notification to each registered midwife with the annual notice of intention to practise form in December 2012.

52.3 Disseminate the new rules and standards to stakeholders (by email) and through events and other communication channels.

c) What plans are in place, if any, to improve your performance in this area?

53 Our developing vision for the NMC puts protection of the public at the heart of everything we do going forward and seeks to reflect the standards of good regulation and 'right touch' principles. This will inform the development of our corporate plan for 2013-2016 and supporting strategies, including our future approach to policy formulation and the development of standards and guidance.

54 We have:

54.1 Identified lessons to be taken forward in any future development work[32].

54.2 Produced a clear rationale and methodology to inform our future approach[33].

54.3 Begun to explore how we can undertake impact assessments as part of our policy and standards development, in order to ensure that we are clear about the regulatory outcomes we are seeking to achieve. This would incorporate and enhance the equality impact assessments which we already undertake.

d) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)?

	55 The supporting material for the content of the final Midwives Rules, Standards and Guidance represents a cohesive, methodological approach to evidence gathering including through the extensive stakeholder and consultation activities we conducted[34].
Second standard	Additional guidance helps registrants to apply the regulators' standards of competence and conduct to specialist or specific issues including addressing diverse needs arising from patient and service user centered care.
Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 56 We have: 56.1 Completed a risk-rating review of all advice and circulars to rationalise these. The next step is to ensure that they reflect our core regulatory functions and to remove material which goes beyond this. 56.2 Refreshed and updated the relevant sections of our website to ensure that it contains only current material relevant to nursing and/or midwifery practice. 56.3 Created a new "regulation in practice" area on our website to help nurses and midwives apply their professional judgement, putting regulatory principles into practice[35]. **b) What plans are in place, if any, to improve your performance in this area?** 57 We continue to maintain and update information as appropriate, for example, we have updated the website section on Medicines management and prescribing to reflect the Human Medicines Regulations 2012. **c) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)?** 58 The major challenge for NMC, as for other regulators, is evaluating the impact of standards in terms of influencing behaviour and actions on the ground. We have engaged with interest in the work which CHRE is taking forward on this as well as engaging with other regulators about their work in this area.
Third standard	In development and revision of guidance and standards, the regulator takes account of stakeholders' views and experiences, external events, developments in the four countries European and international regulation and learning from other areas of its work.
Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 59 We remain committed to taking account of both the views of stakeholders and wider developments across the four countries and internationally in all aspects of our work. However, we consider that we need to be more proactive in ensuring that we give appropriate priority to the views of patients, service users and the public. Our developing engagement strategy (see paragraph 4.8.3 above) seeks to address this.

	60 As indicated (paragraph 23.1 above) we have established a research and evidence team which, amongst other things is tasked to ensure that we take account of learning both from within the NMC and from other regulators. Amongst other things, the team will be 60.1 Looking at how other regulators use evidence to inform the development of policy, standards and guidance, including the scope for collaborative working. 60.2 Reinvigorating our efforts to ensure that we make effective use of the data we hold, including in relation to fitness to practise, to inform the evidence base which supports not just development of guidance and standards but our wider work. 60.3 Analysing the considerable breadth of comments and contributions prompted by our consultations on the proposed fee rise. **b) What progress has been made on:** • **The comprehensive review of the impact of the NMC's guidance and standards, their content and the way in which they are developed, maintained and evaluated?** 61 Council considered proposals for this review in February and March this year (see paragraph 54 above). Due to the wider pressures already described this work is not likely to be progressed until 2013. **c) How does the Council of the regulator assure itself that revised or newly developed guidance and standards prepared by the executive have been informed by various views, external developments and learning from other areas of its work? (only respond to this question if it is different from last year)** 62 As described last year (paragraphs 180-181, NMC submission 2011-2012) Council would expect to see evidence of how account has been taken of learning from elsewhere, the views of stakeholders and others and any other relevant criteria when considering these issues. Our consultation on the Midwives Rules and Standards is a case in point (see paragraph 55 above). **d) What plans are in place, if any, to improve your performance in this area?** 63 We are beginning an exercise to prioritise future work to review and develop standards, in accordance with our proposed strategy (see paragraph 46 above). Priorities are expected to include revalidation and we will shortly be seeking to recruit staff to take forward work on the programme. **e) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)?** 64 No additional comments.
Fourth standard	The standards and guidance are published in accessible formats. Registrants, potential registrants, employers, patients, service users and members of the public are able to find the standards and guidance published by the regulator and can find out about the action that can be

	taken if the standards and guidance are not followed.
Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 65 Like other public sector organisations and in line with Government guidance, we have moved to 'digital by default', that is making material primarily available on line. This will be part of our developing engagement strategy going forward. 66 As indicated above, our reinvigorated engagement strategy includes a commitment to achieving 'Plain English' and similar standards. 67 We have given our public support to two initiatives designed to support nurses and midwives to raise concerns about failings in the level of care delivered to patients or service users: 67.1 We have signed the NHS Employers "Speaking up Charter", to encourage and support staff to raise concerns with confidence. 67.2 Jointly with the Royal College of Nursing (RCN), British Medical Association, GMC and CQC, we have agreed principles of understanding relating to Whistleblowing and continue to keep the Health Committee apprise of our joint work on this issue.[36] **b) What progress has been made on:** • **Providing an information and signposting service on the NMC's website (which is in place of the establishment of a standards and ethics helpline)?** 68 This has been done. 68.1 In line with our statutory functions, we have redirected our efforts to focus on ensuring that nurses and midwives understand how regulation works in practice. We undertook a comprehensive review of all the information and revised and updated the material we make available through the nurses, midwives and education sections of our website[37]. A range of additional resources and materials are also available through these sections, including links to other organisations who can provide advice or other services for nurses and midwives. 68.2 As described above (paragraph 68), we determined that providing a professional advice service was not part of our core regulatory functions. On completion of the above work, we withdrew our professional advice service with effect from 1 July 2012. 68.3 Before doing so, we discussed our plans with the professional bodies and unions and welcomed their positive engagement with us throughout the process. We understand that the professional bodies and unions have not seen a significant increase in demand following closure of our advice service. However, we continue to engage with them to ensure that we understand any impact and implications for them. 69 This exercise has been a helpful step forward in beginning to delineate more clearly for nurses and midwives the respective roles and

	responsibilities of the NMC as regulator and of their professional and representative bodies. **c) What plans are in place, if any, to improve your performance in this area?** 70 As part of our patient and public engagement (see paragraph 16.3 above), we plan to review how we provide information about the standards that can be expected of nurses and midwives and what to do when these standards are not met. We will be involving our Patient and Public Engagement Forum in that review. **d) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)?** 71 The Independent Commission (Willis Commission) established by the RCN undertook an external and independent review of our pre-registration standards. The Commission supported the principle of degree level nursing educations and found no shortcomings in nursing education that could be directly responsible for poor standards of care or a decline in care standards.[38] The report made a number of useful recommendations and we are reflecting on these and how we can take these on board.

Education and training

First standard	Standards for education and training are linked to standards for registrants. They prioritise patient and service user safety and patient and service user centred care. The process for reviewing or developing standards for education and training should incorporate the views and experiences of key stakeholders, external events and the learning from the quality assurance process
Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 72 As described above (Overview, paragraphs 2 to 5), the NMC is embarked on a considerable programme of change designed to deliver improvements in delivery of all our regulatory functions. 73 This includes putting patients and the service users at the heart of our work including in our work to develop and maintain guidance and standards. Our new Public and Patient Engagement Forum (see paragraph 16.3.1 above) will be one of the key channels we will use to help us achieve this. 74 A key output of our change programme, has been the reorganisation of how we deliver our work. We have now combined all our core regulatory functions, except for fitness to practise, within a single directorate to help development of a joined up and seamless approach to our regulatory work. The directorate's work includes: 74.1 Standards and guidance. 74.2 Education and training. 74.3 Registration. 75 We are developing a Registration and Standards strategy for 2013 to 2015 which will set out clearly our aims and objectives for our work in this areas and what success will look like. The strategy will inform our business planning for 2013-2015. The strategy will inform our business planning for 2013-2015 and will be considered by Council in January 2013, alongside those for our Fitness to Practise and supporting functions. In relation to our work on Education, we anticipate that the strategy will include a focus on: 75.1 Development of a clear education strategy that puts the public first. 75.2 Secure a new quality assurance provider to deliver a proportionate model focused on public protection and add value to our evidence gathering. 75.3 Ensure that evidence from our quality assurance framework is used to improve public protection and inform work with other relevant partners. 76 Our focus this year has been on maintaining and embedding existing standards relating to education and training and on revising our

	current and future approach to the quality assurance of education provision. **b) How does the Council of the regulator assure itself that revised or newly developed guidance and standards prepared by the executive have been informed by various views, external developments and learning from other areas of its work?(only respond to this question, if you answer is different to last year)** 77 Council receive regular reports on developments relating to Education and training issues. 77.1 As a matter of course, all Council reports include details of how the views of stakeholders and wider developments have informed our work in this area. 77.2 Our Education Quality Assurance Reference Group[39] is chaired by a Council member who provides direct feedback at Council meetings. 78 Council decided to establish a formal Education Committee in October 2012[40]. The role of the Committee, as confirmed by Council in November, will include advising Council on[41]: 78.1 The NMC's education strategy. 78.2 Development, implementation and monitoring of education standards. 78.3 Development of European requirements relating to competencies and training of nurses and midwives. 78.4 The NMC's quality assurance strategy for education including approval, monitoring and extraordinary review activity. **c) What plans are in place, if any, to improve your performance in this area?** 79 We undertook a review of our advice and circulars over the summer as described above (paragraph 56). We have logged all issues relating to education standards which may need to be reviewed or revised in due course when resources allow. 80 We researched other regulators' governance arrangements in relation to education to inform the options put to Council for strengthening strategic oversight of education issues. **d) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)?** 81 The changing education commissioning arrangements represent a challenge for the NMC, as for others and we are working hard to ensure that we are engaged with all those who have a role within the new landscape.
Second standard	Through the regulator’s continuing professional development/revalidation systems, registrants maintain the standards required to stay fit to practise

Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 82 We have: 82.1 Undertaken a Post-registration Education and Practice (PREP) audit as discussed at paragraph 83 below. 82.2 Continued to develop our approach to revalidation/continuing fitness to practise as discussed at paragraphs 87 to 86 below. **b) What progress has been made on:** • **Revising the NMC's PREP standard?** 83 We conducted a PREP audit earlier this year and analysed the results. This confirmed that our current PREP standards are not evidence based and are driven by inputs rather than being focused on public or patient protection outcomes. 84 We do not consider that public protection would be enhanced by making changes to the current PREP standards as these are not strong enough to support the outcome focused approach needed for the future. Instead we consider that this public and patient safety is better served by concentrating our efforts on developing our continuing fitness to practise/revalidation model. • **Developing the NMC's continuing fitness to practise model?** 85 We have not made as much progress as we would have wished due to the other challenges we have faced (see paragraphs 2 to 5 above) and have had to reprioritise our timetable for the introduction of revalidation and this will now not be before 2015. However, we have undertaken extensive work over the past 12 months which will inform the development of our strategy. 85.1 There has been a considerable programme of stakeholder engagement and 1,700 stakeholders across the UK have been engaged in our thinking. 85.2 In line with the 2011 Health Committee recommendation, we conducted a PREP audit in March 2012 as described above. A random stratified sample of 100 registrants was audited but the audit confirmed our view that the PREP standards are not fit for purpose in that they do not provide adequate assurance of registrants' continuing fitness to practise. We have also strengthened our Midwives' Rules and Standards and reinforced the role of the supervisor in assuring the proficiency of midwives. 85.3 We have undertaken research to help in the development of a risk-based model of revalidation. This has included analysis of key issues such as: 85.3.1 How to evaluate risk, and what the key factors are in this. 85.3.2 The value of Continuing Professional Development (CPD).

85.3.3 The value of our current PREP standards.

85.3.4 What other regulators have done.

85.3.5 Methods of obtaining third party feedback.

85.3.6 The value of supervision and appraisal.

85.4 All of this work was necessary before we could develop evidence-based proposals for revalidation.

85.5 We have reviewed the suitability of our current standards and their applicability to revalidation. In addition to PREP, these include:

85.5.1 Pre-registration standards.

85.5.2 Good health and good character.

85.5.3 The Code.

85.6 We have also considered how far we could move towards a system of revalidation within our current legislation and where we will need to obtain changes to our rules and possibly the Order. We have also assessed options for a phased introduction of revalidation.

86 Our plans are to:

86.1 Establish a clear governance framework going forward including a programme board, external reference group and internal staff programme group by the end 2012.

86.2 Produce a proposed strategy for the development of and implementation of revalidation to Council in the first half of 2013.

86.3 Continue to engage with key stakeholders, other regulators and employers in developing our strategy.

87 Council reviewed progress and our proposed next steps for revalidation on 22 November 2012.[42] Council agreed that there would be member involvement in the Programme Board, as well as active oversight by full Council of developments. In particular, Council is keen to see a series of options for consideration prior to wider consultation.

c) What account has been taken of:

- **The Authority's policy paper on continuing fitness to practise?**

88 We provided input to the development of the Authority's policy paper and contributed and commented on various iterations of the paper. We welcomed the final report published on 7 November 2012 and are considering this can best be used to inform

development of our revalidation model.

d) If you are a regulator that intends to adopt an enhanced version of their current continuing professional development arrangements in place of a revalidation scheme, please explain how the Council of the regulator has assured itself and the public that their proposals will deliver the objectives of revalidation (ie that registrants remain up to date and fit to practise)?

89 Not applicable.

e) What plans are in place, if any, to improve your performance in this area?

90 See paragraph 78 above.

f) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)?

91 We recognise that there is significant work still to be done. A key challenge is finding a meaningful and measurable basis on which to make a judgement about continuing fitness to practise which is proportionate, risk based, encourages good practice and complements the responsibilities of the employer and the individual nurse or midwife.

92 We also recognise that we need to work with employers to improve existing local systems of evaluation which will feed into revalidation.

Third standard	The process for quality assuring education programmes is proportionate and takes account of the views of patients, service users, students and trainees. It is also focused on ensuring the education providers can develop students and trainees so that they meet the regulator's standards for registration
Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 93 We have: 93.1 Decided the future direction of travel of our education quality assurance (see paragraph 94 below). 93.2 Reviewed and revised our approach to quality assurance of education programmes for 2012-2013 both in relation to routine monitoring and extraordinary activity to ensure this is risk based and reflects 'right touch' regulation principles. 93.3 Published an overview of the results of our annual monitoring of nursing and midwifery education programme providers for 2011-2012 on our website and feedback learning to education providers[43]. 93.3.1 We reviewed 130 programmes at 54 Approved Education Institutes (AEIs) 26 AEIs had earned autonomy so were not visited. Importantly, a large proportion of monitoring activity focused on those programmes perceived to carry the greatest risk. 93.3.2 The percentage of AEIs receiving good grades improved. This indicates that good control measures are in place to comply with our standards. There were slight fluctuations in the percentage of AEIs receiving outstanding and unsatisfactory grades. 93.4 Held a successful conference for Quality Assurance reviewers and briefed them on the major changes underway at the NMC; our new approach to monitoring activity for 2012-2013 and our plans for the future. 93.5 Completed a comprehensive update of our database of all approved education programmes and providers. The approved programmes database (APD) is a web based system to record the approval and monitoring of all programmes of nursing and midwifery approved by the NMC. It is a live database with records being added and amended on a regular basis as programmes are approved, modified and monitored. 93.6 The database enables us to generate detailed management reports and information including on programmes by number, type, country, approval dates and monitoring outcomes and makes this accessible through our website. **b) What progress has been made on:** • **The Council's consideration of the strategic direction of quality assurance of education beyond 2013?** 94 Council considered the strategic direction of education quality assurance in June 2012 and decided to continue to outsource the quality assurance of education. In doing so it:

94.1 Examined in detail the benefits, costs and risks of two options: creation of an in-house quality assurance capability or continuing to outsource quality assurance provision.

94.2 Took account of an external report commissioned from C21Fox in 2010, as well as the views of stakeholders, including across the four countries.

95 We are currently running a procurement process for future education assurance provision. The existing outsource contract has been extended until 31 August 2013 to allow sufficient time to run a full procurement process. We aim to award the new contract from April 2013 to enable a smooth transition and ensure that the new arrangements contract takes effect from 1 September 2013.

96 In the meantime we are engaging with a range of stakeholders regarding our future proposals for the quality assurance framework. We are surveying key stakeholders including Chief Nursing Officers, Council of Deans, education commissioners, LMEs, LSAMOs, QA reviewers and AEIs and their responses to the survey will inform the development of the requirements for the future supplier.

97 We will also be exploring ways to ensure input from public and patients as our approach develops.

- **Reviewing the NMC's approach to quality assurance of education to bring it in line with the principles of right touch regulation?**

98 We have responded to the criticisms voiced by CHRE and others that our education quality assurance arrangements were over-burdensome and disproportionate and have taken steps to address this in both the current year's monitoring activity and our future plans by:

98.1 Introducing a risk based and more proportionate monitoring programme for 2012-2013. In determining the programme, Council took account of the evidence that the majority of AEIs are controlling the risks, with only 3 per cent of AEIs demonstrating weakness. Council approved a programme of continuous improvements to existing arrangements effective from September 2012. These improvements ensure a more targeted risk-based, proportionate quality assurance framework, so far as possible, within existing arrangements.

98.1.1 16 monitoring visits will be undertaken this year compared to 54 in 2011-2012. The 16 visits have been selected using clear criteria, including risk. This targeted monitoring will focus on AEIs where there have been recent challenges in controlling the five key risks, especially in resources and practice learning. A proportionate approach to programme selection has been adopted targeting pre registration nursing, pre registration midwifery and Specialist Community Public Health Nursing – health visiting programmes as these programmes continue to be affected by service reconfiguration, resource constraints indicating potential risks to support learning and assessment in practice which is reported in programme approval and monitoring commentary.

98.1.2 For the 64 AEIs who will not be subject to a monitoring the emphasis is on self-declaration and reporting by exception. We have streamlined the requirements and conflated the existing reporting requirements into a single

self-reporting template. This report will focus on the evaluative evidence as a result of managing the key risks, rather than a description of their processes.

98.2 Approving the strategic goals and direction of travel for a new outsourced contract which will be proportionate, responsive to risk and in accordance with 'right touch' regulation[44]. These include:

98.2.1 Enhancing and demonstrating proportionality.

98.2.2 Focusing on education outcomes.

98.2.3 Improving efficiencies and delivering value for money.

98.2.4 Strengthening stakeholder relationships.

98.3 In developing our approach, we have considered approaches taken by other regulators and have identified a range of adjustments to explore in procuring future provision as approved by Council in October, such as[45]:

98.3.1 Introducing a form of provider 'accreditation' – so that we only quality assure institutional data once, and not at every programme approval.

98.3.2 Rebalancing our activity between approval and monitoring.

98.3.3 Linking 'earned autonomy' to greater rewards and/or collective responsibility.

98.3.4 Focusing quality assurance on the riskier elements of education - providers are consistently most challenged by practice placements, and these are also where patients and the public have most exposure to students. QA might usefully adjust its focus accordingly.

98.3.5 Enhancing lay and user involvement – patient and service user involvement is a requirement we place on AEIs and we look at in QA. We do not currently involve lay people in education reviews .We will review our practice, benchmark against that of others and seek to enhance meaningful lay involvement in education QA.

c) What steps (if any) have the NMC taken to ensure that its quality assurance of education providers takes account of findings of the RCN's professional accreditation scheme? (see RCN's press release of July 2012)

99 We are currently only aware of one AEI that has adopted the RCN's professional accreditation scheme for pre-registration nursing education and were able to accommodate this as part of our programme approval arrangements.

d) What plans are in place, if any, to improve your performance in this area?

100 Our approved programmes database (see paragraphs 93.5 and 93.6 above) enables us to develop risk based assessments, share

	data within the organisation and with other regulators as described in paragraph 35 above. **e) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)?** 101 Council has agreed to include quality assurance of Local Supervising Authorities within the scope of the procurement process for provision of education quality assurance. We will be testing the market to see whether both forms of quality assurance can be delivered through the same arrangements. This provides an opportunity to take a more joined up approach to these two areas of quality assurance work if suitable and appropriate proposals are received. 102 We recognise that the timescales for procurement of new education quality assurance provision is extremely tight and represents a major challenge. **Dataset (data to be provided should be that collected for the regulators' most recent reporting period)** • **How many education institutions are you responsible for quality assuring?** 103 We currently quality assure 80 education institutions (2012-2013 academic year).
Fourth standard	Action is taken if the quality assurance process identifies concerns about education and training establishments
Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 104 We have: 104.1 Evaluated the action we have previously taken when concerns have been identified to capture learning. 104.2 Shared learning across our approaches to extraordinary review activity in relation to education and midwifery supervision. 104.3 Developed a new approach, as described at paragraph 106 below, which is based on ensuring that all available information and evidence is triangulated to ensure that our action is targeted and risk based. 104.4 Continued to engage with other regulators both to share intelligence in specific cases and to identify good practice generally. **b) What progress has been made on:** • **Focusing in this year's annual monitoring of education providers specifically on two particular areas that were identified from the annual monitoring that was undertaken in 2011/12 – assuring that there are appropriate and effective governance of practice placements and that teaching staff are maintaining their professional registration and have a recordable teaching qualification?**

105 Both of the above areas have been included in our annual monitoring plan for 2012-2013 which is published on our website[46]:

- **Learning from its extraordinary reviews to evaluate whether the action taken is proportionate and effective?**

106 Council approved a new approach to extraordinary activity in July 2012[47]. This was developed taking into account:

106.1 CHRE's comments in the performance review report 2011-2012.

106.2 Experiences gained in undertaking extraordinary reviews.

106.3 The NMC's corporate risk management approach.

107 Our approach has been redesigned to ensure that any action taken is risk-based, targeted, proportionate, fair and transparent. Any issues identified are triangulated and assessed against clear classification criteria (ranging from minor to critical) with a resulting set of actions, outcomes, reporting structures and timelines.

108 Information on how we assess risk and the extraordinary review process has been incorporated into the quality assurance handbook 2012-2013 which is published on our website[48]:

109 We have identified key learning points from our engagement with United Lincolnshire Hospitals Trust and the Castlebeck Group including the importance of:

109.1 Targeting any action on risk areas (as reflected in our new approach above).

109.2 Developing and maintaining strong relationships and shared accountabilities at all levels.

109.3 Continuing to provide support and assistance to see the provider through implementation of the action plan.

110 We welcomed the decision of the East Midlands Strategic Health Authority to produce a "Lessons Learned" report on the reintroduction of student nurses and midwives at Pilgrim Hospital (www.eastmidlands.nhs.uk/education-commissioning-unit/quality-assurance). This concluded that the action taken to address education standards had:

110.1 Secured improvements in public protection by achieving enhanced quality of learning at Pilgrim Hospital.

110.2 Significantly strengthened systems, process and relationships across all stakeholders.

110.3 Resulted in significant learning which could assist others across the UK with an interest in quality assuring the educational practice learning environment.

c) What plans are in place, if any, to improve your performance in this area?

111 The new Education Committee will provide advice and assurance to Council on our approach to extraordinary review activities and

	scrutinise reports on actions taken in specific cases (see paragraph 78 above). **d) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)?** 112 We continue to engage fully in joint multi-agency inter-regulatory work where concerns have been identified about provision of patient safety or care. We: 112.1 Identify and collate all relevant information held about the provider, for example, any issues relating to lapsed registrants or FtP cases, LSA and Education Quality Assurance reports to triangulate the evidence. 112.2 Ensure any forthcoming quality assurance activity is appropriately focused. 112.3 Share intelligence and contribute to action plans to ensure that appropriate and proportionate action and support is provided to safeguard patients.
Fifth standard	Information on approved programmes and the approval process is publicly available.
Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 113 We continue to make all possible information publicly available through both our website and our joint website with our outsourced provider, including: 113.1 Details of approved programmes and the approval process, including an easy search facility[49]. 113.2 The quality assurance handbook[50]. 113.3 Annual report on approval and monitoring activity[51]. 113.4 Our annual monitoring plan[52]. **b) What plans are in place, if any, to improve your performance in this area?** 114 As described above (paragraph 4.8.3), our developing engagement strategy to be considered by Council in January will include proposals to reshape and improve our website. **c) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)?** 115 We are engaging with Department of Health and other professional regulators around the provisions relating the education commissioning in England in the draft Care and Support Bill.

Registration

First standard	Only those who meet the regulator's requirements are registered
Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 116 As described above (Overview, paragraphs 2 to 5), the NMC is embarked on a considerable programme of change designed to improve the delivery of all our regulatory functions. 117 We have now combined all our core regulatory functions, except for fitness to practise, within a single directorate to help development of a joined up and seamless approach to our regulatory work. The directorate's work includes: 117.1 Standards and guidance. 117.2 Education and training. 117.3 Registration. 118 We are developing a Registration and Standards strategy for 2013 to 2015 which will set out clearly our aims and objectives for our work in this areas and what success will look like. The strategy will inform our business planning for 2013-2015. Continuing to ensure the integrity and accuracy of the register is key to all we do. 119 As mentioned above (paragraph 17) we have identified some gaps in our processes which may present a risk. As a result we are carrying out a review of our registration policy and processes (as part of the registrations improvement plan) starting with overseas applications. 120 In the current year, for our Registration function, a significant consequence of the financial challenges we faced was the necessity of deferring plans to move to online registrations services. 121 Other areas of note include: 121.1 Developing Standard Operating Procedures for most of our registration processes in relation to UK, EU and Overseas applications. 121.2 Continuing to take a robust approach to lapsed registrants who have been found to have continued to work whilst lapsed. All such readmission applications are referred to the Registrars Advisory Group for decision. We write to the registrant, the employer, the NHS Trust/Board, regional authorities and relevant systems regulator. 121.3 Asking registrants to demonstrate how the PREP standards have been met, where there are any concerns or doubts about

an application for renewal or readmission.

b) What progress has been made on:

- **The review of the overseas registration policy (for non-EU nurses and midwives)?**

122 This has been prioritised (see paragraph119 above), as part of the review of registration policy, in recognition of its importance for public protection and work started in November 2012.

c) How does the Council of the regulator assure itself that the registrations process managed by the executive is effective in ensuring only those that met the requirements are registered (eg is there an internal quality assurance process, the outcome of which is reported to the Council) (only respond to this question, if it is different to last year)?

123 Council receives assurance through:

123.1 The monthly Chief Executive's Report and Balanced Scorecard performance report incorporating key performance indicators for a range of registration processes[53].

123.2 Reports on other performance issues on an exception basis[54]. More detailed management information is scrutinised monthly by Directors Group and escalated to Council, as appropriate. A fuller pack of management information is considered by the Director, as described in paragraph 127.2 below.

123.3 Quarterly reports from the Audit Committee, which, where appropriate, would include any risks, issues or concerns relating to registrations identified through internal controls and assurance mechanisms such as internal audit, serious event reviews, complaints or invocation of whistleblowing procedures.

d) What plans are in place, if any, to improve your performance in this area?

124 We are developing:

124.1 A Registration and Standards strategy for 2013-2015 as mentioned above (paragraph 118). This includes our aims and objectives for our Registrations function and what success looks like. This will be used to inform our business and delivery plans for 2013-2015.

124.2 A Registration Improvement Plan to introduce improvements over the next two years through a structured programme under the auspices of the wider change management programme. This encompasses:

124.2.1 The review of registration policies and processes mentioned above (paragraphs 17 and 119).

124.2.2 Short term measures such as, implementing the fees increase, preparing for voluntary removals and making

	information on fitness to practise sanctions available on line 124.2.3 Medium term measures such as, preparing for the introduction of professional insurance indemnity requirements, revisiting our previous plans to move to online registration, as part of our long term IT strategy and moving towards external accreditation for customer service excellence. 124.2.4 Longer term measures such as, planning for the introduction of revalidation and the impact on renewal arrangements. **e) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)?** 125 A number of improvements have been introduced in Registration to help encourage continuous improvement in customer service and which have also helped secure the relatively low staff turnover levels in the Registration Centre (12 per cent compared to an industry average of 20 percent. We have: 125.1 Introduced from October 2012 monthly managers' business improvement meetings (see paragraph 127.2 below). 125.2 Introduced peer review quality assurance from December 2012 of decision of registration teams. 125.3 Developed a welcome pack for new staff, which has also proved useful for the temporary staff who join us to support peak demands. 125.4 Produced a comprehensive desk manual for Registration Centre staff which includes quick reference guides. Similar quick reference guides are to be produced for the other teams in the Registration directorate. 125.5 Piloted a bimonthly staff survey within Registration to get staff feedback and views (from August 2012). 126 Additionally we have: 126.1 Procured training from the Samaritans for a group of staff on how to diffuse difficult calls and situations. Staff feedback on the training has been so positive that we are exploring ways in which we can roll this out or otherwise transfer learning more widely. 126.2 Developed an introduction pack for visitors to the registration centre. 126.3 Ensure cross directorate learning by ensuring that registration staff contribute to the induction training for fitness to practise staff.
Second standard	The registration process, including the management of appeals, is fair, based on the regulators' standards, efficient, transparent, secure, and continuously improving

Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 127 We have made significant improvements including: 127.1 Resourcing registration capacity to required levels following the decision not to proceed with on line registration in the short-term. 127.2 Systematic collection of comprehensive performance and management information across all registration processes. This is used to produce a "Registration and Standards Dashboard" and monthly management information pack. The dashboard and pack are circulated to all directorate staff and is scrutinised in depth at monthly managers' business improvement meetings[55] 127.3 Improving our ability to resource and manage registration capacity to meet workflows due to the availability and use of accurate and timely management information. 127.4 Embedding quality assurance processes across each of the four registrations teams to ensure continuous improvements. 127.5 Introduction of ongoing online surveys to capture: 127.5.1 Customer satisfaction with registration centre service. In September 2012 we achieved: 127.5.1.1 87.4% customer satisfaction rating. 127.5.1.2 77.6% first contact resolution rate. 127.5.2 Satisfaction and feedback on the "search the register" facility. 127.6 The results from each survey are analysed monthly and fed into the management information monthly pack. **b) What progress has been made on:** • **Ensuring that registration applications and queries are dealt with in a timely manner?** 128 We are using the performance and management information described above (paragraph 127.2) to manage the workloads in the Registration Centre more effectively and efficiently. The availability of this data has enabled us to be more agile in responding to real time changes in demand and to redeploy resources more flexibly within the registration section. 129 Between April and September 2012, we met all our key performance indicator targets for registration processes, including during our busiest period in August and September. These are: 129.1 Over 95% initial undisputed registrations applications registered within 5 days (UK, EU and overseas).

129.2 100% EU/Overseas applications acknowledged and advised of further applications within 30 days.

129.3 100% Complete EU/Overseas applications issued with a decision letter within 30 days

129.4 Over 85% change of detail notifications dealt with in 5 days.

129.5 100% applications/renewals involving a caution/conviction declaration determined within 3 months.

129.6 Over 95% re-admission applications decided within 30 days.

129.7 Over 60% customer service calls answered within 20 seconds (see also September performance below).

130 Based on learning from last year and utilising available workflow and management information, a successful business case was made for a temporary increase in registration staff levels in both the Registration Centre and UK Registration Team to cover the busy period in September. Performance was measured on a daily basis and reported to Directors Group to ensure value for money. This temporary increase in capacity resulted in significantly improved performance as follows:

	September 2011	**September 2012**
Number of calls made to the NMC	51,923	49,142
Number of calls answered	21,206	46,005
% of attempted calls answered	40%	93.62%* *approximately 60% answered within one second

131 Our key performance indicator is to answer 60% of calls in 20 seconds. Our performance in September this year was 67.60%, compared to 2.96% in September 2011.

132 We acted on our customer survey feedback by removing in November 2012 the Interactive Voice Response system introduced in the Registration Centre earlier this year. Customers told us that they found the system frustrating and preferred to get straight through to a team member and this was evidenced by system data showing that this option was overwhelmingly chosen from the menu.

- **Ensuring that registration appeals are progressed without delay?**

133 We established a team to manage registration appeals and recently decided to supplement this for the next six months with some in-house legal support. Earlier this year we successfully expanded our pool of appeal panellists from five to thirteen.

134 Appeal panels must be chaired by Council members and at present have two trained Council members which affects our ability to schedule hearings. Thirteen registration appeals were heard between 1 April and 31 October 2012. A further twenty-two are scheduled to be heard between 1 November 2012 and 31 March 2013.

135 On 1 November 2012 we had 30 outstanding appeals of which seven have been awaiting a hearing for more than nine months. In four cases delay was outside our control: two await criminal case outcomes and in two delays were requested by the appellants. We currently aim to conclude hearings within nine months of receipt of an appeal. In the financial year 2013-2014 we will aim to reduce this to between three and six months.

- **The development of a quality assurance/internal audit process for registration decisions?**

136 Internal quality assurance (QA) processes are now firmly established for each of the four registration teams.

136.1 Standard Operating Procedures have been put in place for carrying out the checks which are undertaken by the team managers. From December 2012, the QA checks will be undertaken on a peer review basis: that is, managers will quality assure the work of each other's teams.

136.2 Consistent quality assurance criteria is used across the four teams with errors categorised by severity. Immediate feedback is given to staff and both individual and wider learning needs identified and reflected in training programmes. The introduction of the quality assurance process has resulted in significant reductions in mistakes.

136.3 Quality assurance for the registration centre team includes silent monitoring of a target number of calls each month with staff performance scored, immediate feedback provided and the top five training needs identified.

136.4 All quality assurance results are included in the directorate management information pack which is scrutinised at the monthly managers meeting.

137 A recent internal audit of registration work identified a number of minor process improvements and these are currently being implemented.

- **The development with the Department of Health of indemnity insurance arrangements for independent midwives?**

138 We are continuing to look with the Department of Health at the issues relating to independent midwives as part of the overarching legislative framework to implement the EU requirements that professional indemnity insurance be a condition of registration.

139 We provided comments to the Department of Health on its draft consultation document on implementation of the EU requirements for professional indemnity insurance. We await the formal consultation and will provide further comments on this in due course.

140 We have initiated a project to put in place the necessary adjustments to our registration processes and systems to meet the expected requirements. We recognise that this will present different challenges for different registrants. We are considering the various options

for implementation and undertaking an impact assessment, which will include an assessment of the impact for groups such as independent midwives.

- **The roll out of a new initial registration pack (which was due to begin in April 2012)?**

141 As part of the fundamental re-evaluation of our work (see paragraph 4.5 above), we decided that introduction of the new initial registration pack would neither enhance public safety nor represent best use of our resources. New registrants are sent a welcome letter and a statement of entry on the register[56].

c) How does the Council of the regulator assure itself that the registrations process is managed efficiently and effectively by the executive and that it continuously improves (eg does the Council receive reports on the time taken to process registration applications)? (Only respond to this question, if the answer is different to last year)

142 Council assures itself in the following ways:

142.1 It scrutinises key performance indicators for registration at each meeting as part of the Balanced Scorecard (see paragraph 4.4.1.2 above). This includes performance measures relating to the time taken to process registration applications and appeals (broken down by category that is, UK, EU and Overseas).

142.2 Council members chair registration appeals panels (see paragraph 134 above).

142.3 Council is provided with specific reports where it identifies performance issues it wishes to scrutinise in more detail.

d) What plans are in place, if any, to improve your performance in this area?

143 As indicated above, we have developed a Registration and Standards strategy 2013-2015 and an improvement plan. The Improvement plan pulls together the range of initiatives already underway or planned to improve registrations performance.

e) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)?

144 We introduced a "customer feedback notice board" updated monthly, which is highly visible to all staff. This displays both positive and negative customer feedback and customer satisfaction levels to reinforce learning and help stimulate continuous customer service improvements.

145 We engage with other healthcare regulators to share learning and good practice as follows:

145.1 We participate in the health care regulators customer service network which meets bimonthly.

145.2 We engage with the health care regulators registrations benchmarking group. This meets quarterly and provides a useful

forum for comparing processes and sharing good practice. For example, we used learning from the group in the development of our management information pack and the Group is undertaking some comparative work to look at quality assuring registration processes.

Dataset (data to be provided should be that collected for the regulators' most recent reporting period)

- **What is the total number of registrants on the register?**

146 669,198 at 30 September 2012.

- **How many new initial registration applications did you receive?**

147 We received 8261 new initial registrations between 1 April and 30 September 2012.

- **How many registration appeals did you receive and conclude? What were the outcomes?**

148 The following data is for the period 1 April to 1 November 2012:

Appeals received	19
Appeals concluded	13
Appeals upheld	6
Appeals rejected	5
Appeals adjourned and subsequently deemed withdrawn	2
Appeals Outstanding	30

- **What is the median time taken to process initial registration applications for UK graduates, international non-EU applicants and EU applicants?**

149 The following data is for the period 1 April to 30 September 2012:

Registration type	Median time to process
UK initial applications	0.7 days

International non EU initial applications	1.1 days
EU initial applications	0.9 days

- **What is your annual retention fee?**

150 £76. Subject to the Department of Health ensuring the necessary rule changes are laid in Parliament, this will increase to £100 from 1 February 2013 (see paragraph 4.2.3 above).

151 Council has committed to undertake an annual review of the fee[57].

Third standard

Through the regulators' registers, everyone can easily access information about registrants, except in relation to their health, including whether there are restrictions on their practice

Regulator's evidence

a) What, if anything, has changed in your performance against this standard since your last evidence submission?

152 Our online "search the register" facility is available to anyone who wishes to use it. The register is checked by around 750, 000 unique individuals each year, although we are unable to determine the percentage of those who are patients/members of the public, registrants or employers.

b) What progress has been made on:

- **Ensuring the accuracy of the register by carrying out daily checks of the registration database and improving the interface between WISER and the CMS or improving staff liaison between the registrations and fitness to practise department?**

153 A substantial work programme has been undertaken to ensure the accuracy of the register following the discrepancies identified between the registration system (WISER) and the fitness to practise case management system (CMS). This included:

153.1 Developing reports to identify discrepancies between the systems.

153.2 Developing a process for investigating the discrepancies and taking corrective action. This is overseen by a cross-directorate group of experts.

153.3 Developing an appropriate IT "fix" where necessary to resolve the discrepancies. As a further level of assurance a separate cross-directorate experts group provides scrutiny of any IT corrective action to ensure an audit trail.

153.4 Provision of training by Registrations staff to FtP staff.

153.5 Development of standard operating procedures and initiation of work on a training manual (see below) on updating

WISER/CMS for FtP staff.

153.6 Quality assurance of the methodology and process by Assistant Director of Operations, Registration.

153.7 Quality assurance checks by the FtP Quality assurance team.

154 An independent review by the NMC's external auditors, haysmacintyre found that the controls and processes we have put in place are adequate and are being followed by staff members[58].

155 An action plan was put in place to ensure that all cases identified had been reviewed, investigated and all public protection concerns raised had been addressed by the end of August 2012.

156 Since then daily reports continue to be run and some 5 to 10 discrepancies are usually highlighted each day. These are resolved immediately with continued quality assurance and scrutiny by the experts group. This will continue to be the case until the wider IT systems issues can be resolved as part of the IT stabilisation plan (see paragraph 4.3 above) and longer term ICT strategy.

157 We are planning to develop a training manual that covers how to update CMS and then WISER. Although the team that update WISER and CMS have all been trained and training is also taking place for new starters, we feel that a step by step guide will also assist also help users to update the systems correctly.

158 The programme itself has led to improved liaison between registrations and fitness to practise staff:

158.1 Work has been undertaken by joint teams of Registrations, FtP and ICT staff.

158.2 Improvements in cross-directorate planning, communications and training have been identified and implemented.

- **Including nurses and midwives who have been struck off or suspended on the NMC's public facing register?**

159 We are on track to make this information available from January 2013.

160 In January 2012, Council agreed in principle that information about fitness to practise sanctions should be made available to on line enquirers[59].We consulted on our proposals in June and July 2012 including holding a listening event on 12 July 2012, at which CHRE was represented. Council considered the outcomes of the consultation in September 2012 and confirmed its previous decision.[60].

c) What feedback do you collect about the accessibility of registers? What changes have been made as a result of this feedback in 2012?

161 We introduced an online survey for those using our online "search the register" facility in September 2012. The survey responses are collated at the end of each month, analysed and reported as part of the directorate management information pack. Initial results indicate that:

	161.1 Just under 75 per cent of those who responded to the survey were registrants (though this does not necessarily equate with users of the facility). 161.2 52 percent overall satisfaction and 62 percent for ease of use. Analysis of the comments received indicates that most of these relate to the registration renewal process rather than the search facility itself. **d) What plans are in place, if any, to improve your performance in this area?** 162 In the short term, we aim to introduce an online survey for the Employer Confirmation Service. 163 As part of the public and patient engagement strand of our wider proposed engagement strategy being considered by Council, we are developing proposals to: 163.1 Undertake research to establish public levels of use of the register. 163.2 Continue to actively promote checking the resister as a tool to safeguard the public. We will establish a baseline of current use and set targets for growth in register checks. 163.3 Improve the accessibility of public/patient aspects of our website more generally. **e) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)?** 164 No further comments to add.
Fourth standard	Employers are aware of the importance of checking a health professional's or social worker's registration. Patients, service users, and members of the public can find and check a health professional's or social worker's registration
Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 165 As a public protection measure, we stopped issuing registrants with cards giving their registration Personal Identification Number (PIN) at the end of September 2012. Registrants still receive a receipt confirming their PIN number and expiry date which can be used for tax relief purposes. 166 This enhances public protection: 166.1 PIN cards were only accurate as to registration status on the day of issue. We were aware that some employers and registrants treated the card as proof of registration 166.2 Removing the card should encourage employers to sign up to use our free Employers Confirmation Service which shows all recorded qualifications and any current cautions, conditions of practise, suspensions or striking off orders, or whether

registration has lapsed.

166.3 Similarly, it should encourage the public/service users to check registration status through the public register.

166.4 The money saved (£105k a year) can be used to deliver our core regulatory functions in more effective ways.

167 We communicated our plans to stopping issuing cards extensively both in advance and subsequently. This included explaining how registration can be checked. Activities included: a press release; updates on our website; articles in our e-newsletters for employers, nurses and midwives; an article in NMC Update which nurses and midwives receive on renewal; posts on Facebook and Twitter; correspondence to stakeholders including the professional bodies and Unions, patient groups and our employers' contacts list. Although it is still relatively early, we have not received any complaints to date. We have seen an increase in the number of employers signing up to our Employers Confirmation Service.

168 We continue to write to employers when we find that a registrant has been working when lapsed.

b) What progress has been made on:

- **Extending the integration of data on the NMC's register with employers in Scotland and Northern Ireland?**

169 For the reasons described in paragraph 4.5 above, we have yet to progress this.

c) What feedback have you received from employers about the accessibility of the register and their awareness of the importance of checking a health professional's registration? What action has been taken as a result of this?

170 Just under 12% of those who responded to our new online survey on accessibility of the register were employers and few of those who provided comments would appear to be employers. This is unsurprising given:

170.1 Availability of registration information to NHS employers in England through the Electronic Staff Register (ERS).

170.2 Our separate employers' confirmation service. As indicated, we aim to introduce a similar survey for the employers' confirmation service in due course.

d) What plans are in place, if any, to improve your performance in this area?

171 We are considering what further we can do to raise awareness of the availability of the register search. Feedback from our Patient and Public Engagement Forum in August 2012 suggested that:

171.1 We could do more to raise public and patient groups' awareness of the facility to check registration online.

171.2 The register search facility would be improved by making it possible to search by employer as well as registrant name.

e) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice

	that you have or challenges that you are facing)? 172 No additional comments.
Fifth standard	Risk of harm to the public and of damage to public confidence in the profession related to non-registrants using a protected title or undertaking a protected act is managed in a proportionate and risk based manner.
Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 173 We have introduced more stringent procedures before making changes to a registrant's name on the register, including in relation to the nature of documentation that we require before a change will be made. 174 An added benefit of the action we have taken to remove Pin cards (see paragraph 165 above) is that it removes the opportunity for such cards to be used fraudulently. 175 We have updated developed an 'early warning' fraud guide for staff. **b) What plans are in place, if any, to improve your performance in this area?** **c) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)?** 176 Our response to the Law Commissions consultation on future healthcare regulation discussed the issues around protected titles[61].

Fitness to Practise

First standard	Anybody can raise a concern, including the regulator, about the fitness to practise of a registrant
Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 177 As described above (Overview, paragraphs 2 to 5), the NMC is embarked on a considerable programme of change designed to deliver improvements in delivery of all our regulatory functions. This encompasses the significant programme already underway within Fitness to Practise focused on three key priorities, as agreed with the Department of Health and CHRE to improve: 177.1 The timeliness of case progress, including in particular clearing our historic caseload (cases received before January 2011). 177.2 The quality of customer service. 177.3 The quality and consistency of our decision making. 178 In response to the helpful suggestion in the CHRE Strategic Review[62], we have started to draw the many ongoing initiatives and improvement measures into a single overall strategy setting out our vision of what success looks like for our fitness to practise function. The draft strategy has been a live working document for staff since September and will be formally considered by Council in January 2013, as part of the suite of strategies for the four directorates. The draft strategy is underpinned by the fitness to practise improvement programme which captures the many projects and other activities in place to drive better performance. 179 This includes the major programme to bring investigations in-house which began earlier this year and which, together with other initiatives, has lead to significant restructuring and reorganisation of how workflow and case progression is managed[63]. 180 Council recognised the need to address the past underinvestment in our fitness to practise function and allocated additional resources to support increases in the level of fitness to practise activities to ensure public protection. This has enabled us to recruit a significant number of additional staff, as well as to obtain additional space to accommodate the increased level of hearing activity we are undertaking to clear the historic caseload and increase timeliness of case progression more generally. 181 In relation to this specific standard we are: 181.1 Improving our service to those who call with general queries about fitness to practise by providing a dedicated capacity based in the Registration Centre and will be subject to the established quality assurance systems already in place (silent monitoring and immediate feedback to staff - see paragraph 136.3 above). 181.2 Engaging with patients and the public through our Patient and Public Engagement Forum. 181.2.1 The first Forum on 28 August 2012 captured views on what the public/patients expect from an effective and efficient

regulator including in relation to fitness to practise. A clear message was that we need to make it simpler and easier for patients and the public to refer cases to us.

181.2.2 We developed a revised referral form and took that to our second forum on 28 November 2012 for review and are currently evaluating the feedback from that and discussions on what good customer service looks like for patients and the public.

181.3 Working with employers to improve understanding of when cases should be referred to the NMC.

181.3.1 Our Head of External Liaison continues to provide a key contact point for Directors of Nursing, LSAMOs and HR managers to discuss and seek advice on possible referrals.

181.3.2 We met with NHS Professionals to discuss issues around referrals of agency staff.

181.3.3 We recently held two events for employers (5 and 19 November) focused on making more effective referrals to the NMC. These looked at the NMC advice to employers and referrals decision tree as well as practical case studies. As a result of the events and the constructive input we received, we are taking forward a number of actions:

181.3.4 Firstly we are clear that we need to do more to publicise our advice for employers and we will be making renewed efforts to do this including through our newsletters.

181.3.5 We also identified that one of the aspects of the referrals process that employers find most tricky is in dealing with 'short-term' suspensions. We will be looking at whether we can provide more helpful advice on this.

181.3.6 We will also be looking at the possibility of making the decision tree and on line referrals more interactive, so that the referrer does not feel 'led' to a particular conclusion, though it may take a little time to explore the feasibility of this.

b) What account has been taken of:

- **Chapter 6 of CHRE's modern and efficient fitness to practise adjudication report?**

182 We have taken account of the findings and recommendations in developing the draft FtP strategy (see paragraph 178 above), a key aim of which is to develop excellent customer service including to witnesses and other participants in the fitness to practise process.

c) Can you provide data about the different sources of fitness to practise concerns received/acted upon e.g. number/percentage received from employers, members of the public, service users and registrants?

183 The is contained in the table below which provides figures for the period 1 April to 30 September 2012 sourced from our Case Management System (CMS).

Source of new referrals	Number of new referrals
Employer	858
Member of public	459
Police	260
Self referral	109
Other (including lawyers and colleague referrals)	158
NMC registrar	52
Other regulatory or professional body	19
Referrer unknown	100
Total	**2,015**

d) What plans are in place, if any, to improve your performance in this area?

184 As previously indicated (paragraph 178 above), we have developed a draft FtP strategy which sets out our aims and objectives for the period 1 September 2012 to 31 March 2015 and describes what success will look like. The strategy, once approved by Council, will be given effect through the directorate business plan for 2013-2014.

185 The draft strategy is supported by the FtP Improvement Programme, which is being taken forward under the umbrella of the wider organisational change programme. The improvement programme pulls together all the various projects, initiatives and workstreams being taken forward by FtP.

e) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)?

186 We are contributing to the work being lead by the Parliamentary and Health Ombudsman (PHSO) to look at the development of a complaints hub to provide a single simple access point for patients and the public to raise concerns.

Second standard	Information about fitness to practise concerns is shared by the regulator with employers/local arbitrators, system and other professional regulators within the relevant legal frameworks
Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 187 We introduced a more systematic approach to referring cases to employers in August 2011 where we consider that regulatory action is inappropriate and the matter is one that should be dealt with by local action (see paragraph 190 below and paragraph 376, submission 2011-2012)[64].

188 We have taken the following steps to improve information sharing with other relevant authorities:

188.1 Disclosure Scotland (DS): following a meeting in May 2012 we now have an improved understanding of how it uses information we disclosed to it and of the importance of responding to DS enquires without delay. Further discussions are planned to continue to build understanding of respective roles and responsibilities.

188.2 Independent Safeguarding Authority (ISA): We introduced a Standard Operating Procedure in Screening on referring appropriate cases to the ISA in October 2012. This includes a requirement to update the risk assessment and CMS notes on the case accordingly[65].

188.3 Following the joint meeting with the General Medical Council and Care Quality Commission (CQC) convened by the NMC on partnership working (see paragraph 42 above), a further meeting was held with CQC to improve information sharing in relation to Fitness to Practise. A number of actions are currently being addressed including:

188.3.1 Referring FtP cases which involve evidence of "working whilst lapsed" to CQC.

188.3.2 Consideration of the implications of adding CQC as an "interested party" in all registered manager referrals and the implications for the NMC's disclosure policy.

188.3.3 Consideration of a possible new "third party" referral form for non-employer organisations to make referrals to the NMC.

188.4 We have had a range of meetings with the Care Council for Wales and Care Inspectorate.

188.5 We have a number of Memoranda of Understanding in place with other bodies such as the police[66]. However, we are reviewing how we can give more practical effect to working with other regulators.

188.6 Council will consider further proposals on the NMC's disclosure policy in January 2013.

b) Can you provide data about the number of cases where you have shared data in 2012 with employers and other (system and professional) regulatory bodies?

189 Data has not previously been collected systematically on cases shared with employers or other regulatory bodies. We are currently establishing a system to capture centrally within FtP all cross-regulatory referrals and will be producing guidance and briefing for staff to implement this.

190 However, we have identified that information was shared between 1 April to 30 September 2012 as below:

	Independent Safeguarding Authority	71 cases
	Disclosure Scotland	8 cases
	General Medical Council	1 case
	Health and Care Professions Council	1 case
	Care Inspectorate Scotland	1 case
	Care Quality Commission	Cases are referred on a case by case basis as appropriate[67]. However, no data is held on the number of cases referred
	Employers	110 cases were referred to employers for local action

c) What plans are in place, if any, to improve your performance in this area?
d) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)?

191 We are committed to working effectively with other regulatory bodies and to sharing information in the public interest where appropriate. This represents a challenge for all regulators but we recognise the imperative of developing more effective arrangements.

Third standard	Where necessary, the regulator will determine if there is a case to answer and if so, whether the registrant's fitness to practise is impaired or, where appropriate, direct the person to another relevant organisation
Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 192 Following the changes to our rules which came into effect on 6 February 2012[68] cases no longer need to be submitted to the Investigating Committee to direct that an investigation be undertaken. Instead, FtP staff or external lawyers gather sufficient evidence to enable an Investigating Committee panel to reach a decision on whether there is a case to answer. This has helped Investigating Committees make earlier and better informed decisions because we can now ensure that all necessary evidence has been gathered in advance. 193 In July 2012[69], Council agreed a number of changes to the threshold for closure or referral for investigation of fitness to practise cases including: 193.1 Immediate changes to the current cautions and convictions guidance and the screening closure criteria in relation to minor cautions and convictions proposals for minor motoring offences and other minor cautions and convictions not involving

alcohol and drugs.

193.2 Approving further evidence gathering and consultation work with a view to a potential revision of the current Council policy on cases involving use of alcohol or illegal drugs.

193.3 Development of further guidance around the meaning of impaired fitness to practise including the possibility of a recalibration of our current approach.

194 Council will receive a paper in January on work to review the threshold for closing cases without investigation.

195 These and other changes have contributed to significant reductions in timescales for investigation for example reducing the average time taken to investigate cases by some 6 months this year:

195.1 Our Key Performance Indicator is to progress 90% of cases through the investigation stage within 12 months.

195.2 In October 2012, 76 per cent progressed in 12 months and the average time taken was 10.4 months for all cases. This compares to an average time for investigations for all cases of 17 months in January 2012.

b) What progress has been made on:

- **Working with NCAS on the management of cases at the initial stages of the fitness to practise process?**

196 Not applicable to NMC.

- **Reviewing the guidance available to the Investigating Committee following the rule changes in February 2012?**

197 Considerable support has been provided to assist Investigating Committee panels with the rule changes and to secure continuous improvement at the Investigating Committee stage. Some anonomised examples of decisions in December 2011 and July/August 2012 are included to show the improvements made in panel decisions.[70].

197.1 Training: Advance training on the new arrangements was provided to Investigating Committee panel members and FtP staff including panel secretaries[71]. Further training was run for Investigating Committee panel members, including guidance and practical case studies on establishing whether there is a "case to answer"[72]

197.2 Dedicated Investigating Committee Secretaries: A dedicated team of Investigating Secretaries was set up at the beginning of 2012 and have received both initial and refresher training[73]. Panels are now supported by secretaries experienced in Investigating Committee processes. This has also resulted in significant improvements in the despatch of Investigating Committee decision letters (98% within 5 working days compared to 83% in January 2012).

197.3 Dedicated legal assessor: A lead Legal Assessor has been dedicated to supporting the Investigating Committee since January 2012. She and one other legal assessor attended every Investigating Committee meeting until the end of March to

	ensure that panel members had consistent guidance during the period immediately following implementation of the rule changes and to support a dedicated team of newly appointed IC Secretaries. Since April 2012, the legal assessor has attended two Investigating Committee meeting days each month, sitting with different chairs and panel secretaries so that learning is shared across participants. This also led to implementation of some logistical changes (provision of projectors and screens to assist in drafting determinations) as well as other learning points to assist panel secretaries. 197.4 Standard Operating Procedures: Standard Operating Procedures on Investigating Committee processes were developed in early Spring/Summer. These are kept under constant review and are currently being revised to reflect new processes piloted in July 2012 which have been positively received by panel members. Under the new approach instead of using the first day to read cases and the second day to consider cases and reach decisions, panels now discuss each case and reach a decision after reading the case file. We aim to fully implement the new approach by April 2013. 197.5 Systematic feedback from panel chairs: the Head of Case management has initiated a programme of speaking to each panel chair to gather feedback on processes including paperwork and secretary support. **c) What account has been taken of:** • **The findings of the NMC's audit report 2012?** 198 We have provided detailed comments on the draft report. Consideration will be given to the findings of the final report when published. **d) What plans are in place, if any, to improve your performance in this area?** 199 We will be taking forward further work on the review of thresholds mentioned above (see paragraph 194). **e) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)?** 200 No further comments to add.
Fourth standard	All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and where appropriate referred to an interim orders panel
Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 201 Following the rule changes in February 2012[74], cases no longer need to be referred to an Investigating Committee to refer the case to another Investigating Committee panel for consideration of an Interim order. Instead, cases can now be referred directly to an Investigating Committee panel for an interim order hearing. 202 Each new referral is reviewed on receipt by the Screening Team and a risk assessment undertaken to determine whether an interim

order might be needed. The Screening team has expanded considerably since it was initially set up in January 2011 and since early 2012 has included a dedicated interim order team. The current structure of the Screening team is attached[75].

203 Our policy and practice in conducting and recording risk assessment has been amended and evolved since it was first introduced in 2011 following implementation of the new screening process. There was a requirement from January 2011 to assess each case on receipt for interim order consideration. Since that time we have been steadily making improvements. When the amendments to our rules were introduced in February 2012, we took the opportunity to fully embed our risk assessment process, as CHRE recognised[76]. The process applies across FtP and requires that all risk consideration be documented on a 'living' risk assessment form, which is stored on each case[77]. The risk assessment form is updated throughout the life of the case, so as to ensure that should new information come to light, the case can be referred for an interim order, if appropriate.

204 Training on risk assessment has been delivered to FtP staff and now forms part of induction for new staff[78].

205 We have strengthened our approach to monitoring and reporting how quickly we are impose Interim Orders to help manage and improve our performance.

205.1 During 2011-2012, the focus was on monitoring the average number of days to impose an IO and the average performance for the year was 29.88 days for the year. This was the main indicator reported to Council in relation to interim orders[79].

205.2 Since May 2012, as part of the Balanced scorecard (see paragraph 4.4.1.2 above) we have reverted to using the previous key performance indicator (originally adopted by Council in July 2011) which is to impose 80% of interim orders within 28 days. This represents a more robust measure and helps us to identify whether progress is being made and where we need to improve. In October 2012 we achieved 64.1% of Interim Orders imposed within 28 days, an improvement over 53% achieved in September 2012.

206 Guidance and support for panel members: A determination tool to assist Investigating Committee panel members was issued in February 2012. In addition, the conditions of practice guidance and library for panel members includes guidance on interim conditions of practice (May 2012). All of these documents are publically available on our website[80].

b) What account has been taken of:

- **The findings of NMC's audit report 2012?**

207 See our response at paragraph 198 above.

c) What plans are in place, if any, to improve your performance in this area?

208 Nothing further to add.

d) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)?

	209 No further comments to add.
Fifth standard	The fitness to practise process is transparent, fair, proportionate and focused on public protection
Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 210 The major changes are as described above. Our plans for the introduction of voluntary removal, new case management processes and consensual panel determinations have all been developed on the basis that public protection must be our first and foremost consideration. We have also sought to ensure in designing the operation of the new processes that they are transparent, fair and proportionate. 211 We consider these new measures will enhance public protection by ensuring swifter resolution of fitness to practise concerns whilst having due regard to the human rights of those subject to fitness to practise proceedings. **b) What progress has been made on:** • **Considering the responses to the consultation on case management tools and the introduction of any of the new tools?** 212 Between May and August 2012 we undertook a full consultation on case management and consensual disposal[81]. 339 responses were received, including from the Patients Association; CHRE; the main nursing and midwifery representative bodies; other regulators; large employers of nurses and midwives; and 316 individuals. The results were analysed by an independent research company. 213 Council approved proposals for the introduction of new case management arrangements, including standard directions for practice committees and a system of consensual panel determination at its meeting on 22 November.[82] • **Improving the quality of management data?** 214 Substantial work has been undertaken, including commissioning external expert input, to improve the quality of management data. This includes: 214.1 Appointment of a dedicated management information officer. 214.2 Work to define and record the source, frequency, purpose of each data item to help improve the quality and robustness of the performance information collected. 214.3 Ongoing weekly management information meetings. 214.4 The introduction of monthly super management information meetings.

214.5 Creation of an FtP dashboard to provide high level monitoring of key performance metrics. This is supported by some 150 detailed measures which are tracked across the range of FtP activities. The dashboard is reviewed at the super management information meetings.

214.6 Establishment of a CMS user group to improve how information is recorded on CMS to improve the quality of the resulting data reports.

- **Implementing the quality assurance strategy that the NMC's Council approved in January 2012?**

215 The quality assurance programme is now well established within FtP directorate which includes looking at a range of processes across the complete life cycle of cases. Council was updated on progress in July 2012[83].

216 At the same time, Council approved changes to the quality assurance strategy to reflect the need for a more proportionate approach to sampling cases and to introduce a risk based approach.

217 The FtP quality assurance team also now report directly to the Audit Committee to provide assurance to Council about this work.

218 We are currently seeking to appoint an Assistant Director of Quality and Risk Audit within our Corporate Governance directorate who will lead work across the organisation on corporate quality assurance and risk management to ensure excellence in the delivery of our core regulatory functions. This will include leading the work to strengthen quality assurance within fitness to practise.

- **Reviewing the NMC's approach to serious event reviews to ensure that its approach is robust, as well as introducing monitoring systems to assess whether any changes that are introduced as a result of the review actually prevent recurrence of errors?**

219 Following the introduction of Serious Event Reviews (SERs) in Fitness to Practise, it was decided that a similar approach should be adopted corporately. All corporate SERs are scrutinised by the Audit Committee.

220 As discussed at paragraph 23.2.4 above, a corporate policy encompassing serious event reviews and other untoward incidents is being developed to ensure that learning is identified and implemented across the organisation. Progress will be reported to the next Audit Committee meeting in December 2012.

221 In Fitness to Practise:

221.1 All serious event reviews are considered by the Executive Management Team and appropriate action taken to ensure lessons are learned and implemented.

221.2 FtP SERs which are of corporate significance are also reported to the Directors Group and Audit Committee in accordance with corporate policy.

- **Introducing in-house investigation of fitness to practise cases?**

222 Significant progress has been made and we are on track to achieve our target of 80% of investigations to be conducted in-house from December 2012. This has been a substantial project which has required:

222.1 Major restructuring of the way in which work is undertaken and managed within the FtP directorate.

222.2 Development of new roles and recruitment of staff to undertake the investigation work.

222.3 Implementation of the programme in four phases with new teams coming on stream at various points in the year.

222.4 Continuing to maintain an external investigation capacity for 20% of cases and manage this more effectively.

223 Key milestones have been achieved and three of the in-house investigation teams are now in place with cases being transferred on an incremental basis. The fourth team will be in place by mid-December.

224 As part of the work to bring investigations in-house, we have developed a case assessment tool to allocate cases by seriousness and urgency either in-house or for external investigation. The tool uses a set of criteria to help determine the potential complexity and risks of a case and is being used by the Screening and case investigation teams to determine the complexity and risks[84]. This enables us to:

224.1 Allocate cases more intelligently.

224.2 Show how risk is being considered and ensure a proactive approach at all stages of the investigation.

224.3 Collect performance data which will enable us to analyse trends over time once a baseline has been developed.

- **Considering whether equality and diversity data could be collected from participants in the fitness to practise process?**

225 A significant step forward was the publication in the NMC's Annual Fitness to Practise report 2011-2012 of all available data on the ethnicity and diversity of those subject to fitness to practise proceedings[85]. This has been welcomed by stakeholders.

226 The NMC's equality objectives adopted in July 2012 and related action plan include a commitment to making more effective use of the available data to identify the impact of our procedures on groups with protected characteristics[86].

227 Given the other pressing priorities facing the fitness to practise function, it has not been possible to give further consideration to collecting data directly from participants, other than registrants, in the fitness to practise process.

c) What account has been taken of:

- **The findings of the NMC's audit report 2012?**

228 See our response at paragraph 198 above.

d) What reporting arrangements are in place to ensure that the Council of the regulator is assured that the executive is managing a fitness to practise process which is efficient and effective (eg does the Council receive reports on the time taken to process fitness to practise referrals)? (Only respond if the answer is different from 2011/12)

229 Council has strengthened its oversight of Fitness to Practise work considerably in the past year.

229.1 Council established an FtP Action Plan Group in December 2011.

229.2 The group comprised Council and executive members together with an external independent member from another health care regulator.

229.3 The group has met monthly (except in August and September 2012) to oversee and scrutinise progress against the action plan agreed with Department of Health and CHRE in November 2011.

229.4 The group reported monthly to both Council and CHRE. As well as scrutinising performance, the Group's work has helped to drive improvements in the nature and quality of the management information as described above (paragraph 214).

229.5 Council has now decided to reconstitute the Group as a formal Committee[87]. The Committee's remit was approved by Council in November[88] and the group reconstituted as a Committee is expected to meet from January 2013.

230 In addition, Council receives in its public meeting each month[89]:

230.1 Performance management data through the balanced scorecard. This includes performance against FtP key performance indicators (since May 2012).

230.2 A separate report on FtP performance.

230.3 Specific reports, as appropriate on particular policy or performance issues relating to FtP.

e) What plans are in place, if any, improve your performance in this area?

231 The introduction of voluntary removals will we believe help increase the safeguards provided to the public by enabling us to take appropriate action in a more proportionate, effective and efficient manner. Council approved the necessary rule changes, associated criteria and guidance in September 2012[90].

232 In developing these new arrangements we have sought to safeguard public confidence in the regulatory system and taken close account of the views of both CHRE and the Department of Health, as well as the views expressed as part of the full public consultation conducted in summer 2011 on our original proposals. The full report of the consultation is available on our website[91].

	233 We will be issuing guidance notes on the new voluntary removal procedures which will be published on our website to coincide with the coming into force of the rule changes. Subject to Department of Health agreement, we expect this to be available from January 2013. **f) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)?** 234 No further comments to add
Sixth standard	Fitness to practise cases are dealt with as quickly as possible taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients or service users. Where necessary the regulator protects the public by means of interim orders
Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 235 Improving the speed of progression of fitness to practise cases has been one of the top three priorities for the NMC. In addition to the increase in resources and staffing described at paragraph 180 above, key steps taken to tackle this include: 235.1 Introducing the Rule changes described at paragraph 192 above. 235.2 Development of the case management proposals described at paragraph 213 above. 235.3 A Lean review of our processes to identify more efficient and effective working practices and eliminate unnecessary activities. 235.4 The transition to in-house investigation described at paragraph 222 above. 235.5 Increasing the number of substantive events scheduled (see paragraph 248 below). 235.6 Introduction of new scheduling processes (incrementally between October 2012 and April 2013). **b) What progress has been made on:** • **The progression of cases that were held back pending the rule changes in February 2012?** 236 Cases were held pending the rule changes in the interests of efficiency and effectiveness, so that they could be dealt with more expeditiously under the new rules. All cases (669) held to await the rule changes had screening investigation plans prepared by 4 April 2012. • **Reducing the number of cases where a High Court extension is required in relation to interim orders, the number of cases where an interim order lapses without review and the number of cases where a substantive order has lapsed without review?**

237 Between 1 April and 31 October 2012, we applied for 192 interim order extensions. Council received a report in September 2012 on High Court applications for interim order extensions[92] and now receives an update on this at each meeting and an explanation for the reasons the applications have been made.

238 Between April and September, there was one instance of a substantive order lapsing before being reviewed. We now have a system in place to ensure that the end dates for orders are correctly inputted into the CMS to ensure that cases due for review are identified. The only other interim orders lapsed are those which have been intentionally allowed to do so, due to a reassessment of risk in the case concerned.

- **Reducing the high rate of adjournments and part heard hearings?**

239 The unacceptably high rate of adjourned and part-heard cases is a significant cause for concern, impacting as it does both on the timeliness of the individual case adjourned or delayed and on the wider cases awaiting scheduling time. Accordingly we now track closely the rate of adjourned/part-heard cases and examine the reasons for all such decisions in our weekly management information meetings. Performance is reported to the FtP Action Plan Group and to Council, as well as being included in the Balanced Scorecard. The Council Chair highlighted the challenges of addressing this in a recent article in our monthly e-newsletter for panellists[93]. We have seen a slight lowering of the rate to 30% in October but recognise that this is still too high.

240 We have introduced a log to be completed at every hearing by panel secretaries to record all the factors that may adversely affect the time taken to hear a case. We are also looking at the correlation between the age of a case and hearing length.

241 As reported to Council in November, we have further analysis to do but an initial analysis shows a variety of reasons leading to cases having to be adjourned such as witness issues, registrants requests or cases taking longer than expected due to unrepresented registrants or registrants being represented by non-legal representatives[94].

242 We will be focusing further efforts on seeking to bring down the adjournment/part-heard rate given the impact on our ability to progress both the cases concerned and other cases as quickly as we would wish. The recent appointment of a new Assistant Director of Adjudication will give further impetus to this work.

- **Reducing the caseloads of the screening team and casework teams?**

243 The high caseloads held by our staff compared with other regulators inevitably impacts our ability to achieve the levels of timeliness and customer service we would like, as CHRE has recognised[95]. This has been a major concern and focus for Council and the Executive team. The allocation of additional resource in this year's budget and the ability to significantly increase the levels of FtP staffing should go someway to addressing this.

244 Direct comparisons with previous time periods are currently difficult due to the reorganisation of work and working teams within FtP and the transitional phase we are currently in with the new case investigation teams coming on stream and taking on cases on an incremental basis. We have, however begun to see caseloads reduce in the Screening team and at September those stood at around

83 cases on average from around 101 earlier this year.

245 Ideal caseloads will vary depending on the team and the task being down, so for example in the new case investigation remains, we have caseloads of around 17-25 cases, which we consider appropriate. Currently, the heavier caseloads are in our case preparation reams as the number of cases ready for adjudication has grown as we progress cases faster through the investigation process. Our recent recruitment drive was focused on filling roles in these teams to bring caseloads down to what we consider a manageable level within these teams of 60 to 70 cases.

- **Reducing the time taken for cases to progress throughout the fitness to practise process?**

246 As indicated above, we have achieved significant improvements in the time taken to progress cases. In October 2012, our performance was as follows:

246.1 76% investigations completed within 12 months with all cases taking an average of 10.4 months (including those which are historic), compared with 16 months in December 2011.

246.2 52% cases reaching the first day of adjudication within 6 months and cases taking on average 7.5 months compared with 9.83 months in December 2011.

246.3 Over half of our historic caseload completed and the remaining cases expected to reach a conclusion by autumn 2013.

- **Holding 15/17 final fitness to practise hearings a day?**

247 The original FtP action plan (developed late 2011) provided for an increase from 11 to 15 substantive hearings each day from January 2012 in order to meet our adjudication KPI.

248 The additional investment in FtP previously described has enabled us to increase staffing levels within the scheduling team and lease additional accommodation for hearing space in London. This, together with steps taken to make more effective use of existing space, has enabled us to plan for increased hearings activity as follows:

248.1 16 substantive CCC hearings per day from September 2012.

248.2 18 substantive CCC hearings per day from November 2012.

248.3 20 substantive CCC hearings per day from January 2013.

248.4 22 substantive CCC hearings from June 2013.

249 In September 2012, 16.1 substantive Conduct and Competence hearings were scheduled and 17.3 scheduled in October 2012

250 A new scheduling process has been developed to support this increase in the level of hearings activity. This includes:

250.1 Scheduling panels to rooms (rather than, as previously, scheduling panels to cases)

250.2 Block booking panel members with targets set for the number of days panellists will be used each year.

250.3 Creating a standby list of panellists to cover short notice cancellations.

250.4 Smarter scheduling including: scheduling cases at least three months in advance; overlisting cases; and developing a strategy of listing 'floater cases'.

250.5 Developing plans for block booking shorthand writers and legal assessors.

250.6 Improving customer service to witnesses by ascertaining witness availability by phone followed by email confirmation and by reallocating responsibility for sending decision letters to witnesses to the case preparation team.

251 We began to introduce these initiatives in October but would expect it to take until early 2013 for these to become fully effective.

- **Clearing the historic caseload at both investigation and adjudication stage of the fitness to practise process?**

252 Considerable progress has been made in reducing the historic caseload (that is, cases received before January 2011).We are on track to meet our target for all historic cases to have reached the first day of an adjudication hearing by 1 April 2013 (other than a small number of exceptions) and for all historic cases to have been concluded by the end 2013.

253 A progression plan was developed with monthly targets and progress is scrutinised monthly by the Council FtP Action Plan Group. Since 1 April 2012, the historic caseload has been reduced from 1589 to 727 cases (at 12 November 2012 – source CMS) as follows:

253.1 1 April 2012: Historic caseload =1589 cases

253.2 1 April - 30 September 2012: Cases closed = 862

253.3 12 November 2012: Cases outstanding = 727

253.3.1 96 at investigation stage

253.3.2 82 historic health cases

253.3.3 549 cases awaiting a Conduct and Competence Committee hearing.

253.3.4 There are a further 25 exception cases: these are cases which have previously been closed and have been re-opened on appeal or where the cases are on hold pending third party activity.

254 As the caseload has now been reduced to a manageable level, the progression plan now sets out how each of the outstanding cases will be progressed with either scheduled or target dates. The target is for all remaining cases at the investigation stage (except those outside of our control due to third party activity) to be progressed by December 2012 and for all cases to have reached the first day of a hearing by 1 April 2013 and to have completed to a final substantive outcome by autumn 2013.

c) What account has been taken of:

- **The findings of the NMC's audit report 2012?**

255 Please see our response at paragraph198 above.

d) What reporting arrangements are in place to ensure that the Council of the regulator understands the time it is taking to progress fitness to practise cases and the impact any delays are having on the regulator's performance? (eg does the Council receive reports on the time taken for cases to progress through the fitness to practise process)? (Only respond if the answer is different from 2011/12)

256 Please see the response given at paragraphs 229 to 230 above. The monthly performance reports to both Council and the Council FtP Action Plan Group specifically include information on timeliness and our KPIs for progression of cases. Council recognised that FtP activity had to be increased to ensure that public protection needs were met and acted to address this through the financial and strategic decisions taken earlier this year.

e) What plans are in place, if any, to improve your performance in this area?

257 As indicated, from January 2013, we will have a range of options available to us including:

257.1 The case management tools.

257.2 Consensual panel determinations

257.3 Voluntary removals.

f) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)?

258 No further comments to add.

Dataset (data to be provided should be that collected for the regulators' most recent reporting period)

259 The following data is sourced from the case management system and is for the period 1 April 2012 to 30 September 2012.

	• **How many cases were considered by an investigating committee (and/or case examiners)?** 260 1847 • **How many cases were concluded by an investigating committee (and/or case examiners)?** 261 612 cases were concluded by the IC as No Case to answer • **How many cases were considered by a final fitness to practise committee?** 262 911 cases were considered by the CCC and HC at hearings and meetings • **How many cases were concluded by a final fitness to practise committee?** • 263 569 cases were concluded by the CCC and HC at hearings and meetings • **What is the median time taken from receipt of initial complaint to final fitness to practise hearing determination? (Please provide in 'weeks')** 264 111 weeks • **What was the longest time taken to conclude a case? (Please provide in 'weeks')** 265 309 weeks • **What was the shortest time taken to conclude a case? (Please provide in 'weeks')** 266 42 weeks • **What is the median time taken from receipt of initial complaint to the final investigating committee decision? (Please provide in 'weeks')** 267 51 weeks • **What was the longest time taken to conclude a case? (Please provide in 'weeks')** 268 198 weeks for a final investigating committee decisions • **What was the shortest time taken to conclude a case? (Please provide in 'weeks')**

	269 10 weeks for IC • **What is the median time taken from final investigating committee decision to final fitness to practise hearing decision? (Please provide in weeks)** 270 39.75 weeks • **What is the median time taken from initial receipt of complaint to interim order decision? (Please provide in weeks)** 271 4 weeks • **What is the median time taken from receipt of information indicating the need for an interim order and an interim order decision? (Please provide in weeks)** 272 We do not collect this information. • **How many open fitness to practise cases are there; how many have been open for more than 52 weeks, how many have been open for more than 104 weeks and how many have been open for more than 156 weeks?** 273 At 30 September 2012 the figures were as follows: 273.1 Open 4416 273.2 Open more than 52 weeks 1130 273.3 Open more than 104 weeks 420 273.4 Open more than 156 weeks 170
Seventh standard	All parties to a fitness to practise case are kept updated on the progress of their case and supported to participate effectively in the process
Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 274 Customer service, including improving the information and support provided to parties in fitness to practise cases continues to be one of our top priorities as reflected in the draft FtP strategy and business and improvement plans. 275 Performance is monitored closely against the KPIs we have set by the FtP Executive Management Team, Directors Group, the FTP Action Group and Council. Considerable progress has been made in the timeliness with which information is sent and we are

committed to continuously improving the quality of the letters we send to participants.

b) What progress has been made on:

- **Ensuring that all decision letters are sent within five working days of the decision?**

276 We have a key performance indicator that all decision letters should be sent within 5 working days. Performance is reported monthly to both the Council FtP Action Plan Group and to Council (as part of the Balanced scorecard and FtP performance reports described at paragraph 4.4.1 above).

277 Decision letters are now sent by case preparation team staff instead of Investigating Committee secretaries which has improved timeliness[96].

278 Considerable efforts have been made to improve performance, including close monitoring by managers, with the result that in September 2012 we achieved the following:

278.1 98% of investigation decision letters sent in 5 days and 100% within 10 days.

278.2 97% of adjudication letters sent within 5 days; 99% in 10 days and one letter at 11 days.

278.3 99% adjudication notices were sent within 28 days. In the one case not sent within 28 days, short notice was agreed with the parties and the hearing proceeded as scheduled.

- **Ensuring that all notices of hearings are sent within 56 days of the hearing?**

279 Whilst we continue to endeavour to send notices within 56 days, we now measure performance against the statutory notice period of 28 days. This is more useful and ensures that cases are not held up for this reason alone when the statutory notice period has been met.

- **Introducing compliance systems so that customer service provided to parties to a fitness to practise case can be monitored?**

280 Customer service standards were introduced in August 2011 (see paragraphs 498 to 501, 2011-2012 submission) and since then a customer feedback form has been sent to all participants at the conclusion of a case and is also available on line[97].

281 Response levels remain very low (4.6% for period January to August 2012).The FtP Quality Assurance team produced an analysis of responses and issues raised during this period which was considered by the FtP EMT and heads of teams. This showed that the overall trend in satisfaction levels is improving but the very low level of responses received means that the data cannot be relied on as an accurate picture of the satisfaction levels of referrers and registrants.

282 As a result, further efforts are being made to ensure that feedback forms are sent out on all closed cases (57% was achieved in

August 2012).

- **Responding to or learning from information provided on the customer feedback forms or from complaints from parties involved in the fitness to practise process?**

283 As indicated above, the work of the QA team includes an analysis of all feedback responses received along with complaints to identify key areas of dissatisfaction which need to be addressed. This work has identified that referrers are most likely to report low levels of satisfaction (primarily being kept informed of progress) and are also the source of most complaints (40%) and that most complaints relate to dissatisfaction with the hearing/process.

284 Analysis of the feedback suggests that once we are clear that the case is one we can take forward (in the form required), the focus tends to switch away from the referrer and onto the registrant. As a result, we have identified the need to ensure that we intensify efforts to meet our customer service standard of contacting referrers at least once every six weeks to keep them updated on what is happening on the case. In the absence of automated systems to prompt staff, managers have been reminded of their responsibility to ensure this happens.

285 We introduced new corporate arrangements for managing complaints in April 2012 (see paragraph 24 above). In relation to FtP complaints, we continue to have a KPI to respond to all complaints within 20 days of receipt and progress is reported monthly to Council (see balanced scorecard). In September, 90% of complaints were answered within 20 days and the remaining 10% (one complaint) in 28 days.

c) What account has been taken of:

- **Chapter 6 and the recommendations of the Modern and Efficient Fitness to Practise Adjudication report?**

286 As part of the FtP improvement plan and reorganisation of work we have created case preparation teams to undertake work to progress cases from the completion of investigations to post adjudication stage. Amongst other things, it is a key responsibility of case officers in these teams to ensure that high standards of customer care are provided at all times in line with the customer service standards[98].

- **The findings of the NMC's audit report 2012?**

287 Please see response at paragraph 198 above.

d) What plans are in place, if any, to improve your performance in this area?

288 The FtP draft strategy and Improvement Plan described above include specific aims to continue to improve standards of customer service.

	e) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)? 289 No further comments to add.
Eighth standard	All fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession
Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 290 Improving the quality of our decision-making is one of FtP's three key priorities and a range of steps have been taken to tackle this issue. The impact of these initiatives is beginning to feed through, for example, in two recent appeal cases, high court judges have given positive feedback on the work of panels: 290.1 In one case, the Judge described the panel's determination as ".... an extremely well-reasoned document and the reasons given for each of the decisions that were made are well-reasoned, and full explanations are given" (Heydon-Burke).[99] 290.2 In another case, an appeal against sanction, the Judge described the panel's reasoning as "meticulous" (Ajala)[100]. 291 Appointments Board: In January 2012, we reconstituted the Appointments Board, a formal committee of Council but which comprises entirely non-Council members. The Appointments Board oversees the process for recruitment, appointment, induction and appraisal of Panel chairs and members. 292 Panel Chairs and members: As CHRE is aware, as part of our ongoing improvement programme, in early 2012 we recruited just under 100 panel chairs to a new role specification with a particular focus on chairing and case management skills. A further recruitment exercise was conducted earlier this year to recruit 25 midwife panel members. In September 2012, the Appointments Board approved plans to recruit an additional 50 registrant panel members by early 2013, in order to support the planned increase in substantive hearings (as described in paragraph 248 above). 293 Training for Panel members - A comprehensive training programme is in place for panellists[101].Training this year has included: 293.1 24 January 2012: Training on Rule changes. 293.2 12-13 July 2012: Refresher training on Interim Orders. 293.3 4-5 October 2012: Training on Health and Conduct and Competence Committee processes, Interim order hearings and case to answer.

293.4 We are continuing to improve training provision for panellists including:

293.4.1 Introducing distance learning, for example on voluntary removals, from January 2013.

293.4.2 New format induction training form February 2013

293.4.3 From April 2013, distance learning programme on information/knowledge with classroom training on application of knowledge and behaviours.

294 Other support provided by our Panel Support Team to panellists over the past year has included:

294.1 Maintaining panel member guidance folders for all hearings and developing an online reference for the guidance. All guidance documents and selected training presentations for panel members are accessible on our website[102].

294.2 Issuing a monthly e-newsletter for panel members (introduced October 2011)[103]

294.3 Launching 360 degree post panel feedback in April 2012 to produce feedback reports for individual panel members after each completed event.

294.4 Developing profiling of panel members using our new HR database.

294.5 Developing new procedures to deal with concerns informally.

294.6 Establishing panel member regular drop-in surgery sessions.

294.7 Developing a system to record and monitor performance based on CHRE learning points, 360 degree and decision review group feedback to identify training needs and broader issues.

294.8 Initiating meetings with panellists with regards CHRE learning points, adjournments and other concerns.

b) What progress has been made on:

- **Ensuring learning from the Decision Review Group, internal quality assurance systems and feedback from CHRE/the Authority on decisions leads to improvements in decision-making?**

295 As described in our previous submission, the Decision Review Group (DRG) was set up in November 2011 to review and monitor panel decision making to improve the quality and consistency of decisions. This includes reviewing any section 29 appeals or learning points received from CHRE, as well as from decisions referred internally, to identify the need for guidance, training or learning for panel members or staff. The Group meets monthly and progress against actions identified are reviewed at each meeting. Since the Group was set up in November 2011, it has considered on average 10 cases each month.

296 As well as any direct feedback to individual panel members or FtP staff, any learning issues of wider application will be drawn to the

attention of all panellists through normal communication channels such as information evenings and monthly e-newsletters.

- **The introduction of toolkits for Interim Order hearings and Restoration hearings?**

297 The determination tools for Interim Orders and Restoration applications were finalised in February 2012 and are available on our website[104].

c) What account has been taken of:
- **CHRE's report on Modern and Efficient Fitness to Practise Adjudication and its recommendations?**

298 See our response at paragraph 182 above.

- **CHRE's/The Authority's learning points?**

299 On receipt, CHRE learning points are circulated to the individual panel members and staff involved in the relevant case and comments requested as appropriate.

300 CHRE learning points are considered by the Decision Review Group and are used to inform panel and staff training, create panel guidance and develop FtP toolkits. Learning points of general application for all panellists are included in the panel e-newsletter.

301 Since May 2012, we have provide full written feedback to CHRE in response to all learning points communicated to us, including where we do not agree with a particular point raised. Any comments received from the panel members involved. However, we have yet to receive any comments or response from CHRE.

d) What reporting arrangements are in place to ensure that the Council of the regulator is assured that the fitness to practise panels are making well reasoned, consistent decisions that protect the public and maintain confidence in the profession? (ie does the Council receive reports on the outcomes of any internal quality assurance of decisions made by the panels?) (Only respond to this if the answer is different from 2011/12)

302 At regular intervals the Council FtP Action Plan Group receives reports on CHRE learning points. This includes information on the number of learning points percentage of decisions on which learning points received (16% for the period August 2011-June 2012) and an analysis of the nature of the learning points received.

303 As part of the FtP performance report provided to Council each month, we have begun to include learning from litigation and high court cases and have also included an update on CHRE learning points[105].

e) What plans are in place, if any, to improve your performance in this area?

	304 Nothing further to add. **f) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)?** 305 No further comments to add. **Dataset (data to be provided should be that collected for the regulators' most recent reporting period)** • **How many registrant appeals against final fitness to practise decisions have there been? Please summarise the findings for each appeal.** • **How many appeals were successful?** 306 Between April and September 2012, 13 appeals were lodged. 307 We have had 4 determinations all of which were decided in favour of the NMC. These are summarised below: 307.1 HEYDON-BURKE - The registrant was challenging the panel's findings of dishonesty and her subsequent striking off. The judge found that the Panel's reasons had been 'impeccable'. The judge's positive comments have been fed back to the panel. 307.2 DUBLAS - The registrant sought to argue that the NMC had to prove impairment to the criminal standard. The judge rejected this submission. This is a useful in reiterating that impairment is a matter of judgement for the panel not proof. 307.3 ADESINA - The court accepted the NMC's evidence that the notice of decision letter was sent out on a particular date and consequently the Appellant's notice had been lodged out of time. We are reviewing whether there is scope to use this decision more widely to strike out appeals that are lodged out of time. 307.4 BAINES - The 28 day time limit for making a statutory appeal starts at the point of deemed rather than actual service. Deemed service can occur on non-working days. We will be looking at the scope to use this decision more widely to strike out appeals that are lodged out of time.
Ninth standard	All final fitness to practise decisions, apart from matters relating to the health of a professional, are published and communicated to relevant stakeholders
Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 308 We: 308.1 Publish details of all final decisions, except in health cases, on our website.

	308.2 Provide information for the media on fitness to practise outcomes through press releases and our media. 308.3 Distribute a monthly circular of outcomes to employers. 308.4 Circulate a monthly news letter to employers. 308.5 Now provide a summary of fitness to practise outcomes in our monthly e-newsletter for patients and the public. **b) What key performance indicators are in place around communicating decisions to complainants, registrants and employers?** 309 Our key performance indicator is that final decisions are communicated to all parties within 5 working days. Performance is reported monthly to the FtP Action Plan Group and to Council through the balanced scorecard and the FtP performance report[106] 310 As indicated, our performance in September 2012 was as follows: 310.1 97% of adjudication letters sent within 5 days; 99% in 10 days and one letter at 11 days. **c) What plans are in place, if any, to improve your performance in this area?** 311 We intend to publish FtP sanctions on line from January 2013 (see paragraph 159 above). 312 As part of our patient and public engagement plan and wider engagement strategy we are exploring how we improve communication of fitness to practise outcomes to the public including through national and local media[107]. This includes learning from the feedback from our Patient and Public Engagement Forum about the information they want and looking at: 312.1 More proactive engagement with the media, journalists and opinion formers. 312.2 Working with patient representative organisations to produce information more tailored to needs. 312.3 Research and identify opportunities to engage with key groups face to face through social media or other communications channels. 312.4 Build an evidence base to inform our future approaches. **d) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)?** 313 As indicated (paragraph 16.3.2 above), we now include a summary of fitness to practise activity and outcomes in our new monthly public e-newsletter[108].
Tenth	Information about fitness to practise cases is securely retained

standard	
Regulator's evidence	**a) What, if anything, has changed in your performance against this standard since your last evidence submission?** 314 We have: 314.1 Introduced new guidance on protecting electronic registrants data when it is in transit (April 2012). 314.2 Implemented a new policy on handling data which is shared with the police. This policy further protects registrants' data by defining the job roles within the NMC which may share registrants' information with the police, and mandates the use of secure channels for information sharing with the police, such as the use of the Criminal Justice Secure Mail System. 314.3 Tightened our policies on the use of portable media and introduced encrypted USB keys. 314.4 Begun to systematically update all our information security policies following a defined annual schedule. **b) What progress has been made on:** • **Carrying out a security gap analysis (it was meant to be undertaken in the first two quarters of 2012/13)?** 315 The security gap analysis has been completed. 316 This is being used to inform a risk-based programme of information security activities for the remainder of 2012- 2013 and 2013-14 focussed on the areas of greatest risk to the security of registrants' data. 317 A comprehensive action plan has been developed to address the gaps identified in the gap analysis. This will be considered by the Audit Committee on 11 December 2012 and Council in January 2013. 318 An internal audit health check of data security was undertaken as part of the 2011-2012 internal audit programme and the resulting recommendations also form part of the action plan. • **Reducing the number of incidents where information was not retained securely by the NMC?** 319 All staff (including those who are on fixed term contracts or temporary) in FtP are required to read and sign the data security policy to say they understand and will adhere to when they start employment with us. We have recently recirculated this to all FtP staff to reinforce the message around data protection, our duties and our policies. We have asked all staff to re-read this and sign it to ensure that they are all covered by it[109]. 320 It is important to recognise the considerable volume of activity undertaken by FtP and in particular that activity has almost doubled over the past year, when viewing the figures below. 321 Between April and September 2012, we had 23 information security incidents, 20 of which originated in FtP. All were classified as

'minor' or 'insignificant' and none have warranted self reporting to the Information Commissioner

322 The majority of incidents are the result of human error.

322.1 5 indicated a need to change a policy or procedure. Where an incident indicated an improvement required to a policy or process, we have implemented the recommended improvement as part of the remedial action plan following the incident.

322.2 The root cause of 2 incidents was an error by a third party.

322.3 One minor incident was a case of deliberate non-compliance with our information security policies.

323 In 2011-2012, we had 26 information security incidents, 22 of which originated in FtP.

323.1 4 incidents were classed as ‘moderate’ and one of these four incidents was reported by us to the Information Commissioner. All the remaining incidents were classified as 'minor' or 'insignificant'.

323.2 21 incidents indicated that an improvement was needed to a policy or procedure and in these situations remedial action was taken as part of the incident management process.

323.3 The root cause of 2 incidents was an error by a third party.

323.4 One minor incident was a non-compliance with one of our information security policies and was the result of deliberate action.

323.5 The remaining incidents were the result of human error.

c) What plans are in place, if any, to improve your performance in this area?

324 Please see paragraph 317 above.

d) Is there anything further, relevant to your role as a regulator, that you wish to tell us about (this includes any good practice that you have or challenges that you are facing)?

325 No further comments to add.

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Endnotes: links and references

[1] CHRE Strategic Review Interim Report (April 2012) and Final Report (July 2012) http://www.chre.org.uk/_img/pics/library/120702_CHRE_Final_Report_for_NMC_strategic_review_(pdf)_1.pdf
[2] CHRE Performance Review Report 2011-2012 (June 2012) http://www.chre.org.uk/_img/pics/library/120620_CHRE_Performance_review_report_2011-12,_Vol_II_(Colour_for_web_-_PDF)_1.pdf
[3] CHRE Right Touch Regulation (2010) http://www.chre.org.uk/_img/pics/library/100809_RTR_FINAL.pdf
[4] http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/20121025%20Council%20Bundle.pdf
[5] KPMG report NMC/12/138c Annexe 2 http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/1883070%20To%20Follow%20bundle.PDF
[6] October 2012 NMC/12/144 http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/20121025%20Council%20Bundle.pdf
[7] The new organisational structure is enclosed: in the supporting documentation – Document 1
[8]Section 6, CHRE Strategic review final report (July 2012) www.chre.org.uk/_img/pics/library/120702_CHRE_Final_Report_for_NMC_strategic_review_(pdf)_1.pdf
[9] July 2012 NMC/12/104 http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/1695867%20%20Council%20open%20agenda%20papers%20v1.PDF
[10] Integrity of WISER and CMS, haysmacintyre November 2012: a copy of the report will follow when finalised -see supporting documentation (Document 2)
[11] NMC/12/129 September 2012 http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/1792810%20%20Council%20open%20session%20agenda%20bundle%20V2.PDF
[12] Recommendation 15, http://www.chre.org.uk/_img/pics/library/120702_CHRE_Final_Report_for_NMC_strategic_review_(pdf)_1.pdf
[13] Paragraph 8.16 “the NMC has under invested in fitness to practise compared to other health professional regulators” www.chre.org.uk/_img/pics/library/120702_CHRE_Final_Report_for_NMC_strategic_review_(pdf)_1.pdf
[14] http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/uc639-i/uc63901.htm
[15] November 2012 NMC/12/164 http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/20121122%20Council%20bundle.pdf
[16] http://www.nmc-uk.org/Get-involved/Consultations/NMC-consultation-on-fitness-to-practise-case-management-and-consensual-disposal/
[17] http://www.nmc-uk.org/Get-involved/Consultations/NMC-fee-increase/
[18] http://www.nmc-uk.org/Get-involved/Consultations/Draft-equality-objectives-for-2012-2015/
[19] http://www.chre.org.uk/_img/pics/library/100809_RTR_FINAL.pdf
[20] November 2012 NMC/12/159 http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/20121122%20Council%20bundle.pdf
[21] Directive 2005/36/EC http://ec.europa.eu//press/press_releases/2011/pr1158_en.htm
[22] www.legislation.gov.uk/uksi/2012/2745/contents/made and www.dh.gov.uk/health/2012/11/changes-constitution-nmc/
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[24] Recommendations 2 to 5, http://www.chre.org.uk/_img/pics/library/120702_CHRE_Final_Report_for_NMC_strategic_review_(pdf)_1.pdf
[25] www.nmc-uk.org/Get-involved/Events/Past-events/How-can-healthcare-regulators-better-engage-with-patients-and-the-public
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[27] November 2012 NMC/12/157 http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/20121122%20Council%20bundle.pdf
[28] http://www.nmc-uk.org/Press-and-media/Latest-news/NMC-and-GMC-release-joint-statement-on-professional-values/
[29] www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Midwifery-New/Midwifery-extra-ordinary-reports/

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[30] September 2012 NMC/12/124 http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/1792810%20%20Council%20open%20session%20agenda%20bundle%20V2.PDF
[31] October 2012 NMC/12/143 http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/20121025%20Council%20Bundle.pdf
[32] February 2012 NMC/12/29 http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/Council-papers-20120223.PDF
[33] March 2012 NMC/12/53 http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/Council-papers_20120329.pdf
[34] June 2012 NMC/12/90 http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/Council-Papers-20120621-1.pdf
[35] www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice
[36] Joint letter to Health Committee 12 July 2012 - See enclosed supporting documents (Document 3).
[37] http://www.nmc-uk.org/Nurses-and-midwives
[38] www.williscommission.org.uk/recommendations
[39] See paragraphs 31 & 46, NMC performance review submission 2011-2012
[40] October 2012 NMC/12/144 http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/20121025%20Council%20Bundle.pdf
[41] November 2012 NMC/12/164 http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/20121122%20Council%20bundle.pdf
[42] http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/20121122%20Council%20bundle.pdf
[43] www.nmc-uk.org/Educators/Quality-assurance-of-education/Reviewing-and-monitoring/2011-2012
[44] October 2012 NMC/12/146 http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/20121025%20Council%20Bundle.pdf
[45] As at footnote 43.
[46] www.nmc-uk.org/Documents/QualityAssurance/Annual%20monitoring%20review%20plan%202012-2013.pdf
[47] July 2012 NMC/12/115 http://www.nmc-uk.org/Documeunitedkingdomnts/CouncilPapersAndDocuments/Council2012/1695867%20%20Council%20open%20agenda%20papers%20v1.PDF
[48] www.nmc.mottmac.com/infoprogproviders
[49] www.nmc-uk.org/Approved-Programmes
[50] www.nmc.mottmac.com
[51] www.nmc-uk.org/Educators/Quality-assurance-of-education/Reviewing-and-monitoring/2011-2012
[52] As for footnote 50 above.
[53] NMC/12/152 http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/20121122%20Council%20bundle.pdf and NMC/12/152 Annexe 1 http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/To%20follow%20Bundle%20november%202012.PDF
[54] An example of this is from September 2012, NMC/12/132 http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/1792810%20%20Council%20open%20session%20agenda%20bundle%20V2.PDF
[55] Examples of the Registration and Standards dashboard and management pack for September 2012 are included in the supporting documentation at Documents 4 and 5.
[56] An example of the information provided to new registrants is included in supporting documentation at Document 6.
[57] November 2012 NMC/12/149 & NMC/12/157 http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/20121122%20Council%20bundle.pdf
[58] Integrity of WISER and CMS, haysmacintyre, November 2012: a copy of this report will follow – see endnote 10 above.
[59] January 2012 NMC/12/06 www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/NMC_Open-Council-Papers_26-January-2011.pdf
[60] September 2012 NMC/12/129 www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/1792810%20%20Council%20open%20session%20agenda%20bundle%20V2.PDF
[61] http://www.nmc-uk.org/Documents/Consultations/NMC-responses/2012/Law-Commission-consultation-NMC-response-May-2012.pdf

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[62] CHRE Strategic Review (July 2012) paragraphs 8.27-8.30 and Recommendation 15
http://www.chre.org.uk/_img/pics/library/120702_CHRE_Final_Report_for_NMC_strategic_review_(pdf)_1.pdf
[63] FTP organisational structure October 2012 – enclosed in supporting documentation at Document 7.
[64] http://www.nmc-uk.org/Documents/FtP_Information/Advice-and-information-for-employers-of-nurses-and-midwives20110816.pdf
[65] Standard Operating Procedure for referrals to ISA – see supporting documentation – Document 8.
[66] http://www.nmc-uk.org/About-us/Who-we-work-with
[67] See anonomised examples in supporting documentation at Documents 9a-c
[68] http://www.legislation.gov.uk/uksi/2007/1887/pdfs/uksi_20071887_en.pdf
[69] July 2012 NMC/12/109 http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/1695867%20%20Council%20open%20agenda%20papers%20v1.PDF & September 2012 NMC/12/118 http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/1792810%20%20Council%20open%20session%20agenda%20bundle%20V2.PDF
[70] Anonomised examples of decisions made in December 2011 and in July/August 201 are enclosed Supporting documentation – Document 10
[71] The training materials are enclosed in our supporting documentation at Document 11
[72] http://www.nmc-uk.org/Hearings/Green-Guidance-Folders/Investigating-Committee
[73] The Investigating Panel Secretary role profile and training materials are enclosed in our supporting documentation at Documents 12 to 14
[74] http://www.legislation.gov.uk/uksi/2012/17/pdfs/uksi_20120017_en.pdf and http://www.nmc-uk.org/Documents/Legislation/NMC-fitness-to-practise-legislation-guidance-notes-31012012.pdf
[75] The current structure of the Screening team is enclosed in our supporting documentation as Document 15
[76] http://www.chre.org.uk/_img/pics/library/120620_CHRE_Performance_review_report_2011-12,_Vol_II_(Colour_for_web_-_PDF)_1.pdf, paragraph 17.49
[77] The risk assessment form, which contains detailed operational notes, is enclosed in our supporting documentation at Document 16
[78] Staff training material on risk assessment is included in our supporting documentation at Document 17.
[79] http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/NMC-Council-papers-May-2012.PDF
[80] www.nmc-uk.org/Hearings/Green-Guidance-Folders/Investigating-Committee
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[84] Case Assessment Tool enclosed in supporting documentation at Document 18
[85] http://www.nmc-uk.org/Documents/Annual_reports_and_accounts/FtPannualReports/Nursing%20and%20Midwifery%20Council%20Annual%20Fitness%20to%20Practise%20Report%202011-2012.pdf
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[89] http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/To%20follow%20Bundle%20november%202012.PDF
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[92] September 2012 NMC/12/45c http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/1792810%20%20Council%20open%20session%20agenda%20bundle%20V2.PDF
[93] The panellists e-newsletter for October 2012 is included in our supporting documentation at Document 19
[94] http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/To%20follow%20Bundle%20november%202012.PDF
[95] CHRE performance review 2011-2012, paragraph 17.32 https://www.chre.org.uk/_img/pics/library/120620_CHRE_Performance_review_report_2011-12,_Vol_II_(Colour_for_web_-_PDF)_1.pdf
[96] Job description for case preparation officers in supporting documentation at Document 20
[97] http://www.nmc-uk.org/Hearings/Fitness-to-practise-feedback-form
[98] The role profile for case preparation team officers is included in the supporting documentation at 20, as indicated at end note 96 above
[99] Judgement transcript included in supporting documentation at Document 21
[100] Judgement transcript included in supporting documentation at Document 22
[101] The panellists training programme is included in our supporting documentation at Document 23
[102] www.nmc-uk.org/Hearings/Green-Guidance-Folders
[103] Example e-newsletter included in supporting documentation – Document 19
[104] www.nmc-uk.org/Hearings/Green-Guidance-Folders.
[105] November 2012, NMC/12/153 http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/To%20follow%20Bundle%20november%202012.PDF
[106] http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/To%20follow%20Bundle%20november%202012.PDF
[107] http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2012/To%20follow%20Bundle%20november%202012.PDF
[108] An example is enclosed in our supporting documentation at Document 24
[109] The FTP data protection policy, staff form and staff training slides are included in the supporting documentation and at Documents 25 and 26