

**Better legislation  
for better  
regulation: the  
case for legislative  
reform**

## Better legislation for better regulation: the case for legislative reform

- 1 The Nursing and Midwifery Council (NMC) is the healthcare regulator for nursing and midwifery in the UK. We exist to protect the health and wellbeing of the public. We do this by setting standards of education, training, conduct and performance for nurses and midwives. We also hold the register of those who have qualified and meet those standards. If an allegation is made that a registered nurse or midwife is not fit to practise, we have a duty to investigate that allegation and, where necessary, take action to protect the health and wellbeing of the public.
- 2 We are the largest healthcare regulator in the world with over 680,000 nurses and midwives on our register, most of whom work in front-line healthcare roles. Our costs are funded by the registration fees paid by these nurses and midwives.
- 3 This statement explains why we are calling for further urgent legislative changes and why the government should complete the process of reform it started when publishing its command paper, *Enabling Excellence*, in 2011.

### Where we are now

- 4 The number of fitness to practise referrals we receive is a key driver of our costs. We continue to take measures to improve our efficiency and reduce the unit cost of a fitness to practise hearing. However, we cannot significantly reduce the number of hearings without further legislative change to allow us to deal with our cases in a more appropriate and proportionate manner.
- 5 The General Medical Council (GMC) has had the power to agree undertakings or give warnings at the end of the investigation stage for 10 years and this significantly reduces the number of final hearings it holds. The GMC receives over 10,000 referrals each year. 2,371 GMC referrals proceeded to a full investigation in 2013–2014 but only **241** cases went to a final hearing. By contrast, we receive around 4,000 referrals each year. 2,961 of our referrals proceeded to a full investigation in 2013–2014 and **1,756** cases went to a final hearing. We do not currently have any alternative options for resolving cases at the investigation stage and as a result we are currently holding more than twice as many final hearings as all the other nine UK healthcare professional regulators added together.<sup>1</sup> The average cost of each hearing is £13,000 and this hearing activity significantly affects the level of our registration fees.
- 6 At present, 77 percent of our budget is spent on our fitness to practise work. We have made significant efficiencies, but our fitness to practise caseload continues to rise. Without the means to be able to deal with all our cases in the most appropriate and proportionate manner, if referrals continue to increase further fee rises will be necessary in order to protect the public.

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<sup>1</sup> According to figures in the PSA performance review 2013–2014.

## Our current legislative framework

- 7 As a statutory regulator, all our powers and duties are set out in our legislation. Our current legislative framework is made up of one overarching Order and nine other Orders and sets of rules. The Nursing and Midwifery Order 2001 is an Order of the Privy Council contained in a statutory instrument made under powers set out in the Health Act 1999. It can only be changed by means of a further order made under section 60 of that Act or by other primary legislation.
- 8 The Order contains rule-making powers for the Council that have been used to make rules covering all our key functions. Although these rules are made by the Council, they have to be approved by the Privy Council under the terms of the Order and are therefore also subject to a form of parliamentary process. In practice, the Department of Health (DH) acts on behalf of the Privy Council in relation to all the necessary procedural steps.
- 9 Our Order and rules are very prescriptive and contain a significant amount of unnecessary procedural detail. They do not allow us to adapt and modernise and prevent us from adopting the more proportionate and cost-effective approaches to regulation used by some other healthcare regulators, and in particular the GMC.

## Changing our legislation

- 10 Changing our legislation is a time-consuming process which takes about 18 months to 2 years and requires a lengthy period of collaboration with the DH and securing parliamentary and Privy Council time. We are dependent on finite policy and legal resource in the DH to make these changes happen and this resource is also called on by all the other health professional regulatory bodies.
- 11 The length of time that the process takes prevents us from responding in a timely fashion to the constantly evolving health and social care environment in which we operate.
- 12 These problems were recognised by this government in *Enabling Excellence* in 2011, which led to the Law Commission report and draft bill. The particular problems we face were also recognised by the Prime Minister in February 2013. When making a statement to Parliament in relation to the Francis report into Mid-Staffordshire NHS Foundation Trust, he said “*we will ask the Law Commission to advise on sweeping away the Nursing and Midwifery Council’s outdated and inflexible decision-making processes.*” The government’s position continues to be that our legislation is “*restricting its ability to effectively carry out its fitness to practise regulatory functions.*”<sup>2</sup>
- 13 Also, while ministers recognise that it is important that regulators are “largely independent from Government”,<sup>3</sup> in practice we are very dependent on the Government for adapting our legislation to changing circumstances and allowing us to best fulfil our statutory obligations to protect the public.

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<sup>2</sup> In its consultation on the current section 60 Order.

<sup>3</sup> Dr Daniel Poulter, Parliamentary Under-Secretary of State, Department of Health, oral evidence to the Public Administration Select Committee, 10 September 2014.

- 14 Despite this recognition of these issues, the progress towards a new legislative framework for the NMC has been extremely slow. In 2011, we made a request to DH for around 30 changes to our legislation. After a long period of consultation by the DH with the Professional Standards Authority during 2012, in mid-2013 we secured a commitment to proceed with a limited section 60 Order containing five changes. These changes will come into force in 2015 after lengthy internal DH and parliamentary processes.
- 15 The remaining changes that we sought, including creating a single fitness to practise panel and the power to agree undertakings, were not included in the section 60 Order on the grounds that they would be taken forward during 2014 as part of the Law Commission bill. This planned new primary legislation has not secured the necessary parliamentary time before the election. In the meantime, the need for further urgent changes to our legislation remains and we are now in a queue with other regulators for DH resource and for parliamentary time.
- 16 The House of Commons Health Committee in its 2013 NMC accountability report welcomed our ambition to shorten our target period for resolving fitness to practise cases to 15 months. The committee also recommended that we work with the DH to introduce all the necessary legislative changes by no later than the end of 2014. This deadline will not be met and we are very concerned about the effect of further delay on the public and patients we are here to protect, those who are involved in such proceedings, and the nurses and midwives who fund this activity through their fees.

## **Where we need to be**

- 17 In order to become a modern, effective and efficient regulator, we need an overall legislative framework which is less prescriptive to allow us to be flexible and responsive in a constantly changing regulatory and healthcare environment.
- 18 We also need power to make our own rules within a high-level statutory framework shared with other healthcare regulators, to ensure consistency and transparency in language and available outcomes, but leaving methods of delivery flexible to reflect our different situations. This would give us the ability to innovate and respond more quickly to external changes.
- 19 In particular, we urgently need the following key changes in relation to our governance, registration and fitness to practise functions:
  - 19.1 Powers to work more closely with other regulators and to share certain functions.
  - 19.2 Increased flexibility in our fitness to practise investigations, with a single fitness to practise panel in place of the current practice committees; a wider range of possible outcomes and sanctions at each stage; greater powers to resolve non-contentious matters without full panel hearings; and more flexibility over the location of hearings. This would align our provisions with those of some other healthcare regulators.

- 19.3 Powers allowing reconsideration of the structure, parts and annotations of our current register and our protected titles.
- 19.4 Powers allowing reconsideration of the current arrangements for midwifery regulation if any decision made by the Council in the light of the recommendations of the Kings Fund independent review means that legislative change is required.
- 19.5 Removal of the requirement for the Privy Council to approve fee changes which would reduce unnecessary process, time and costs.
- 20** We also need many other procedural, minor and consequential rule changes. Taken together, these changes would enable us to improve our registration processes and reduce the overall timescale for our fitness to practise cases in line with our commitments to the Health Committee.

### **What could the future look like?**

- 21** In the medium to long term, if fitness to practise referrals continue to rise, legislative reform which allows cases to be concluded more appropriately without expensive full public hearings will help keep down the costs of professional regulation. This, of course, would help the nurses and midwives who ultimately pay for the cost of regulation via their fees.
- 22** We conservatively estimate that the number of full hearings that we hold could be reduced by about 20–25 percent if we had new powers to deal with our fitness to practise cases in a more appropriate and proportionate manner with a wider range of possible outcomes and sanctions at each stage, including warnings and undertakings. The average cost of a hearing could also be reduced if we were given more flexible hearing procedures, resulting in a shorter average hearing length.
- 23** As we have said, 77 percent of our budget is currently spent on our fitness to practise work. We want to be able to better balance our resources between our fitness to practise work and our other core functions: education, standards, registration and revalidation. Our sustainability, as well as our effectiveness, depends on us being able to spend more time and money on areas such as revalidation, education and standards where our work can help prevent poor practice and promote good practice.

**We call on all the main political parties to make a manifesto commitment to take all these urgent amendments forward as soon as possible in the next parliament, either by means of an overarching healthcare regulation bill, based on the report and draft bill published by the Law Commission earlier this year, or by a section 60 Order and associated rule changes.**