Meeting of the Council

To be held from 09:30am on Wednesday 25 November 2015 at 23 Portland Place, London, W1B 1PZ.

Agenda

Dame Janet Finch Chair	Fionnuala Gill Secretary

1	**Welcome and Chair's opening remarks**	NMC/15/86	09:30
2	**Apologies for absence**	NMC/15/87	
3	**Declarations of interest**	NMC/15/88	
4	**Minutes of the previous meeting** Chair	NMC/15/89	
5	**Summary of actions** Secretary	NMC/15/90	
6	**Chief Executive's report** Chief Executive and Registrar	NMC/15/91	09:35

Corporate reporting

7	**Performance and risk report** Interim Chief Operating Officer	NMC/15/92	09:45
8	**Financial monitoring report** Interim Director of Finance	NMC/15/93	10:30
9	**Corporate quality assurance strategy** Director of Strategy	NMC/15/94	10:50

Matters for decision

10	**Quality assurance of education and local supervising authorities annual report 2014-2015** Director of Continued Practice	NMC/15/95	11:20

BREAK (11:35 – 11:55)

11	**Revised registration policy for EEA trained applicants** Director of Registrations (interim)	NMC/15/96	11:55
12	**Approval of extension of legal assessor appointments** Director of Fitness to Practise	NMC/15/97	12:05
13	**Governance: Committee terms of reference** Secretary	NMC/15/98	12:15

Matters for discussion

14	**Questions from observers** Chair of the Council	NMC/15/99 (oral)	12:25

Matters for information

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

15	**Chair's action taken since the last meeting of the Council** Chair of the Council	NMC/15/100
16	**Welsh language scheme annual report 2014-2015 and Standards** Director of Strategy	NMC/15/101

17	**Audit Committee Report** Chair of the Audit Committee	NMC/15/102
18	**Midwifery Committee Report** Chair of the Midwifery Committee	NMC/15/103

The next meeting of the Council will be held on 27 January 2016 at 09:30am at 23 Portland Place, London, W1B 1PZ.

Meeting of the Council
Held at 10:00am on 8 October 2015
at 23 Portland Place, London W1B 1PZ

Minutes

Present

Members:

Dame Janet Finch	Chair
Karen Cox	Member
Maura Devlin	Member
Maureen Morgan	Member
Robert Parry	Member
Quinton Quayle	Member
Carol Shillabeer	Member
Amerdeep Somal	Member
Stephen Thornton	Member
Dr Anne Wright	Member
Lorna Tinsley	Member

NMC officers:

Jackie Smith	Chief Executive and Registrar
Alison Sansome	Interim Chief Operating Officer
Jon Billings	Director of Strategy
Katerina Kolyva	Director of Continued Practice
Sarah Page	Director of Fitness to Practise
Annette Clinnick	Interim Director of Human Resources and Organisational Development
Rachel Murphy	Interim Chief Technology Officer
Fionnuala Gill	Secretary to the Council
Clare Padley	Revalidation Programme Lead
Alison Neyle	Governance and Committee Manager

Minutes

NMC/15/73 Welcome from the Chair

1. On behalf of the Council, the Chair welcomed all attendees to the meeting and extended a particular welcome to Alison Sansome, in her new role as interim Chief Operating Officer; Annette Clinnick, Director of Human Resources and Organisational Development; Dame Eileen Sills, Chief Nursing Officer at Guys and St Thomas' Hospital and Senior Nursing Advisor to the NMC; and Donna Ockenden, Co-Clinical Director of the Maternity Strategic Clinical Network at NHS England (London region) and Senior Midwifery Advisor to the NMC.

NMC/15/74 Apologies for absence

1. Apologies for absence were received from Louise Scull and from Camilla Black, interim Director of Finance.

NMC/15/75 Declarations of Interest

1. All registrant members present declared an interest in NMC/15/79 – Revalidation, by virtue of being members of the nursing and midwifery professions.

2. The Chair determined that the interests declared were not material and that all members would be permitted to participate in discussions.

3. The Chair resolved that registrant members did not need to declare an interest in NMC/15/80 – English language requirements for registration, and that any interest declared would not be material.

NMC/15/76 Minutes of previous meeting

1. The minutes of the previous meeting of the Council held on 29 July 2015 were confirmed as a correct record.

2. It was noted that the minutes made reference to an expectation of the section 60 Order being in place by June 2015 (NMC/15/60 2a); however the Chief Executive's report now suggested that this would be July 2016. It was possible that the date could slip further.

NMC/15/77 Summary of actions

1. The Secretary gave apologies for two incorrect entries in the summary actions and updated the Council as follows:
    - NMC/15/65 (page 24) – ICT Dashboard: to use non-technical language. This has been completed and appears in the papers at Item 10, annexe 1i.

- NMC/15/65 (page 26) – Information Security: ensure more urgency is attached to addressing information security. This is being addressed through an updated improvement plan.

2. The Council noted the report on progress in implementing actions from the meeting held on 29 July 2015.

NMC/15/78 Chief Executive's report

1. The Council discussed the Chief Executive's report on key external developments, strategic engagement, and media activity since the Council held on 29 July 2015.

2. In discussion, the following points were noted:

a) Changes to renewal processes in preparation for the introduction of phased payments in 2016 meant that any registrants not renewing on time would have to go through readmission processes. The changes were being communicated to registrants and should encourage registrants to recognise the importance of renewing on time, since it was illegal to practise without registration.

b) Plans were in place to monitor the impacts of the changes. Monitoring information, including on time taken to process readmissions and the impact on registration service delivery, would be included in future performance and risk reports. The online process should assist with both reducing time and registration workload.

c) Progress on the work being undertaken by Dame Jill Macleod Clark, which includes exploring the implications of those recommendations within the Shape of Caring review report directed at the NMC as well as wider issues. An interim report will be available in November 2015 with the final report to be delivered by January 2016.

d) The NMC's involvement in discussions, initiated by the NHS in England, about whether there needs to be a new role to bridge the occupational gap between Health Care Assistant and Registered Nurse. The Chief Executive and Registrar emphasised that she had agreed to chair a group convened by Health Education England (HEE), on the basis that she would act solely as an independent Chair. The group had met three times but no decisions have been taken. As a four country regulator, the NMC continues to encourage HEE to engage with all four countries around the issues.

e) Recent media interest in Romanian applications. There had been a need to provide clarification of the qualifications

recognised under EU rules as they are applied to all EU applications.

f) NMC engagement with other regulators across the four countries, including those responsible for social care. There was more work to be done in this respect, recognising that many registered nurses worked in social care settings.

Action:	**Include monitoring information on the impact of the renewal changes, including time taken to process readmissions and the impact on service delivery in future performance reports**.
For:	**Interim Director of Registrations**
By:	**25 November 2015**

NMC/15/79a **Introduction of Revalidation**

1. The Council received a presentation on the introduction of revalidation for nurses and midwives from the Director of Continued Practice.

2. The model had been developed over a number of years in close collaboration with the professions and other stakeholders. Throughout, account had been taken of views and feedback of all concerned and adjustments made, including learning from the pilots and the independent reports commissioned from KPMG and IPSOS Mori. There was tremendous support and momentum for the introduction of revalidation across all four countries, stakeholders, professional bodies and unions. The model was a starting point for the first phase of revalidation and changes would continue to be made throughout the lifetime of the process to ensure that it continued to be achievable and proportionate.

3. The Chief Executive and Registrar reported that she had attended recent meetings of all four country Programme Boards, chaired in each case by the Chief Nursing Officer: each had confirmed readiness for implementation. Assurances requested by the Welsh Programme Board were addressed in the paper. The Chief Executive and Registrar noted that the key questions for the Council to determine were whether the model was effective, achievable and proportionate and whether revalidation should be introduced from April 2016.

4. The Chief Executive and Registrar also reported that Sir Robert Francis QC, who had recommended the introduction of a system of revalidation in his report into Mid-Staffordshire NHS Hospitals Trust (2013), had expressed his support for proceeding with introduction of the model and for this to be shared with the Council.

5. The Chair of the Midwifery Committee noted that the Committee had been closely engaged and contributed throughout the

development of the model. At its most recent meeting, the Committee had received positive and helpful reports from two of the pilot sites. The Committee was able to assure the Council of its support for the model in principle, subject to minor changes of detail, for example, such as to the guidance.

6. In discussion the following points were noted:

a) The process of development of the proposed model of revalidation has been extensive. Across all four countries, the public, professions, stakeholders and others have been consulted, listened to and engaged with throughout. Many of those who had contributed were present and the Council expressed appreciation for the hard work and commitment and the significant contribution made in getting to this stage.

b) The Council was cognisant of the views previously expressed by the Professional Standards Authority that the NMC should adopt a risk-based approach to the introduction of revalidation. However, the findings of King's Fund review of midwifery regulation had made clear that there was no evidence on which to formulate such a risk based approach and the issue for the Council was whether the model now developed was proportionate.

c) Revalidation is an important step in ensuring nurses and midwives are 'living' by the professional standards in the Code and reflecting on the role of the Code in their practice.

d) The only significant change from the model now proposed from that piloted was that it was now proposed to maintain the current requirement for 35 hours continuing professional development (CPD) and not increase this to 40 hours. This would also help ensure that the model was proportionate in terms of impact and likely benefits. There was insufficient evidence to suggest that increasing the total CPD hours to 40 would make a difference to the quality of practice.

e) The evidence suggested that new requirement for 20 participatory learning hours and the new requirements relating to feedback and reflection would help drive improvements.

f) The approach to participatory hours was flexible, taking into account the difficulties for those practising in non-traditional settings.

a) In relation to the confirmation process, the guidance now

made clear that the role of the confirmer is not to make a judgment about a registrant's fitness to practise. Instead, the role of the confirmer is to ensure the nurse or midwife has demonstrated that they have met the revalidation requirements. The NMC would be contacting the confirmer as part of the verification process. It is not intended that revalidation should be used to identify concerns about a nurse or midwife's fitness to practise. Any such concerns should be identified in a timely fashion, and be referred through the established Fitness to Practise process.

g) In relation to the process of verification, it was noted that this was designed to test the risks of compliance with revalidation rather than clinical risks. Being selected for verification did not mean that an individual was a 'risky' professional. Verification will not place any additional burden on individuals who are selected; so long as the individual has followed the guidance they will simply need to produce the information already compiled.

h) Those selected to take part in the verification process will have their registration extended, if needed, until the process is completed. An individual's registration will only lapse if they fail to comply with the verification process. The NMC will ensure that individuals are fully informed and aware that the process is a requirement of revalidation and registration.

i) The independent assessment of the internal auditors provided assurance of the NMC's readiness as a business to implement revalidation and there were detailed plans across the organisation including in IT, Registration and the call centre to cope with contingencies and increased demand. Teething problems were to be expected in introducing any new system and mechanisms were in place to capture and address these.

j) A comprehensive communications plan had now been developed, again with the help and support of all four country Programme Boards, including arrangements for reaching every registrant.

7. **Decision: The Council agreed:**

- **To introduce the first phase of revalidation for all nurses and midwives on the register.**
- **That the first registrants to have to meet the new revalidation requirements would be those who are due to renew their registration in April 2016.**

8. The Chief Executive and Registrar noted that it would be important

to monitor and evaluate the impact of revalidation from the outset. Monitoring plans were well developed. Now that the Council had agreed the introduction of revalidation from April 2016, arrangements would be made to scope what should be addressed through evaluation.

9. **Decision: The Council agreed:**

- **That the proposed revalidation model should be the subject of a full evaluation process, to be scoped and determined at the earliest opportunity.**

Action:	**Update on progress on development of the scope of evaluation of the revalidation process.**
For:	**Director of Continued Practice**
By:	**27 January 2016**

NMC/15/ 79b **Revalidation Standards, Policy and Guidance**

1. The Council considered the proposed Revalidation policy, standards and guidance.

2. In the discussion the following points were noted:

a) Some of the legal requirements for Revalidation are based on existing provisions in legislation; however some requirements need to be set out in new standards, as outlined in item 7b, annexe 2.

b) The new standards for revalidation and readmission will replace the current Prep standards, but the current Prep standards remain in force until 31 March 2016. The new standards will not be published separately. Instead, all the requirements relating to legislation, standards and guidance are contained in *"How to Revalidate with the NMC"*. This publication will replace the Prep handbook from April 2016.

c) New readmission standards have been created to ensure that it is not easier to lapse from the register and seek readmission than to complete the revalidation process. Provisions have been put in place for those with genuinely extenuating circumstances which prevent them completing the process on the required timescale. This is in addition to having in place reasonable adjustments, as required by law.

d) Standards in relation to return to practice currently published in the Prep handbook have been included in the standards. This is to ensure that when the Prep handbook is revoked in April 2016, these standards remain in place, recognising that further work is required on this area more generally. These standards will be published separately.

e) Following advice from the Midwifery Committee, it was proposed to make a further minor change to standard 3 as set out in the papers, to replace "registration period" with "three year renewal period" for clarity and to allay any concerns.

f) In relation to the UK registration policy at annexe 2, the Executive Board had agreed updated decision-making guidance on health and character requirements which would be published.

3. **Decision: The Council:**

- **Approved the final revalidation policy (Annexe 1)**
- **Approved the final revalidation and readmission standards (Annexe 2)**
- **Approved the revised UK Registrations Policy (Annexe 3)**
- **Noted the "How to Revalidate with the NMC" online publication (Annexe 4)**

4. The Chair of the Council noted that the decision was the product of a huge amount of work and effort over the past two years and thanked all those involved in the process, particularly stakeholders, Council members and staff. The care and flexibility exhibited in progressing the work was a model of how the NMC would wish to continue working with the professions, stakeholders and others in the future both in implementing revalidation and in other areas of work.

Questions from observers

1. The Chair of the Council invited questions from observers. The following points were noted:

a) Congratulations were extended to the Director of Continued Practice and her team in delivering Revalidation.

b) There was disappointment that there had not been an opportunity in the meeting to comment on the Revalidation proposals prior to the Council making their decision.

c) Some in the sector would be disappointed that the NMC had chosen to retain the current CPD requirements and that the Council had not challenged more robustly the argument for maintaining the current 35 hours. Monitoring and evaluation of this element of revalidation would be important.

d) The revalidation model was a positive step forward and an

improvement on existing requirements, although possibly less so for midwives in view of the existing supervisory arrangements. However, introduction of revalidation in April should be seen as a key staging post in a longer journey and in that respect was welcome.

e) There was concern that some employers may be seeking to require use of electronic portfolios, which would affect portability. Portfolios should be owned by registrants not employers and clear guidance from the NMC to this effect would be welcome. The Revalidation Programme Lead confirmed that this was addressed in the guidance. The level of engagement across the four countries had been extremely positive in creating a groundswell of collaborative working between the NMC and professions and it was hoped that this would be replicated in taking forward work on education.

f) The clarity of the guidance 'How to Revalidate" particularly the use of plain English and absence of jargon was commended.

g) In relation to the work of Dame Jill Macleod Clark, assurance was sought that there would be a greater focus on the mental health needs of children, including consultations with children, parents and families. The Director of Continued Practice noted that this work was at an early stage but she would pick this up outside the meeting.

NMC/15/80 English language requirements for registration

1. The Council considered the summary of findings from the NMC's consultation on English language requirements and the process for registration, and the proposals to implement the English language competence policy and guidance for European Economic Area (EEA) applicants.

2. In discussion, the following points were noted:

a) The NMC, other regulators and EU member states had sought strengthened provisions to ensure regulators were able to impose language requirements on EEA applicants.

b) Following legislative change, the Council has been given the power to specify English language requirements in guidance. This innovation by the Department of Health is welcome as subsequent changes will be possible by a decision of the Council rather than requiring legislative change.

c) The consultation indicated that 41 percent of respondents had concerns about the use of the international English language testing system (IELTS) and the minimum requirement score of 7.0. Some of the respondents articulating this view had a direct interest in the outcome.

d) IELTS is an established and evidence based English language proficiency test and is the preferred method of other UK healthcare regulators and Government departments. By adopting IELTS, EEA applicant requirements would be consistent with those for overseas applicants.

e) Whilst the percentage who opposed the test was significant, the NMC's overriding responsibility is to ensure public protection.

f) There is a potential risk that the new process might have an impact on the number of EEA trained nurses and midwives able to register with the NMC. This reinforces the importance of applicants preparing in advance for the test. The impact of the policy would be closely monitored and reviewed, if necessary.

g) The Council would be asked to make amendments to the Fitness to Practise and Registration rules by correspondence, once the rule making powers came into effect on 19 October 2015. At that time the Council would be provided with assurance of the extensive legal and other scrutiny undertaken before finalising the rule changes.

3. **Decision: The Council:**

- **Approved the policy for English language competence for the registration of nurses and midwives (Annexe 2).**
- **Approved the guidance for EEA trained applicants on evidence that will satisfy the Registrar that they have necessary knowledge of English (Annexe 3).**
- **Agreed to take a decision by correspondence to make Rules to implement the changes, once the rule making powers came into effect.**

Action	**Ensure arrangements are put in place to monitor the impact of the changes to English language requirements.**
For:	**Director Strategy**
By:	**March 2016**
Action	**Arrange for the Council to take a decision by correspondence to make rules implementing the necessary changes**
For:	**Secretary**

By:	**28 October 2015**

NMC/15/81 **Governance: Amendments to the scheme of delegation**

1. The Council considered the proposal to make a minor amendment to the scheme of delegation to provide more flexibility in governance structures below Council level.

2. In the discussion the following points were noted:

   a) Council members welcomed the appointment of a Chief Operating Officer (COO), and congratulated Alison Sansome on her appointment as interim COO.

   b) The interim COO would normally deputise in the absence of the Chief Executive and Registrar. However, the Chief Executive and Registrar remained accountable in respect of all matters delegated by the Council and would continue to fulfil all responsibilities as the Accounting Officer appointed by the Privy Council Office.

   c) A fuller review of the scheme of delegation was planned which would include clarification of the remit of the Remuneration Committee.

3. **Decision: The Council agreed the proposed amendment to the scheme of delegation.**

Action:	**Undertake a review of the current scheme of delegation in consultation with Council members.**
For:	**Secretary to the Council**
By:	**January 2016**

NMC/15/82 **Performance and Risk**
Directorate updates, KPI's and dashboards

1. In discussion, the following points were noted:

   a) Registrations: The Council congratulated the Executive on exceeding the goal of having more than 65 percent of registrants signed up to NMC online by December 2015. Work continued to target those who are yet to sign up. A positive outcome had been an increased uptake in completion of the equality and diversity monitoring information.

   b) In relation to the secondary target for processing registration applications within 30 days, the large number of cases where further information had to be requested was noted. In some cases this was due to the need to seek additional information (for example, in relation to declared cautions/convictions). However, steps were being taken to ensure that all applicants

understood the information that had to be provided in the first instance to reduce the number of cases where further requests had to be made.

c) KPI 1b: Overseas applicants had two opportunities to take each part of the test of competence but then had to wait six months before reapplying to preserve the integrity of the tests. It was too early to say if the pass/fail rate showed an expected pattern of distribution. The Council noted that the figures demonstrated that NMC requirements were not the cause of delays in overseas applicants taking up posts.

d) Council noted changes in registration trends with EEA trained applicants now exceeding the number of applications from those trained overseas. Together EEA and overseas applicants accounted for around 30% of applications.

e) In relation to call centre performance (dashboard), introduction of a call back system for complex enquiries was helping to reduce the number of abandoned calls.

f) FtP: In relation to KPI 2 (Interim Orders), although the number of cases in which Orders were not imposed was higher than expected, the Director of Fitness to Practise was satisfied that the causes for this had been addressed and figures were expected to stabilise in October.

g) Lower than expected throughput at screening, case examiner decision and adjudication points was a concern but measures had been put in place to increase activity within available resources. Performance should be where originally expected by year end. September figures were encouraging.

h) Similarly, the increase in the average number of hearing days raised concerns, mainly due to a lower than expected level of alternative disposals. Further work was being done to look at ways to address this. The Director of Fitness to Practise would report back on how half day cases were calculated in the results.

i) The Council welcomed the soft launch of the Employer Link Service. The programme has been well received in the first phase. A further progress update would be provided at the Council Seminar in October.

j) Continued Practice: The North Wales extraordinary review reports were expected to be published shortly.

k) In relation to the termination of the Local Supervising Authority arrangements with Gibraltar, it remained the case that nurses

and midwives registered with the NMC but practising in Gibraltar are regulated in the same way as other registered nurses and midwives working outside the UK.

l) Strategy: In relation to customer service, Council welcomed ongoing work and looked forward to further detail at future meetings. A progress update on the corporate communications and engagement plan would be provided at the Council seminar in October.

m) Estates, Finance and Procurement: In terms of KPI 4 (available free reserves) Council noted that available free reserves are forecast to be on budget. It was important to establish the extent of likely draw down on contingency as soon as possible.

n) TBS: Improvements in the ICT dashboard were welcome, in particular, the use of less technical terminology and more specifics on timelines and deadlines. The reduction in reliance on contractors and move to permanent staffing arrangements was positive.

o) Concerns were raised about the inconsistencies between the ICT dashboard and the corporate risk register, in particular the ICT business systems remaining at a red-rated risk. Council members were advised that the rating was expected to improve to amber by the next meeting of the Council, due to mitigation strategies being put in place.

p) Human Resources and Organisation Development: Council welcomed the information on the staff survey results and plans to take forward actions at organisational and directorate level. Both the Chief Executive and Registrar would continue to play an active role in staff engagement alongside the interim Chief Operating Officer.

q) Some of the scores gave mixed messages and further analysis was needed to understand this including around job satisfaction and engagement. More work was also planned on exit interviews in order to provide more insight into the high staff turnover rate.

r) It was disappointing that there was no equality and diversity breakdown of the data: this should be incorporated for future surveys.

s) The Council had a responsibility and active interest as employer of the staff, and a more in-depth discussion in confidential session would be helpful so that the Council could gain a better understanding of the results and the issues driving these.

Action:	**Review scope to reduce the number of registration applications where further information needs to be requested through effective communication of the requirements.**
For:	**Director of Registrations**
By:	**25 November 2015**
Action:	**Report back on the increases in hearing days and how half days are accounted for in the calculations.**
For:	**Director of Fitness to Practise**
By:	**25 November 2015**
Action:	**Include scope for equality and diversity factors to be captured in future staff surveys.**
For:	**Interim Director of HR and OD**
By:	**April 2016**
Action:	**Council to discuss the results of the staff survey in greater depth.**
For:	**Interim Director of HR and OD**
By:	**25 November 2015**

NMC/15/82 **Corporate Risk Register**

1. The Council discussed the refreshed draft corporate risk register. In discussion the following points were noted:

   a) The draft refreshed risk register should be regarded as work in progress.

   b) Aligning risks with the NMC strategy was a positive improvement, however this may have led to the current draft becoming too comprehensive in scope and overcomplicated. Some risks would be the result of external factors outside the NMC's control which could not be managed through a risk register. It might be more beneficial to develop a Board assurance framework, rather than attempt to capture everything through the risk register.

   c) The concerns articulated in relation to the previous risk register that some pre and post mitigating scores remained the same had not been resolved. There may be value in looking at toleration levels, as well as the potential to separate strategic and operational risk classifications.

2. It was agreed that further work on the draft risk register would be undertaken in the light of these points.

Action:	**Undertake further work on the draft refreshed corporate risk register taking account of the points raised.**
For:	**Chief Operating Officer**
By:	**25 November 2015**

NMC/15/83 Financial monitoring report to 30 August 2015

1. The Council considered the report, which set out the financial position to 30 August 2015.

2. In discussion, the following points were noted:

a) The picture at August showed income in line with expectations, however, revenue spend was £1.6 million lower than expected mostly due to underspends in staffing costs. Directorates still expect that a full year spend will be in accordance with budget.

b) The Executive had approved a provisional draw-down on contingency of £1.4 million to take account of items whose costs were unknown at the time the budget was approved, including the organisational review, education agenda, and employing NMC special advisors.

c) Reference to the need to develop a formalised programme of efficiencies related to identification of future efficiencies.

d) The Council would welcome clearer presentation and a simple guide to the detailed financial monitoring information.

Action:	**Improve the clarity of financial monitoring information and provide a simple guide for the next meeting.**
For:	**Interim Director of Finance**
By:	**25 November 2015**

NMC/15/84 NMC Equality and Diversity Annual Report 2014-2015

1. The Council received the annual equality and diversity (E&D) report 2014-2015, which outlined the NMC's progress against its equality objectives and planned work for 2015 – 2016.

2. In discussion, the following points were noted:

a) The equality and diversity objectives would benefit from review to ensure that these were SMART.

b) Further work needs to be done to improve the quality of data and analysis: this would be a continued focus in 2015-2016.

c) The report identified areas that the NMC, as an employer needs to work on improving including the diversity of individuals holding positions at senior levels.

d) As indicated earlier, there had been significant increase in the number of equality and diversity monitoring questionnaires completed following the move to NMC

online.

e) However, the adequacy of the data did not allow for any robust analysis of whether there was any disparity of representation of BME registrants at each stage of the Fitness to Practise process.

f) The question of whether a greater number of BME registrants were referred to Fitness to Practise was a matter for employers and could be indicative of cultural and behavioural issues at senior levels. However, once referred to the NMC the question of any disproportionality for example at the various Fitness to Practise stages was a matter for the NMC. Research has been commissioned to look at the past two years data which may assist in this respect.

g) There may be value in looking at whether registrants were trained in the UK or elsewhere, as the GMC had done, to see if this was an issue.

h) More regular monitoring of E&D issues was needed and scope for including E&D monitoring in performance and risk reporting arrangements should be explored.

3. **Decision: Council members noted the equality and diversity annual report 2014-2015.**

Action:	**Ensure equality and diversity monitoring is included in future performance and risk reporting.**
For:	**Director of Strategy**
By:	**27 January 2016**

NMC/15/85 Questions from observers

Please note there were no questions as the item was dealt with as part of at an earlier agenda item, item 7: Revalidation.

The date of the next meeting is 25 November 2015.

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

SIGNATURE: *DRAFT*

DATE: *DRAFT*

Item 5
NMC/15/90
25 November 2015

Council

Summary of actions

Action:	For information.
Issue:	A summary of the progress on completing actions agreed by the meeting of Council held on 08 October 2015 and progress on actions outstanding from previous Council meetings.
Core regulatory function:	Supporting functions.
Strategic priority:	Strategic priority 4: An effective organisation
Decision required:	To note the progress on completing the actions agreed by the Council.
Annexes:	None.
Further information:	If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

Secretary: Fionnuala Gill
Phone: 020 7681 5842
Fionnuala.gill@nmc-uk.org

Summary of outstanding actions arising from the Council on 8 October 2015

Minute	Action	Action owner	Report back to: Date:	Progress to date
NMC/15/78	**Chief Executive's report** Include monitoring information on the impact of the renewal changes, including time taken to process readmissions and the impact on service delivery in future performance reports.	Interim Director of Registrations	Council 25 November 2015	The first registrants who will be affected by the changes to the readmission process are those due to renew in November 2015. We will provide a full report to the January 2016 Council.
NMC/15/79a	**Introduction of Revalidation** Update on progress on development of the scope of evaluation of the revalidation process.	Director of Continued Practice	27 January 2016	Included as part of the Continued Practice performance and risk update on the agenda.
NMC/15/80	**English language requirements for registration** Ensure arrangements are put in place to monitor the impact of the changes to English language requirements.	Director of Registrations	23 March 2016	Existing systems will enable us to monitor and report on activity as a result of the introduction of English language controls. Council will be updated on the implementation at the first appropriate Council meeting following the introduction.
NMC/15/80	**English language requirements for registration** Arrange for the Council to take a	Secretary	28 October 2015	Council agreed to make rules on 26 October 2015. See separate Chair's action item on the agenda.

Minute	Action	Action owner	Report back to: Date:	Progress to date
	decision by correspondence to make rules implementing the necessary changes.			
NMC/15/81	**Governance: Amendments to the scheme of delegation** Undertake a review of the current scheme of delegation in consultation with Council members.	Secretary	27 January 2016	Some minor amendments are addressed in the separate agenda item on Committee terms of reference. A fuller review is being planned for Q1 of 2016.
NMC/15/82	**Performance and Risk Directorate updates, KPIs and dashboards** Review scope to reduce the number of registration applications where further information needs to be requested through effective communication of the requirements.	Director of Registrations	25 November 2015	Information has been provided to employers and recruitment agencies to address the most common reasons for incomplete applications. We now identify and return incomplete applications to applicants at an earlier stage in the process.
NMC/15/82	**Performance and Risk Directorate updates, KPIs and dashboards** Report back on the increases in hearing days and how half days	Director of Fitness to Practise	25 November 2015	Hearings are taking slightly longer to conclude than our planning assumptions. We have addressed this in the Fitness to Practise performance and risk report and believe our original planning assumption is still reasonable.

Minute	Action	Action owner	Report back to: Date:	Progress to date
	are accounted for in the calculations.			If a hearing that was scheduled to run for a whole day concludes within half a day, it is recorded as a whole day in the average hearing length calculation. Panels that finish early are provided with stored work to fill the remaining time, for example interim order meetings, substantive order review meetings, and notices of hearing.
NMC/15/82	**Performance and Risk Directorate updates, KPIs and dashboards** Include scope for equality and diversity (E&D) factors to be captured in future staff surveys.	Interim Director of HR and OD	25 November 2015	Questions on equality and diversity were included in the 2015 survey for the first time. These were centred on the information and training that people received on E&D at the NMC and their awareness of our approach to E&D. We have asked People Insight to provide further analysis of the 2015 survey responses by E&D groupings and will review these to identify any issues that require further analysis. We will also consider whether the E&D elements of the survey can be enhanced in future surveys.
NMC/15/82	**Performance and Risk Directorate updates, KPIs and dashboards** Council to discuss the results of the staff survey in greater depth.	Interim Director of HR and OD	25 November 2015	This is on the agenda for the Council confidential session.
NMC/15/82	**Corporate Risk Register**	Chief Operating	25 November	The Chief Operating Officer and Director of

Minute	Action	Action owner	Report back to: Date:	Progress to date
	Undertake further work on the draft refreshed corporate risk register taking account of the points raised.	Officer	2015	Strategy met with the Chair to discuss the draft refreshed risk register and further work is underway.
NMC/15/83	**Financial monitoring report to 30 August 2015** Improve the clarity of financial monitoring information and provide a simple guide for the next meeting.	Interim Director of Finance	25 November 2015	Financial monitoring report seeks to address this.
NMC/15/84	**NMC Equality and Diversity Annual Report 2014-2015** Ensure equality and diversity monitoring is included in future performance and risk reporting.	Director of Strategy	27 January 2016	Work is currently underway to develop an appropriate report.

Summary of outstanding actions arising from the Council on 29 July 2015

Minute	Action	Action owner	Report back to: Date:	Progress to date
NMC/15/62	**Shape of Caring review** Commission a review to inform any future decisions relating to the Shape of Caring review.	Chief Executive and Registrar	Council 25 November 2015	See Chief Executive's report.
NMC/15/65	**Performance and risk report: *Corporate plan progress report Quarter 1 2015-2016*** Ensure commentary in future progress reports is focused on the substantive issues on which the Council requires assurance.	All Directors	Council 25 November 2015	The Chief Operating Officer has tightened the process for reviewing commentary for Quarter 2 to ensure it is focused on the substantive issues on which the Council requires assurance.
NMC/15/65	**Performance and risk report: *Corporate plan progress report Quarter 1 2015-2016*** Reflect on options for taking forward student related work.	Director of Continued Practice	Council 25 November 2015	See Quarter 2 report in the performance and risk report.

Minute	Action	Action owner	Report back to: Date:	Progress to date
NMC/15/65	**Performance and risk report: *Continued Practice Update*** Keep under review the resources available to address issues and risks requiring extraordinary reviews or similar action.	Director of Continued Practice	Council 25 November 2015	This has been addressed as part of the budget and contract with our Education and LSA quality assurance provider.
NMC/15/65	**Performance and risk report: *HR& OD Update/KPI*** Consider staff turnover rate tolerance levels as part of outcomes of organisational capability review; identify key benchmarks; and reflect in positioning of NMC as an employer.	Interim Director of HR	Council 25 November 2015	Staff turnover rates will be considered when outcomes of the KPMG organisational review are known. The review is expected to be completed by the end of 2015. In the meantime, HR is planning an analysis of turnover and retention as part of the work to develop a People Strategy which will be a key deliverable in 2016/17. This analysis will enable a better understanding of the different categories of leaver, reasons for turnover and how these may link to the wider issue of reward and recognition.

Summary of outstanding actions arising from the Council on 25 March 2015

Minute	Action	Action owner	Report back to: Date:	Progress to date
NMC/15/23 and NMC/15/26	Schedule Council seminar discussion on customer service Bring forward proposals for customer service / quality measures	Director of Strategy	Council Seminar 29 October 2015	This was originally scheduled for 29 October 2015 Council seminar and we need to identify a future seminar slot for this item.
NMC/15/26	**KPI 3** i) Report against minimum expectation that performance not fall below 65%; ii) bring forward proposals for primary and secondary targets in October 2015; iii) consider further how to account for cases affected by third party activity	Director of Fitness to Practise	i) May to October 2015; ii) and iii) 8 October 2015	(i) Complete: reported as part of the Performance and Risk report since April 2015. (ii) Discussed in the performance and risk report on this agenda. (iii) We have in the past reported on cases which have been on put on hold subject to third party input during their lifetime. We are now able to separately report on cases which are currently on hold and those which have been on hold but become active again. We will integrate this information into our reporting where it aids clearer understanding of our performance.

Item 6
NMC/15/91
25 November 2015

Council

Chief Executive's report

Action: For information.

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

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

Strategic priorities: Strategic priority 3: Collaboration and communication.

Decision required: None.

Annexe: There are no annexes attached to this paper.

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

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Context:

1 This is a standing item on the Council agenda and reports on (a) key developments in the external environment; and (b) key strategic engagement activity. The focus of recent strategic engagement continues to be primarily around revalidation.

2 Updates on operating performance can be found in the Performance and Risk Report.

Discussion:

External developments

Legislation issues

3 Following its October meeting the Council approved changes to the NMC's Registration Rules and Fitness to Practise Rules in order to introduce new English language requirements for registration. The Amendment Rules were subsequently signed, sealed and supplied to the Privy Council. Following approval by the Privy Council the Amendment Rules will be laid in Parliament and are expected to come into force on 19 January 2016.

Accountability and oversight

Health Committee

4 The Chief Executive met with the Chair of the Health Select Committee, Dr Sarah Wollaston MP, at this year's Conservative Party Conference in October 2015. We understand that currently there are no plans to hold an accountability hearing with us this year. There may be a move towards broader hearings on specific topics, for example it could be beneficial to have a session with the Committee shortly after the introduction of revalidation to discuss its implementation.

Professional Standards Authority (PSA) issues

5 The Privy Council has now determined the fees for 2015-2016: as expected the NMC fees for the period 1 August 2015 to 31 March 2016 will be just under £1.288m. Consultation on the 2016–2017 fees by the PSA is expected to begin shortly.

6 While we await the detail of the new performance review process for 2015–2016, we have received an initial request from the PSA for policies, practices and procedures we use to operate the following functions: registration; continuing fitness to practise; education; standards; fitness to practise; and governance. The PSA has said it will use this information to decide what type of review process is required.

7 The audit report of our initial stages fitness to practise process was published on the PSA website on 6 November 2015. We will present a paper to the Council in January 2016 setting out the findings of the

audit and our response, including the actions we propose taking.

Stakeholder Engagement and Communication

Revalidation

8 The Council will be pleased to note that all four UK countries have now provided written confirmation that they support the introduction of revalidation and the timetable approved by the Council. The agreed timetable means that the first nurses and midwives to have to meet the new revalidation requirements will be those who are due to renew their registration in April 2016.

9 The Chief Executive and senior team continue to engage with the four country programme boards on the implementation of revalidation. We have also undertaken a significant amount of engagement and communications activity. This has included:

9.1 Targeted communication to all registrants about the introduction of revalidation. Following a sustained drive to increase the number of registrants signed up to NMC Online, as at 31 October we had 513,000 sign ups (74% of the register).

9.2 We have finalised and published on our website, a range of guidance including ‘How to revalidate with the NMC’, ‘Employers guide to revalidation’ and ‘Information for confirmers’. In addition, we have also published a range of forms and templates for nurses and midwives to record how they meet the requirements.

9.3 We continue to host Twitter chats on revalidation. These have proven particularly popular, attracting an increased level of attention from a variety of audiences.

Chief Executive’s engagement

10 Revalidation remained the key focus of the Chief Executive’s speaking engagements during this period, which included presentations at the following events:

10.1 Shelford Group of senior nurses in London on 15 September.

10.2 London directors of nursing meeting, organised by Caroline Alexander, Chief Nurse, NHS England (London region) on 18 September 2015.

10.3 Nursing Appraisal and Revalidation - co-presented with Dame Eileen Sills on 19 October 2015.

10.4 Best practice in nursing national conference in Birmingham on

21 October 2015.

10.5 Nursing Times Directors of Nursing Conference in Brighton on 22 October 2015.

10.6 Unison conference in Glasgow on nursing revalidation on 23 October 2015.

10.7 Associate of Prescribers Annual Conference on 12 November 2015.

10.8 Nursing Times Revalidation conference on 13 November 2015.

Midwifery issues

11 The Director of Continued Practice and the Chair of Midwifery Committee attended a colloquium led by the Royal College of Midwives (RCM) and the Royal College of Obstetricians and Gynaecologists (RCOG) on 23 October 2015.

Education

12 There are a range of issues that we need to address in the education arena, including around the ongoing issues on workforce flexibility. We will be reporting to Council on education in January 2016, including on the work that we have commissioned from Dame Jill Macleod Clark on the nurse of the future. As part of Dame Jill's work, the Chief Executive attended two events which were attended by a number of directors of nursing and leading educationalists from the four countries. Further events with additional groups of student and newly-qualified nurses and patient groups are planned. We have also engaged more widely with key stakeholders in each of the four countries exploring our strategic direction in developing nurses and midwives for the future. As part of the five events we held in October 2015 across the UK, over 200 stakeholders shared their views on our regulatory role in education.

Advisory Group activity

13 Our Patient and Public Advisory Group met on 16 September 2015. Views were sought from attendees on how best we can strengthen and expand our engagement with patients and the public, ensuring a genuine reach across the four countries of the UK. There was also a presentation and discussion about our ongoing work on our strategic intent in education.

14 Our Professional Strategic Advisory Group met on 15 October 2015. The group discussed the launch of the NMC's Employer Link Service, including how best to evaluate the success of the service. There was also an update and discussion on the implementation of

the Mutual Recognition of Professional Qualifications Directive.

Shortage Occupation List and Test of Competence

15 Following the Government's decision on 15 October 2015 to add nurses to its Shortage Occupation List on an interim basis, we are expecting a significant increase in applications from nurses who qualified overseas. The registration team had already been preparing for the possibility of this outcome, anticipating resource and training needs and liaising closely with external stakeholders to ensure that we are sighted on volumes and implications.

16 On 9 October we gave a presentation on the overseas Test of Competence to NHS employers, including key statistics, an update from UK Visas and Immigration regarding visas and a question and answer session. The session was positive and addressed some key concerns around application processing times and capacity for the part 2 test (OSCE) run by the University of Northampton.

Engagement with other regulators

17 With the Director of Strategy, the Chief Executive attended the NHS England/Professional Standards Authority joint seminar on professional codes and encouraging candour among professionals. We continue to work closely with the General Medical Council on this issue and following the meeting, a further joint letter was sent to Sir Bruce Keogh who is leading on this work for the Department of Health.

18 The Director of Continued Practice participated in a workshop as part of the General Medical Council's Education and Training Advisory Board on 20 October 2015. The workshop focused on national assessment strategies for doctors.

Media activity

19 Media activity and coverage continues to centre on Council's decision to introduce revalidation. A series of commissioned articles are now being published on a weekly basis in the Nursing Times. Other recent coverage included interviews with Laura Donnelly in the Daily Telegraph and BBC Radio 5 Live. The story was also picked up by the Daily Mail and in UK-wide regional news outlets as well as across all trade publications.

20 We received widespread media coverage of our return visit to Guernsey to conduct a follow up visit, 12 months after our extraordinary review. The Chief Executive was interviewed by BBC TV and radio, Channel TV, Guernsey Press and Island FM.

21 Our joint extraordinary review of education programmes and midwifery supervision in North Wales also received significant

coverage in the Welsh media including BBC Wales and Wales Online.

22 The Chief Executive was also quoted extensively in relation to the Government's decision to temporarily place nursing on the list of shortage professions. Coverage appeared in the Daily Mirror, the i and across trade press.

Public protection implications: 23 No direct public protection implications.

Resource implications: 24 No direct resource implications.

Equality and diversity implications: 25 No direct equality and diversity implications.

Stakeholder engagement: 26 Stakeholder engagement is detailed in the body of this report.

Risk implications: 27 No direct risk implications.

Legal implications: 28 No direct legal implications.

Item 7
NMC/15/92
25 November 2015

Council

Performance and risk report

Action: For discussion.

Issue: Reports on performance and risk management since the October 2015 Council meeting.

Core regulatory function: All of our core regulatory functions.

Strategic priorities: All.

Decision required: The Council is recommended to:

- Note and discuss the Quarter 2 assessment of progress against the corporate plan 2015–2016 (paragraph 9).
- Approve, subject to any comments, the proposals for reframing commitments 6, 21 and 22 (paragraph 10).
- Note that commitments 5 and 14 will not be met as originally framed and approve the proposed way forward to address these commitments (paragraph 11)
- Note and discuss the KPI information for September and October 2015 (paragraph 16).
- Agree that no changes are required to the KPIs for the second half of the financial year (paragraph 19).
- Discuss and comment on the corporate risk register (paragraph 22).

Annexes: The following annexes are attached to this paper:

- Annexe 1: Quarter 2 report against corporate plan 2015–2016 and midyear review
- Annexe 2: Performance and risk information
- Annexe 3: Corporate risk register
- Annexe 4: Risk map of corporate and directorate risks

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

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Context:

1 This paper provides an overview of performance and the management of risk since the last Council meeting in October 2015.

Performance

2 The Quarter 2 report at **Annexe 1** presents progress against the corporate plan 2015–2016.

3 Further operational developments, performance updates, Key Performance Indicators (KPIs) and risk information are presented within **Annexe 2** as part of the directorate summaries. The summaries are not intended to be comprehensive, rather an update on significant developments since the last Council meeting which are not reported elsewhere on today's Council agenda.

Risk

4 The refreshed corporate risk register is presented at **Annexe 3**. In October the Council accepted the register as a working document which will be subject to further review over the coming months.

Discussion:

Q2 report against the corporate plan 2015–2016

5 **Annexe 1** reports on our progress in Quarter 2 (July to September 2015) against the 22 commitments in our corporate plan 2015–2016. We have assessed both our progress and our overall performance against our corporate plan commitments using the red/amber/green rating system.

6 Our assessment for Quarter 2 is:

6.1 Good progress/performance against nine of our commitments, with most if not all aims/outcomes/objectives being achieved (green).

6.2 Mixed progress/performance against nine of our commitments, with some aims/objectives/outcomes at risk of not being achieved (amber).

6.3 Four commitments where progress is not where it should be with significant risk of not being achieved (red).

7 We have undertaken a thorough review of our progress against those commitments where progress is not where it should be or has been overtaken by events (ambers and reds). In doing so, we have reflected on what we have achieved so far during the financial year, what remains to be done and the external landscape. Where appropriate we are proposing to reframe the commitment to reflect what we now aim to achieve or we have identified how the original

commitment can best be addressed.

8 The relevant commitments are:

8.1 Commitment 5: Develop the necessary policy positions for specific aspects of the register in preparation for a possible regulation bill. We will carry out initial scoping and research for a longer term review of the role, structure and content of the register to ensure it supports public protection in a changing healthcare and practice landscape – this is red due to the lack of a regulatory reform bill, so the commitment cannot be met as originally framed. We are proposing to undertake preparatory work this year and to address this through the education agenda.

8.2 Commitment 6: Publish and begin to implement an education strategic delivery plan. This will include completing the evaluation of our pre-registration education standards, publishing new fit for purpose standards for prescribing and revising our pre-registration midwifery standards for publication in 2016 - this is red as the commitment will not be met as initially framed due to change in the external strategic environment. We are proposing to reframe this commitment as follows: Publish the NMC's strategic plan on nursing and midwifery education for the future.

8.3 Commitment 14: Establish a student forum and carry out a student survey in order to strengthen our relationships with future registrants and to learn from what they can tell us about professional education and practice - this is red as the commitment will not be met as initially framed due to change in the external strategic environment and resource limitations. We are proposing to address this through our work on communications and engagement.

8.4 Commitment 21: Invest in our workforce to ensure it is engaged, high-performing and able to meet the future needs of the organisation. We will do this by incremental pay-reform, undertaking a review of our workforce structure and capabilities and putting in place a programme of learning and development - this is red as we have been unable to progress at the pace required. We are proposing to reframe this commitment as follows: Invest in our workforce to ensure it is engaged, high-performing and able to meet the future needs of the organisation. We will do this by: undertaking a review of our workforce structure and capabilities, the outcomes of which will inform the development of a People Strategy in 2016–2017; and by putting in place a programme of learning and development.

8.5 Commitment 22: Drive through a programme of efficiencies to

ensure the ongoing effective use of our resources – this is amber because we have not yet established a programme of efficiencies. We are proposing to reframe this commitment as follows: Establish a programme of efficiencies and savings to ensure the ongoing effective use of our resources.

9 **Recommendation: The Council is invited to note and discuss the Quarter 2 assessment of progress against the corporate plan 2015–2016.**

10 **Recommendation: The Council is invited to approve, subject to any comments, the proposals for reframing commitments 6, 21 and 22.**

11 **Recommendation: The Council is invited to note that commitments 5 and 14 will not be met as originally framed and approve the proposed way forward to address these commitments.**

Performance and risk information

Corporate KPIs 2015–2016

12 We are reporting against the KPIs agreed by the Council in March 2015. Information for September and October is reported here.

13 Looking across the business areas, there has been some improvement in performance over the two months in relation to FtP, 15 month end to end performance and staff turnover.

14 Performance against the other KPIs has remained consistent and above target.

15 As reported on the Registration dashboard and in the Registration overview, 17.8% of total calls received for both September and October were abandoned, a notable increase on the previous months. September and October are peak months for calls and although we plan on the basis of forecast assumptions, the high profile decisions around revalidation resulted in greater than forecasted calls and call durations. Call duration increased in October by over 32 seconds on average compared to last October, largely due to the number of calls relating to setting up NMC Online accounts following the revalidation decision.

16 **Recommendation: The Council is invited to note and discuss the KPI information for September and October 2015.**

Midyear changes to KPIs 2015–2016

17 Directorates have reviewed their KPIs as part of a midyear review, to ensure these remain relevant and up-to-date for reporting in the second half of the financial year. No changes are being proposed at

this stage. An overview is provided here, with particular focus on the two KPIs where potential changes had been previously discussed:

17.1 **KPI 1b, EU/overseas registration applications (Annexe 2a)**

17.1.1 No changes are proposed. We anticipate a considerable increase in demand in this area due to both the nursing shortage generally and the recent addition of nurses to the shortage occupation list. This means that applications that have been held by the immigration quotas can now be released causing potential temporary, but significant spikes in application volumes.

17.1.2 Whilst this landscape is being proactively managed to ensure we continue to meet our timescale commitments, it would not be sensible to reduce processing times at this point. We are therefore proposing to retain the target of 90% of assessments completed within 70 days for the second half of the year, with a view to re-assessing this in March 2016.

17.2 **KPI 3, FtP 15 month end to end performance (Annexe 2c)**

17.2.1 No changes are proposed. Our current caseload includes a number of older investigation cases which we expect to clear investigations by the end of the financial year. These will have an impact on KPI performance as those cases are concluded either by the Case Examiner or at the adjudication stage.

17.2.2 We are therefore proposing not to set a target for KPI 3 at this stage and to continue monitoring performance against the current commitment of not falling below 65%.

17.3 No changes are proposed to **KPIs 1a, 2, 4 and 5.**

18 The KPIs will next be reviewed at the end of this financial year, for 2016–2017 reporting.

19 **Recommendation: The Council is invited to agree that no changes are required to the KPIs for the second half of the financial year.**

Risk

Refreshed corporate risk register

20 Since the Council accepted the corporate risk register as a working version on 8 October 2015, corporate risks have been updated.

21 One risk has decreased in post-mitigation score: corporate risk **CR12 (ICT business systems)** has decreased from 4x4 (red) to 3x4 (amber), owing to the progress we have made so far with the IT improvement programme.

22 **Recommendation: The Council is invited to discuss and comment on the corporate risk register.**

23 A risk map of corporate and directorate risk is at **Annexe 4**.

Public protection implications: 24 Public protection implications are considered when reviewing performance and the factors behind poor or good performance.

Resource implications: 25 Resource implications will be captured in the financial monitoring report.

Equality and diversity implications: 26 Equality and diversity implications are considered when rating the impact of risks and determining the action required to mitigate risks.

Stakeholder engagement: 27 KPI information and performance dashboards are in the public domain.

Risk implications: 28 The impact of risks is assessed and rated on the risk register. Future action to mitigate risks is also described.

Legal implications: 29 No direct legal implications.

Quarter 2 report against the corporate plan 2015–2016 and midyear review

1 July – 30 September 2015

Our corporate plan sets out the key commitments we made for 2015–2016 towards achieving the corporate strategy 2015–2020. This report presents a Q2 update and assessment of our performance and progress against each commitment.

As part of the Q2 report process, we have undertaken a midyear review of our corporate plan commitments to ensure they still remain relevant. Proposed changes are stated in this report.

Definitions of table headings

Commitment for 2015–2016		Work we are undertaking in 2015–2016 as stated in the corporate plan 2015–2016.
Q2 update (July-Sept)		Explanation of performance during quarter 2 and progress/achievements made.
Red / amber / green (RAG) rating – for overall performance after Q2	**R**	Significant aims/objectives/outcomes for this commitment are not being achieved or are at risk of not being achieved.
	A	Mixed performance – some aims/objectives/outcomes for this commitment are being achieved and some are not or are at risk of not being achieved.
	G	We are performing well and most, if not all aims/objectives/outcomes for this commitment are being achieved or are on track to being achieved.
For reference: PSA 2014–15		This column states our performance for 2014–2015 against relevant PSA Standards of Good Regulation. This is here to give wider context to our Q2 performance. For reference, the Standards of Good Regulation which we inconsistently met or did not meet during 2014–2015 were: - Education and Training 2 (revalidation): not met - Registration 3 (register accuracy and integrity): not met - FtP 5 (fairness and transparency of process): inconsistently met - FtP 7 (customer service): not met - FtP 8 (quality of decisions): not met - FtP 10 (information security): not met.
Are there proposed changes to the commitment?		As part of the midyear review of business plans, we have reviewed whether commitments, as currently framed, are still relevant for the last six months of the year. Proposed changes are stated in this column.

Strategic priority 1: Effective regulation
We must deliver our core statutory regulatory functions consistently well in order to protect the public and secure public confidence. We will continue to improve our core functions, focusing on speed, customer service and the quality of our decisions. In addition we will need to respond to new requirements and legislative change.

	Commitment for 2015–2016	**Q2 update** *To include: Key achievements/outcomes and setbacks.*	**RAG**	**For ref: PSA 2014-15**	**Are there proposed changes to the commitment?**
1	Work in partnership with the four UK governments to launch an effective, transparent and proportionate model of revalidation in late 2015.	Model for revalidation approved by Council in October 2015. We continue to ensure continuity between the programme and operational readiness. Business readiness and implementation plans have been developed. A programme for awareness is in train and staff, including revalidation coordinators, are in place and equipped to support registrants. A comprehensive communications plan is in place having been developed in collaboration with the four UK programme boards as well as other key stakeholders including professional bodies, trade unions and employers. The Chief Executive has maintained close links with the four CNOs, both individually and collectively during this period.	**G**	Edu & training 2, Reval (not met)	No change.
2	Make the necessary changes to our processes to implement the new requirements of the EU Directive on Mutual Recognition of Professional Qualifications. This will include introducing language controls.	Language control processes have been completed and mapped. Initial awareness training has been delivered to International Team and Call Centre staff. User stories for IT development are complete and development is commencing imminently. Policy and guidance documents completed. European Professional Card and Alerts: we have ensured that systems will be in place to ensure legal compliance with the directive from the go-live date of January 2016.	**G**		No change.

	Commitment for 2015–2016	**Q2 update** *To include: Key achievements/outcomes and setbacks.*	**RAG**	**For ref: PSA 2014-15**	**Are there proposed changes to the commitment?**
3	Embed and evaluate the new case examiner function, implement the new powers to review 'no case to answer' decisions, and invest in strengthening our screening and investigation functions to secure consistent quality of regulatory decisions across all our fitness to practise processes.	Case Examiners are now embedded. The number of decisions being made is increasing and quality reports have exceeded expectations. The power to review function is also now embedded. Take up has been steady and indications are that the quality of our decisions stands up to the additional scrutiny. Lawyers focusing on proportionality, timeliness and quality have been embedded in investigation teams and a ring fenced screening legal team has been introduced, focusing on interim orders and maximising screening closure potential.	**G**	FtP 5 – Process (inconsistently met) FtP 7 – cust service (not met) FtP 8 – Decisions (not met)	No change.
4	Establish an employer link service which facilitates information sharing, increases understanding of our processes and helps employers decide which fitness to practise concerns warrant referral to us and which are better handled locally.	The set up phase completed successfully and we have progressed to a soft launch phase. Over 60 trusts have been contacted and a number of engagements set up with Directors of Nursing in all four countries of the UK. An Assistant Director ELS and Risk Intelligence has been appointed and will take up their post from Q3. The Head of Service Delivery and two Regulation Advisers who were originally seconded to Employer Link are now in the substantive posts. We also expect to appoint a further four Regulation Advisers in Q3.	**G**	FtP 1, referrals (met) FtP 2, info sharing (met)	No change.
5	Develop the necessary policy positions for specific aspects of the register in preparation for a possible regulation bill. We will carry out initial scoping and research for a longer term review of the role, structure	Due to the lack of a regulatory reform bill, this commitment will not be met as originally framed.	**R**		We are proposing to undertake preparatory work this year and to address this through our education agenda.

	Commitment for 2015–2016	**Q2 update** *To include: Key achievements/outcomes and setbacks.*	**RAG**	**For ref: PSA 2014-15**	**Are there proposed changes to the commitment?**
	and content of the register to ensure it supports public protection in a changing healthcare and practice landscape.				
6	Publish and begin to implement an education strategic delivery plan. This will include completing the evaluation of our pre-registration education standards, publishing new fit for purpose standards for prescribing and revising our pre-registration midwifery standards for publication in 2016.	This commitment will not be met as initially framed due to change in the external strategic environment. An update on our work in the education arena is contained in the Chief Executive's report.	**R**		Yes **Proposed reframed commitment:** *Publish the NMC's strategic plan on nursing and midwifery education for the future.*
7	Undertake policy and legislation development work towards removing midwifery supervision from our legislation.	The Department of Health (DH) confirmed a section 60 order to bring about legislative change. The scope of change has been shared with Midwifery Committee and DH. Working timelines (subject to change) are: • DH consultation on legislation in Spring 2016 • Parliamentary process towards the end of 2016 • Legislative change complete by Spring 2017 Legal advice and drafting has been commissioned. A communications and stakeholder engagement plan has been developed and engagement is ongoing. Continued participation in the DH/CNO process around the future of supervision outside of regulation. We are on track in terms of operational delivery, but this commitment is rated amber due to timing not being within our gift and managing stakeholder expectations around this.	**A**		No change.

	Commitment for 2015–2016	**Q2 update** *To include: Key achievements/outcomes and setbacks.*	**RAG**	**For ref: PSA 2014-15**	**Are there proposed changes to the commitment?**
8	Deliver a programme of quality management reviews across all our regulatory directorates. Quality objectives will be incorporated into staff objectives and we will review the overall impact of our quality programme in early 2016.	All three QA reviews scheduled for Q1 have been completed with most recommendations accepted. The Q2 reviews are on track to be completed on schedule and the Q3 reviews are about to start. At the staff conference in April 2015 we launched the requirement for quality and customer service to be incorporated into staff objectives. Evidence from a recent internal audit review suggests most staff do now have objectives that include these elements. This commitment is amber pending implementation of recommendations from internal audit to strengthen the review reporting process, but we expect the commitment to be delivered as described.	**A**		No change.

Strategic priority 2: Use of intelligence
By better using evidence from data and research we will gain insights into what we do, helping us to be more effective, transparent and proportionate. As a first step, we need to ensure that our systems support the improvement of the collection and use of both our own data and intelligence from other sources.

	Commitment for 2015–2016	**Q2 update** *To include: Key achievements/outcomes and setbacks.*	**RAG**	**For ref: PSA 2014–15**	**Are there proposed changes to the commitment?**
9	Strengthen our approach to managing regulatory risk intelligence about settings where nurses and midwives practise. We will do this by establishing new systems and processes alongside the employer link service for collating, evaluating and acting on intelligence about risk from different sources.	A model for our approach to risk intelligence has been developed and is under review. We will continue to strengthen our management of regulatory risk as we further develop the Employer Link Service team in Q4 (see commitment 4) and with the development of both the allegations code framework and an approved coding for employer settings. This commitment is amber because this work is still in very early stages of development.	**A**		No change.
10	Deliver a programme of research and analysis activities that provides insight for effective regulation – for example work to improve insights from fitness to practise data.	We received the report of a stakeholder perceptions study – this will provide important evidence to inform the corporate communications and engagement plan. We commissioned a study on FtP allegations – this will inform development of a coding framework for allegations. We held the first meeting of the steering group for the BME FTP project and sent out requests for expressions of interest invitation to possible suppliers. We commenced scoping revalidation evaluation. We undertook analysis of midwife FtP cases for Midwifery Committee and undertook analysis into early career referrals. Although we are delivering a series of research and analysis activities, this commitment is rated amber because a strategic programme approach is not yet in place.	**A**		No change.

Strategic priority 3: Communication and collaboration
We will continue to improve the quality of our relationships to support our overarching purpose of public protection. To support this we will develop an overarching communications and engagement plan. Public, professional and employer awareness will be priorities. We will seek out opportunities to work in partnership with others to achieve shared goals. **Update:** Work on the overarching communications and engagement plan is ongoing.

	Commitment for 2015–2016	**Q2 update** *To include: Key achievements/outcomes and setbacks.*	**RAG**	**For ref: PSA 2014–15**	**Are there proposed changes to the commitment?**
11	Promote the Code through an ongoing campaign aimed at nurses, midwives and employers. We will produce and disseminate materials for patients and service users so that they understand what they should expect from nurses and midwives.	We have disseminated copies of our leaflet for patients and the public through our strategic relationships, including our Patient and Public Advisory Group. The feedback from patient facing organisations and charities has been positive and constructive. We also publish a monthly newsletter for patients and the public. We have also produced specific information for employers on the Code. Promotion of the standards and values of the Code are central to the ongoing work to implement revalidation. In quarter two we held five events across the four countries focusing on our role in education. As part of these events, the Code was promoted considerably. There is strong buy in for the Code to be embedded in new education standards in the future. We continue to promote the Code through our routine engagement on revalidation. The Chief Executive continues to promote the Code and its central link with the revalidation process through speaking events and her engagements with key stakeholders.	**G**	Guid & Stds 4, public info (met)	No change.
12	Develop and publish employer facing resources on the implications and	We have developed a range of materials for employers including information on the Code; a dedicated monthly newsletter and guidance for employers on revalidation.	**G**	Guid & Stds 4, public	No change.

	Commitment for 2015–2016	Q2 update *To include: Key achievements/outcomes and setbacks.*	RAG	For ref: PSA 2014–15	Are there proposed changes to the commitment?
	responsibilities of employing registered nurses and midwives.	Employer Link Service (ELS) specific update: Guidance for employers will be published on the ELS website to coincide with the full launch of the service in Q1 of the next financial year.		info (met)	
13	Engage effectively with registered nurses and midwives and our stakeholders to ensure the smooth implementation of revalidation.	We have developed a comprehensive communications and engagement plan to support the introduction of revalidation. This includes a significant effort to communicate both directly with registrants and also through cascading information via our partners and stakeholders, including professional bodies, royal colleges, trade unions and employers. We have communicated directly (via email and letters) to all registrants twice August and October) and we will deliver a dedicated email programme to support nurses and midwives through their revalidation journey, supporting them with case studies, films, animations and other hard copy and digital resources. As part of wider stakeholder engagement, the Chief Executive spoke at a number of events about the NMC's work to develop the model of revalidation. This commitment is rated amber until key products have been commissioned and delivered fully. The commissioning process is going to plan.	**A**	Edu & Training 2, Reval (not met)	No change.
14	Establish a student forum and carry out a student survey in order to strengthen our relationships with future registrants and to learn from what they can tell us about professional education and practice.	This commitment will not be met as initially framed due to change in the external strategic environment and resource limitations. Going forward, our approach to corporate engagement will consider student input to the education function. An update on our work in the education arena is contained in the Chief Executive's report.	**R**		We are proposing to address this through our work on communications and engagement.

	Commitment for 2015–2016	Q2 update *To include: Key achievements/outcomes and setbacks.*	RAG	For ref: PSA 2014–15	Are there proposed changes to the commitment?
15	Develop sound relationships with other regulators – including system regulators, and train our staff to implement information sharing protocols consistently and well. We will launch joint guidance on candour with the General Medical Council.	Developing and reviewing Memorandums of Understanding (MoUs) – progress on track. MoU with NHS Education for Scotland finalised and drafting advanced with HSE and NHS Protect. We produced joint guidance with the GMC on the professional Duty of Candour, and launched this with an event for a professional audience of key influencers. We are liaising with other regulators on best practice and benchmarking in relation to Human Resources and Organisational Development. The Chief Executive continues to engage regularly with her opposite number at the General Medical Council on a range of issues, including taking forward the work arising from the NHS England and Professional Standards Authority's joint summit meeting on culture and professional codes. The Director of Continued Practice sits on the General Medical Council Education and Training Board.	**G**		No change.

Strategic priority 4: An effective organisation
We will further develop our systems, resources and culture to support our journey to becoming an intelligent, collaborative forward looking regulator.

	Commitment for 2015–2016	Q2 update *To include: Key achievements/outcomes and setbacks.*	RAG	For ref: PSA 2014–15	Are there proposed changes to the commitment?
16	Increase our focus on service to our customers and stakeholders by adopting the Cabinet Office's Customer Service Excellence® standard across the organisation. We will commission a programme of staff training and an initial assessment in July 2015, before developing an action plan to address any areas for improvement.	Customer Service Excellence training workshops have been attended by champions from across the organisation. We have undergone the initial external assessment against the standards and have received the assessor's report. This found that progress is being made to change the customer culture of the organisation however there are further opportunities for improvement, such as joint working across directorates to share best practice. Lead Champions in directorates have drafted action plans to respond to the areas for improvement and these will be taken into account to ensure customer service is reflected in the business planning process.	**G**	Reg 2 (met) FtP 7 cust service (not met)	No change.
17	Implement a programme of ICT improvement to support our core functions more efficiently and to provide a sound basis on which to build more transformational change.	The improvement programme is progressing well with some improvements implemented and the remainder on schedule: • Strengthened ICT system development and delivery processes. • Stabilised ICT function – reduction in reliance on contractors achieved, further reduction planned. • Disaster Recovery capability in development in line with Business Continuity demands. • IT Strategy in development. • Stronger contract management in place. • Established more collaborative working practices across ICT and business areas through Business	**A**	FtP 10, Info security (not met)	No change.

	Commitment for 2015–2016	Q2 update *To include: Key achievements/outcomes and setbacks.*	RAG	For ref: PSA 2014–15	Are there proposed changes to the commitment?
		Relationship Management. The amber rating relates to the tight delivery timeframe for the build of Disaster Recovery as a service alongside a data centre move and continuing to deliver against the priority projects.			
18	Carry out an assessment and mapping of our data and begin a programme of data cleansing as essential groundwork for our future data and intelligence gathering, reporting and dissemination.	An initial assessment of our data has been completed and a plan has been produced detailing short, medium and long term actions. This will need to be continually reviewed and a further more substantial assessment conducted in 2016–2017. We are establishing a Data Improvement programme and board replacing the previous Data Steering Group to take this work forward with the appropriate degree of urgency. Data cleansing activity will begin during the current financial year. In parallel we have progressed the Data Warehouse/Business Intelligence work to build an initial capability which is currently being used for project based reporting requests. This is a tactical solution at present and will need to be scaled up to manage demand in the future. We are establishing a specific Data and Business Intelligence function within the current Technical Business Services (TBS) restructure to consolidate data management within our applications and reporting functionality to move us to clear, consistent, timely and accurate provision of all reporting requirements (internal and external). This commitment is rated amber because the new Data Improvement board and programme that will drive the required data cleansing work is not yet formally established and the required structure within TBS is not yet in place.	**A**		No change.
19	Promote equality, diversity and inclusion in carrying out our functions as a	We completed our equality and diversity annual report 2014-2015.	**A**		No change.

	Commitment for 2015–2016	Q2 update *To include: Key achievements/outcomes and setbacks.*	RAG	For ref: PSA 2014–15	Are there proposed changes to the commitment?
	regulator, a service provider and as an employer. This will include improving the collection and use of diversity data about our registrants, commissioning research, and ensuring we maintain accessibility to our services for people with disabilities.	We continue to action and monitor progress against our equality objectives action plan 2015-2016, with directorates providing quarterly updates on progress which are discussed by the Equality and Diversity Steering Group. **Equality and diversity data about our registrants** We have improved the collection of equality and diversity data through the introduction of a questionnaire on NMC online. Since March 2015, when we introduced the new questionnaire, 247,519 nurses and midwives have completed it (36% of the register). We are seeking to maximise the completeness of our equality and diversity data about our registrants. We will continue to promote the importance of providing equality and diversity data, for example through our newsletters to registrants, and will work with other organisations to utilise their communications networks. This commitment is rated amber because there is still considerable work needed to improve the collection and utilisation of data in this area.			
20	Provide a facility for nurses and midwives to make registration fee payments in instalments.	One of the preliminary requirements for the introduction of this facility is the change to the readmissions process, which went live over the weekend of 6 to 8 November. Phased payments high level requirements have now been developed and will be converted to user stories for system development. The communications plan has been completed. This includes ensuring that all registrants affected by changes to the readmission process have received written notification and have access to information about this on our website and via newsletters and NHS employers.	**G**		No change.

	Commitment for 2015–2016	Q2 update *To include: Key achievements/outcomes and setbacks.*	RAG	For ref: PSA 2014–15	Are there proposed changes to the commitment?
21	Invest in our workforce to ensure it is engaged, high-performing and able to meet the future needs of the organisation. We will do this by incremental pay-reform, undertaking a review of our workforce structure and capabilities and putting in place a programme of learning and development.	The organisational review has made progress and Council discussed this at a seminar on 29 October 2015. The outcomes of this review will inform the development of a People Strategy in 2016–2017 including the NMC's approach to reward and recognition. This commitment is rated red because we have been unable to progress at the pace required.	**R**		Yes. **Proposed reframed commitment:** *Invest in our workforce to ensure it is engaged, high-performing and able to meet the future needs of the organisation. We will do this by: undertaking a review of our workforce structure and capabilities, the outcomes of which will inform the development of a People Strategy in 2016–2017; and by putting in place a programme of learning and development.*
22	Drive through a programme of efficiencies to ensure the ongoing effective use of our resources.	A methodology to capture, measure and report the impact of identified efficiencies has been developed and is in operation within Fitness to Practise. It will be rolled out to the other directorates by March 2016. Each of the operational directorates has identified potential savings and efficiencies which are being incorporated into the 2016–2017 business plans and budgets. Efficiencies and savings will continue to be included in monthly overall directorate financial reviews meetings, and separate meetings focused specifically on delivery of further efficiencies and savings will occur monthly. This commitment is rated amber because we have not yet established a programme of efficiencies and savings. This will need to be informed by the organisation and accommodation reviews.	**A**		Yes. **Proposed reframed commitment:** *Establish a programme of efficiencies and savings to ensure the ongoing effective use of our resources.*

Item 7: **Annexe 2**
NMC/15/92
25 November 2015

Performance and risk information

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NMC/15/92
25 November 2015

Registration performance and risk update

Performance overview

This overview summarises recent operational developments and performance in the Registration directorate and includes commentary on the Registration Key Performance Indicators (KPIs) and dashboard.

NMC Online

1 As of 31 October 2015, 513,000 registrants had signed up for NMC Online (74% of the register). This represents a 14% increase in take up since the last report to the Council in July.

2 Having met the initial target of 65% of registrants signed up to the online service by the end of December 2015, we are now aiming to achieve 80% at the same date. We continue to focus on registrants due to renew under revalidation processes from April next year to ensure they are set up online well in advance.

Applications and appeals

3 In September 2015, 2,235 UK, 754 European Union (EU) and 203 overseas applicants were registered.

4 In October 2015, 8,942 UK, 1,266 EU and 126 overseas applicants were registered.

5 We are seeing a 52% increase in EU applications compared to October last year.

UK applications

6 During September and October we issued 95,520 renewal and retention packs. 41,471 periodic renewals were completed in September, with 99.79% of these completed within five days. In October, 17,380 renewals were completed, with 99.23% completed within five days. 140,733 retention transactions were completed during the reporting period.

7 The KPI information below provides more detail about the 2,235 UK initial applications processed during September and the 8,942 in October. Despite this being the peak period, performance during the two months under review has improved and we met both the primary and secondary KPIs.

Appeals

8 There were a total of 36 outstanding registrations appeals at the end of October, of which 30 have been scheduled for hearings (one had been scheduled for 28 October but was postponed at the request of the appellant). In September, seven appeals cases were heard, all but one of which were completed within six months of the appeals being lodged. In October, 10 appeals cases were heard, and again all but one were completed within six months of the appeals being lodged. Of those 17 appeals heard during the reporting period, 14 were successful, and three were dismissed. Seven new appeal cases were

received by the Registrar's Appeals Support team during September and three during October.

International applications

9 During the reporting period, 436 people sat the first part of the test of competence (CBT). Of these, 370 people (84.9%) passed the examination.

10 50 applicants completed stage 2 of the test of competence (OSCE) in September and October. As at 31 October, a total of 71 applicants had completed stage 2 of the test since it commenced in April, of which 52 (73.2%) have passed. There is a 100% pass rate for applicants attempting the OSCE for a second time.

11 The numbers completing the OSCE remains lower than expected due to visa restrictions; however we anticipate that the recent decision to add nurses to the Government shortage occupation list on an interim basis will lead to an increase in numbers coming through the system.

12 The KPI information below provides more detail about the number of international applications assessed during September and October. 99.9% of applications have been assessed within 70 days.

Customer service

13 During September and October 2015 the Registration Centre received a total of 102,545 calls. Of these 84,292 calls were answered and 18,253 calls were abandoned (17.8%). Call duration has also increased in October on average by over 32 seconds compared to last October, largely due to the number of calls relating to NMC Online and revalidation. In response to the inconsistent performance in this area we have commissioned a full review of the call centre particularly in relation to resourcing, forecasting and technology. This will report in December 2015 – leading to an action plan which will commence in January 2016.

14 As shown on the Registration dashboard, across the two month reporting period an average of 91% of respondents to the customer service survey felt that their overall experience of contacting NMC Registrations was satisfactory or above, with 79% stating their experience was good or very good. An average of 84% of respondents stated that the call centre had resolved their query.

Key performance indicators

15 Secondary target figures are also presented within the UK KPI and, for both September and October, performance met the target of 99% within 30 days.

16 We propose to introduce a quality dashboard before the end of 2015 as a step towards the ultimate introduction of a quality KPI in 2016.

Midyear changes to KPIs – <u>none proposed</u>

17 We are meeting the target for KPI 1(b) relating to international assessments. As part of our drive to improve our customer service in this area, we are taking a view of our processes from end to end, looking to reduce customer waiting time. We initiated this through recent improvements in the processing of EU and Overseas applications post, which have had a significant impact. We propose that we retain the current KPI 1(b) target of 90% of assessments being completed within 70 days – we anticipate a considerable

increase in demand in this area due to both the nursing shortage generally and the recent addition of nurses to the shortage occupation list. We propose to review this in March/April 2016.

Corporate risk update – please refer to corporate risk register at Annexe 3

18 Registration risks are encompassed in the two new risks, under Strategic Priority 1, around systemic regulatory failure and failure to develop our regulatory functions to meet changing public protection needs. Both these risks are amber.

KPI 1a - Percentage of UK initial registration applications completed within a set time

Strategic priority 1: Effective regulation

Rationale	The KPI measures NMC assessment time for UK initial applications.
Definition	This KPI will measure the time elapsed between receipt by the NMC of a new complete UK application and when the applicant joins the register or is notified of refusal.

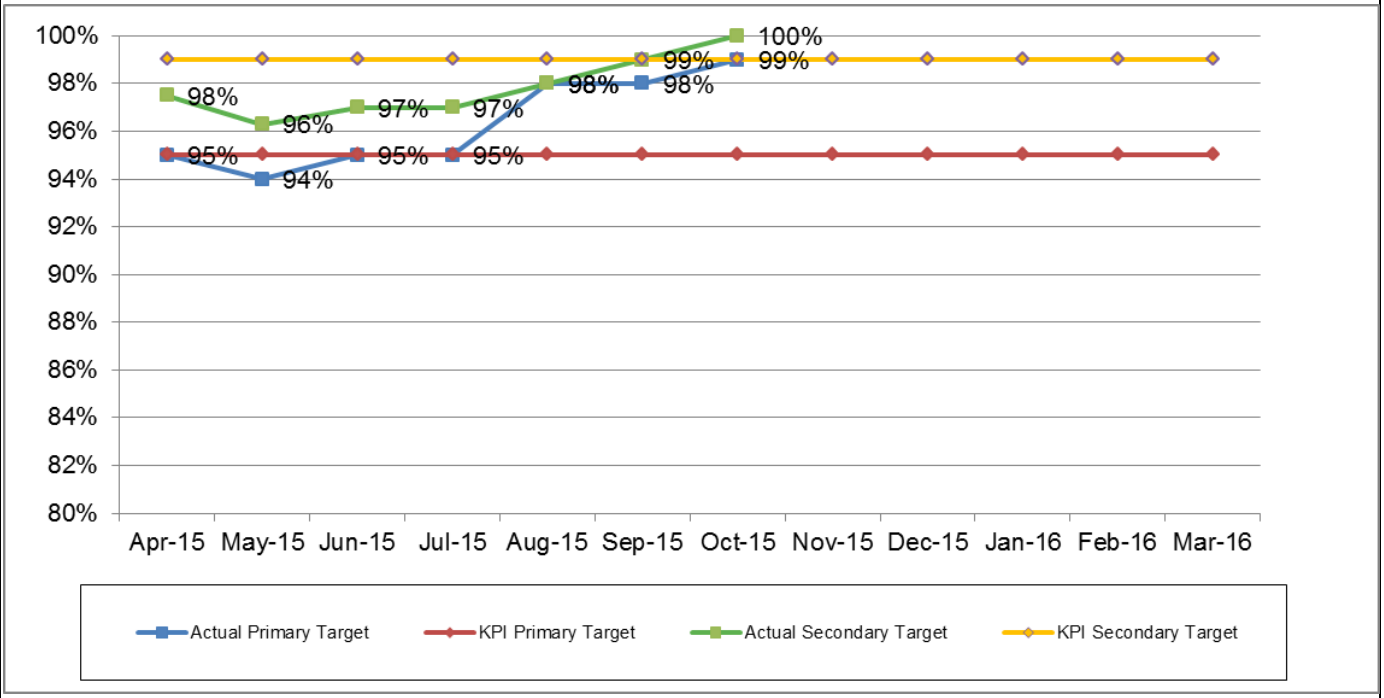
	August 2015		September 2015		October 2015		Year to date average	Year end average target
	No. of apps within KPI	As a %	No. of apps within KPI	As a %	No. of apps within KPI	As a %		
Primary figures/ target	858	97.5%	2207	98.7%	8863	99.1%	96.4% (Green)	95% within 10 days
Secondary figures/ target	864	98.2%	2218	99.2%	8932	99.9%	97.9% (Amber)	99% within 30 days

Number: Number of applications completed within the KPI target
As a %: That number expressed as a proportion of the total for the month
Year to date average: The cumulative average from April 2015.
RAG: Year to date average vs. year end average target

Red/Amber/Green rating (primary target):
Green = figure matches or is higher than the target figure of 95%.
Amber = figure is between 90 and 94%.
Red = figure is 89% or lower.

Red/Amber/Green rating (secondary target):
Green = figure matches or is higher than the target figure of 99%.
Amber = figure is between 94 and 98%.
Red = figure is 93% or lower.

Graphical information and commentary:



September 2015

We processed a total of 2,235 UK initial registrations of which 98.7% were completed within 10 days. A total of 99.2% of applications were completed within the secondary target of 30 days with 0.5% (11) being completed between 10 and 30 days.

In 0.8% of cases (17 cases) it took over 30 days to obtain and process the required information. These relate to applications where further information was requested from individuals, or expert reports were called for in connection with declarations of cautions/convictions.

October 2015

We processed a total of 8,942 UK initial registrations of which 99.1% (8,863) were completed within 10 days. In respect of the secondary target, 99.9% of applications were completed within 30 days, with 10 applications (0.1%) taking longer. Again, these all relate to cases where further information was required or cautions and convictions have been declared.

As can be seen from the numbers, these were our peak months for UK initial registration and we achieved the primary and secondary KPIs in both months.

KPI 1b - Percentage of EU/overseas registration applications assessed within 70 days

Strategic priority 1: Effective regulation

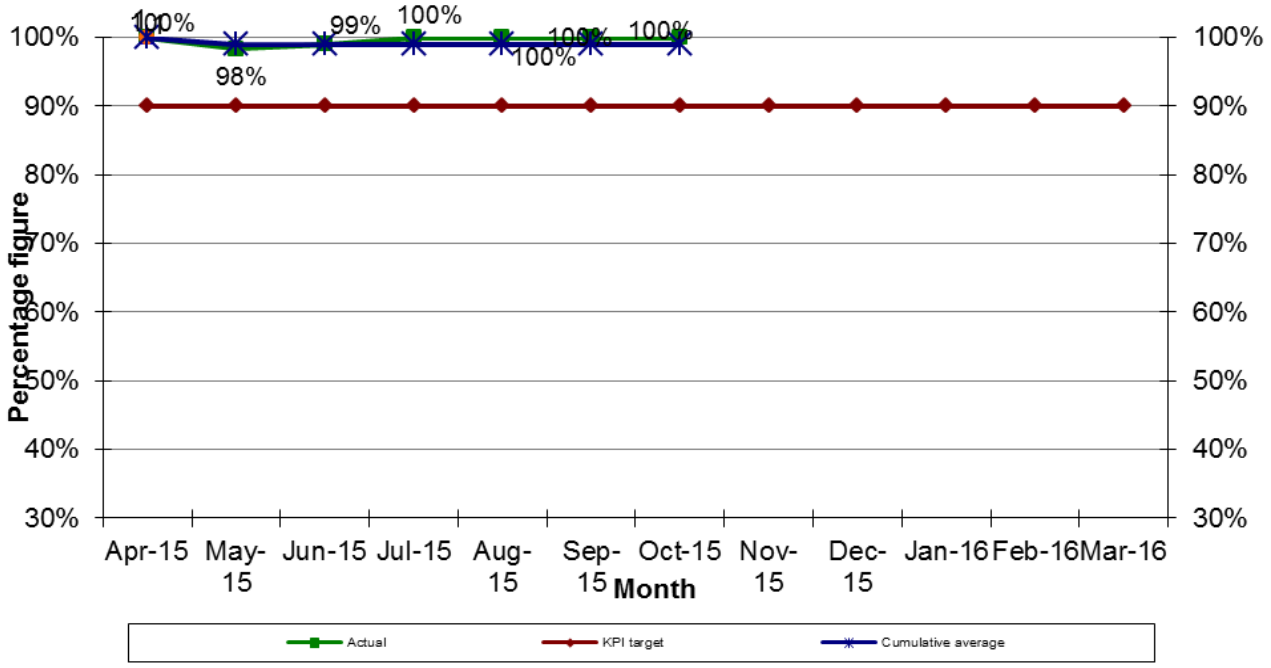
Rationale	The KPI measures the time taken to assess EU/overseas applications
Definition	This is the percentage of EU/overseas applications which are assessed within 70 days of receipt. This KPI will measure the time elapsed between receipt by the NMC of a complete international (EU and non-EU) application and when an assessment decision is issued on that application. Applications submitted with invalid documents will be reassessed when requested corrected documents are received; the KPI will measure the time elapsed between receipt of required information and each new assessment decision.

August 2015		September 2015		October 2015		Year to date average	Year end average target
Number	**As a %**	**Number**	**As a %**	**Number**	**As a %**		
1821	100%	1557	99.8%	2504	99.8%	99% (Green)	90%

Number: Number of assessments within the KPI target
As a %: That number expressed as a proportion of the total assessments for the month
Year to date average: The cumulative average from April 2015
RAG: Year to date average vs. year end average target

Red/Amber/Green rating:
Green = figure matches or is higher than the target figure of 90%.
Amber = figure is between 85 and 89%.
Red = figure is 84% or lower.

Graphical information and commentary:



September 2015

1,560 international registration assessments were carried out, and all but three were completed within 70 days.

EU applications remain consistently high, with 1,229 assessments representing 79% of completed international assessments in September. Of these, 53% were completed within 30 days.

October 2015

International assessment activity increased significantly in October. We carried out 2,510 international registration assessments and all but six were completed within the KPI.

There were 1,932 EU assessments completed, which represents 77% of completed international assessments. Of these, 34% were completed within 30 days.

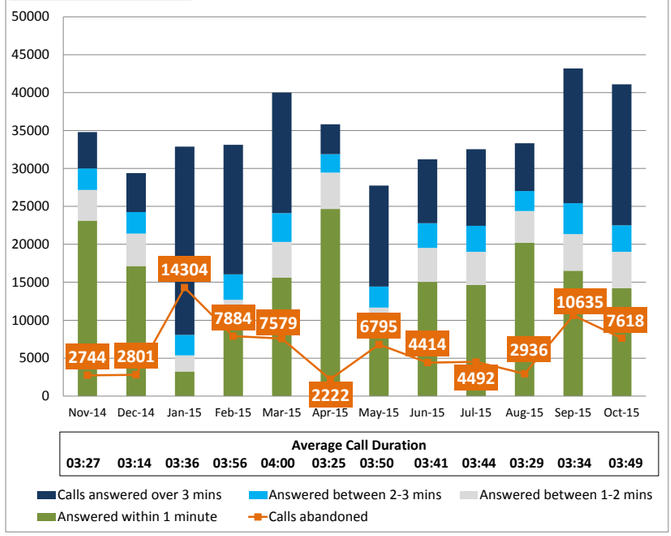
For both months, applications received from Spain, Portugal, and Romania remained consistently high, and over the two month period accounted for 70% of EU registrations.

REGISTRATIONS PERFORMANCE DASHBOARD SUMMARY FOR COUNCIL

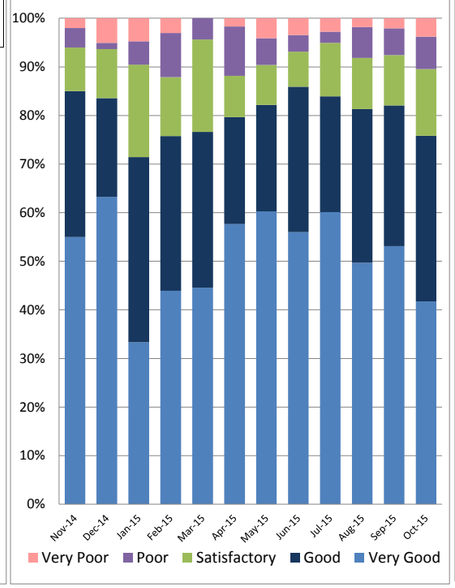
Call Centre Performance

Cumulative average of abandoned calls 2015/2016
13.8%

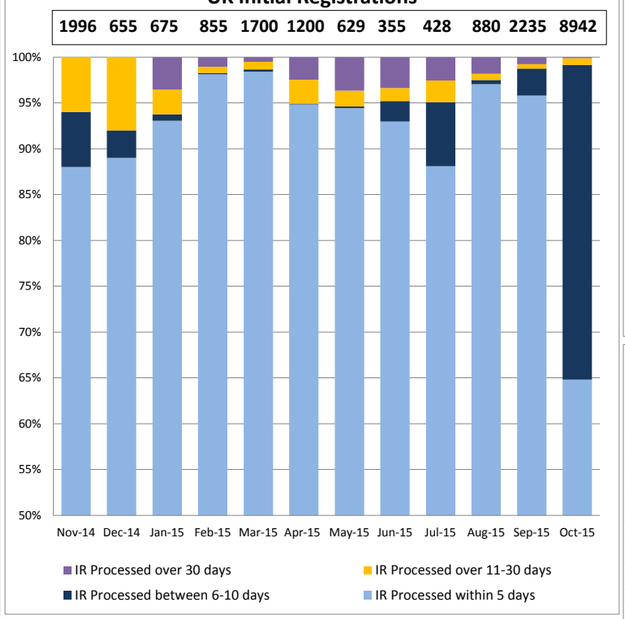
Cumulative average of abandoned calls 2014/2015
11.5%



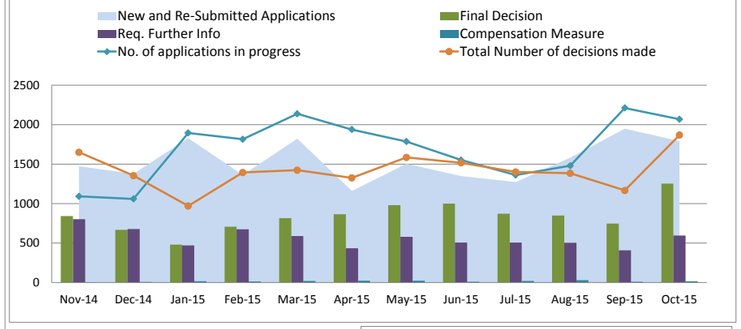
Customer Survey - How would you rate your overall experience?



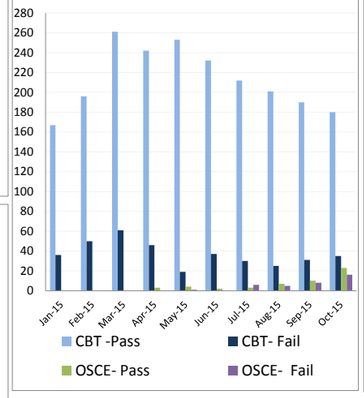
UK Initial Registrations



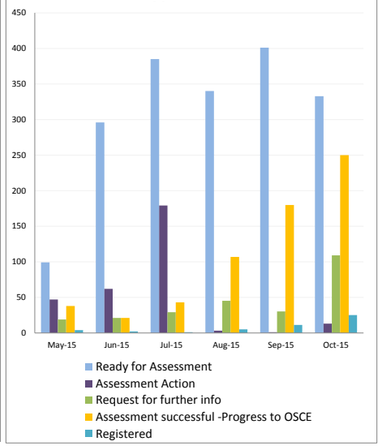
EU Applications



Overseas Test of Competence (CBT/OSCE Outcomes)



Overseas Application Assessment



Online Sign Up and Activated Accounts

Online Activity

Customer Survey - Did we resolve your query?

UK Periodic Renewals

Number of Appeals

Outstanding Appeals

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Fitness to Practise performance and risk update

Performance overview

This overview summarises recent operational developments and performance in the Fitness to Practise (FtP) directorate and includes the FtP Key Performance Indicators (KPIs).

Employer link service (ELS)

1 The ELS completed the set up phase successfully and has now soft launched ready for the full launch in early 2016. Over 60 Trusts have now been contacted and a number of engagements set up with Directors of Nursing in all four countries of the UK. The Head of Service Delivery and two Regulation Advisers who were originally seconded to Employer Link are now in substantive posts. An Employer Link Officer and Administrator have also been successfully recruited. The Assistant Director for ELS has been recruited and will be taking up her post on 1 December, followed soon after by four more Regulation Advisors.

Case management system (CMS)

2 The CMS upgrade has a targeted launch date of 7 December 2015. The project has entered an intense period of system testing, training and data migration. Weekly project board meetings are scheduled to closely monitor progress and risk as the launch date approaches.

Review of our planning assumptions

3 We have undertaken a mid-year review of our key planning assumptions. In summary:

3.1 Referrals were lower than we planned for during the first two quarters. However, we have seen an increase in the second quarter and often see an increase later in the year and have retained our original planning assumption.

3.2 Closure rates at screening and investigations are both higher than our original planning assumption. This reflects our continuing work to adopt a more proportionate approach and the introduction of case examiners. We expect to maintain these levels and have revised our planning assumptions accordingly. The screening closure assumption has been increased from 39.5% to 47% and investigation closure assumption from 51.5% to 60%.

3.3 Alternative disposals have been lower than expected and we have revised the planning assumption downwards to 24%, which is what we averaged last year. We are continuing our work to identify potential alternative disposals as early as possible in the process and consider the revised assumption to be achievable.

3.4 Substantive hearings have been taking over four days on average to conclude. Our planning assumption is that they should take three and a half days [as a note, we do not record half days which is consistent with historic data and our planning assumptions]. Based on historical trends, we think the original planning assumption is still reasonable. We are continuing to strengthen our case management

throughout the process and encourage earlier engagement with registrants which are both key to achieving more focused hearings and consensual panel determination (CPD) disposals.

End to end performance (KPI 3)

4 We previously committed to the Council that we would not allow performance against KPI 3 to drop below 65% whilst we allowed time for changes to our process, including the introduction of case examiners, to embed. Over the last six months, performance against the KPI has increased steadily and currently stands at 77%. We have included information about the numbers and median ages of cases closing at each stage of the process below in the KPI commentary.

5 We have modelled throughput of cases using the revised planning assumptions discussed above. Our current caseload includes a number of older investigation cases which we expect to clear investigations by the end of the financial year. These will have an impact on KPI performance as those cases are concluded either by the case examiner or at the adjudication stage. Taking these factors into account, we expect performance to stabilise at around 80% over the next 12 months.

6 We are therefore recommending that the Council does not set a target for KPI 3 at this stage and that it continues to monitor the current commitment not to fall below 65%.

Quality dashboard

7 We have developed a set of quality measures and a summary assessment of our quality framework. These have been brought together into a quality dashboard which was well received in its draft form by the Audit Committee. We intend to develop it further before presenting it to the Council at a future meeting.

Corporate risk update – please refer to corporate risk register at Annexe 3

8 Changes to FtP planned actions on the corporate risk register can be summarised as follows:

8.1 Launch of the CMS upgrade has been scheduled for December and this has been reflected in the risk around systemic regulatory failure.

8.2 Initial development of risk intelligence as part of ELS has been delayed until Q4. This is a planned action which will mitigate the risk on operational use of intelligence. The standardised taxonomy for logging different types of referrals in CMS, which also feeds into the mitigation of the risk, is now expected in 2016-2017.

KPI 2 – Percentage of interim orders (IO) imposed within 28 days of opening the case

Strategic priority 1: Effective regulation

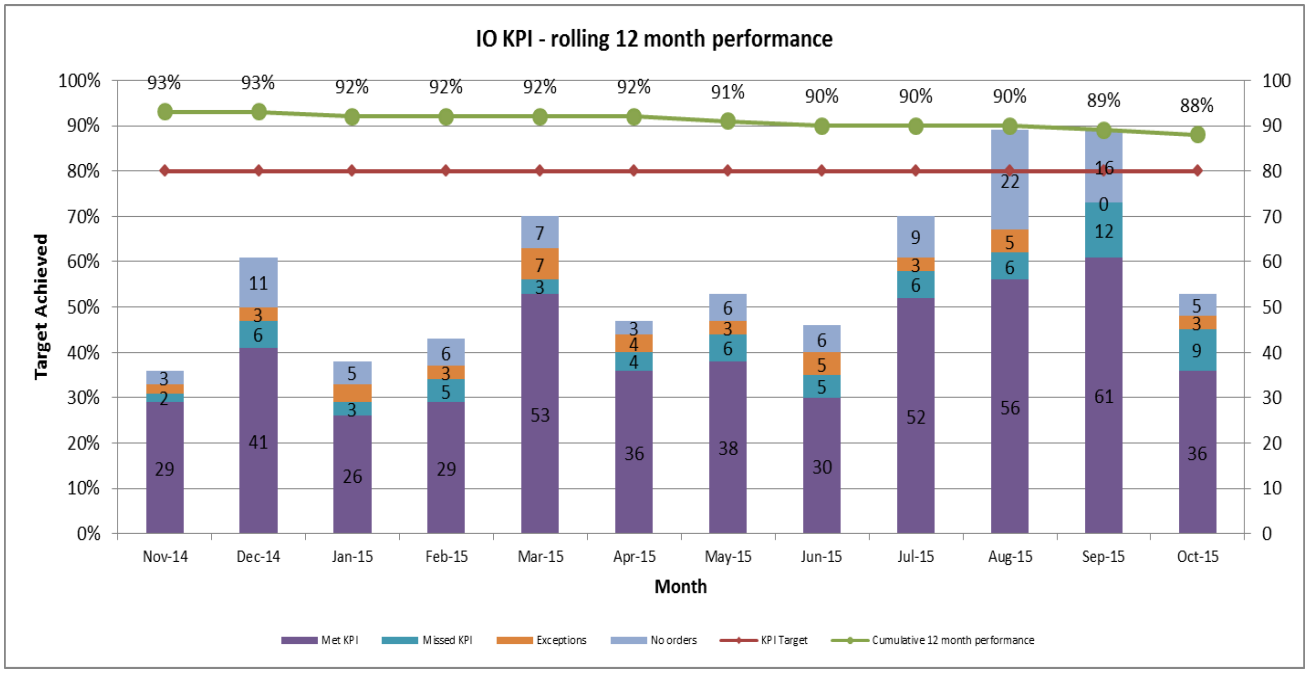
Rationale	A measurement of how quickly we protect the public in the most serious cases by applying restrictions to a nurse or midwife's practice.
Definition	Percentage of interim orders imposed within 28 days of opening the case. The measure will use the cumulative number of interim orders imposed over a rolling 12 month period. Our target is to exceed 80% every month. Definition of the start and end points of the measure - The period starts on the day that a case is logged on the case management system and the day that an interim order is imposed is the end of the measurement period. Cases which do not have an order imposed are not counted towards this measure.

Historical figure (also March 2015) Average for 2014–15	**August 2015**	**September 2015**	**October 2015**	**Year end average target**
92%	90%	89%	88% (Green)	80%

Each monthly figure is based on numbers for a rolling 12 month period, thus presenting a longer term trend.
RAG rating: October figure vs Year end average target.

Red/Amber/Green rating
Based on 10% variance threshold:
Green = figure matches or is higher than the target figure
Amber = figure is between 70-79%
Red = figure is 69% or lower

Graphical information and commentary:



Interim order applications in October reverted to a level consistent with historic performance. Changes in personnel reviewing applications led to higher numbers being submitted in the preceding two months.

This has been addressed and a more proportionate approach has been reinstated.

48 new IOs were imposed in October which is consistent with the long term average. There was a 9% no order rate and nine cases missed the KPI of 28 days.

KPI 3 - Proportion of FtP cases concluded within 15 months of being opened

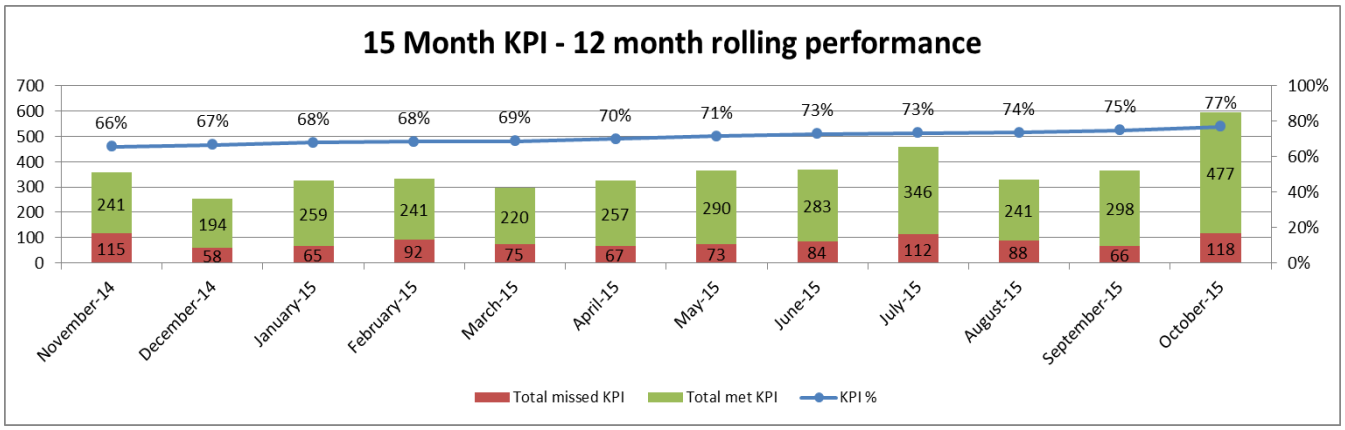
Strategic priority 1: Effective regulation

Rationale	Measures timeliness of the end to end FtP process.
Definition	This is the proportion of FtP cases which are concluded within 15 months of being opened. By concluded, the case has either been: 1. Investigated at Screening and closed 2. Closed no case to answer by Investigating Committee or case examiners 3. Closed by voluntary removal 4. Concluded at an adjudication hearing or meeting 5. Cases where a registrant has lapsed or cannot be identified are *not* included.

Historical figure (March 2015) Average for 2014–15	**August 2015**	**September 2015**	**October 2015**	**Expected minimum performance***
69%	74%	75%	77%	65%

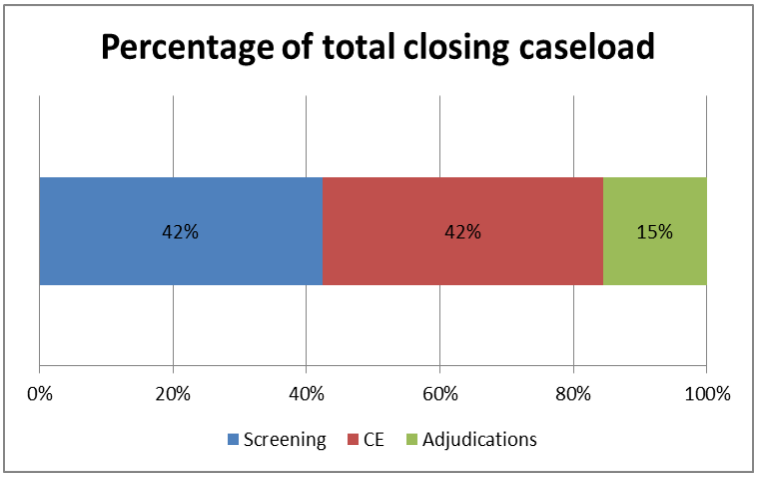
*Performance is expected to match or be higher than 65% each month. This is not a formal target and there is no RAG rating. Following a midyear review of the KPI, we are proposing not to set a target for the second half of the year and to continue monitoring performance to prevent it falling below 65%.

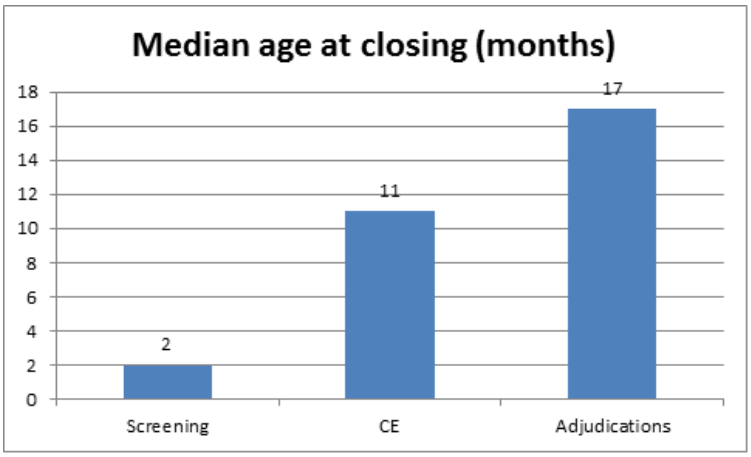
Graphical information and commentary:



September and October saw consistent performance against this measure, with October also seeing a significant increase in throughput.

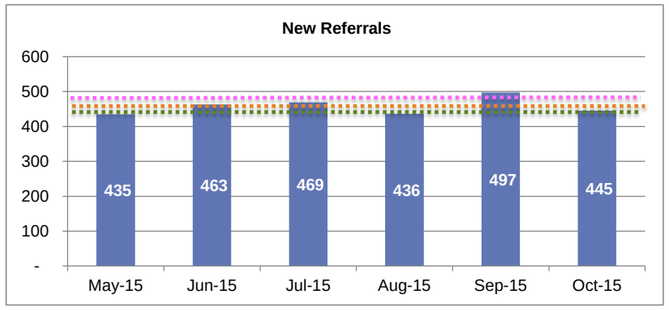
A breakdown of the cases used in calculating the KPIs will be presented as a set of supporting indicators. An example of how this will look is set out below using cases closed in October.


Percentage of total closing caseload
42%
42%
15%
0%
20%
40%
60%
80%
100%
Screening
CE
Adjudications

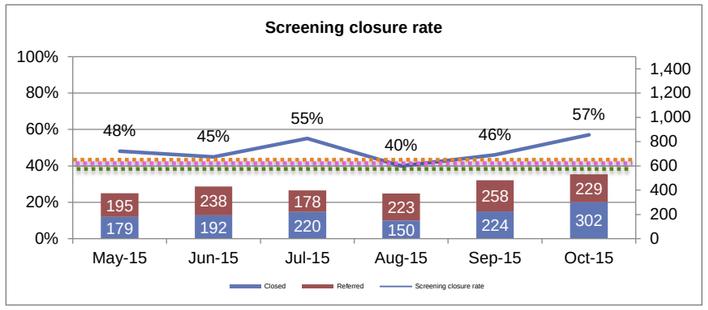

Median age at closing (months)
18
16
14
12
10
8
6
4
2
0
2
11
17
Screening
CE
Adjudications

Item 7: **Annexe 2d**
NMC/15/92

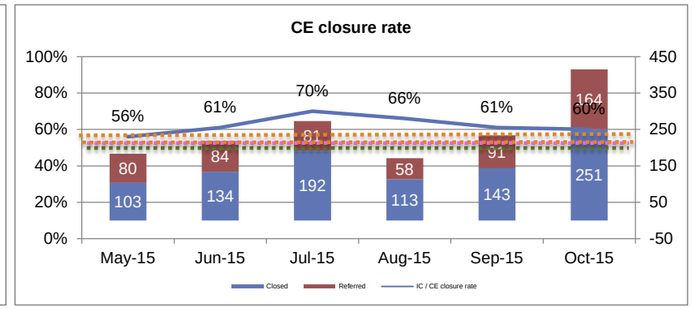
FtP Performance for May to October 2015



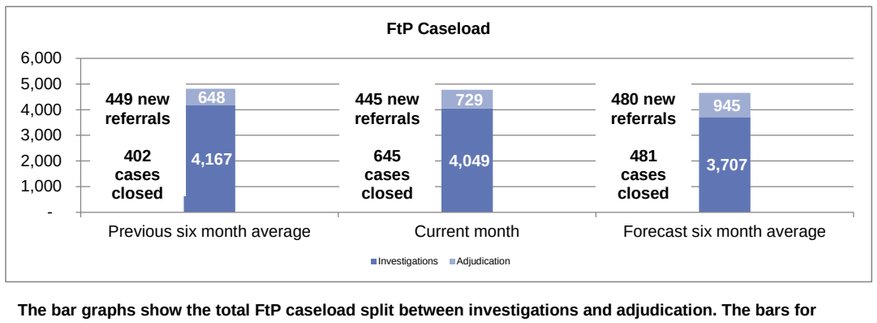
New referrals logged during the month



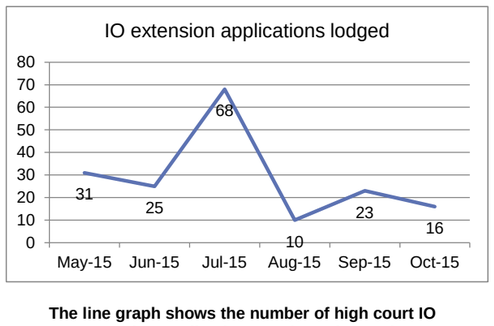
The line graph represents the proportion of cases closed after screening. The planning assumption and 12 month average lines apply to the closure rate. The bars underneath show how many cases were considered each month, split by their outcome.



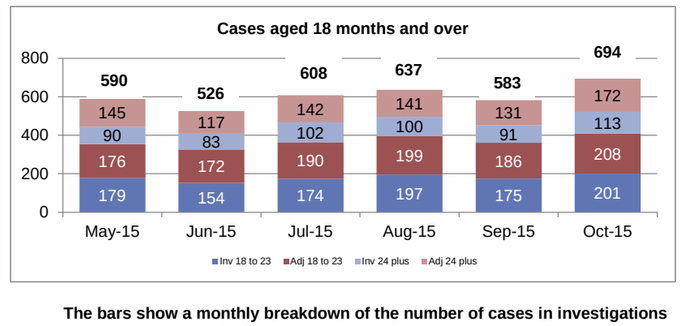
The line graph represents the proportion of cases closed by the investigation committee prior to 9 March, and then by case examiners. The planning assumption and 12 month average lines apply to the closure rate. The bars underneath show how many cases were considered each month, split by their outcome.



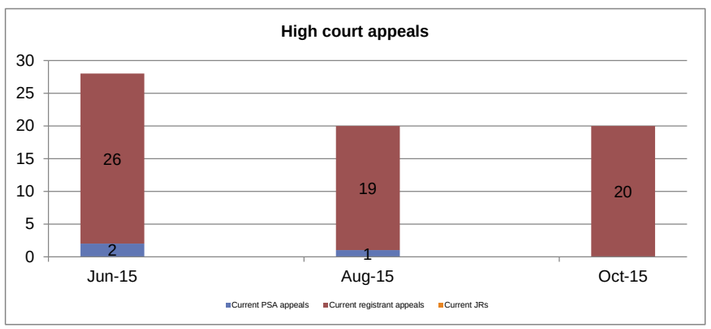
The bar graphs show the total FtP caseload split between investigations and adjudication. The bars for the previous six months and forecast six months show average caseloads over those periods so that when viewed together they demonstrate the direction of travel. The current month bar is the closing caseload for the period under review. The numbers of new referrals and cases closed next to each bar follow the same methodology, averages for prior and forecast periods and the closing numbers for the period under review.



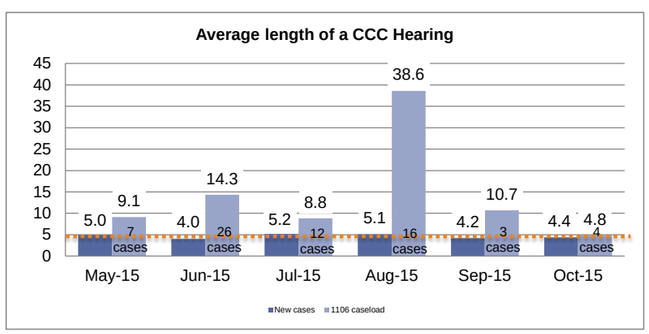
The line graph shows the number of high court IO extension applications made each month.



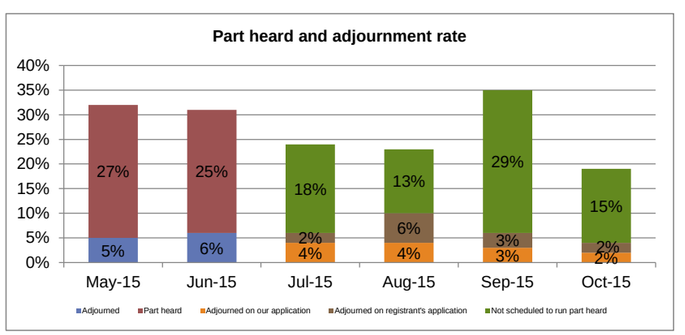
The bars show a monthly breakdown of the number of cases in investigations and adjudication over 18 and over 24 months old.



This graph shows the number of open appeals at the end of each reported month.



The bars show the average number of days taken to reach a decision on cases concluded during the reporting month. All hearing days pertaining to the case are counted, even if they took place in prior months. Currently cases are being split into those referred before 1 July 2014 and those referred after that date. We don't account for half days, which is consistent with historic data and our planning assumptions.



This graph shows the proportion of hearings which were stopped during the month without a decision having been reached. The split between adjourned and part-heard demonstrates that the majority fall into the latter category.

Item 7: **Annexe 2e**
NMC/15/92
25 November 2015

Continued Practice performance and risk update

Performance overview

This overview summarises recent operational developments and performance in the Continued Practice directorate.

Quality assurance of education and local supervising authorities

1 Following the extraordinary review in North Wales on 20-22 July 2015 our reports were published on our website on 26 October 2015.

2 We have refreshed and published our Quality Assurance (QA) framework in preparation for the next year's QA activities. In line with our published process we have selected the Approved Education Institutions (AEIs) and local supervising authorities (LSAs) for annual monitoring visits. All AEIs and LSAs selected will be informed six weeks in advance of the review visit.

3 Following last year's extraordinary review in Guernsey and in line with our QA timeframes, the review team has returned to Guernsey one year on for a follow up review. We will publish the reports from this review in late December 2015.

Education

4 An update on our work in the education arena is contained in the Chief Executive's report.

Corporate risk update – please refer to corporate risk register at Annexe 3

5 Following the Council's decision of 8 October, we have updated both corporate revalidation risks to reflect the current position.

Item 7: **Annexe 2f**
NMC/15/92
25 November 2015

Strategy performance and risk update

Performance overview

This overview summarises recent operational developments and performance in the Strategy directorate.

Communication and engagement

1 We have produced a revalidation communications plan which will support all revalidation communications activity up to and beyond the introduction of revalidation in April 2016. This plan was designed with the input of a range of key stakeholders and is referred to in the Chief Executive's report.

External reviews

NHS England Maternity Review

2 We have made a submission to the Review's call for evidence and we met the Vice Chair of the review, Sir Cyril Chantler, at the end of October.

Gosport Independent Panel

3 We had a second meeting with the Panel to update them on our progress with reviewing Gosport-related material and to discuss our proposed approach to disclosure. We are currently identifying individuals named in materials earmarked for disclosure in order that we can, as far as possible, give them due notice.

Section 60

4 We continue to work with the Department of Health on the preparatory stages of our section 60 Order.

5 With reference to the midwifery component, we continue to be closely involved in stakeholder engagement. We have met with the Royal College of Midwives (RCM) and with the lead midwives for education (LMEs) across the UK, as well as providing updates for the Council of Deans and the Parliamentary and Health Service Ombudsman.

Female Genital Mutilation (FGM): New mandatory reporting duty

6 Following consultation, the Government has introduced a new mandatory duty to report cases of FGM arguing that it will help increase the number of reports of FGM to the police from professionals. The duty, which applies in England and Wales, was introduced through the Serious Crime Act 2015 and came into effect from 31 October 2015 onwards.

7 Since the Act was passed, we have been working with the Department of Health, Home Office and other regulators to support the implementation of the new duty including placing a briefing document on our website drawing the attention of nurses and midwives to the new duty.

Corporate risk update – please refer to corporate risk register at Annexe 3

8 No significant updates to report with regard to Strategy-related aspects of the corporate risk register.

Item 7: **Annexe 2g**
NMC/15/92
25 November 2015

Estates, Finance and Procurement performance and risk update

Performance overview

This overview summarises recent operational developments and performance in the Estates, Finance and Procurement directorate.

Accommodation review

1 We have commenced a review of our estate to determine the NMC's long term requirements, in advance of the expiration of building leases in 2019. This review is being carried out in conjunction with the organisational review, and the work will run until December 2015.

Finance and Procurement improvement

2 In early October we commenced work to provide a high level financial strategy and plan. This will be based on assumptions arising from the organisational and accommodation reviews.

3 In line with the directorate's improvement plan, we are taking steps to strengthen our financial controls and improve financial management capability.

4 A procurement pipeline has been developed in conjunction with directorates. This will be used to plan procurements, moving the function from a reactive one, to one which is positioned to add value.

5 We are taking steps to strengthen our procurement governance, including a review of our purchase to pay procedures.

Corporate risk update – **please refer to corporate risk register at Annexe 3**

6 The two relevant corporate risks; Use of resources and sustainability and Business Interruption, have been updated with no changes to the scores. Both risks remain amber and continue to be managed.

KPI 4 – Available free reserves

Strategic priority 4: An effective organisation

Rationale	The NMC's budget and financial strategy is predicated on a restoration of minimum available free reserves to a minimum target level of £10m by January 2016. This KPI measures how close we are to our plan for achieving this target. This KPI also demonstrates delivery against meeting the target as agreed with the Department of Health.
Definition	The level of available free reserves at month end compared with budgeted available free reserves at that month end.

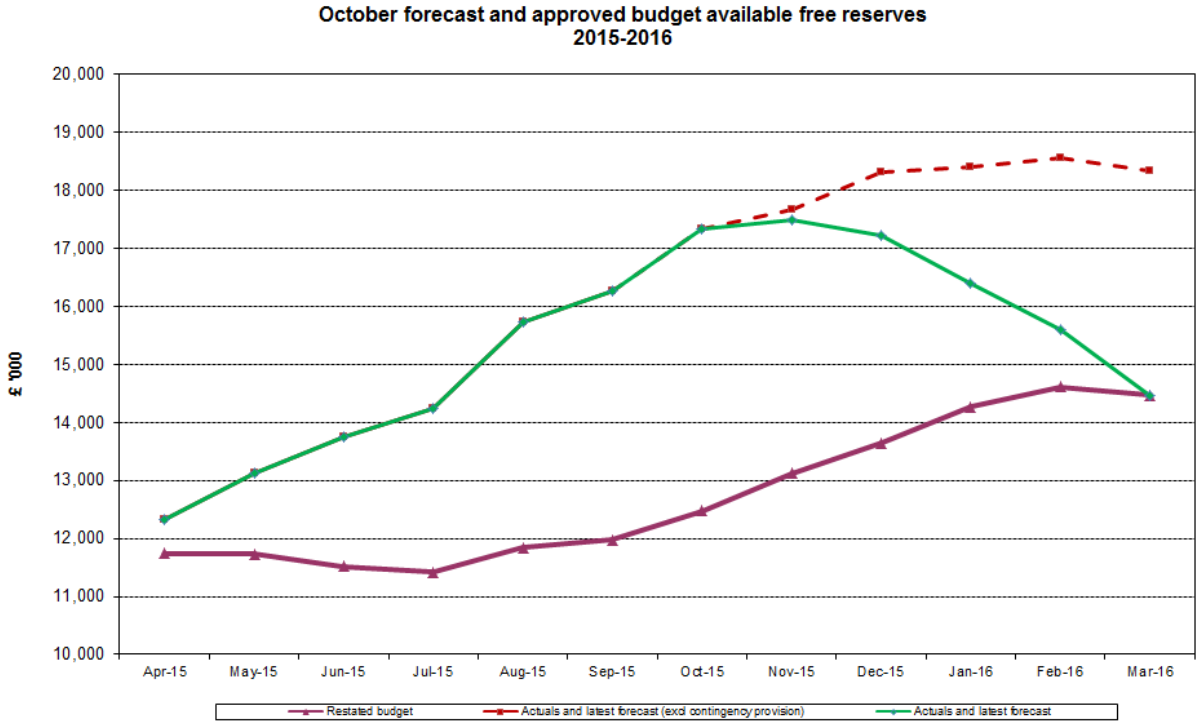
2014–15 year end (March 2015)	August 2015	September 2015	October 2015	October 2015 budget	Year end (March 2016) current forecast	Year end (March 2016) target
£11.8m	£16.0m	£16.3m	£17.3m	£12.5m	£14.5m* (Green)	£14.5m*

Available free reserves are derived by taking into account revenue expenditure, capital expenditure, movements in working capital and the pension deficit

RAG rating: Year end forecast vs Year end target
* As adjusted for restatement of opening balance sheet

Red/Amber/Green rating:
Green = the figure matches or is above the target figure.
Amber = within 5% of the target figure.
Red = greater than 5% of the target figure.

Graphical information and commentary:



At October 2015, available free reserves were £17.3 million compared with the budgeted level of £12.5

million. This variance is predominantly driven by lower staff costs, the release of the Old Bailey dilapidation provision and current forecast that there will be un-utilised contingency of £3.1m of the £4.5m budgeted.

Available free reserves are budgeted to be £14.5 million at 31 March 2016. However, should the latest forecast crystalise and, if no further draw-down is made on contingency, available free reserves would be £18.3 million at 31 March 2016.

Item 7: **Annexe 2h**
NMC/15/92
25 November 2015

Technology Business Services performance and risk update

Performance overview

1 This overview summarises recent developments and performance in the Technology Business Services (TBS) directorate.

2 We continue to make good progress against a challenging programme of work despite some additional requirements, including a physical move of our data centre from one location to another during November 2015.

IT Improvement

3 Progress continues towards implementation of the proposed permanent structure, following completion of the consultation process. In view of the organisational review immediate recruitment is focusing on the high priority roles. Reliance on contractors has been reduced from a 70% contractor staff level to 40% in a six month period. We intend to progress recruitment to the full structure in early January 2016.

4 A disaster recovery (DR) capability has been procured and is being implemented in advance of the physical move of our existing data centre. This contributes to the mitigation of our corporate risk around business interruption.

5 The physical move of our data centre from one location to another utilising the DR capability means we will have undertaken a test of our DR strategy. This will become an annual event in future.

6 The procurement process is underway for our new data centre and responses are due back in late November 2015.

IT Portfolio

7 The core systems for all three critical projects are on track (Readmissions, Phased Payments and Mutual Recognition of Professional Qualifications (MRPQ) work).

8 Readmissions went live over the weekend of 6 to 8 November 2015.

9 Requirements for readmissions phase 2 (to align with revalidation rollout) and phased payments are being captured and are scheduled to be complete by the end of November 2015. These are planned for delivery post January 2016.

Corporate risk update – please refer to corporate risk register at Annexe 3

10 CR12 *ICT business systems* has been reduced to amber, to reflect the good progress made so far with the IT improvement programme.

Item 7: **Annexe 2i**

IT Improvement Plan

87

Completed on: 5/11/15
Completed by: Rachel Murphy

Executive Summary

Progress	Risk	Control
A	A	G

Recruitment to priority roles in permanent structure. Reliance on contractor resource reduced to 40%. Remaining recruitment planned in new year to align with Organisation Design Review output.
Procurement process underway for new data centre with invitation to tender issued 28 October 2015.
Analysis of programme management functions (PMO) for Technology Business Services (TBS) and the business completed and plan being proposed on joining up these functions.
Effective engagement between IT and business continues. Focus groups across all sites to assess progress against April 2015 survey.
Internal TBS improvements on working culture and morale up from 38% to 60% and faith in new Leadership from 38% to 60%.
RAG status applied to top 15 contracts in TBS and regular supplier and contract meetings ensuring proactive approach to service.
Disaster recovery (DR) as a service has been brought forward on the timeline due to A365 data centre move in November 2015. This is on track for delivery.
Data centre shutdown during November 2015 on track and extensive engagement with the business to plan for staff working over these weekends where necessary.

Output Plan for Next Reporting Period

- Disaster recovery as a service in place.
- Test of disaster recovery undertaken.
- Second phase of recruitment to TBS structure underway.
- Self service and service catalogue available to internal staff to consume TBS services.
- Results of the second all-staff survey shared with directors.
- Moore Stephens output from IT improvement review.
- First draft of TBS Strategy.
- Evaluation of data centre bidders underway.

Workstream Dashboard - Summary

WS 1: Portfolio Process	G	
WS 2a: Service Management	G	
WS 2b: Infrastructure Resilience	R	Competing priorities are making this high risk to schedule and deliver. The rating reflects complexity rather than likelihood to deliver.
WS 2c: Commercial	G	
WS3: DR	G	
WS4: Strategy and Architecture	G	
WS 5: Financial Management	G	
WS 6: Comms & Engagement	G	
WS 7: Business Transformation	G	
WS 8: Information Security	G	

IT Portfolio Summary

Executive Summary

Progress	Risk	Control
A	A	G

Number of interdependencies with data centre activity has added additional challenge to delivering prioritised portfolio.
Agile management methodology adoption and training continues across TBS and business PMO.
Closer working relationship with business PMO in forming a joint portfolio.
The core systems delivery for all three critical projects are on track.
Readmissions has gone live successfully over the weekend of 6-8 November 2015.
Requirements for readmissions phase 2 (to align with revalidation rollout) and phased payments are being captured and are targeted to be ready by end of November 2015. Once these are completed TBS can review resource capacity to deliver these post January 2016.

Output Plan for Next Reporting Period

- Review key roles for priority projects post initial go-live dates.
- CMS 4.1 goes live.
- MRPQ goes live.
- Revalidation goes live.
- Commidea 27 November go live date at risk.
- Plan for development and delivery of prioritised projects post Christmas.

Project Dashboard - Summary

Revalidation	A	IT delivery on track for 8 Jan 2016. Budget for delivery of Phase 2 and beyond has not been finalised and approved.
Phased Payments (RAdm)	G	Delivered
Phased Payments (FPP)	R	Detail definition still in progress. Will be reassessed when finalised late November 2015.
MRPQ	G	IT delivery on track for 8 Jan 2016
CMS 4.1	A	Serious defect identified in testing. Fix identified and under retest. Implementation being planned once test confirmed
Commidea	R	Rework in progress as previous plan could not be supported by current infrastructure provider.

Item 7: **Annexe 2j**
NMC/15/92
25 November 2015

Human Resources and Organisational Development performance and risk update

Performance overview

This overview summarises recent operational developments and performance in the Human Resources and Organisational Development (HR and OD) directorate.

Organisational review

1 KPMG attended the Council Seminar on 29 October to engage with Council members and gain their input to options under consideration.

2 KPMG are developing the final report which will be submitted to the Chief Executive in mid-November 2015.

3 A staff communications and engagement plan has been developed, with actions including an iNet page with information about the Integrated Reviews (organisation, accommodation and finance strategy), an email inbox for queries and frequently asked questions that will be updated regularly. These have all now gone live.

Staff survey

4 Staff Survey Action Plans have been developed by all directorates, providing opportunities for employee engagement at all levels.

5 An integrated Staff Survey Action Plan has been produced which summarises the top two or three key themes for each directorate and actions that are being taken to address these areas. This has been shared with the Staff Consultation Group and was published on the intranet in October 2015. A progress update will be published in January 2016.

Key performance indicators

6 There are no proposals to change the KPI for the remainder of 2015–2016. Latest performance figures are shown below.

Corporate risk update – please refer to corporate risk register at Annexe 3

7 No change. The risk around staff capacity and capability now and in the future is rated amber.

KPI 5 – Staff turnover rate

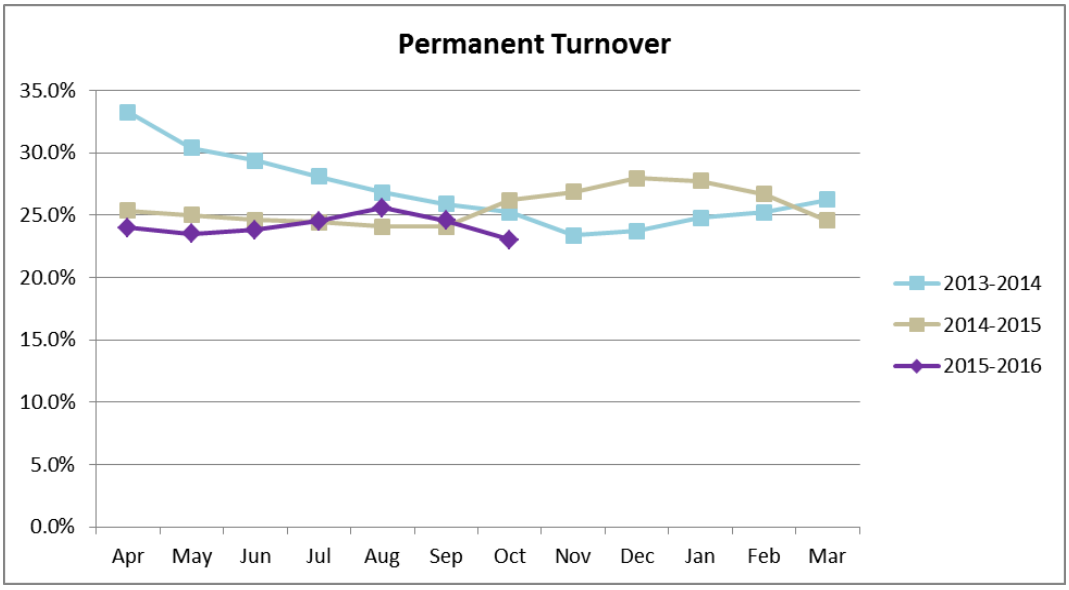
Strategic priority 4: An effective organisation

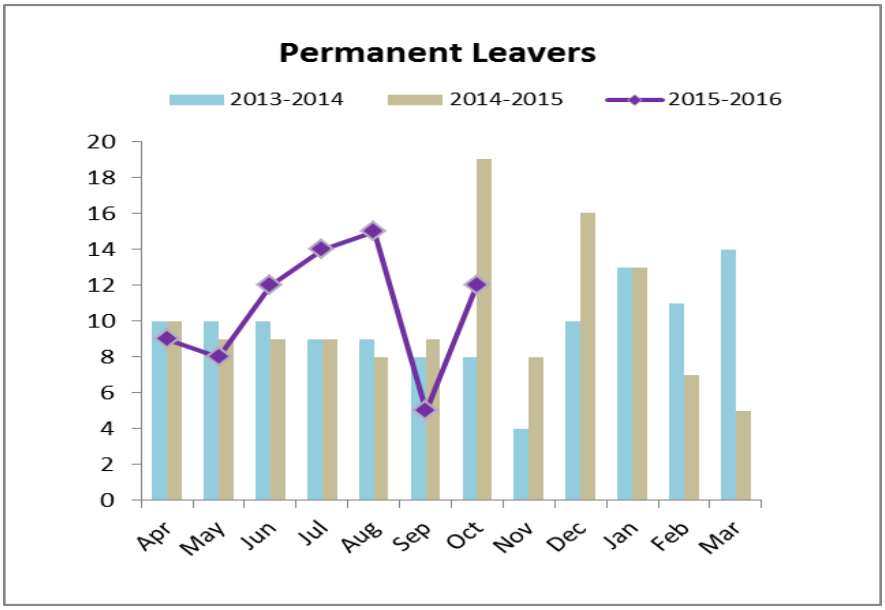
Rationale	The level of staff turnover is consistently high and represents a recognised risk to organisational effectiveness.
Definition	Sum of permanent leavers in past 12 months (X) Average number of permanent staff in post in last 12 months (Y)

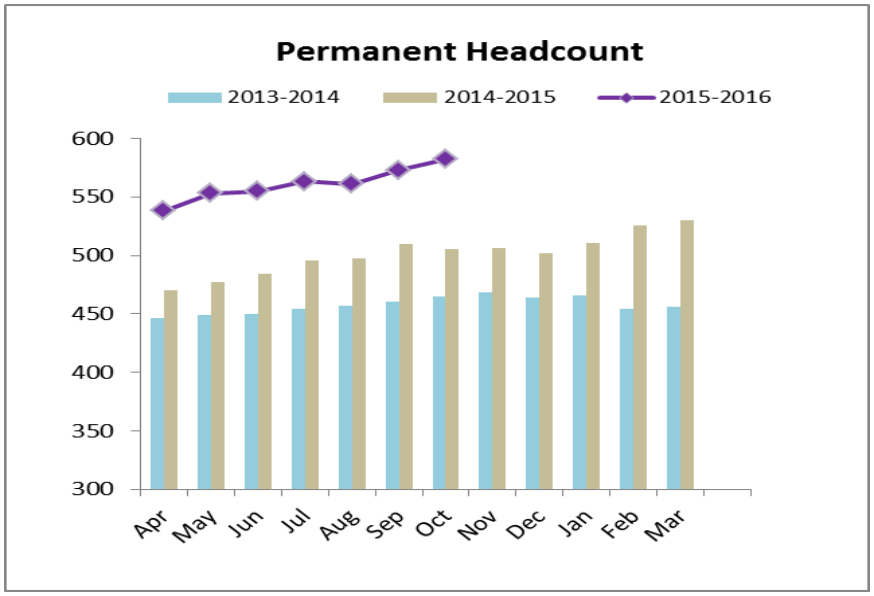
2014–15 year end spot figure (March 2015)	July 2015	August 2015	September 2015	October 2015
24.5%	24.5%	25.6%	24.6%	23.0%

No target has been set for 2015–16 and no forecast reported. It would be difficult to set a meaningful target due to unpredictability over the size of the permanent workforce over the year, due to a high period of growth. Instead, performance will be monitored and will include reference to longer historic trends.

Graphical information and commentary:







The permanent headcount continued to increase and at the end of Quarter 2 stood at 573 employees. There were 42 leavers in this period with the majority (27) coming from FtP. Of the 42 leavers, 34 employees completed the exit interview questionnaire. The average length of service of leavers in Quarter 2 was two years. Turnover in September decreased to 24.6 percent and October figures show a further fall to 23 percent. The permanent headcount at the end of October was 582.

Since the implementation of the online exit questionnaire in January 2015 there has been a steady increase in the number of leavers completing exit interviews with an 85 percent completion rate for Quarter 2, compared to 33 percent in Quarter 4 of the last financial year.

Analysis of Quarter 2 exit interviews indicates that ‘career progression’ continues to be the main reason for leaving and given that the average length of service was two years, this is not entirely unexpected. Second to this is ‘change in career’, with a small number of employees returning to education. Exit questionnaires are reviewed by HR to explore any potential underlying issues and these are followed up with line managers as appropriate.

The majority of leavers gave positive feedback on their line managers, in particular on relationship and communication. A majority also felt that they had received the appropriate training to do their job effectively. However, career development is consistently negative with a low score across all quarters. Of the negative feedback, a high percentage related to ‘my role’, which covers the areas of job satisfaction, manageable workload and recognition. This quarter showed a lower score across this section compared to the previous quarter, in particular around recognition.

We are reviewing the exit interview questionnaire to identify where we can make improvements to enable a more meaningful analysis of the data. For example; understanding what leavers actually mean by the ‘lack of recognition and career development’. There could be a number of reasons both from a management and/or organisational perspective. The area, ‘my role’ needs more scrutiny to enable meaningful conclusions to be drawn; currently the data is open to interpretation in a number of ways.

Corporate risk register 2015-2016

Note: The 'inherent risk scoring' column does not take into account any mitigation. The 'post-mitigation scoring' involves taking into account the mitigation in place but not the planned action.

Date: 11 November 2015					**Issue No: 3**										
No.	**Date of origin**	**Risk Scenario**			**Inherent risk scoring**			**Mitigation in place / Planned action**	**Post-mitigation scoring**			**Risk Owner (and Mitigation Owner)**	**Dates updated**	**Status** (open / closed plus whether on track / not on track to reduce scoring)	**Direction** (of risk score)
		Root cause(s)	**Potential situation**	**Consequences**	**Likelihood**	**Impact**	**Score**		**Likelihood**	**Impact**	**Score**				
Strategic priority 1: Effective regulation															
		Systemic failure of one of our regulatory functions													
		Our operational arrangements and supporting systems may be ineffective and subject to error. Regulatory processes are complex and rely on multiple systems and manual intervention. Volume of demand fluctuate markedly and are not within our control. We may fail to take timely or appropriate action on specific issues.	We may fail to protect the public as a result of systemic failure in one of our regulatory functions.	Our register may not have integrity in terms of its accuracy or reliability and may not reflect FtP sanctions applied. We may fail to take appropriate action to limit or prevent the practice of a nurse or midwife through our fitness to practise procedures where this is necessary for public protection. Our quality assurance processes may not identify concerns about educational programmes or settings or LSAs. Compromised public protection. Loss of public confidence. Reputational damage.	4	5	20	**<u>Overall</u> mitigation in place:** 1. Operational policies and procedures in place covering all functions, with regular review cycle and supported by staff training. 2. Performance monitoring scrutinised via Performance and Resources Board and Council. 3. Department and team level quality management arrangements checked as part of quality assurance review programme. **Planned action:** 4. Organisation review to develop short, medium and long term organisational models to align with progress towards meeting strategic aims (First stage report in Jan 2016). **<u>Register integrity specific</u> mitigation in place:** 5. Daily reconciliation reports and manual processes to pick up and deal with system anomalies. 6. Weekly checks include reviewing determinations from website to ensure no discrepancies. **Planned action:** 7. WISER improvements continue to be implemented (ongoing). 8. Further process refinements and alignment of FtP and registrations data, supported by regular inter-directorate business meetings (ongoing). Additional focus from January 2016 will mean that all register updates will be undertaken by Registration staff in a dedicated team. 9. Data cleansing work (Q4). **<u>Fitness to practise specific</u> mitigation in place:** 10. Detailed profiling and forecasting of caseload and activity levels, focussing on new end-to-end timescale. 11. Additional resource to increase focus on quality of early stage decision making. 12. Case examiners and power to review 'no case to answer' introduced 9 March 2015. 13. Decision review process in place. **Planned action:** 14. Roll out of new case management system functionality to provide better management information expected December 2015. **<u>Education Quality Assurance specific</u> mitigation in place:** 15. Closely monitored external provider contract in place. 16. QA framework year two evaluation undertaken. 17. Ongoing review of potential risks (RESQ Group) 18. Extraordinary reviews have been undertaken in response to concerns during 2015/16. **Planned action:** None at this stage. Continuous improvement and change to our quality assurance function as part of business planning 2016/17.	3	4	12	Chief Executive (and relevant directors)	23.10.2015 - risk updated	Open - new corporate risk This is a new composite risk. We would expect the overall score to come down over time as local improvements are made in directorates and the benefits of improved ICT and organisation arrangements come to fruition.	
Cross ref:															

No.	Date of origin	Risk Scenario			Inherent risk scoring			Mitigation in place / Planned action	Post-mitigation scoring			Risk Owner (and Mitigation Owner)	Dates updated	Status (open / closed plus whether on track / not on track to reduce scoring)	Direction (of risk score)
		Root cause(s)	Potential situation	Consequences	Likelihood	Impact	Score		Likelihood	Impact	Score				
Cross ref:		**Failure to develop our regulatory functions to meet changing public protection needs**						**Mitigation in place:** 1. Our corporate strategy and corporate plan articulate the changes we need to make. 2. Strategic development programme structure is in place overseen by Regulation Board. 3. A Future FtP Steering Group has been established to bring a more focused and consistent approach to change initiatives and optimisation of end-to-end process. **Planned action:** 1. Programmes have been set up as part of 2015/16 plan to take forward the following: - Pursuing legislative change (ongoing). - Midwifery regulation changes (2015/16). - Role of the register strategic review - (scoping 2015/16). - Pre-registration standards evaluation - Council discussion in January 2016.					23.10.2015 - risk updated.	Open - new corporate risk The most effective mitigation will be limited without legislative change so this risk may stay at amber for some time.	
		Changing external environment and demands. Changing nature of practice and workforce. Public have greater access to data and information and expectations of registrants are changing. Our current legislative framework is outdated and limits our ability to adapt and improve the effectiveness of our processes.	We fail to design and deliver regulatory policies and practices that enable us to be flexible and adapt to changing needs to deliver public protection in the future.	Our regulatory functions fall behind modern-day needs and do not deliver appropriate public protection.	4	4	16		3	4	12	Chief Executive (relevant directors)			
CR13 A **Cross ref:**	May-13 (previously risk CR3/CP1. Date of origin: May-13)	**Revalidation - model delivery**						**Mitigation in place:** (1-3) Close working with DH around revalidation priorities and future legislation (if/as required following phase one). Close working relations with all four UK governments and four-country programme boards around readiness and delivery. (1-3) Final Standards and guidance published. (3) Clear programme governance structure and resources in place. (2-3) Communication and engagement plan in place. (1, 3) Extensive ongoing stakeholder engagement activities across settings and four countries including specialist stakeholder groups. (3) Pilot organisations selected to reflect the diversity of scopes of practice and settings. (2,3) Independent review of NMC readiness assessment by internal auditors. **Planned action:** (2) Communication and engagement programme being implemented (October 2015 onward). (3) Continuous close working with four programme boards across the UK.				Director, Continued Practice	Risks updated 17.08.2015 to distinguish between delivery of revalidation model and regulatory effectiveness of the model. 26.10.15: Risk updated following 8 October decision.	Open - Programme to be achieved in April 2016 Engagement activity has moved to focus on strategic partnership building. Stakeholder groups have been re-shaped to support programme's needs.	
		(1) Decrease/ loss of government and/ or four-country programme boards support. (2) Time and resource constraints around delivery. (3) Complexity of revalidation model delivery at four country level and across settings.	(1) Revalidation not delivered to set time/quality/ budget. (2) Inadequate preparations made to effectively support or comply with revalidation process due to lack of understanding or unaddressed resistance. (3) Inconsistent level of preparation and readiness.	(1) Revalidation is not delivered as planned. (2) Criticism by employers, registrants, other regulators, media etc. (1,3) Impact on public protection and credibility of NMC around delivery. (1-3) Public protection compromised. Negative impact on nurses and midwives, and employers.	4	4	16		3	4	12				

No.	Date of origin	Risk Scenario			Inherent risk scoring			Mitigation in place / Planned action	Post-mitigation scoring			Risk Owner (and Mitigation Owner)	Dates updated	Status (open / closed plus whether on track / not on track to reduce scoring)	Direction (of risk score)
		Root cause(s)	Potential situation	Consequences	Likelihood	Impact	Score		Likelihood	Impact	Score				
CR13 B	May-13 (previously risk CR3/CP1. Date of origin: May-13)	**Revalidation - regulatory impact** (1) Lack of buy-in from stakeholders and accountability authorities (PSA, HSC). (2) NMC revalidation model is developed within current legislative framework. (3) Inconsistent levels of buy-in across the system and register. (4) Stakeholders expectations / understanding of revalidation model are not accurate.	(1) Revalidation may not improve on existing PREP process. (2) Delivered model may fail to be applicable to all scopes of practice and nurses and midwives across four countries.	(1) Criticism drawn as PSA standards of good regulation, and expectations of HSC are not met. (2, 3, 4) Criticism /confusion from nurses and midwives and stakeholders. (2, 3, 4) Loss of nurses and midwives from the register. (2, 3, 4) Unable to effectively support/ engage with revalidation process. (4) Contributes to a loss of nurses and midwives from the register.	4	4	16	**Mitigation in place:** (1) Agreed model to add more value than PREP through reflection on the Code and challenging professional isolation. (2) Agreed model with inherent flexibility for different scopes of practice. (3) Pilots tested in different settings and scopes of practice (3) Pilots informed perceptions of benefits. (4) Final Standards and guidance published. **Planned action:** (1) Evaluation framework to be commissioned (November 2015). (2) Communication and engagement plan implemented (October 2015 onwards) (3) Continuous close working with four programme boards across the UK	3	4	12	Director, Continued Practice	Risks updated 17.08.2015 to distinguish between delivery of revalidation model and regulatory effectiveness of the mode. Update - all mitigations have influence on the risk score, however the communications products will provide the most effective mitigation when in place. 26.10.15: Risk updated.	Open - Programme to be achieved in April 2016 Engagement activity has moved to focus on strategic partnership building. Stakeholder groups have been re-shaped to support programme's needs.	
Strategic priority 2: Use of intelligence															
Cross ref:		**Operational use of intelligence** Still building up stronger links with key stakeholders, for the sharing of information. Limited protocols in existence to share data. Our internal systems to enable visibility and sharing are still in development. The data we hold is not readily accessible. Historic data may be unreliable.	We fail to receive, act on or share information that may be relevant to public protection. Serious and high profile failures of care in settings. Higher expectations that regulators will work together. External expectations not met.	Failure to identify risk and/or mitigate harm. Serious high profile failures in care settings go undetected. Failure to initiate appropriate regulatory action in line with our duties and powers.	4	4	16	**Mitigation in place:** 1. Corporate data and intelligence group established to review risk intelligence. 2. Procedures in place for NMC attendance at risk summits and quality surveillance groups (England). 3. Memoranda of Understanding or operational protocols in place or in development with key agencies. **Planned action:** 1. We will establish a corporate risk intelligence function alongside the Employer Link Service (new function scoped Q3). Initial development of risk intelligence as part of ELS to proactively address potential sources of referrals is expected Q4 2015-2016. 2. We will improve our use of employer data by adopting a standardised taxonomy and exploring ways of more reliably linking registrant data to settings (2016-2017).	3	3	9	Director of Fitness to Practise Director of Strategy	23.10.2015 - risk updated.	Open - new corporate risk We expect this risk score to go down with the establishment of the risk intelligence function in Q3. Initial development of risk intelligence as part of the ELS function is now due in Q4, so risk score may remain until this is in place. Due to timescales being extended during the earlier procurement process, it is looking unlikely that taxonomy will take place this financial year. Implementation of code frames into CMS will now take place in 2016-2017.	

No.	Date of origin	Risk Scenario			Inherent risk scoring			Mitigation in place / Planned action	Post-mitigation scoring			Risk Owner (and Mitigation Owner)	Dates updated	Status (open / closed plus whether on track / not on track to reduce scoring)	Direction (of risk score)
		Root cause(s)	Potential situation	Consequences	Likelihood	Impact	Score		Likelihood	Impact	Score				
Strategic priority 3: Communication and collaboration															
Cross ref:		**Communication** Large diverse external stakeholder group and emergence of multi discipline professional teams. Complex external environment subject to constant change. Rapid growth internally across all functions. Internal systems still in development. Our current internal resources may not be sufficient to deliver necessary programme of work. Strategic engagement plan still in development.	We fail to communicate and engage effectively with our key internal and external stakeholders in a way that adds value to our work and meets their needs.	Failure to maximise impact of our regulatory activity. Limited ability to influence. Stakeholder dissatisfaction. Reputational damage that impacts ability to transform services efficiently. Ineffective engagement with staff	4	4	16	**Mitigation in place:** 1. We have a communications, media and strategic engagement team in place undertaking a programme of work. 2. The chief executive and directors engage in regular communications and engagement activities. 3. We have engaged external resources to support key areas as an interim measure. 4. We have recruited internal communications resource. **Planned action:** 1. We will develop a business case for investment in resources to deliver the communications and engagement plan (as part of business planning Q3), augmenting capacity in key areas on an interim basis in the meantime. 2. We are developing a comprehensive communications and engagement plan to support the organisational strategy.	3	4	12	Director of Strategy	Reviewed 10/11/15 - Mitigations and planned actions updated.	Open - new corporate risk	
Strategic priority 4: An effective organisation															
Cross ref:		**Use of resources and sustainability** We must maintain sufficient resources to sustain effective operations and deliver an ambitious programme of change. We must prioritise our resources to ensure we achieve best value for the public and our fee payers. We must ensure the organisation remains financially viable with sufficient resources to meet ongoing and new requirements. Our long term accommodation needs have yet to be determined.	We may have insufficient financial resources to meet operational requirements and deliver change.	Inability to deliver corporate strategy, plans and improvements. Reserves depleted and need to increase fees. Failure to deliver value for money. Reputation damaged.	3	4	12	**Mitigation in place:** 1. Delegation letters have been drafted and are due for sign off by Chief Executive and Registrar in October. This is a move towards increased financial accountability and responsibility within the Executive team. 2. Additional capability in place by the appointment of interim and permanent resources. 3. Initial steps have been taken to improve financial reporting. Structured monthly financial reporting and forecasting meetings take place with the Finance Director and budget holders. 4. Legal advice has been sought on pension scheme risks. This is now under consideration. 5. An accommodation review has been commissioned. **Planned action:** 1. Implement a scheme of financial delegation, linked to business priorities (Sept 2015). 2. Provide greater transparency to the reporting of financial results (Oct 2015). 3. Define methodology to capture efficiencies. Agree a savings plan and determine high level efficiencies (Q3). 4. Develop and implement an efficiency programme. 5. Develop a financial strategy (Dec 2015). 6. Define and commence implementation of a Procurement Improvement Programme (Q3, 2015). 7. Working in conjunction with the PMO, ensure that a robust process for business cases exists. To ensure that scarce resources are utilised effectively and benefit realisation is captured. 8. New procurement team structure will be proposed. 9. Undertake a NAO Financial Management Maturity Assessment (Q3).	3	4	12	Director of Finance	09.09.2015 22.10.2015	Open - new corporate risk	

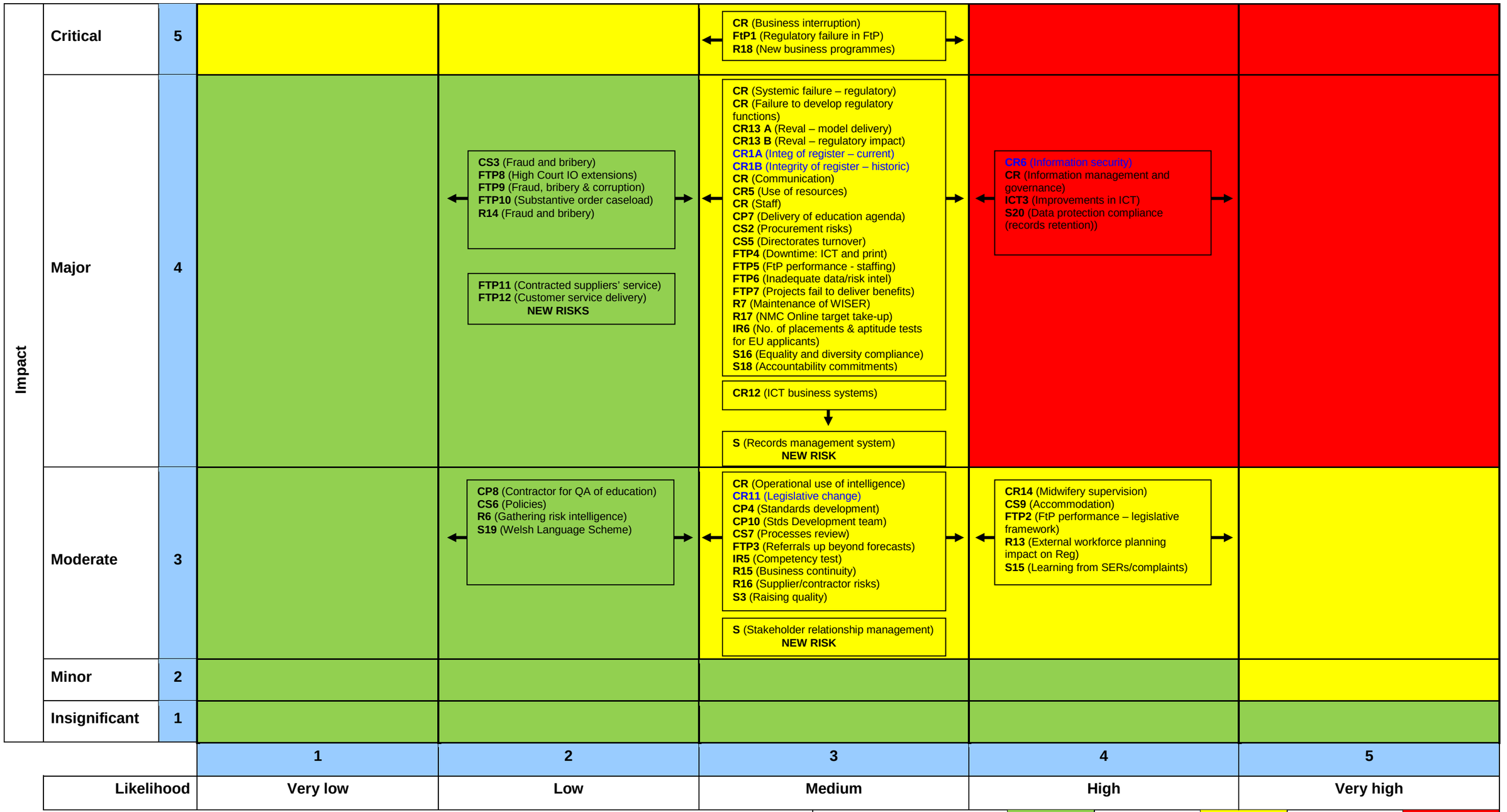
No.	Date of origin	Risk Scenario			Inherent risk scoring			Mitigation in place / Planned action	Post-mitigation scoring			Risk Owner (and Mitigation Owner)	Dates updated	Status (open / closed plus whether on track / not on track to reduce scoring)	Direction (of risk score)
		Root cause(s)	Potential situation	Consequences	Likelihood	Impact	Score		Likelihood	Impact	Score				
Cross ref:		**Staff - capacity and capability now and in the future** We must deliver an ambitious programme of change. Our organisational structure is inflexible and requires review. We face challenges in terms of recruitment and retention.	We may not have the right organisational structure and capabilities to deliver high performing operations and achieve our ambitions for transformation.	Inability to deliver corporate strategy, plans and improvements. Negative impact on staff morale, motivation and performance. Continuing high staff turnover. Poor customer service. Poor decision-making.	4	4	16	**Mitigation in place:** 1. Organisation review under way will propose options for future structure that is fit for purpose and sustainable into the future. 2. Review of current recruitment policy, practices and their impact is being scoped with the aim of gaining a better understanding of recruitment and retention challenges. Report providing a baseline of evidence around 'as is' planned for Quarter 4, 2015/16. 3. Staff Survey Action Plans established to address key themes arising from staff survey. Published and kept under review. **Planned action:** 1. The Development of a Workforce Strategy will ensure NMC can attract, recruit, develop and retain the people it needs to deliver effective regulation now and into the future. Workforce planning, succession planning and talent management will be key enablers of the strategy, will take place in 2016/17 and will be a key deliverable in the 2016/17 HR & OD business plan. This work will be a priority for the permanent leadership of HR & OD following the outcome of the organisation review and a target date of July 2016 is proposed for the development of a draft strategy for consultation with the Executive (assuming a permanent HR lead is in post by April 2016). A more detailed analysis of employee turnover will be undertaken in Q4 to inform perceptions around turnover and its link to retention and reward. 2. Development of the HR team and planning of organisational change HR-related activities to ensure readiness to support changes arising from the organisation review.	3	4	12	Director of HR and OD	26.10.2015 - risk updated 10.11.2015 - risk updated	Open - new corporate risk	No change
Cross ref:		**Business interruption** Our business continuity arrangements require updating. Insufficient priority placed on planning and testing business continuity arrangements. We need to build resilience into our organisational arrangements.	We may not be prepared in the event of actions giving rise to a loss of business continuity.	Our ability to protect the public is compromised. Loss of services. Financial loss. Reputation damaged.	3	5	15	**Mitigation in place:** 1. Limited business interruption Insurance cover in place. 2. Specialist advisers engaged and engagement with directors commenced. 3. Business Impact Assessment (BIA) completed with independent advisor input. 4. IT deep dive undertaken on business continuity risks. **Planned action:** 1. Development of incident management plans and emergency response plans (2015/16). 2. Establishment of business continuity steering group (Q4, 2015/16). 3. Follow up review of BIAs and allignment with IT requirements (Q4, 2015/16) 4. Business continuity policy, framework, training and awareness programme to be released (Q1 2016/17). 5. Testing and Business continuity plan in place by end of Q3, 2016/17. 6. Closure of IT risks under IT improvement programme (2015-16). 7. TBS: The 'datacentre move' scheduled for November 2015 will enable the testing of IT infrastructure arrangements.	3	5	15	All Directors. Director of Finance to lead	09.09.2015 22.10.2015	Open - new corporate risk	

No.	Date of origin	Risk Scenario			Inherent risk scoring			Mitigation in place / Planned action	Post-mitigation scoring			Risk Owner (and Mitigation Owner)	Dates updated	Status (open / closed plus whether on track / not on track to reduce scoring)	Direction (of risk score)
		Root cause(s)	Potential situation	Consequences	Likelihood	Impact	Score		Likelihood	Impact	Score				
Cross ref:		**Information management and governance** Our governance around data requires clarification. We lack the ability to harness and use information effectively. Our structures, policies, procedures, processes and controls must be kept up to date. Large volume, complex, information processing with high reliance on paper-based processing. Processing involves high volumes of sensitive personal data.	Our information management and governance could fail to ensure appropriate storage, access and use of data and information.	Limited ability to support our regulatory, legal, risk, environmental and operational requirements. Information security breaches. Reduced opportunities to enter into data sharing arrangements with other organisations.	5	4	20	**Mitigation in place:** 1. Information security and data protection policies. 2. Mandatory training for staff and panellists. 3. Oversight by Information Governance Steering Group. 4. Information security management system in place. 5. Review meeting held with Information Commissioner's Office and voluntary ICO information risk assessment taken. 6. April 2015 11 priority areas for improvement remain, with mitigating actions on defined information security work plan 2015-16. 7. Established data management function in ICT. **Planned action:** 1. Establishment of a data improvement programme (Q3). 2. Implement information security work plan 2015-16. 3. Review of records management and retention practices (reporting Q3). 4. Accountability for this area of work will be addressed as part of the organisational review (Q3).	4	4	16		01.09.2015	Open - new corporate risk	
CR12 Cross ref:	May-14	**ICT business systems** 1. Lack of robust procedures and controls over the management, testing and roll-out of changes to hardware and software, and development of new products and systems. 2. Ongoing use of critical business systems that are now unsupported by suppliers. 3. Insufficient capacity in our telephony system to handle peak periods in the Registration call centre. 4. Inadequate management of key third party ICT supply contracts and lack of contracts in some cases. 5. Lack of quality-assured ICT service support. 6. Lack of planning for business continuity and disaster recovery. 7. IT infrastructure insufficient to cope with our operational requirements. 8. High reliance on contractors, including a contractor CTO.	Our systems do not support effective business delivery or strategic transformation.	1. Critical business operations either stop or performance is negatively impacted. 2. Key performance targets or corporate commitments are not met or are put at risk. 3. Staff frustration contributes to poor motivation and increases staff turnover. 4. Wasted resources used in reacting to events. 5. Loss of confidence by staff, the Council and external stakeholders.	4	4	16	**Mitigation in place:** 1. IT improvement programme and IT portfolio programme is in place, to manage IT delivery. We are undertaking work to align the IT programme management function with the business one. 2. We have improved how we govern and manage processes and procedures, for running an effective IT function. This includes strengthened governance and reporting on IT issues, the use of IT KPIs, and reviews of the technical design of all technology projects. **Planned action: To undertake a comprehensive IT Improvement Programme during this financial year that tackles the following workstreams and deadline dates for delivery.** a. Project and Portfolio Delivery - Implementation of Agile methodology and prove the concept during Re-Admissions go-live 8th Nov 2015 for MVP 1. **Achieved.** Next phase of work is to explore a join together of the programme management functions in IT and Strategy during Q1 of 2016. b. (i) Service Management - Achieve a Maturity level 2 across core ITIL processes by Xmas 2015 and introduce a SLA to the business that we report on (By Xmas 2015); (ii) Supplier & Contract Management Robust list of key contracts and active management of suppliers; (iii) Infrastructure Resilience - Improve core infrastructure, re-let datacentre contract by April 2016. c. Disaster Recovery - procure and implement a DR solution - this will be live by end Nov 2015. d. Strategy & Architecture - clarity on Hold/Invest & retire from an Infrastructure perspective, staff being hired to support S&A function in permanent recruitment by Mar 2016. e. Financial Management (RUN & CHANGE) – baseline budget in place and being monitored against Opex and Capex with Finance business partner. f. Comms & Engagement - introduction of Business relationship management function, all staff surveys, focus groups, blogs etc. g. Business Transformation - new structure been agreed by Executive Team. Formal consultation runs till end of Oct 2015 and new structure will be released on 2/11. Recruitment of eight priority roles will happen before Xmas. Two ADs have been appointed to the structure. h. Information Security.	3	4	12	Chief Operating Officer and Chief Technology Officer	06.05.15 - Risk fundamentally updated to reflect findings of the recent CTO Review. 15.07.2015 - Risk updated. 22.10.2015 - risk updated. Post-mitigation reduced from red to amber to reflect the progress made so far with the Improvement Programme. 10.11.2015 - risk updated.	As issues have been driven out through the CTO Review and an improvement plan is being established - this risk is expected to incrementally reduce over the next few months - by Dec 2015.	Decreasing

Risk map of all corporate and directorate risks as at 30 October 2015

This map shows post-mitigation score changes for corporate and directorate risks between 11 September (preparation of papers for 8 October Council meeting) and 30 October 2015 (preparation of papers for 25 November Council meeting).

- Older corporate risks, for which agreement is required on closure or relegation to directorate level, are highlighted in blue (CR1A, CR1B, CR6, CR11).



Arrows indicate the direction of travel:

↑ Risk score has increased since 11 September 2015

↓ Risk score has decreased since 11 September 2015

↔ Risk score has stayed the same since 11 September 2015

Risk references:

CR: Corporate risk
FTP: Fitness to Practise risk
IR: Registration risk (International Reg)
R: Registration risk
S: Strategy risk
CS: Estates, Finance & Procurement or HR and OD risk (to be re-numbered)
CP: Continued Practice risk
ICT: ICT risk

* due to their 'Critical' impact, an amber rating is also given to risks which score 5 for Impact and 1 for Likelihood

Item 8
NMC/15/93
25 November 2015

Council

Financial monitoring report to 31 October 2015

Action: For information.

Issue: The provision of financial performance information for current and future reporting periods.

Core regulatory function: Supporting functions

Strategic priorities: Strategic priority 4: An effective organisation.

Decision required: None.

Annexe: The following annexe is attached to this paper:

- Annexe 1: October 2015 management accounts
- Annexe 2: Waterfall chart showing full year financial forecast at October 2015

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

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Context: **Financial information**

1 The Performance & Resources Board (PRB) will regularly review and approve the financial results and forecast each month.

2 The financial monitoring report is presented to Council at each meeting and this covers income, expenditure and reserves.

Discussion: **Executive summary**

3 **Available free reserves**: The budgeted target for available free reserves is £14.5 million at 31 March 2016. However, should the latest forecast crystalise and, if no further draw-down is made on contingency, available free reserves would be £18.3m at 31 March 2016.

4 **Income**: Year to 31 October 2015 income is in line with budget. The full year forecast is for income to be £0.3 million higher than budget.

5 **Expenditure**: Year to 31 October 2015 revenue expenditure is £2.5 million less than the budget excluding contingency provision of £4.5 million. This is driven largely by lower staff costs (£1.7 million), an accrual release (£0.3 million), and lower professional fess (£0.6 million).

6 Currently, the full year forecast is for expenditure to be just under approved budget (£0.4 million), taking into account provisional draw down of £1.4m contingency (as reported at the October meeting).

Income

7 The full year forecast for registration fee income is broadly in line with budget at £76.9 million.

8 Total income for the full year is forecast to be marginally higher than budget by £0.3 million primarily due to overseas and European Union (EU) assessment fee income.

9 We are continuing to see an increase in the number of EU applicants, a trend which is expected to continue into 2016. As a result, EU assessment fee income is now forecast to be £0.5 million more than budget.

10 This is partly offset by lower grant income which has been updated to match the test of competence expenditure.

Expenditure

11 The approved revenue expenditure budget for 2015-2016 is £82.1m: £77.7 million planned expenditure and £4.5m contingency for unplanned or unexpected expenditure.

12 Year to 31 October 2015: Revenue expenditure has been slower to ramp up than expected and is £2.5 million lower than budget. However, the year end forecast is for revenue spend to be £1.0 million higher than the £77.7 million budget.

13 Council were advised in October 2015 that a number of unplanned expenditure items had been identified involving potential draw down of £1.4 million of the £4.5 million contingency. No further additional draw down on contingency is forecast, at present.

14 Overall therefore, the year end forecast is for revenue expenditure to be £0.4 million lower than the approved budget after this potential drawdown has been taken into consideration.

15 Year to 31 October 2015 revenue expenditure is £2.5 million less than the budget excluding contingency provision of £4.5 million. This is driven largely by lower staff costs (£1.7 million), an accrual release (£0.3 million), and lower professional fess (£0.6 million).

16 Key movements forecast for the period from November to 31 March 2016 are:

16.1 £0.3 million underspend in Strategy primarily from the delay of the staff conference and delay in hiring in the Programme Management Office (PMO)

16.2 £0.1 million reduction in TBS spends following successful renegotiation of an infrastructure services contract.

16.3 An increase of £0.8 million of revenue project expenditure following the reallocation of number of projects from capital expenditure

17 Fitness to Practise full year budget is £39.8 million and is forecast to be on target with budget. For the first half of the year hearings were running at 20 events per day. This is has now increased and is planned to continue at an average of 24 per events per day for the remainder of the year.

18 The PMO is favourable to the approved budget by £0.7 million. This is a due to the reallocation of spend to projects (£0.2 million) and reduced resource requirements (£0.5 million) as budgeted projects are not being initiated this year.

19 Revalidation spend across the programme's three year implementation period remains within the agreed business case.

As reported previously some expenditure has been brought forward to support increased focus on communication and engagement activities as well as the evaluation of Revalidation as agreed to start in early 2016. Revalidation spend is expected to reach £4.2 million of its £5 million budget by 31 March 2016.

Capital expenditure

20 Year to date capital expenditure is in line with budget.

21 In September 2015 the forecast for capital expenditure was reviewed and resulted in the reallocation of £0.8 million expenditure to revenue project spend and a number of projects were reforecast.

22 Following this review full year capital expenditure is now forecast to be £4.2 million, £0.5 million lower than budget.

Risks

23 The major risk areas identified at this stage and subject to ongoing monitoring include the risk that:

23.1 Internal investigations will not be processed at the budgeted run rates.

23.2 The number of registrants on the register decline and the trend seen in EU assessments does not continue, both resulting in reduced income.

Opportunities

24 The key items identified at this stage with the potential to crystalise this year and subject to ongoing monitoring on a monthly basis are:

24.1 As reported previously, we continue to work with HMRC to secure the repayment of income tax and National Insurance paid on FtP panellist expenses in prior years.

24.2 The nursing profession has temporarily been put on the shortage occupation list and will be reviewed in February 2016. Meanwhile overseas income has the potential to increase, although this may be offset in part by expenditure to deploy additional resources to meet the increased demand.

24.3 It is increasingly likely that the full contingency will not be required and that revenue spend will be lower than the current full year forecast.

Efficiencies

25 Efficiencies are currently being measured against the £55 million of efficiencies and savings previously identified and confirmed as an appropriate estimate in 2014 as part of the fee strategy. Efficiencies of £12.9 million are forecast for 2015/16, £4.9 million adverse against those forecast in 2014.

26 Total efficiencies of £22.1 million are currently forecast for the first two years of the three year strategy. This is £13 million below the target for the same period.

27 The targets were set using assumptions about variables in the process and throughput of cases which have changed over time.

28 The reduced forecast is a result of:

28.1 Lower throughput from the in-house case investigation teams in the first year. Performance has improved throughout the year. The number of cases in September and October is double that seen in the first half of this year and is expected to increase by a further 10% in the second half.

28.2 Lower than planned alternative disposals; 14.2% for 2015/16 compared with 31.5% assumption.

28.3 Case examiners have now been in place for six months and have started to deliver efficiencies, albeit later than anticipated. Completion of case examiner training has seen the cost per decision reduce by 25% since September 2015.

29 Continued emphasis on early engagement with registrants and their representatives along with lawyers embedded in screening and investigation teams should have a positive impact on the number of cases resolved without the need for a full hearing.

30 Closure rates at both the screening and case examiners stage are running at around 10% above their respective fee strategy assumptions.

31 Whilst this will result in cost avoidance as fewer cases progress to increasingly more expensive stages in the process it will also result in fewer substantive hearings on which the predicted efficiencies can be realised.

Public protection implications:

32 The monitoring of financial results and forecasts enables the NMC to ensure it has sufficient resources to deliver continued public protection.

Resource implications:	33	The key financial indicators for current and projected levels are discussed in this paper.
Equality and diversity implications:	34	None.
Stakeholder engagement:	35	None.
Risk implications:	36	Risks in relation to forecasting and financial resourcing are set out in directorate and corporate risk registers.
Legal implications:	37	None.

Annexe 1: October 2015 management accounts

	Full Year				
2015/2016	Actual & Forecast	Budget	vs budget	% vs budget	
Total Income:	**79,864**	**79,538**	**326**	**0%**	
Office of the Chair & Chief Executive	925	618	(308)	(33%)	Includes additional capacity and expertise through the appointment of and interim Chief Operating Officer and specialist nursing & midwifery advisors
Strategy	4,754	5,809	1,055	22%	Favourable variance primarily due to unfilled vacancies in the PMO
Registration	4,063	4,285	222	5%	
Continued Practice	5,068	5,031	(37)	(1%)	
TBS	5,828	5,811	(17)	(0%)	
Estates, Finance & Procurement	8,182	8,001	(181)	(9%)	Includes additional spend on interim leadership and financial strategy activity offset by release of dilapidations on Old Bailey.
HR&OD	3,373	3,057	(316)	(9%)	Includes interim leadership and the organisational review activity
FTP	39,778	39,801	22	0%	
Total directorate revenue spend	**71,971**	**72,411**	**440**	**1%**	
Projects	1,663	807	(856)	(51%)	Includes Test of Competence (Phase 2) and Shape of Caring projects. Increase is driven by a reallocation of projects from capital spend into revenue
Depreciation	3,500	3,315	(184)	(5%)	
NMC Corporate/General	382	57	(325)	(85%)	Includes a provision for 2015/16 unused holidays (Financial Reporting Standards 102)
PSA Fee	1,228	1,133	(95)	(8%)	
Total revenue spend (excl contingency)	78,744	77,724	(1,020)	(1%)	
Contingency	3,064	4,463	1,399	46%	Draw-down on contingency relates to specialist advisors and interim contractors enhancing capacity and capability, both the organisational review and financial strategy and funding for the increased PSA levy and provision for 2015/16 unused holidays
Revenue Spend	**81,808**	**82,187**	**379**	**0%**	
Surplus / (Deficit)	**(1,944)**	**(2,649)**	**705**	**36%**	
Capital	**4,178**	**4,651**	**473**	**11%**	Includes capital expenditure relating to Revalidation, Phased Payments and MRPQ EU directive. Favourability is driven by a reallocation of projects from capital spend into revenue
Cash at bank	**79,813**	**78,434**	**1,379**	**2%**	
Available free reserves (excluding pension deficit & restricted funds)	**14,469**	**14,469**	**0**	**0%**	Available free reserves are budgeted to be £14.5 million at 31 March 2016. However, should the latest forecast crystalize and no further draw-down is made on contingency available free reserves will be £18.3 million.

BREAKDOWN OF SPEND BY COST CATEGORY

Income	**79,864**	**79,538**	**326**	**0%**
Staff costs (permanent)	28,443	31,223	2,780	10%
Temporary & contractor costs	4,027	1,817	(2,210)	(55%)
Other staff costs	3,643	3,281	(363)	(10%)
Professional & Legal fees	16,155	15,261	(894)	(6%)
Panellists costs	9,999	9,124	(875)	(9%)
Witness & Others	840	1,091	250	30%
Members costs	346	360	15	4%
Building costs	3,647	4,337	690	19%
Depreciation	3,500	3,315	(184)	(5%)
Event & Communications Costs	1,015	675	(340)	(34%)
Office admin and systems costs	4,799	4,747	(53)	(1%)
Print & postage	1,138	1,215	78	7%
Quality Assurance Costs	1,192	1,278	86	7%
Revenue Spend (excl contingency)	**78,744**	**77,724**	**(1,020)**	**(1%)**
Surplus\(Deficit) (excl contingency)	1,120	1,814	694	62%
Contingency	3,064	4,463	1,399	46%
Surplus\(Deficit) (incl contingency)	**(1,944)**	**(2,649)**	**705**	**36%**

Favourable variance in permanent staff is mainly due to vacancies in FtP and senior management vacancies in other areas. Contractors are being used to offset the FtP vacancies and interims are filling permanent senior leadership roles.

These items are resources together and the overspend in contractor costs is managed to be within the level of underspend on permanent headcount

Driven by finance strategy, organisational review and FtP activity

Driven by increased hearing activity in FtP forecast for the remainder of the year

Benefit flowing from prior year

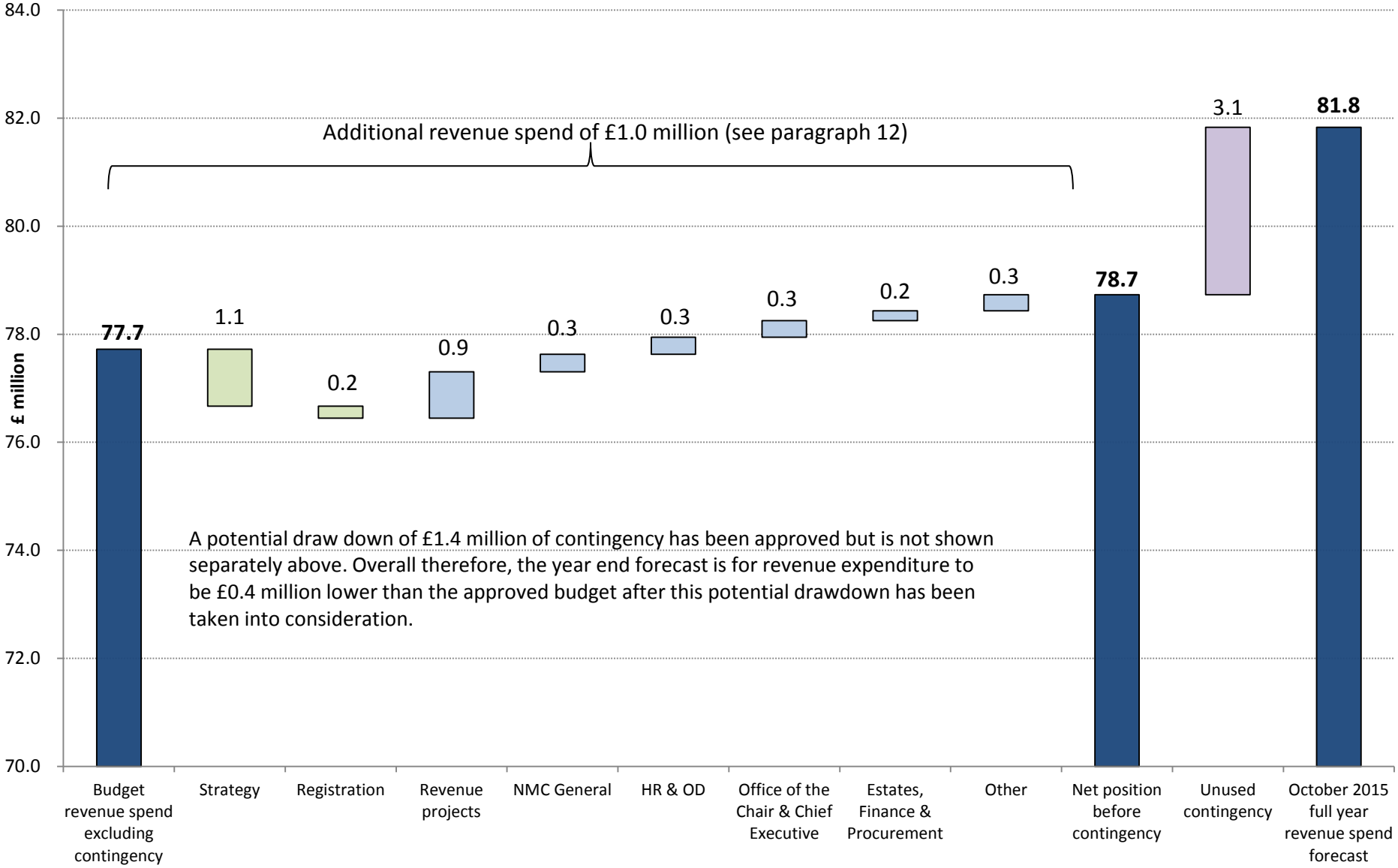
Due to releasing the Old Bailey dilapidation and lowerthan anticipated spend

Accelerated Revalidation communications

Additional costs to be incurred through the provivion of disaster recovery as a service offset by reduction in costs following successful renegotiation of the A365 Contract

Reduced demand for Mott MacDonald work

Annexe 2: Full Year financial forecast at October 2015



Item 9
NMC/15/94
25 November 2015

Council

Corporate Quality Assurance Strategy

Action: For discussion.

Issue: An update on progress with implementing Council's quality assurance strategy and a discussion of the way forward.

Core regulatory function: Supporting functions.

Strategic priority: Strategic priority 4: An effective organisation.

Decision required: Council is recommended to note the update in relation to the QA strategy and the particular focus continues to be on consolidation of the strategy especially in terms of embedding the learning and improvement aspects.

Annexe: The following annexe is attached to this paper:

- Annexe 1: The corporate QA strategy agreed by Council in July 2013.
- Annexe 2: The Assurance Map Version 1.0 dated 13 November 2015.

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

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Context:

1 This paper summarises progress against the NMC Quality Assurance (QA) Strategy and explores possible next steps in this area. A similar update was provided to the Audit Committee and the Council had asked to be brought up to date on this work.

2 The current strategy was agreed by Council at its meeting on 18 July 2013. At the time, the Audit Committee noted that the strategy was critical to the delivery of corporate business assurance.

3 The QA Strategy was agreed at a time when the NMC had recently been subject to the Strategic Review by the Commission for Healthcare Regulatory Excellence (now Professional Standards Authority - PSA), and had received critical performance reviews and initial stages audit reports in Fitness to Practise (FtP). One of the key rationales for the strategy was for us to be able to gain assurance on the standard of our performance, identify areas of weakness and address these issues ourselves rather than relying on the PSA and other bodies to do so for us.

4 The strategy was informed by practice from other health professional regulators and has three central outcomes:

4.1 Outcome 1 – the development and implementation of a performance and quality management framework.

4.2 Outcome 2 – an annual programme of QA reviews.

4.3 Outcome 3 – an embedded culture of learning and continuous improvement.

5 Over the last year the Audit Committee has received three internal audit reports (including one follow-up report) on implementation of the QA strategy.

6 Overall these show good progress in implementing the strategy within directorates (Outcome 1) and an annual programme of reviews (Outcome 2) focusing on Outcome 1 measures is in place. Although elements in support of establishing an embedded culture of learning and continuous improvement (Outcome 3) have been achieved, work is still required to embed the required culture of learning and ensure continuous improvement across the organisation (Outcome 3).

7 The Assurance Map is attached at Annexe 2 and this also identifies the need for further work in some areas.

8 The latest internal audit report was considered at the Audit Committee on 28 October 2015. Among other things, the audit report recommends that, two and a half years on from adopting this approach, we take stock of our strategic approach to quality

assurance. This is in keeping with Council's previously expressed intentions and hence inclusion of this issue on the meeting's agenda.

Discussion and options appraisal:

Progress in implementing the QA Strategy

Evidence of progress

9 Over the period since the adoption of the QA Strategy, we have made substantial progress in improving quality and performance as evidenced by:

9.1 Having a stronger grip on our performance through better management processes, performance information and dashboards – reported to executive boards and Council;

9.2 Delivering improved performance against corporate Key Performance Indicators (KPIs); and

9.3 Year on year increase in the number of PSA standards of good regulation met.

10 We have also made notable improvements in customer service, such as the witness liaison service, NMC Online and the quality of our complaints handling. All of this has been achieved in the context of delivering increased operational activity as well as planning considerable changes such as the development of revalidation and Mutual Recognition of Professional Qualifications.

11 Regular directorate updates to the Audit Committee via quality and continuous improvement reports have given greater insight into how the strategy and other initiatives are being implemented in operational areas and what work is being undertaken to make further improvement.

12 The next section sets out our progress on the three outcomes identified in the strategy.

Outcome 1

13 Under Outcome 1 there should be arrangements in place for managers to check and control the quality of work in their areas. This part of the strategy was aimed at strengthening Level 1 assurance as set out in the assurance map.

14 The corporate QA team led a cross-organisation project last autumn to ensure Outcome 1 was implemented across the organisation. This resulted in each directorate having a performance and quality management framework in place by January 2015. Since then there has been considerable work on refining these frameworks according to defined quality plans.

15 The most recent internal audit report has confirmed that there has been a good level of progress in the delivery of Outcome 1 and a generally good level of compliance with processes and requirements put in place to support this area.

Outcome 2

16 The annual programme of quality reviews under outcome 2 and the associated scrutiny at directorate and executive levels seek to provide assurance that the appropriate controls are in place and therefore contributes to strengthening Level 2 assurance as set out in the assurance map.

17 Since April 2015 the QA reviews have focussed on how well regulatory directorates' performance and quality management frameworks (Outcome 1), are working.

18 Initial feedback on this revised approach to QA reviews is that it helps directors to understand where their arrangements are working well and where they need to be strengthened. The reports highlight areas of risk and make recommendations for any additional controls or necessary changes. Scrutiny of the reports and action plans at the Performance and Resources Board ensures a corporate view.

19 The recent internal audit highlighted that we still have work to do to improve the consistency of the reviews and ensuring timely follow up to maximise the opportunity to drive further improvement.

Outcome 3

20 This outcome aims to promote systematic processes to ensure that we capture organisational learning, carry through the necessary improvements to address the learning and generate a culture of continuous improvement.

21 Although this has not yet been achieved, we have put supporting activities in place. To support this outcome we have developed and implemented revised policies and processes for the reporting and handling of serious event and adverse incidents (SERs) and complaints. There is a programme of training for staff on handling SERs and complaints and we have developed corporate databases for SERs and complaints which aim to capture learning and changes as a result.

22 Taken together, these have resulted in higher levels of reporting with 251 reported in 2014 and 179 reported in 2015 to date. There have been good examples of learning and action being taken in response to individual incidents.

23 The recent internal audit highlighted that progress had been slower in this area and identified the particular need to ensure a consistent

quality in incident reporting and for better analysis of trends and patterns to support cross organisational learning and action.

24 These recommendations are now being actively progressed.

Discussion and future developments

25 The last two years have seen substantial improvements in our management of quality and operational performance. However, as the most recent internal audit, our own quality assurance reviews and the assurance map show, there remain areas for improvement.

26 The QA Strategy continues to provide a useful framework for improving our quality management arrangements and its focus on getting basics right is a pragmatic and sound platform to build from.

27 We have a longer term aspiration to move towards a more dynamic approach to quality management. Given the current position outlined above it is clear that we have further work to do to fully achieve the current strategy. Therefore the timing for adopting a longer term approach needs to be carefully considered.

28 This issue was discussed by the Audit Committee at the meeting on 28 October 2015. While the committee recognised improvement in some areas, they expressed disappointment about progress on implementing the organisation wide aspects of the strategy. As a result they considered that we had further work to complete the current strategy, while supporting the longer term aspiration to explore other quality improvement models.

29 Whilst we do have an ambition to explore options for a revised approach to quality management, including the potential to adopt an appropriate accredited quality management system, it is recognised that we must first complete the implementation of the strategy paying particular attention to the corporate learning opportunities.

30 **Recommendation: Council is recommended to note the update in relation to the QA strategy and the particular focus continues to be on consolidation of the strategy especially in terms of embedding the learning and improvement aspects.**

Public protection implications:

31 Failure to implement the QA strategy could undermine the effectiveness of our public protection.

Resource implications:

32 No specific resource implications arising from this paper.

Equality and diversity implications:	33	No direct equality and diversity implications resulting from this paper.
Stakeholder engagement:	34	The QA Strategy was informed by good practice from other organisations, including professional regulators.
Risk implications:	35	Improved levels of assurance should support the NMC in managing risks more effectively.
Legal implications:	36	None identified.

Item 9: **Annexe 1**
NMC/15/94
25 November 2015

Corporate Quality Assurance Strategy

Vision

1 The Quality Assurance (QA) function will act as a catalyst for raising the quality of work across all of our functions. Working with the rest of the organisation, the QA team will develop and embed a performance and quality management framework and process and a culture of learning and continuous improvement. This will result in improved performance and a focus on quality outcomes delivered in a timely and efficient way.

2 The QA team's programme of work will prioritise those areas where there is the greatest risk to public protection and the reputation of the NMC. Where necessary, and working with others, the team will facilitate and implement change and improvement that is based on good practice.

Key Outcomes

3 The purpose of this strategy is to provide a clear focus on delivering quality outcomes, which ensure that the NMC improves its work, embedding a consistent approach to learning and continuous improvement which continues to protect the public and enhances its reputation. It will enable us to identify areas of weakness and risk before they are identified by others and to take action to address them before they impact on the delivery of our key functions.

4 There are three outcomes from the strategy:

Outcome 1 - A performance and quality management framework

5 The framework is outlined in annexe 2. It stresses that all staff are responsible for the quality of the work they undertake. Each directorate is responsible for defining appropriate quality standards in their area taking account of the views of key stakeholders. The QA team is responsible for assuring the necessary quality management processes are in place and working effectively.

6 The framework provides three tiers of internal quality management and assurance which is recognised as good practice. The three tiers are outlined below and details of the roles of each of the tiers is described on the reverse of the chart in annexe 2.

6.1 Individual's work which is overseen by local management.

6.2 Internal independent reviews carried out by the QA team.

6.3 External independent audit carried out by Internal Audit.

7 The key milestones and success measures in achieving this outcome are:

7.1 QA framework is explained to all managers and staff by end of August 2013.

7.2 QA team's programme of quality assurance work starts in July 2013.

7.3 Training and advice given to all managers on performance and quality management by end of 2013.

7.4 Teams have their local quality arrangements in place by the end of 2013.

8 We aim to have the whole framework in place and embedded by October 2014.

Outcome 2 - The QA team's annual programme of work is developed and delivered

9 The QA team will carry out a programme of quality assurance reviews each year and an end to end review of the operation of the key regulatory functions.

10 The annual programme will be informed by an assessment of the key risks taking account of the following:

10.1 The corporate and directorate risk registers.

10.2 Professional Standards Authority annual performance review and audits.

10.3 Views of directors and other senior managers.

10.4 Information from complaints and corporate serious event reviews.

10.5 Performance data.

10.6 Any other intelligence that comes to the attention of the QA team or directors, including feedback from individual staff members or external stakeholders.

11 The key milestones and success measures in achieving this outcome are:

11.1 The QA team has a delivery plan in place from July 2013.

11.2 The programme of work delivers assurance and highlights areas where quality can be improved from July 2013.

11.3 The QA team facilitates learning in any areas where quality can be improved from July 2013.

Outcome 3 –An embedded culture of learning and continuous improvement

12 Our aspiration is for the QA Team to promote continuous improvement and model good practice. This will include, in due course, actively seeking views and suggestions from staff, working with them on solutions and ensuring that change is implemented and embedded properly. The team will also assess how change is implemented in the organisation, both at directorate level and through the programmes and projects of the Change Management Portfolio Board.

13 The key milestones and success measures in achieving this outcome are that from July 2013 onwards:

13.1 There are clear lines of communication between the QA team and managers in each function and an exchange of information around good practice.

13.2 There is demonstrable evidence that staff feel more able to raise concerns about quality.

13.3 Action is taken where the QA team identify concerns around quality and that change is managed effectively with involvement of staff.

13.4 Stakeholders, including the PSA through its annual review, acknowledge progress in NMC performance and status as a learning organisation.

Item 9: **Annexe 2**
NMC/15/94
25 November 2015

Assurance Map – November 2015

1 The Assurance Map was originally drawn up in conjunction with our internal auditors, Moore Stephens. It is designed to record the current strength of the sources of assurance in place in each of the business functions across the organisation. It enables the executive to target those areas where the current controls and assurance are insufficient.

2 Ratings are given for each of the three lines of defence. Typically the first line of defence relates to local management controls, the second line to internal assurance beyond immediate line management and the third line to external sources of assurance. The definitions of the colour ratings are included in the key at the bottom of the current version of the Assurance Map below.

3 The ratings are based on an assessment made by each of the directors for the areas for which they are responsible accompanied by the evidence they have relied upon in forming that view. The Assurance Map is subject to regular scrutiny and challenge at the Performance and Resources Board (PRB) and this consideration is informed by a table of supporting evidence which includes details of the key sources of assurance. The Assurance Map is also regularly considered by the Audit Committee.

4 The Audit Committee last considered the Assurance Map at the meeting on 28 October 2015.

5 The up arrows show where a recent change has been made to denote an improved level of assurance. The down arrows denote that the assessment of assurance has recently been reduced, which would normally result from specific audits or issues being highlighted. The arrows are indicating areas where a change has been made and do not denote any further direction of travel.

6 An explanatory note for the ratings in each area is detailed in the table beneath the Assurance Map.

Objective or Function	First Line	Second Line	Third Line
Effective regulation			
Registration			
Education			
Standards			
Revalidation Programme			
Revalidation Process	⬆	⬆	⬆
Fitness to Practise			
Communication and collaboration			
Communication & external relations	⬆		⬆
An effective organisation			
Governance			
Projects, Programmes & change			
Strategy, business planning & performance			
Risk Management			
People, knowledge & skills			
Data security , protection, records mgt			
IT	⬆	⬆	
Legal & regulatory compliance			
Finance & payroll	⬇	⬇	
Procurement			⬇
Business continuity	⬆		
Health & safety			
Efficiency and financial resources	⬇	⬇	⬇

Key to the Assurance Map

Green	*Unlikely that further assurance activity is required in principle.*	
Yellow	*Assurance activity not sufficient but planned new assurance activity is moving this to a level of assurance that is reasonable.*	
Amber	*Limited assurance, requires improvement.*	
Red	*No assurance activity understood to be in place.*	
White	*New activity, no assurance activity as yet required*	
	Director's assessment of increased level of assurance	⬆
	Director's assessment of decreased level of assurance	⬇

Objective or Function	Commentary
Effective regulation	
Registration	The first line yellow rating reflects the planned implementation of a number of measures which will enhance assurance. Historically there have been concerns about the CMS/WISER interface with checking and discrepancy reporting having been put in place. From January 2016 this will be supplemented by dedicated work to provide additional scrutiny of the register. Team dashboards are being introduced to enable granular focus on quality and performance in each area and will be subject to regular scrutiny by the senior management team. A technology solution for the uploading of registration information from universities is currently being piloted and due for wider rollout.
Education	For education quality assurance all three lines of defence focus on quality management at the team level, supported by assurance by the external provider. Both the corporate QA review and the internal audit review have provided assurance around the contract management. The PSA have commented positively on the QA framework and our activity around extraordinary reviews in particular. The Midwifery Committee provides additional oversight and advice to Council on QA reporting for midwifery education and LSA functions. Assurance on an education strategic plan is in development. The first line of defence needs particular focus while the Education Advisory Group has provided a good external scrutiny to the development of a strategic intent.
Standards	Frameworks for the development of standards and quality criteria are in place. The external evaluation of the standards provides areas for specific focus. Additionally the Midwifery Committee provide oversight of standards development. Both the first and second lines of defence need strengthening around quality and risk management.
Revalidation Programme	Senior leadership with both internal (business/operational) and external (engagement/communications) focus is guaranteed across policy and operational functions reporting directly to the NMC Programme Board. Scrutiny and support is provided by the central programme office around the programme management. An internal communications group is overseeing the communications plans and deliverables. Externally, the four country programme boards oversee development and in the future delivery of the process. The external KPMG, IPSOS MORI reports have fed into the assurance around the pilot process. The RSAG have fed into the development of the programme and the model. Internal Audit have provided assurance on internal readiness. The PSA and Health Select Committee provide an accountability overview.
Revalidation Process	

Objective or Function	Commentary
Effective regulation	
Fitness to Practise	Extensive review and scrutiny of FTP demonstrate that there are sufficient measures and safeguards supporting each of the three lines of defence. These are in place and operating, but we are always looking to improve where we can. The QA team has reviewed our quality management framework and have provided positive feedback about the controls we have in place. FTP output is subject to considerable regular independent scrutiny as well as regular review by the PSA
Communication and collaboration	
Communication & external relations	The first line rating of yellow reflects the fact that we have plans to strengthen our operational capacity and capability to meet our strategic ambition in this area. The amber rating at second level reflects the fact the corporate communication and engagement plan is in draft The need to develop a corporate plan is the subject of an outstanding internal audit recommendation and we would expect the third level rating to return to green once completion of this recommendation is confirmed by our internal auditors.
An effective organisation	
Governance	Rated as strong at all three lines of defence based on outcomes of annual effectiveness reviews of Council and Committees, strengthening of sub-Council governance structures and external assessment rating of enhanced governance in September 2014.
Projects, Programmes & change	We have an established programme management office (PMO) and agreed methodology and project management framework; however we know these need to be applied more consistently. We have commissioned an external review of PMO and expect the first level assurance to strengthen with implementation of its recommendations. We have established the Performance and Resources Board with supporting arrangements to oversee the portfolio of projects. As these bed in, we expect the second level assurance to strengthen.
Strategy, business planning & performance	We have well established business planning and performance processes in each directorate. This is yellow at the first level to reflect the planned organisational realignment and personnel changes. The appointment of the Chief Operating Officer and transfer of corporate responsibility for this area to their office provides strengthened second level assurance. Internal audit has provided third level assurance in this area during 2015-2016
Risk Management	Rated as strong at all three lines of defence based on outcomes of internal audit March 2015 and implementation of agreed actions. Directorates continue to comply with our risk management framework and our internal Risk Scrutiny Group continues to scrutinise risk registers from across the organisation.

Objective or Function	Commentary
Effective regulation	
People, knowledge & skills	The yellow rating reflects the organisation review and the plan to introduce appropriate processes to support personnel through the uncertainty that people inevitably feel during periods of change. Assurance around the effectiveness of HR & L&D policies is provided through HR scrutiny of compliance, scheduled reviews and evaluation to ensure policies and practices add value and are fit for purpose. Oversight on reward and recognition is provided by the Remuneration Committee and Council; reward is kept under review, taking account of the external environment and economic factors. The annual staff survey provides a regular indicator of employee engagement and action plans are developed to address key themes arising.
Data security , protection, records mgt	The first line of defence reflects the actions contained in the IT improvement programme to following assessment of the maturity of the core processes. This will drive a better level of service with more consistency on how we handle issues. Governance processes have been improved by introducing regular management scrutiny and KPI reporting has been in place since June 2015. The second line of defence remains Amber but is improving. We have conducted a series of internal audit reviews covering the IT aspects of the Revalidation project and the IT Improvement Programme both of which have resulted in positive feedback. Additionally we have now completed all activities Moore Stephens recommended in Jan 2015 in relation to ITIL processes. For the third line of defence we have engaged a third party Mason Advisory to undertake a QA of the Data Centre ITT. They reported positively around the approach both technically and from a procurement perspective. We will be undertaking another independent Maturity Assessment across all processes late Nov 2015
IT	
Legal & regulatory compliance	We have clear arrangements in place for monitoring progress against our equality objectives and have strengthened second level assurance by enhancing the role of our Equality and Diversity Steering Group. The third level is yellow because while we have undertaken an initial engagement in external benchmarking, this is not yet fully embedded in our monitoring processes.
Finance & payroll	A review of existing systems of assurance has been undertaken within the Estates, Finance and Procurement directorate. This has included a procurement review undertaken by a specialist provider, external advisers engaged to assist with business continuity arrangements, close working with internal and external auditors. This review has highlighted areas of weakness and risk requiring action. Whilst a holistic finance and procurement improvement programme has been initiated to address
Procurement	
Business continuity	

Objective or Function	Commentary
Effective regulation	
Health & safety	these issues going forward, the assurance ratings (for first and second line defences within finance, payroll, procurement and efficiency, and third line defences for procurement) have been amended from yellow to amber to reflect the current weaknesses identified. The ratings for business continuity have been amended from red to amber in first line defence on the basis of increased assurance arising from feedback from our ongoing work with external contractors. The ratings for health and safety remain green as adequate systems of assurance are in place and regularly reviewed by the Health and Safety steering group.
Efficiency and financial resources	

Item 10
NMC/15/95
25 November 2015

Council

Annual report on the quality assurance of education and local supervising authorities 2014-2015

Action: For decision.

Issue: To approve the draft annual report on the quality assurance (QA) of education and local supervising authorities (LSAs) 2014-2015.

Core regulatory function: Education and setting standards.

Strategic priority: Strategic priority 1: Effective regulation.

Decision required: The Council is recommended to approve the draft annual report on the QA of education and LSAs 2014-2015.

Annexes: The following annexe is attached to this paper:

- Annexe 1: Draft annual report on the QA of education and LSAs 2014-201)

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

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Context:

1 We produce an annual report on the key themes that have emerged from our Quality Assurance activity of education and Local Supervising Authorities (LSAs). The annual report for 2014-2015 is at Annexe 1.

2 Improvements to enhance our QA function introduced in 2014-2015 included strengthened exceptional reporting from AEIs and LSAs directly to the NMC; the timing of monitoring reviews; strengthened reviewer training; and evaluation of the input of lay reviewers.

3 The Midwifery Committee reviewed the draft report in October 2015 and endorsed it for approval by the Council.

Discussion:

Education QA key findings

4 There are currently 77 Approved Education Institutions (AEIs) across the UK running 951 approved programmes.

5 Our quality assurance framework requires AEIs to self-report on compliance with our standards on an annual basis. In addition we selected 17 AEIs (22%) for a monitoring visit. Our monitoring focused on resources, admissions and progression, practice learning, fitness for practise and quality assurance. All AEIs have action plans in place to address issues identified during the monitoring visits.

6 Key areas identified for attention as a result of this year's QA activity included mentorship and placement capacity. On a short term basis, we will address these issues both with stronger communication to AEIs and their networks, and through a stronger focus on these areas in our QA framework. On a longer term basis, we will consider our expectations from mentorship as part of our education standards review.

LSA QA key findings

7 LSAs are required to report on a quarterly and annual basis on their ability to meet our Midwives rules and standards (2012). Four LSAs (29%) were selected for a monitoring visit this year.

8 Key issues identified included:

8.1 Concerns that many LSAs were not meeting best practice timelines for completing LSA supervisory investigations. We continue to communicate the importance of this to LSAs as delays can present a risk that supervisory investigation findings are not shared or escalated to us in a reasonable timeframe.

8.2 Concerns about whether issues are being escalated in a timely and appropriate manner, most frequently with midwives

at the beginning stages of their career. This led to recommendations for managers in the North West region to review preceptor programmes for midwives. We will also be looking at how to ensure greater clarity around when to escalate concerns as part of the midwifery education standards review.

8.3 Concerns around ongoing resourcing and support for supervision, in the light of service configurations in some regions and the proposed legislative changes. In some areas, there has been a withdrawal of support for midwives to undertake the preparation for the supervision of midwives programmes. We have made clear to LSA Midwifery Officers that compliance with Midwives rules and standards (2012) remains a requirement until legislative changes take effect. We plan to strengthen communication on this particular issue.

Extraordinary reviews

9 We conducted two extraordinary reviews in Guernsey and North Wales and are following up closely with the relevant parties through detailed action plans. A year on from the Guernsey extraordinary review, we have noted significant progress in a number of areas. We will continue to monitor the LSA and education provision in both Guernsey and North Wales.

10 **Recommendation: Council is recommended to approve the draft annual report on the QA of education and LSAs (2014-2015).**

Public protection implications:

11 The report sets out the contribution our QA activity makes towards protecting the public in ensuring that newly qualified nurses and midwives meet our education standards and are safe and competent to join our register.

Resource implications:

12 None arising directly from this report.

Equality and diversity implications:

13 We are committed to ensuring that our approved nursing and midwifery programmes comply with all equality and diversity legislation. In accordance with our quality assurance framework, approved education institutions must provide evidence of an equality and diversity policy, recruitment, selection and admissions policy and evidence of providing support to students that promotes equality and diversity.

14 LSAs are expected to address equality and diversity requirements in meeting the Midwives rules and standards (2012).

Stakeholder engagement:

15 A wide range of stakeholders, including service users and carers, contributed to the QA findings summarised in the report. Our close collaboration with NHS Education Scotland this year has proved useful for intelligence gathering in Scotland.

Risk implications:

16 Failure by AEIs and LSAs to comply with our education standards and Midwives rules and standards (2012) could impact upon public protection.

17 In our planning for the 2015-16 year we are identifying the mitigation necessary to reduce the risks, in particular, during transition pending formal legislative change regarding LSAs.

Legal implications:

18 The Nursing and Midwifery Order 2001 (the Order) sets the legislative context for the QA of education and LSA. The Order is suplemented by our education standards and the Midwives rules and standards (2012), which form the basis of our QA of education and LSAs respectively.

Item 10: **Annexe 1**
NMC/15/95
25 November 2015

DRAFT

Nursing and Midwifery Council

Annual report on the quality assurance of education and local supervising authorities (2014–2015)

Contents

Introduction

Who we are and what we do: quality assurance of education and local supervising authorities

1 We are the independent nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland. We exist to protect the public.

2 We set standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare throughout their careers. We make sure that nurses and midwives keep their skills and knowledge up to date and uphold our standards and we maintain a register of nurses and midwives allowed to practise in the UK. We have clear and transparent processes to investigate nurses and midwives who fall short of our professional standards.

3 The Nursing and Midwifery Order 2001 (the Order) sets the legislative context for the quality assurance (QA) of education and local supervising authorities (LSAs). The Order is supplemented by our education standards and the Midwives rules and standards (2012) which form the basis of our QA of education and LSAs respectively. [1]

4 This annual report examines the key risks and themes that have emerged from our QA activity of approved education institutions (AEIs) and LSAs in the 2014-15 reporting year. The reporting year for AEIs covers the period 1 September 2014 to 31 August 2015 (the academic year). The reporting year for LSAs covers the period 1 April 2014 to 31 March 2015.

Strategic context for 2014-15

NMC strategy

5 The NMC strategy for 2015–2020 places dynamic regulation at the heart of what we do. Our education function also needs to be dynamic as well as fit for the future. Our strategic intent is to have education standards, regulatory policies and processes that look forward and address the needs of the future population.

6 Our strategy places significant focus on collaboration and intelligence. Last year we signed a memorandum of understanding with NHS Education for Scotland (NES), which has helped us to improve our collaborative work in the quality of education in Scotland. It also supports intelligence sharing.

7 In 2014-2015 we co-sponsored the Shape of Caring review of nursing education with Health Education England (HEE)[2]. Recommendations from

[1] http://www.nmc.org.uk/standards/additional-standards/
[2] http://hee.nhs.uk/wp-content/blogs.dir/321/files/2015/03/2348-Shape-of-caring-review-FINAL.pdf

the Raising the Bar report[3] published in March 2015 touch upon our role as the regulator and, including our QA education function.

The NMC Code and the launch of revalidation

8 Our revised Code[4] (published in March 2015) and our model for revalidation of nurses and midwives agreed by Council in October 2015 puts professionalism, reflection and continuous improvement at the heart of the future of regulation. This approach needs to be considered as part of our review of education standards in the future.

Midwifery regulation

9 In January 2015, following the publication of the King's Fund report, Council took the decision to ask for a change in our legislation in order to remove the additional layer of regulation applying to midwives. We requested the review of midwifery regulation following a number of critical incidents and independent reports in maternity services. The review confirmed that the current arrangements are not appropriate for public protection. The changes to our legislation will make sure that, as the regulator, we are responsible for all regulatory decisions regarding midwives.

10 On 16 July 2015, the Secretary of State for Health announced that the UK government would be changing our legislation governing the regulation of midwives and removing statutory supervision. This has particular implications for LSA QA. The timings of change will depend on Parliament timelines. We continue to work closely with LSAs during this time to ensure that compliance with our Midwives rules and standards (2012) is maintained during this transitional period.

Oversight of our work

11 The Professional Standards Authority (PSA) for Health and Social Care has oversight of our work and each year they examine a number of areas of our work.[5] In its 2014-15 performance report PSA commented on our QA activity and in particular the extraordinary review conducted in Guernsey. PSA stated that our recent QA work amounted to "good practice" and that "taking an active leadership role on such a high profile matter [was] also likely to have a positive impact on public confidence in the NMC and the system of regulation".[6]

[3] Raising the Bar, Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants (2015)
[4] The Code: Professional standards of practice and behaviour for nurses and midwives http://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/revised-new-nmc-code.pdf
[5] Full details of the Professional Standards Authority's work and their reports on our work can be found at http://www.professionalstandards.org.uk/regulators/overseeing-regulators
[6] http://www.professionalstandards.org.uk/docs/default-source/scrutiny-quality/performance-review-report-2014-2015---print-ready.pdf?sfvrsn=0

Improvements to our QA activity

12 Improvements in 2014–15 made to enhance our QA function included:

13 **Exceptional reporting**: Following a strategic reference LSA Midwifery Officer (LSAMO) forum, we reviewed our internal processes for managing and escalating these reports and ensure that they are shared with the newly established Employer Link service.

14 **Endorsements**: Following the extraordinary review in Guernsey in October 2014, we put the approval of any new endorsed programmes on hold whilst we undertook a legislative review into our jurisdiction and legal relationship with overseas territories. We met with all AEIs approved to run endorsed programmes and sought assurance from them that they were continuing to meet our standards.

15 **Internal QA scrutiny meeting group**: In response to the recommendations made by the internal audit of our QA of education and LSA contract, we created a QA scrutiny meeting group which examines programme requests made by AEIs and strengthens internal decision-making.

16 **QA reviewer training**: We evaluated and undertook a training needs analysis where QA reviewers were given the opportunity to identify their areas of strengths and weaknesses.

17 **Timing of monitoring reviews:** In line with our revised QA published process we notified each AEI and LSA six weeks in advance of our monitoring reviews which was substantially shorter compared to 2013-14 when they received up to nine months' notice. We have increased the time spent conducting some monitoring reviews (three days at some locations in 2014-15, instead of two days throughout the previous year).

18 **Feedback on monitoring reviews**: As part of our monitoring reviews, we asked AEIs and LSAs to complete an evaluation of how the event went and the process that was followed. This year we received a high number of positive responses. Areas for improvement included focusing on making communication more rapid, increasing the user-friendliness of the online QA portal, and providing more reviewer feedback on the outcomes at the close of the monitoring visit.

19 **QA portal**: We have continued to develop the QA online portal which was created in 2013 and acts as a document repository and information sharing platform for AEIs and LSAs.

20 **Lay reviewers**: We have continued to use lay reviewers as part of our monitoring reviewing teams. This has been positively received and we have found that our lay reviewers add valuable insight and perspective to our monitoring events.

Part one: quality assurance of education

21 There are currently 77 AEIs across the UK. Since 1 September 2014, we have approved 92 programmes bringing our total number of programmes in approval to 951.

22 We conducted monitoring visits between January and March 2015 on a selection of AEIs to ensure compliance with our standards. This year 17 AEIs (22 %) were monitored and we focused on the following key themes: resources, admissions and progression, practice learning, fitness for practice and quality assurance.

23 Despite AEIs previously declaring as part of their self-reporting that they were meeting our standards in December 2014, eight out of 17 AEIs went on to receive a ‘standard not met’ outcome with respect to at least one key theme. Five AEIs received at least one ‘requires improvement'. Only four out of 17 AEIs met all five of our key themes. This is in contrast to 2013-14 where none of the selected AEIs received a ‘standard not met’ for any key theme and five AEIs received a ‘requires improvement’. For the purposes of this report we have separated the key risks impacting upon the safety and quality of student learning versus impacting upon internal processes and governance.

Key risks to public protection and the student learning environment

Mentorship

24 As part of annual self-reporting, 17 out of 77 AEIs identified incidents on practice placements due to service reconfigurations, restructuring of schools and departments and increased commissions creating challenges for access to mentors. We received assurance from each of the AEIs that they had actions in place to ensure compliance with our standards. Due to a significant number of AEIs raising mentorship as an issue, we focused a portion of our reviews on ensuring that mentors were up to date with training and were providing adequate support to students.

25 During our monitoring events we discovered that a number of AEIs had out of date mentor databases and, in some cases, mentors who had not completed their annual updates and triennial reviews. A lack of clarity on collaboration and who holds responsibility for maintaining and updating these databases was reported as contributing to the prevalence of this outcome. In total two AEIs received a ‘not met’ and four AEIs received a ‘requires improvement’ for standards regarding mentorship.

26 Two AEIs were found to have inadequate systems to ensure that their placement partner local mentor databases were up to date, and that non-compliant mentors were suspended from the register. One of those AEIs was also found to have insufficient records for mentors in private, voluntary and independent sector placements. Four AEIs also required their mentor databases to be updated or the processes surrounding them to be strengthened.

27 All AEIs were required to take immediate action to reassign their students and/or update their mentors and mentor databases. This was reflected in an action plan which we monitored and ensured timeframes were met. We now have assurance that all AEIs have met this key risk and all mentors and mentor databases are up to date.

Resources

28 47 out of 77 AEIs (over two thirds) self-reported issues relating to changes in staff resources necessary to deliver NMC programmes. This included the need to recruit due to staff leaving or retiring, or to support increased commissions of student numbers for existing programmes or a new pathway.

29 Two AEIs did not meet this key theme when monitored. At one AEI we found that the midwifery programme leader did not have a recorded teaching qualification, while their lead midwife for education (LME) required support to develop at a strategic level. The other AEI did not effectively monitor staff NMC registration statuses. Their records of staff teaching qualifications also required updating.

30 This raised issues as staff could have potentially been teaching and making judgements about students when they were not qualified to do so. This, in turn, had the potential to compromise our register as students could have been signed off as being competent. Given the risks identified, both AEIs were required to prioritise an action plan and demonstrate evidence of resources being put in place to ensure that staff were updated and monitored. These actions have now been completed and we have assurance that both AEIs have ensured that appropriate resources are in place to meet our standards.

Placement capacity

31 15 out of 77 AEIs self-reported concerns relating to placement capacity either due to increased student numbers, reduced placement provision, or reconfiguration of services and the resulting variability of quality within practice learning. Five AEIs in England reported placement areas that were subject to Care Quality Commission (CQC) visits and two AEIs noted difficulties in releasing practice staff to undertake continuing professional development (CPD) as a consequence of poor staffing levels within clinical areas. This had an impact on mentors being released to receive their annual updates and triennial reviews.

Key risks relating to AEI's processes and internal governance

Preparation of AEIs for programme approvals

32 We approved 92 programmes in this reporting year. A large majority (73 programmes) were subject to both conditions and recommendations while ten programme approval events resulted in withheld approval. This is a significant enough figure to conclude that a number of AEIs were not

adequately prepared to meet our standards, despite requesting their preferred date for an approval event.

33 In total 187 individual conditions were applied to programmes in this reporting year. No AEIs were approved to run a programme without conditions or recommendations, and the number of conditions and recommendations has increased from last year. This suggests that there is a variability of preparedness between AEIs for approval events with resource implications to the NMC.

Admissions and progression

34 Five out of 17 AEIs monitored this year failed to meet the key theme 'Admissions and progression'. The main areas of concern around this key theme related to the absence of equality and diversity training, the absence of a practitioner and/or service user in the recruitment process and issues with the way AEIs were managing their fitness to practise (FtP) procedures.

35 One AEI's processes for ensuring health clearance and DBS/Protection of Vulnerable Groups (PVG) checks were not robust and another did not routinely include practitioners in the student selection process. The processes at two AEIs for addressing issues of poor performance of students were also not sufficiently robust and required improvement. Finally, one AEI was found to have no strategy or action plan in place to capture the involvement of service users and carers in the admissions and selection process and this also required improvement.

36 At the time of report, four out of five AEIs have completed their action plans. The remaining AEI continues to be monitored until its action plan has been completed.

Fitness for practice

37 The majority of AEIs self-reported robust fitness to practise policies and procedures which are annually reviewed. Three AEIs raised concerns about the change in protocols from Criminal Records Bureau (CRB) to Disclosure Barring Service (DBS) vetting. They reported delays in students commencing practice placements due to delays in DBS clearances and outstanding immunisation requirements. Other incident reports included a rise in fraud concerns, the increase in the number of FtP cases relating to inappropriate use of social networking, and students' ill health raising professional concerns. Several AEIs positively acknowledged our new social media guidance published in early 2015.

38 One AEI (out of 17) did not meet this key risk theme during monitoring due to not having clear documentation on the practice hours required to meet programme outcomes, and not being able to demonstrate clear and consistent practices for monitoring student practice hours. This was not declared in their annual self-report however that AEI has completed its action plan and provided evidence of complying with this key theme.

Quality assurance

39 AEIs self-reported on student evaluations and National Student Survey (NSS) scores and highlighted that reduced scores tended to relate to concerns about management and organisation, communication, feedback and time-tabling.

40 Three out of 17 AEIs did not meet this key theme during monitoring and were unable to demonstrate robust external examiner processes including failing to respectively show that due regard was assured, that the role of the external examiner was consistently applied, and that the examiner engaged sufficiently with assessment of practice learning.

41 These AEIs have now completed their action plans and have provided evidence of meeting our standards.

Notable practice

42 As part of our QA activity, we invite reviewers and AEIs to report back to us on any examples of an AEI demonstrating notable practice. The definition of notable practice is described as practice which is innovative and worthy of dissemination.

43 This year QA reviewers identified a number of examples of notable practice which included:

43.1 inter-professional learning with the use of simulators (University of South Wales);

43.2 partnership working into the assessment process of the specialist community public health nursing (SCPHN) programme (Anglia Ruskin University);

43.3 online professional forum and learning activities (The Open University);

43.4 integration of the improving quality together (IQT) silver award national learning programme within the course (University of South Wales);

43.5 the Pan-London assessment tool for pre-registration midwifery (eight AEIs in and around London);

43.6 student nurses undertaking service user led education alongside mental health service users whilst in practice (Kingston University and St George's University Hospital);

43.7 a 'staying in touch contact' model where regular contact is made with students who are on an interruption of studies (Cardiff University);

43.8 use of the Hyland and Donaldson psychological assessment tool in the district nursing students' professional practice to ensure that

nurses and midwives are compassionate and caring (Birmingham City University);

43.9 Collaborative Learning in Practice (CLiP) project, developed in partnership between the University and Health Education East of England and piloted at hospitals in Norfolk, being rolled out across the East of England (University of East Anglia); and

43.10 a peer assisted student support project where students promote the use of the skills centre to existing students and people who are interested in beginning an undergraduate degree in nursing (Edinburgh Napier University).

Part two: quality assurance of LSAs

44 This year we conducted monitoring visits between December and March 2015 on a selection of LSAs to ensure continued compliance with our Midwives rules and standards (2012). We selected four LSAs (29%) to be monitored as part of our QA of supervision of midwives.

45 We selected seven rules that we identified as key themes. The rules were: notification by the LSA (Rule 4), records (Rule 6), the LSA Midwifery Officer (Rule 7), Supervisors of Midwives (SoMs) (Rule 8), LSA responsibilities for SoMs (Rule 9) publication of LSA procedures (Rule 10) and suspension from practice by LSAs (Rule 14).

46 Despite LSAs declaring they were meeting our standards in their quarterly and annual self-reporting, two out of four LSAs went on to receive a ‘standard not met’ with respect to at least one key risk theme. One LSA received a ‘requires improvement' and only one LSA met all seven of our key risk themes. We have separated the key risks impacting upon the safety of women and babies versus impacting upon internal processes and governance.

Key risks to public protection and the safety of women and babies

Supervisory investigations

47 At the conclusion of the LSA reporting year, 11 out of 14 LSAs were not meeting best practice timelines for completing LSA supervisory investigations. The following reasons for the delay in completing the investigations were consistently provided by LSAMOs through their reporting:

47.1 sickness of midwives under investigation;

47.2 annual leave of either the midwife under investigation or the investigating SoM;

47.3 lack of protected time for statutory supervision activity;

47.4 clinical duties seen as a priority over SoM role; and

47.5 length of time to write reports due to delays in midwives returning statements and signed interview transcripts as well as delays in retrieving information.

48 These delays present a risk that the findings of the supervisory investigations, which relate to individual midwives’ fitness to practise, are not shared or escalated in a reasonable time frame. This potentially presents a risk to public protection as midwives could be practising and providing care whilst under local investigation. This will need to be closely monitored during the transitional period.

49 Key themes in LSA investigations this year included record-keeping, cardiotocograph (CTG) interpretation, medicines management, decision making and escalation. We have also seen an increase in reporting on the inappropriate use of social media which could be due to the publication of our social media guidance earlier this year.

Escalating concerns

50 Many LSAs described a consistent theme of midwives failing to escalate concerns in a timely manner and to the appropriate people. They also reported that there was a lack of understanding around accountability. This failing appeared to occur more frequently with midwives at the beginning stages of their career. This finding led to recommendations to managers to review preceptor programmes for midwives in the North West region.

Concerns or investigations by any other regulators or serious reviews

51 The majority of LSAMOs reported their awareness of concerns or investigations by other regulators throughout the year. Nine regions of NHS England LSA reported information pertaining to issues and outcomes from external reviews of maternity services including reviews by CQC, Clinical Commissioning Groups (CCGs), and Monitor. All LSAMOs across the four countries reported working closely with Heads of Midwifery (HoMs) and SoM teams to support maternity services in developing action plans and taking forward recommendations from external reviews.

Key risks relating to the compliance of Midwives rules and standards (2012)

Supervisor of Midwives (SoM)

52 The Midwives rules and standards (2012) set the ratio of SoMs to midwives at 1:15 to ensure midwives have adequate access to and support from a SoM. Although a significant proportion of maternity units were compliant with this ratio, the majority of LSAMOs reported ratios greater than 1:15 in one or more maternity units. Ten LSAs were compliant for the overall annual LSA average ratios; and of those, four were consistently compliant with the LSA ratios across all four quarters. Four LSA regions were not compliant with our ratio overall, reporting annual average ratios of 1:16 to 1:18.

53 LSAs self-reported that some SoMs were not receiving dedicated time for supervision due to pressures from their clinical workload. This impacted on the time available to fulfil their SoM roles and impacted on the length of time taken to complete supervisory investigations. This was consistent with the findings and judgements made when we monitored LSAs.

54 A ‘standard not met’ outcome was given during one of our monitoring review visits to an LSA which did not have robust processes in place to ensure the ratio of SoMs to midwives in one area reflected local need and circumstances and SoMs did not have adequate resources to undertake their role. An action plan was formulated to address this issue and the LSA

has now provided evidence of having the necessary processes in place and consequently has met this standard. We continue to monitor this through our quarterly telephone calls with LSAMOs.

55 We also found evidence during our monitoring reviews of SoMs being called upon to work in clinical settings while on-call for midwifery supervision when maternity services were at full capacity. The relevant LSAMO had previously met with the HOM to discuss this issue however the situation was unresolved at the time of the review and a 'requires improvement' outcome was given.

56 Two LSAs were unable to verify that an effective system was in place to ensure that every practising midwife had completed an annual supervisory review (ASR) with their named SoM for the practice year 2014–15. A 'standard not met' grade was given as assurance could not be provided that midwives were complying with our standard to maintain their midwifery registration. These issues have been addressed and we have received assurance that our standards are now being complied with. We continue to follow up on this during our quarterly telephone calls.

Preparation for the Supervision of Midwives (PoSoM) programmes

57 LSAs reported on succession planning through the enrolment of midwives onto PoSoM programmes. However, more recently, increasing numbers of LSAMOs have reported that some HoMs are reluctant to place midwives onto existing programmes. Specifically: London LSA reported that the King's Fund decision has resulted in three HoMs withdrawing support for midwives to undertake the PoSoM programme and notes that this will impact on SoM to midwife ratios; West Midlands LSA reported that the LSAMO had discussions with the regional Director of Nursing (DoN) and a decision was made to cancel the spring intake of the PoSoM programme at Birmingham City University; and East of England LSA reported that there would be no further recruitment of midwives to the PoSoM programme.

Resources

58 All LSAs self-reported and confirmed that there were adequate resources in place for the 2014-15 reporting year. However, since the reporting year concluded on 31 March 2015, several LSAMOs have raised concerns that those resources are no longer available following the reconfigurations in NHS England and Scotland which is consistent with our findings from monitoring. Regions are geographically larger with less LSAMOs and a reduced number of SoMs assigned. We will be closely monitoring this in the 2015-16 reporting year through our routine QA and we continue to encourage LSAMOs to exceptionally report to us on any risks to the provision of midwifery care and the LSA's ability to comply with our Midwives rules and standards (2012).

Key risks relating to process and internal governance

Records

59 No issues were discovered around records (Rule 6) and particularly the secure storage of records, which was the only standard not met in the previous year's monitoring cycle. All LSAs monitored were found to be compliant with data protection policies and guidelines for the retention of midwifery records.

Governance

60 All LSAs were found to have an appropriately qualified LSAMO in post and their duties, which cannot be delegated, were in all cases covered by another LSAMO in times of annual leave or sickness.

Notable practice

61 This year, QA reviewers identified a number of examples of notable practice within LSAs across the four countries.

61.1 Northern Ireland LSA has developed a new, interactive e-learning resource to help midwives understand their responsibilities when administering medicines.

61.2 South East and West of Scotland LSA created a new birth plan document which clearly shows reasons for deviation and agreed forward plans.

61.3 London LSA demonstrated good practice in providing psychological support for women; supportive working with colleagues; collaborative support with women and specific care for family post-natally.

61.4 Many LSAs have reported innovative practice around the safe use of social media (Facebook and Twitter).

61.5 Some maternity providers in two of the LSAs reviewed (HIW and South West LSA) have implemented full time SoMs as a solution to the problem of maintaining the ratio. HIW's 'Future Proofing Supervision' work has been recognised by other LSAs and HIW has shared and collaborated on this work across the four countries.

61.6 The CPD programme provided for SoMs by West Midlands LSA was described as innovative by the QA reviewing team and the delivery of the programme was evaluated as being of high quality by SoMs.

Part three: responding to risks

Extraordinary activity

62 Where serious adverse incidents are identified regarding an AEI, practice placement or LSA, we may decide to conduct an unscheduled event called an extraordinary review.

63 This year we conducted two extraordinary reviews. In August 2014, we were notified about escalating concerns around the supervision of midwifery and the provision of midwifery care within maternity services in the Princess Elizabeth Hospital (PEH), Guernsey. We convened a meeting on 11 September 2014 at the Health and Social Services Department (HSSD) in Guernsey in order to fully discuss the issues with all relevant organisations. Following this meeting we took the decision to conduct an extraordinary review, which took place in October 2014.

64 During this event, the reviewing team found that a number of our standards had not been met. In addition, concerns were raised about issues such as the care environment, governance, policies and procedures, and the organisational culture. While we have no legislative powers to force improvement in the wider environment of maternity care, in the absence of a system regulator, we took the unprecedented step to raise these issues publicly in order to drive improvements in the interest of public protection in Guernsey. We continue to support those organisations as they further progress the comprehensive action plan and it is our intention to follow up on progress later in 2015.

65 South West LSA and the Health and Social Services Department (HSSD) Guernsey both provided action plans which responded to the concerns raised during the extraordinary review. Student nurses were also removed from placement by the AEI. A follow-up visit was conducted in February 2015 and we found that progress had been made however assurance remains fragile. A full report from this extraordinary review is available on our website. It is our intention to return in the 2015-16 year to assess the sustainability of this progress.

66 We have also very recently undertaken a joint extraordinary review into pre-registration adult and mental health nursing and midwifery education and statutory supervision in North Wales. This extraordinary review was conducted following an escalation of concerns by HIW LSA and Bangor University that were impacting on our education standards and Midwives rules and standards (2012). The findings of this extraordinary review will be published on our website in October 2015.

Part four: conclusions and forward focus

67 The year's education QA activity provides an opportunity both for continuous improvement of the current QA process and future changes to our education standards and their assessment. This year's LSA QA activity provides further insight on areas of focus around changes to midwifery regulation and transition for the change.

68 Summarising the key themes from education QA activity, while we can be assured that standards are now met following action plans on the monitoring visits, there are a number of points worthy of our attention. Our key findings from this year's activity focus on AEIs governance processes and their overall preparedness at the point of approval, which are clearly for the AEIs to address as well as wider system issues within the environment where student learning operates, which is for the AEIs to address in collaboration with their practice partners.

69 Issues that arose from our monitoring activity around governance and process lead us to the conclusion that AEIs preparedness against NMC standards at the point of approval varies considerably. The majority of the AEIs this year have not been able to demonstrate full compliance despite selecting themselves the date for approval and having sufficient time to prepare for the approval event. On a short term basis and as part of our QA continuous improvement we will want to address this issue both with stronger communication to AEIs and their networks and through the potential of considering specific action with AEIs that have not demonstrated preparedness over a number of occasions. On a longer term basis and as part of our education standards review and their assessment in the future, we will want to consider how we address the significant variability of compliance at the point of approval.

70 Issues that arose from our monitoring activity around the student environment lead us to the need for a stronger focus around practice placement. Normally, issues that can have an impact on the student experience are in the practice environment. These include mentorship, practice placement and resource management. These issues are for the AEIs to manage in close collaboration with their practice partners. On a short term basis and as part of our QA continuous improvement, we will want to address this issue both with stronger communication to AEIs and their networks and through process changes of QA to strengthen our focus in this particular area. On a longer term basis and as part of our education standards review, we will want to consider our position and expectations from mentorship and the theory and practice relationship. As part of our strategic intent for stronger interregulatory working, we will want to strengthen our relationships with other regulators (both professional and system) in this area. Direct input from students around their learning experience through student surveys forms also part of future plans.

71 Summarising the key themes from LSA QA activity, it would be fair to conclude that our review of midwifery regulation and changes in the configuration of the LSA function within England and Scotland seem to be

leading to increased concerns raised to us by the LSAs. We have made it clear to LSAMOs that compliance with Midwives rules and standards (2012) remains a matter for the NMC until the change of midwifery regulation is complete. As part of our partnership work with the system we will want to strengthen communication on this particular issue.

72 There is clearly an issue around our assurance on LSA investigations and how timely and effectively these are escalated to the NMC. Short term we will want to continue to communicate the importance of this issue with LSAs while our employer link service could look at this particular aspect of escalation of FtP as part of the transition period of the review of midwifery regulation. Longer term this is addressed as part of our change to midwifery regulation.

73 Finally, issues around midwives' clarity around their accountability and the ability to escalate concerns are points for us to consider as part of the midwifery education standards review.

Item 11
NMC/15/96
25 November 2015

Council

Revised registration policy for EEA trained applicants

Action: For decision.

Issue: This paper seeks approval for a revised policy for the management of applications for registration from European Economic Area (EEA) trained nurses and midwives, which incorporates amendments resulting from recent changes to European legislation relating to recognition of professional qualifications.

Core regulatory function: Registration.

Corporate objectives: Strategic priority 1: Effective regulation.

Decision required: The Council is recommended to:

- Approve the policy for applications for registration from EEA nurses and midwives (paragraph 9).

Annexes: The following annexe is attached to this paper:

- Annexe 1: Policy for applications for registration from EEA nurses and midwives.

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

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Context:

1 The Council has received a number of updates about the changes being introduced by the revised Directive 2005/36/EC on the recognition of qualifications ('the Directive').[1] The amended Directive introduces a number of new registration provisions including the European Professional Card, partial access to a profession, and the ability for Member States to introduce language controls.

2 Member States, including the UK, must transpose the new requirements into national law and comply by 18 January 2016.

3 At its meeting in October, the Council, having considered and approved the outcomes of a public consultation, agreed to implement proposals to implement English language controls for EEA trained nurses and midwives. The new process to implement these new requirements will launch in January 2016.

4 The remaining new provisions of the Directive are being introduced through Regulations made by the Government which do not require separate approval by the Council (see paragraph 20).

5 The NMC policy dealing with the assessment of EEA applicants to the register needs to be revised and approved by the Council to reflect these legislative changes and to consolidate other recent legislative changes.

Discussion:

Content of revised EEA policy

6 The policy document consists of the following components:

6.1 The legislative framework which informs the document;

6.2 The key principles of the policy in terms of how the NMC will assess applications and ensure that the process is robust;

6.3 The statutory requirements for registration with the NMC, as articulated by Article 9 of the Order;

6.4 The requirements for recognition of a nurse or midwife's qualification, including definitions of the different types of approved qualification as defined by legislation;

6.5 The requirements for holding an appropriate indemnity arrangement, being capable of safe and effective practice and having the necessary knowledge of English, in order to be eligible for registration;

6.6 The requirements for nurses and midwives trained in the EEA who wish to provide temporary and occasional services in the

[1] As amended by Directive 2013/55/EU of the European Parliament and of the Council

UK; and

6.7 The process for appeals against NMC decisions.

7 The policy has been revised to reflect the requirements of the legislation outlined in paragraphs 19 and 20, including new amendments to this legislation resulting from the amended Directive.

8 Detailed decision making guidance has been created for the registration directorate which outlines the different routes to recognition and registration provided for in the Directive, as well as the documents that are required by the NMC to support an application. This guidance incorporates the changes being introduced by the amended Directive.

9 Recommendation: The Council is recommended to approve the policy for registration from EEA nurses and midwives.

Public protection implications:

10 The policy document attached to this paper derives directly from the NMC's existing governing legislation as well as from the new requirements of the amended Directive. The NMC's processes for managing applications for registration from the EEA have robust procedures in place to ensure that only those who meet the EU and NMC requirements can enter the register.

11 A number of the provisions of the amended Directive will have a positive impact on public protection. These include the alert mechanism for fitness to practise sanctions, and the ability to introduce language controls for EEA trained nurses and midwives.

Resource implications:

12 Resources to develop the policies to implement the requirements of the amended Directive have been accounted for within existing budgets. Additional resources for legislative and process development have been allocated from project funds set aside for this purpose.

Equality and diversity implications:

13 An equality impact assessment has been carried out in relation to the attached policy and on the decision making guidance that sits beneath this. This assessment has highlighted no specific impact in relation to the protected characteristics.

14 A separate equality impact assessment was carried out in conjunction with the stakeholder engagement exercise undertaken on the proposals to introduce language controls for EEA trained nurses and midwives. This assessment was further updated following consideration and analysis of the responses to the public consultation.

Stakeholder engagement:

15 The NMC has conducted a consultation on the new requirements relating to English language in accordance with Articles 3(14) and 47(3) of the Nursing and Midwifery Order 2001. The outcome of the consultation was reported to the Council in paper NMC/15/80 of 8 October 2015.

16 No consultation was carried out on the attached policy because it reflects the requirements of external legislative change that has itself been subject to separate consultation.

17 As part of the wider project to implement the requirements of the Directive, information for employers and the public is being updated. This includes information on the responsibilities of employers in relation to ensuring that the nurses or midwives they employ are fit to practise.

Risk implications:

18 Risks associated with the wider implementation of the Directive have been articulated in previous papers to the Council, along with mitigating actions. There are no additional risks associated with the approval of this policy document.

Legal implications:

19 Legal implications are addressed in the paper.

Item 11: **Annexe 1**
NMC/15/96
25 November 2015

NMC Registration policy: EEA trained applicants

Contents

EEA registration policy

This document explains the Nursing and Midwifery Council's (NMC's) policy that applies to nurses and midwives trained within the European Economic Area (EEA) who apply for recognition of their qualification and registration with the NMC.

This policy document is for internal use only and must be used by NMC staff who process applications for registration and handle related appeals.

This policy became operational on 18 January 2016 having been approved by the Council on 25 November 2015.

No change or amendment should be made to this document without the approval of the Council.

Who this policy applies to

1 This policy applies to EEA applicants seeking establishment in the UK or to provide temporary and occasional provision of services and who are:

1.1 Nurses and midwives who are EEA nationals and who were trained in an EEA Member State and who meet the requirements to be assessed in accordance with the relevant provisions of European and UK legislation on the recognition of qualifications;

1.2 Nurses and midwives who are EEA nationals who were trained outside the EEA but who have been registered in an EEA Member State and have been lawfully practising in that Member State for at least three consecutive years; or

1.3 Nurses and midwives holding an enforceable EU right who are the spouse, civil partner, child or dependent under the age of 21 of an EEA national and are using their right to relocate together with their spouse, civil partner or parent in accordance with EU law.

Aims of the policy

2 The aim of this document is to set out the NMC's obligations under EU and UK law when assessing applications for the recognition of qualifications and registration from EEA trained nurses and midwives. It also sets out the key principles that the NMC will apply in considering applications.

Legislative framework

3 A number of different pieces of legislation govern the operation of the EEA registration process. These are:

3.1 The Nursing and Midwifery Order 2001 ('the Order'); [1]

3.2 The Nursing and Midwifery Council (Education, Registration and Registration Appeals) Rules 2004 ('the Registration Rules); [2]

3.3 European Nursing and Midwifery Qualifications Designation Order of Council 2004; [3]

3.4 Directive 2005/36/EC on the recognition of qualifications; [4]

3.5 Commission Implementing Regulation (EU) 2015/983; and [5]

[1] SI 2002/253 (as amended)
[2] SI 2004/1767 (as amended)
[3] SI 2004/1766 (as amended)
[4] As amended by Directive 2013/55/EU of the European Parliament and of the Council of 20 November 2013
[5] Implementing Regulation on the European Professional Card and the alert mechanism

3.6 European Union (Recognition of Professional Qualifications) Regulations 2015. ('the General Systems Regulations) [6].

Key principles of the policy

4 Applications from EEA nurses and midwives will be assessed in accordance with EEA and UK legislation in terms of recognition of their qualifications. If their qualification is recognised they will then be required to meet the NMC's registration requirements in order to enter the register.

5 All applications for registration will be processed in line with the NMC's primary duty, which is to protect the public through efficient and effective regulation.

6 All recognition and registration processes must comply with the relevant legislation.

7 Nurses and midwives may apply for recognition and registration by applying directly to the NMC or via the European Professional Card portal hosted by the European Commission.

8 Nurses and midwives will only be registered if they meet all of the requirements for entry to the register outlined in the Order.

9 There will be robust procedures in place to prevent anyone securing registration fraudulently. This will include procedures to assess that the documents received as part of an application are genuine. Processes and policies relating to registration will comply with data protection and document retention regulations.

10 Where we refuse an application for recognition of qualifications or registration we will provide a full explanation to the applicant.[7] We will have a clear process to deal with appeals against our decisions in a fair and timely manner.[8]

11 This policy is supplemented and supported by decision making guidance for those considering applications for recognition and registration.

Statutory requirements for registration with the NMC

12 Article 9 of the Order sets out the statutory requirements that applicants must meet in order to be registered. Nurses and midwives wishing to apply for registration must make an application in the prescribed form and manner as set down in Rule 5 of the Registration Rules.

13 In order to meet the requirements for registration, applicants must satisfy the Registrar that:

13.1 They hold an approved qualification; [9]

[6] SI *(to be confirmed following laying in Parliament)*
[7] Article 9(4)(b) of the Order
[8] Article 37 of the Order and Part IV of the Registration Rules
[9] Article 9(2)(a) of the Order

13.2 There is in force or will be in force as necessary, appropriate cover under an indemnity arrangement; [10]

13.3 They meet the Council's requirements in relation to being capable of safe and effective practice; [11]

13.4 They have the necessary knowledge of English; and [12]

13.5 Have paid the prescribed fee as set out in the Fees Rules.[13] [14]

14 The documents and evidence that an EEA trained nurse or midwife must supply to the Registrar are set out in Rule 5 of the Registration Rules. Applications for recognition of qualifications and registration will be considered in accordance with the timescales set down in legislation.[15]

Recognition of a nurse or midwife's qualification

15 Nurses and midwives trained in the EEA must follow a two-step process before they can be registered. The first is the process for recognition of their qualification through which a decision is reached about whether they have an approved qualification. Once this has been completed they will be required to meet the NMC's other registration requirements before they can be registered.

Approved qualifications

16 An EEA trained nurse or midwife can only be recognised if they have an approved qualification.

17 Applicants will have an approved qualification for the purposes of entry in the relevant part of the register where:

17.1 They hold a qualification as a nurse responsible for general care (adult nurse) that meets the requirements for automatic recognition, being listed in annexe V.2. point 5.2.2 of the Directive; [16] [17]

17.2 They hold a qualification as a midwife that meets the requirements for automatic recognition, being listed in annexe V.5. point 5.5.2 of the Directive; [18] [19]

17.3 They hold a qualification as a nurse responsible for general care (adult nurse) which meets the requirements for acquired rights by virtue of the

[10] Article 9(2)(aa) of the Order
[11] Article 9(2)(b) of the Order
[12] Article 9(2)(ba) of the Order
[13] Article 9(2)(c) of the Order
[14] The Nursing and Midwifery Council (Fees) Rules 2004 (SI 2004/1654)(as amended)
[15] Article 51 of the Directive and article 9 of the Order
[16] Article 21 of the Directive
[17] Article 3(1) of the European Qualifications Designation Order (SI 2004/1766)
[18] Articles 21 and 41 of the Directive
[19] Article 3(1) and 3(2) of the European Qualifications Designation Order

nurse undertaking the required period of lawful and effective practice, certified by the competent authority of their home Member State; [20]

17.4 They hold a qualification as a midwife which meets the requirements for acquired rights by virtue of the midwife undertaking the required period of lawful and effective practice, certified by the competent authority of their home Member State; [21]

17.5 They hold a qualification as a nurse or midwife and whose application falls within regulation 3(9)(a), (c), (d) or (e) of the General Systems Regulations, and:

17.5.1 The qualification meets the NMC's standards; or

17.5.2 The qualification does not meet the NMC's standards but the applicant has successfully completed an adaptation period or passed an aptitude test in accordance with article 14 of the Directive. [22]

18 A nurse or midwife's qualification can only be recognised if it meets one of the options outlined above. Detailed information on how to assess qualifications will be set down in decision making guidance.

NMC requirements for registration

19 Once an EEA applicant's qualification has been recognised they will be required to meet the other statutory requirements outlined in article 9 of the Order in relation to holding an appropriate indemnity arrangement, being capable of safe and effective practice, and having the necessary knowledge of English.

Professional indemnity insurance

20 EU Directive 2011/24/EU[23] requires that healthcare professionals have an appropriate indemnity arrangement in force appropriate to their role. In order to meet this requirement nurses and midwives will be required to declare that they hold an appropriate indemnity arrangement, or will do when they begin practising. In this context practising means any activity undertaken by virtue of their registration as a nurse or midwife. Nurses and midwives who are not able to make this declaration will not be eligible for registration.

Health and character

21 In satisfying the Registrar that they are capable of safe and effective practice nurses and midwives must meet the NMC's health and character requirements which are set out in Rule 6 of the Registration Rules.[24]

22 In order to satisfy the health requirement, the applicant may be required to provide further information to the NMC for review if necessary.[25] The requirement to

[20] Articles 23 and 33 of the Directive and articles 4 to 10 of the European Qualifications Designation Order
[21] Articles 23 and 43 of the Directive and articles 4 to 10 of the European Qualifications Designation Order
[22] Article 14 of the Directive and articles 13(1)(e) and (f) of the Order
[23] Directive 2011/24/EU *'on the application of patients' rights in cross border healthcare'*
[24] Article 5(2)(b) of the Order and Rule 6 of the Registration Rules

demonstrate 'good health' under Rule 6 of the Registration Rules relates solely to the need for the applicant to be capable of undertaking safe and effective practice.

23 In order to assure itself that the applicant meets the character requirements for registration, the NMC must take into account certain criminal convictions, cautions or determinations by competent authorities.[26] Further information to support the character requirements may include information about charges and determinations by other professional and competent authorities.

English language

24 EEA trained nurses and midwives wishing to register with the NMC must satisfy the Registrar that they have the necessary knowledge of English.[27] In accordance with article 5A of the Order, the Council has published guidance for EEA applicants outlining the process that they should follow to demonstrate having the necessary knowledge of English, and the type of evidence that may be accepted.

25 The NMC cannot formally require evidence of having the necessary knowledge of English until after the recognition of qualifications is complete.[28]

26 Decisions about whether a nurse or midwife is able to satisfy the Registrar that they have the necessary knowledge of English must be carried out in accordance with the Council's policy on English language requirements for registration.[29] Where an applicant does not supply any evidence of having the necessary knowledge of English as part of their application or following a formal request, the Registrar may require the applicant to successfully pass an English language assessment.[30]

27 Nurses and midwives who are unable to satisfy the Registrar in relation to language competence are not eligible for registration with the NMC.

Applications for temporary and occasional provision of services

28 EEA trained nurses and midwives may apply to provide temporary and occasional services in the UK. Applications must be assessed on an individual basis and in accordance with article 39A and Schedule 2A of the Order.

29 In order to provide temporary and occasional services for the first time, a nurse or midwife must supply the Registrar with the documents outlined in paragraph 5(2) of Schedule 2A of the Order. Nurses and midwives who meet the requirements to provide temporary and occasional services are entitled to be registered in the appropriate part of the register.[31]

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[25] Article 5(2)(b) of the Order and Rule 6(5) of the Registration Rules
[26] Rules 6(6)(c) and 6(6)(d) of the Registration Rules
[27] Article 9(2)(ba) of the Order
[28] Articles 5A(3) and 5A(5) of the Order
[29] TRIM REF
[30] Article 5A(6) of the Order
[31] Paragraph 8(1) of Schedule 2A of the Order

30 An entitlement to provide temporary and occasional services ceases if the nurse or midwife becomes established in the UK and wishes to practise on a full time basis.[32] In such a case the nurse or midwife must apply for full registration.

Partial access to the register

31 The Directive makes provision, in very limited circumstances, for EEA nationals to apply for partial access to a profession. The parameters in which this would take place are set out in article 4f of the Directive. Any applications for partial access to the NMC register will be considered on a case by case basis and against the NMC's objective of protecting the public.

Appeals

32 An EEA applicant may appeal decisions made by the NMC relating to applications for recognition of qualification and registration. The grounds for appeal are set down in article 37 of the Order. Article 37 also outlines where a right to appeal does not apply.

33 Detailed information relating to the appeals process is published on the NMC website.

[32] Paragraph 8(5) of Schedule 2A of the Order

Item 12
NMC/15/97
25 November 2015

Council

Legal Assessors: extension of current terms of appointment

Action:	For decision
Issue:	The terms of office of the current pool of Legal Assessors, who are appointed by the Council to advise Fitness to Practise panels, expire on 31 December 2015.
Core regulatory function:	Fitness to Practise
Strategic priorities:	Strategic priority 1: Effective regulation Strategic priority 4: Effective organisation
Decision required:	The Council is recommended to re-appoint the Legal Assessors set out in Annexe 1.
Annexes:	Annexe 1**:** List of legal assessors
Further information:	If you require clarification about any point in the paper or would like further information please contact the author or the Director named below:

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Director: Sarah Page
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sarah.page@nmc-uk.org

Context:

1. The current pool of Legal Assessors reach the end of their current terms of office on 31 December 2015. The Appointments Board considered the re-appointment of Legal Assessors on 2 October and 3 November 2015. There is a requirement under article 34 of the Nursing and Midwifery Order 2001 for Legal Assessors to be appointed by the Council. Article 34(5) states that a Legal Assessor must have 10 years' experience as a barrister or advocate. The current Legal Assessors were appointed on the basis of their qualification, experience, and suitability in accordance with Article 34(5).

Discussion and options appraisal:

2. The NMC has reviewed and discussed with the Appointments Board the operational requirements regarding hearing capacity, the eligibility of current legal assessors for re-appointment under Article 34(5), and information regarding their performance. On that basis, the Appointments Board recommends the appointment of 134 Legal Assessors for 12 months and one Legal Assessor for 6 months. The Appointments Board will discuss proposals regarding the recruitment, training, and performance monitoring of Legal Assessors at its meeting in February 2016.

3. **Recommendation: The Council is recommended to re-appoint the Legal Assessors as set out at Annexe 1.**

Public Protection Implications:

4. No direct public protection implications. Legal Assessors contribute to panel decisions which protect the public.

Resource Implications:

5. No direct resource implications. Legal Assessor costs are included in existing budgets.

Equality and Diversity Implications:

6. No direct equality and diversity implications arising from the re-appointments process. Any future recruitment will aim to attract applications from as diverse a group of individuals as possible.

Stakeholder Engagement:

7. None required.

Risk Implications:

8. Operational risks to the delivery of Fitness to Practise hearings have been taken into consideration in recommending the re-appointment of Legal Assessors. Feedback mechanisms are in place to mitigate performance risks and the NMC is not obliged to instruct appointed Legal Assessors where concerns about appointment exist.

Legal Implications

9. As noted above, the appointment of Legal Assessors is a matter for the Council under Article 34 of the Order.

Appointment as a Nursing and Midwifery Council Legal Assessor

The following 135 lawyers have declared they are qualified for appointment as a legal assessor according to the criteria set out in Article 34 of the Nursing and Midwifery Order 2001 (SI 253/2002), and that they have regulatory experience.

Following the recommendation from the Appointments Board, the Council is asked to appoint the following Legal Assessors for 12 months.

No.	Forename	Surname	Extend until
1	George	Aliiott	31 December 2016
2	Charles	Apthorp	31 December 2016
3	Ian	Ashford-Thorn	31 December 2016
4	Tracy	Ayling	31 December 2016
5	Philip	Barlow	31 December 2016
6	Jeremy	Barnett	31 December 2016
7	Fiona	Barnett	31 December 2016
8	John	Bassett	31 December 2016
9	Michael	Bell	31 December 2016
10	Tim	Bradbury	31 December 2016
11	John	Bromley-Davenport	31 December 2016
12	Iain	Burnett	31 December 2016
13	Jacqueline	Carey	31 December 2016
14	Sheena	Cassidy	31 December 2016
15	John	Caudle	31 December 2016
16	Valerie	Charbit	31 December 2016
17	David	Clapham	31 December 2016
18	Maria	Clarke	31 December 2016
19	Gerard	Coli	31 December 2016

No.	Forename	Surname	Extend until
20	Charles	Conway	31 December 2016
21	Kate	Cornell	31 December 2016
22	Charles	Curtis	31 December 2016
23	Graeme	Dalgleish	31 December 2016
24	Toby	Davey	31 December 2016
25	Andrew	Davies	31 December 2016
26	Margaret	Dodd	31 December 2016
27	John	Donnelly	31 December 2016
28	Hamish	Dunlop	31 December 2016
29	Michael	Epstein	31 December 2016
30	Adam	Feest	31 December 2016
31	Richard	Ferry-Swainson	31 December 2016
32	Robert	Frazer	31 December 2016
33	Justin	Gau	31 December 2016
34	Juliet	Gibbon	31 December 2016
35	Marian	Gilmore	31 December 2016
36	Alain	Gogarty	31 December 2016
37	Elliott	Gold	31 December 2016
38	Linda	Goldman	31 December 2016
39	Patricia	Gordon	31 December 2016
40	Andrew	Granville- Stafford	31 December 2016
41	Charlotte	Hadfield	31 December 2016
42	Kenneth	Hamer	31 December 2016
43	Sean	Hammond	31 December 2016
44	Iain	Harris	31 December 2016
45	Caroline	Hartley	31 December 2016
46	Robin	Hay	31 December 2016
47	Conor	Heaney	31 December 2016

No.	Forename	Surname	Extend until
48	Hala	Helmi	31 December 2016
49	Graeme	Henderson	31 December 2016
50	Paul	Hester	31 December 2016
51	Alison	Hewitt	31 December 2016
52	Adam	Hiddleston	31 December 2016
53	Douglas	Hogg	31 December 2016
54	Matthew	Holdcroft	31 December 2016
55	James	Holdsworth	31 December 2016
56	Robert	Horner	31 December 2016
57	Michael	Hosford-Tanner	31 December 2016
58	William	Hoskins	31 December 2016
59	Kate	Hughes	31 December 2016
60	Leighton	Hughes	31 December 2016
61	Angela	Hughes	31 December 2016
62	Robin	lnce	31 December 2016
63	Nigel	Ingram	31 December 2016
64	Alexander	Jacobs	31 December 2016
65	Stephen	Jeary	31 December 2016
66	Peter	Jennings	31 December 2016
67	Rupert	Jones	31 December 2016
68	Stewart	Jones	31 December 2016
69	Trevor	Jones	31 December 2016
70	Cyrus	Katrak	31 December 2016
71	Timothy	Kendal	31 December 2016
72	Hassan	Khan	31 December 2016
73	Paul	Kilcoyne	31 December 2016
74	Gelaga	King	31 December 2016
75	Sanjay	Lal	31 December 2016

No.	Forename	Surname	Extend until
76	Robin	Leach	31 December 2016
77	Nicholas	Leviseur	31 December 2016
78	Michael	Levy	31 December 2016
79	Nigel	Lithman	31 December 2016
80	Petter	Lodder	31 December 2016
81	Angus	MacPherson	31 December 2016
82	David	Marshall	31 December 2016
83	Nicola	Martin	31 December 2016
84	Michael	Mather-Lees	31 December 2016
85	Anne	McCamley	31 December 2016
86	Christopher	McKay	31 December 2016
87	Neil	Mercer	31 December 2016
88	Mark	Miliken-Smith	31 December 2016
89	Richard	Miller	31 December 2016
90	Nigel	Mitchell	31 December 2016
91	John	Moir	31 December 2016
92	Susan	Monaghan	31 December 2016
93	Fiona	Moore	31 December 2016
94	Adrienne	Morgan	31 December 2016
95	Oba	Nsugbe	31 December 2016
96	Tony	Ostrin	31 December 2016
97	Melissa	Pack	31 December 2016
98	Suzanne	Palmer	31 December 2016
99	Michael	Parroy	31 December 2016
100	Nigel	Parry	31 December 2016
101	Charles	Parsley	31 December 2016
102	Ian	Partridge	31 December 2016
103	Nigel	Pascoe	31 December 2016

No.	Forename	Surname	Extend until
104	Mark	Piercy	31 December 2016
105	Moira	Ramage	31 December 2016
106	Michael	Ranaghan	31 December 2016
107	Douglas	Readings	31 December 2016
108	Andrew	Reid	31 December 2016
109	David	Richards	31 December 2016
110	Iain	Ross	31 December 2016
111	Jane	Rowley	31 December 2016
112	Graeme	Sampson	31 December 2016
113	Barrie	Searle	31 December 2016
114	David	Sharpe	31 December 2016
115	Michael	Simon	31 December 2016
116	Christopher	Smith	31 December 2016
117	Duncan	Smith	31 December 2016
118	Ben	Stephenson	31 December 2016
119	Ian	Stern	31 December 2016
120	Mark	Sullivan	31 December 2016
121	Mark	Sutton	31 December 2016
122	David	Swinstead	31 December 2016
123	Megan	Topliss	31 December 2016
124	Richard	Tyson	31 December 2016
125	Michael	Vere-Hodge	31 December 2016
126	John-Paul	Waite	31 December 2016
127	Simon	Walsh	31 December 2016
128	Richard	Whittam	31 December 2016
129	Lucia	Whittle-Martin	31 December 2016
130	Jeffrey	Widdup	31 December 2016
131	Nicholas	Wilcox	31 December 2016

No.	Forename	Surname	Extend until
132	Lachlan	Wilson	31 December 2016
133	Oliver	Wise	31 December 2016
134	Andrew	Young	31 December 2016

We ask the Council to appoint the following Legal Assessor for six months.

No.	Forename	Surname	Extend until
135	Karen	Rea	30 June 2016

Item 13
NMC/15/98
25 November 2015

Council

Governance: Committee terms of reference

Action: For decision.

Issue: Proposes minor adjustments to Remuneration Committee terms of reference and formalisation and terms of reference of the Council Budget Scrutiny Group.

Core regulatory function: Supporting functions.

Strategic priority: Strategic priority 4: An effective organisation

Decision required: The Council is recommended to:

- Approve the proposed amendments to the Remuneration Committee terms of reference at **annexe 1**.
- Approve, subject to any comments, the proposed addition to the Scheme of Delegation at **paragraph 13.**
- Approve, subject to any amendments, the proposed terms of reference for the Council Budget Scrutiny Group at **annexe 2**.

Annexes: The following annexes are attached to this paper:

- Annexe 1: Proposed amendments to the Remuneration Committee Terms of Reference
- Annexe 2: Proposed Council Budget Scrutiny Group Terms of Reference

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

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Context:

1 The Council Constitution Order and Standing Orders provide for the Council to establish discretionary Committees. Discretionary Committees established by the Council include the Audit Committee and the Remuneration Committee.

2 The Council Committee review looked at the current committee structures, composition and terms of reference of committees to ensure these are best suited to current and future NMC priorities and responsibilities.

3 The outcomes of the review suggested that there was scope to revisit current Committee terms of reference to ensure they remain appropriate or make adjustments as necessary.

Discussion and options appraisal:

Audit Committee

4 The current Audit Committee terms of reference were approved by the Council in July 2013. The Audit Committee reviewed its current terms of reference on 28 October 2015. The Committee is satisfied that the terms of reference remain appropriate and fit for purpose.

Remuneration Committee

5 The current Remuneration Committee terms of reference were also approved by the Council in July 2013. The Council committee review suggested that there was scope to clarify the terms of reference of the Remuneration Committee.

6 The Remuneration Committee reviewed the current terms of reference on 29 October 2015. The Committee identified some adjustments to ensure greater clarity of roles and responsibilities going forward, particularly in relation to matters reserved to the Council, matters delegated to the Committee and matters delegated to the Chief Executive and Registrar.

7 The Committee noted that as the proposed Council Budget Scrutiny Group (see below) would be responsible for considering high level budgetary assumptions, including funding provision in respect of staff pay, this did not need to be addressed within the Committee's terms of reference. The Committee suggested that it would be helpful to develop an explanatory memorandum clarifying roles and responsibilities in this respect. This will be considered by the proposed Budget Scrutiny Group.

8 The proposed adjustments to the Committee's terms of reference are set out at **annexe 1**.

9 Recommendation: That the Council approve the amendments to the Remuneration Committee Terms of Reference at annexe 1.

Council Budget Scrutiny Group

10 Under the Council's Scheme of Delegation responsibility is reserved to the Council for approving the financial strategy, reserves policy, fees strategy, annual corporate plan and budget.

11 The Council has previously identified that it would be helpful to have the facility for earlier engagement with development of the annual business plan and budget, through a short term task group to operate during the budget setting process.

12 The Group will be chaired by the Chair of the Council and additionally comprise the Chairs of the Audit and Remuneration Committees. The Group's role would be to provide advice to the Executive and assurance and, as appropriate, recommendations, to the Council. The Council as a whole would continue to be responsible for approving the annual corporate plan and budget.

13 Facility to establish such a Group needs to be formalised within the Council's governance framework through the following minor addition:

Scheme of Delegation, add new paragraph as follows:-

15.4 The Council Budget Scrutiny Group is a short term group which may operate during the budget setting process to provide scrutiny in relation to budget development, advise the Executive and provide assurance or make recommendations to the Council.

14 Suggested terms of reference for the Group are set out at **annexe 2** Subject to the Council's approval, these would be added as annexe 2e to the Standing Orders.

15 **Recommendation: The Council is invited to:**

15.1 **Approve, subject to any comments, the proposed addition to the Scheme of Delegation at paragraph 13 above.**

15.2 **Approve, subject to any amendments, the proposed terms of reference for the Council Budget Scrutiny Group at annexe 2.**

Public protection implications:	16	None.
Resource implications:	17	None.
Equality and diversity implications:	18	None.
Stakeholder engagement:	19	None.
Risk implications:	20	None.
Legal implications:	21	None.

Item 13: **Annexe 1**
NMC/15/98
25 November 2015

Amended Remuneration Committee Terms of Reference

1 The Remuneration Committee is established by the Council under Article 3 (12) of the Nursing and Midwifery Order 2001.

Remit

2 The remit of the Remuneration Committee is to ensure that there are appropriate systems in place for remuneration and succession planning at the NMC.

Responsibilities

Chief Executive and Registrar, Directors, and other employees

3 Approve and oversee the process for the recruitment and selection of the Chief Executive and Registrar.

4 Consider and recommend to the Council an appropriate reward strategy for the Chief Executive and Registrar, Chief Operating Officer and the Directors.

5 Approve annually the reward package, including any performance related element, of the Chief Executive and Registrar, Chief Operating Officer and the Directors in line with the reward strategy set by the Council.

6 Approve the process for~~, and review reports from the Chair regarding,~~ the setting of objectives for and performance appraisal of the Chief Executive and Registrar.

7 Review reports from the Chief Executive and Registrar regarding the setting of objectives for and performance appraisal of the Chief Operating Officer and Directors.

8 Approve the arrangements for succession planning for the Chief Executive and Registrar and review those for the Directors.

9 Approve any request to be made to HM Treasury by the Chief Executive, as Accounting Officer, in relation to special severance payments ~~to be made~~ in the event of the termination of employment of the Chief Executive and Registrar or a Director, and any other special payments to employees.[1]

10 Review, as necessary, any significant changes to ~~HR policy~~the People Strategy, the employee pay and grading structure, or the pension scheme.

The Chair and the Council

11 Recommend to the Council any changes to the remuneration and terms of service of the Chair and Council members, seeking independent advice as appropriate.

12 Approve the expenses policy for the Chair and Council members.

[1] The respective roles of the Remuneration Committee, the Chief Executive and Registrar, and the Privy Council are set out in a separate explanatory memorandum.

13 Recommend to the Council the arrangements for the induction, appraisal and development of the Chair and Council members.

14 Approve and oversee the process for the recruitment of Council members, in accordance with PSA guidance and the requirements of the Privy Council.

Approved by the Council
18 July 2013 (amended 25 November 2015)

Item 13: **Annexe 2**
NMC/15/98
25 November 2015

Budget Scrutiny Group: Terms of Reference

Remit and membership

1 The Budget Scrutiny Group is a short term group established from time to time by the Council. It will operate only during the budget setting process.

2 The Group shall be chaired by the Chair of the Council and additionally comprise the Chairs of the Audit and Remuneration Committees.

3 The Group's purpose is to:

1.1 provide scrutiny in relation to budget development and advice to the Executive; and

1.2 provide assurance to the Council that appropriate analysis and consideration has been undertaken in the construction of the financial plans and budgets.

Terms of reference

4 The terms of reference of the Group are to:

4.1 Review the financial plans during development and prior to submission of budget proposals to Council including:

4.1.1 Any underpinning volume and budgetary assumptions being made

4.1.2 Any capital investment proposals.

4.1.3 The identification of efficiencies / savings.

4.2 Provide assurance to Council that detailed analyses of financial options, sensitivities and risk have been considered by the Executive in relation to financial plans.

4.3 Review the budget in the context of the Corporate Plan to provide assurance to Council that the budget allocation process has taken into account core regulatory core business and any desired improvement.

4.4 Review the above in the context of the emerging NMC financial strategy.

5 Recommend to the Council any high level budgetary assumptions to be used for budget planning purposes including any funding provision to be made in relation to the paybill.

6 The Chair of the Council will report on the Group's work to the Council, in seminar, confidential or open session as considered appropriate.

7 The Council will review the need for the Budget Scrutiny Group on an annual basis.

Item 15
NMC/15/100
25 November 2015

Council

Chair's action taken since the last meeting of the Council

Action:	For information.
Issue:	Reports actions taken by the Chair of the Council since 8 October 2015 under delegated powers in accordance with Standing Orders.
Core regulatory function:	Supporting functions.
Strategic priority:	Strategic priority 4: An effective organisation.
Decision required:	None.
Annexe:	The following annexes are attached to this report: • Annexe 1: Chair's action – Annual report and accounts 2014-2015 and letters of representation to external auditors and National Audit Office. • Annexe 2: Decision to make the Nursing and Midwifery Council (Fitness to Practise) (Education, Registration and Registration Appeals) (Amendment No. 2) Rules Order of Council 2015.
Further information:	If you require clarification about any point in the paper or would like further information please contact the author or the director named below

Secretary: Fionnuala Gill
Phone: 020 7681 5842
fionnuala.gill@nmc-uk.org

Chair's action

NMC annual report and accounts 2014 - 2015 and amendments to the accompanying letters of representation to external auditors and the National Audit Office (NAO)

1 The Council approved in principle the annual report and accounts for 2014-2015 on 29 July 2015 and authorised the Chair to sign these and the accompanying letters of representation to external auditors and NAO.

2 Prior to signature a minor amendment was made to the financial review section of the annual report to correct a non-material change to the statement of free reserves. This change was reported to the Audit Committee. The Chair of the Council approved and signed the annual report and accounts on 28 October 2015.

3 In addition, amendments were made to the letters of representation to the external auditors and NAO to reflect an over-provision in the accounts for dilapidations which were confirmed after the accounts had been closed. Following review and recommendation by the Audit Committee, the Chair of the Council signed the amended letters of representation on behalf of the Council on 28 October 2015.

4 Further details of the action are set out at **annexe 1**.

Decision to make the Nursing and Midwifery Council (Fitness to Practise) (Education, Registration and Registration Appeals) (Amendment No. 2) Rules Order of Council 2015

5 On 26 October 2015 the Council approved, by correspondence, the changes to the NMC's Registration Rules and Fitness to Practise Rules in order to introduce new English language requirements for registration.

6 On behalf of the Council, the Chair and the Chief Executive, signed the Amendment Rules for submission to the Privy Council.

7 A copy of the Council decision record, signed by the Chair, is at **annexe 2.**

Public protection implications:

8 None arising directly from this report.

Resource implications:

9 None arising directly from this report.

Equality and diversity implications:	10	None.
Stakeholder engagement:	11	None
Risk implications:	12	None.
Legal implications:	13	None.

Nursing & Midwifery Council

Chair's Action

Under NMC Standing Orders, the Chair of the Council has power to authorise action on minor, non-contentious or urgent matters falling under the authority of the Council (Scheme of Delegation, paragraph 4.6). Such actions shall be recorded in writing and passed to the Chief Executive and Registrar who shall require a record to be maintained of all authorisations made under this paragraph. The Chair shall report in writing, to each Council meeting the authorisations which have been made since the preceding meeting.

Each Chair's action must be affixed to an accompanying report setting out full details of the action that the Chair is requested to authorise on behalf of the Council.

Date: 28 10 2015	Requested by: Mary Anne Poxton Corporate Business Planning Manager

1. Financial Review NMC annual report and accounts 2014-2015

Council approved in principle the annual report and accounts 2014-2015 on 29 July 2015 and authorised the Chair to make any minor amendments required before signature.

A non-material amendment has been made to the stated level of available free reserves in the Financial Review (to reflect an upwards adjustment to the pension deficit estimate). This is now stated as £11.5m (rather than £11.8m).

2. Amendments to the accompanying letters of representation to external auditors and NAO

The Council also authorised the Chair to sign the letters of representation from the external auditors and NAO relating to the accounts 2014-2015.

Subsequently, amendments have been made to the letters of representation, as agreed with external auditors and NAO, and reported to the Audit Committee. This is due to non-material overprovision within the accounts for dilapidations on 20 Old Bailey. The Audit Committee has recommended that the amended letters of representation be signed by the Chair and Chief Executive and Registrar.

The Chair is asked to approve the amendment to the Financial Review and the amended letters of representation on behalf of the Council.

Signed Janet Finch (Chair)

Date 28.10.15.

Decision of the Council
26 October 2015
At 23 Portland Place, London W1B 1PZ

Nursing & Midwifery Council

Decision by correspondence

NMC/15/86 **Proposal to make the Nursing and Midwifery Council (Fitness to Practise) (Education, Registration and Registration Appeals) (Amendment No. 2) Rules Order of Council 2015.**

1. On 19 October 2015 a notice was circulated:

   (a) attaching a report recommending that the Council make the Amendment Rules that will give effect to the Council's policy decisions of 8 October 2015 regarding new English language requirements for registration with the NMC and in relation to fitness to practise and a copy of the Nursing and Midwifery Council (Fitness to Practise) (Education, Registration and Registration Appeals) (Amendment No. 2) Rules Order of Council 2015;

   (b) advising the Council that it had the power to decide matters by correspondence, in accordance with procedure set out in the Standing Orders;

   (c) inviting Council members to respond by noon on 26 October 2015 indicating whether or not they approved the recommendation.

2. The Council's decision as at noon on 26 October 2015 was to approve the recommendation and make the Nursing and Midwifery Council (Fitness to Practise) (Education, Registration and Registration Appeals) (Amendment No. 2) Rules Order of Council 2015.

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

Signed: Janet Finch Date: 28.10.15.

Item 16
NMC/15/101
25 November 2015

Council

Welsh Language Scheme Annual Report 2014 - 2015 and Standards

Action: For information.

Issue: Provides the NMC's Welsh Language Scheme Annual Report 2014 – 2015 and the proposed schedule for the implementation of the new Welsh Language Standards.

Core regulatory function: Supporting functions.

Strategic priority: Strategic priority 4: An effective organisation.

Decision required:

1. Council is asked to note the annual report.
2. Council is asked to note the proposed schedule for the implementation of the new Welsh Language Standards.

Annexes: The following annexes are attached to this paper:

- Annexe 1: NMC Welsh Language Scheme Annual Report 2014 - 2015.
- Annexe 2: The proposed schedule for the implementation of the new Welsh Language Standards

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

Author: Sarah Phillips
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Sarah.phillips@nmc-uk.org

Director: Jon Billings
Phone: 020 7681 5399
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Context:

1 The NMC, as a public body, is subject to the Welsh Language Act 1993 which requires us to:

1.1 Establish the principle that the English and Welsh languages should be treated on a basis of equality in the conduct of public business.

1.2 Facilitate the use of the Welsh language.

2 In 2011, the Welsh Government introduced the Welsh Language Measure, which granted the Welsh language official status in Wales and established the office of the Welsh Language Commissioner (The Commissioner). It also announced that schemes, such as the NMC's, would be replaced by the new statutory Welsh Language Standards (the Standards).

Discussion:

The Welsh Language Scheme Annual Report 2014 – 2015.

3 This is our third Welsh Language Scheme annual report. The report covers the period of 1 April 2014 to 31 March 2015 (annexe 1) which was specified by the Commissioner. The format of the report is specified by the Commissioner.

4 The report highlights that we need to increase our focus on Welsh language implications, especially in preparation for the implementation of standards.

5 Close engagement with the Commissioner and professional healthcare regulators in England and Wales was an important step forward in this regard. Taking further steps to embed the Standards will continue to be our focus in 2015 onwards.

6 After submission to the Council, the report will be translated into Welsh and submitted to the Commissioner by the deadline set of 30 November 2015.

7 **Recommendation: The Council is asked to note the Welsh Language Scheme Annual Report 2014 – 2015.**

The proposed schedule for the implementation of the new Welsh Language Standards.

8 The Welsh Language Measure 2011 gives the Commissioner, statutory powers to implement a new set of statutory standards which will replace existing Welsh Language Schemes. The Standards will place a duty on us to ensure that the Welsh language is treated no less favourably than the English language.

9 To understand and assess how the Standards would be applied, the

Commissioner conducted a series of consultations, called investigations. The NMC was subject to investigation round two.

10 The policy team worked with all directorates to coordinate a response, which was agreed by the Director of Strategy, and submitted to the Welsh Language Commissioner on 6 February 2015.

11 A proposed schedule of the implementation of the Standards is at annexe 3 and it is anticipated the Standards will be implemented from 2016.

Recommendation: The Council is asked to note the proposed schedule for the implementation of the Welsh Language Standards.

Welsh Language Commissioner investigation under section 17 of the Welsh Language Act 1993

12 The Commissioner conducted a compliance investigation into the Welsh language implications of the Code for nurses and midwives. The Commissioner found areas of non-compliance and made four recommendations that must be implemented by March 2016.

13 In December 2015, the Director of Strategy will be meeting the Commissioner to discuss the recommendations and their implications.

Resource implications:

14 Resource implications arising from this report relate to the compilation, translation and publication of the report, which are covered within current staffing and budgeting resources. However resource implications may arise from the implementation of the Standards.

Equality and diversity implications:

15 The NMC has adopted the principle that in conducting its public business in Wales, it will recognise both the Welsh and English languages equally. Welsh language considerations are included in our equality analysis toolkit and will continually be reviewed to ensure that our policy development framework is vigorous.

Stakeholder engagement:

16 Officers have engaged with external stakeholders, including with other healthcare and non-healthcare regulators and the Commissioner, in working to ensure the NMC adopts a ‘good practice’ approach in this area.

Risk

17 None arising directly from this report. However, the investigation

implications:		Round Two response report highlighted key areas of possible financial, operational and reputational risk. It also considered the NMC services that could be affected by the Standards. This risk is assessed and monitored through our Strategy's risk register.
Legal implications:	18	As set out in paragraphs 1 and 2.

Item 16: **Annexe 1**
NMC/15/101
25 November 2015

Nursing & Midwifery Council

The Welsh language Scheme Annual Monitoring Report

1 April 2014 – 31 March 2015

Introduction

Our role

1 We are the independent regulator for nurses and midwives in England, Wales, Scotland and Northern Ireland. Our role is to protect patients and the public through the effective regulation of nurses and midwives.

1.1 We set and promote standards of education, training, conduct and performance for nurses and midwives, maintaining and updating the register of those who have qualified and meet those standards.

1.2 We provide guidance to help nurses and midwives maintain and develop their skills and knowledge to uphold our professional standards.

1.3 We investigate and where necessary, deal with nurses and midwives who are alleged to have fallen short of our standards. By doing this, we promote public confidence in nurses and midwives and in regulation.

Welsh language progress

2 In accordance with Section 21 of the Welsh Language Act 1993, we have adopted the principle that, in the conduct of public business and the administration of justice in Wales it will treat Welsh and English equally, as far as is appropriate in the circumstances and reasonably practicable. In January 2011, our Welsh language scheme was approved by the Welsh Language Board.

3 The aim of the annual monitoring report is to summarise our progress in implementing our Welsh language scheme during the period from 1 April 2014 to 31 March 2015. We are pleased to share our progress over the past year.

4 We recognise that it is important that we continue to focus on our role and Welsh language scheme to achieve our high standards. We will continue to engage with the Welsh Language Commissioner to help inform and develop an approach, especially in light of the Commissioner's new standards.

Corporate commitment

5 Members of the Council, the Chief Executive and Registrar, the Strategy and Policy Board, and the Performance and Resources Board, and all staff play a part in delivering our Welsh language scheme.

6 Specific responsibilities include the following:

6.1 The Council is responsible for determining our overall strategy.

6.2 The Strategy and Policy Board, and the Performance and Resources Board are responsible for implementing our strategy and for determining internal

policies and business plans that support the delivery of the Welsh language scheme.

6.3 The Director of Strategy is responsible for coordinating the business planning and for monitoring delivery.

6.4 The Equality and Diversity Steering Group monitors progress against the Welsh language scheme and provides a forum for sharing good practice.

6.5 The Equality, Diversity and Inclusion Manager is responsible for driving forward the agenda and providing support and guidance for individual action owners and our staff.

Progress on implementation

7 A summary report is set out in Annexe one which demonstrates how we are implementing each area of the scheme.

Key actions for the next year

8 Over the next year, we will focus our efforts on:

8.1 Implementing the set of standards;

8.2 Developing stakeholder relationships with healthcare and non-healthcare regulators to share best practice; and

8.3 Improving the accessibility of our new website.

Conclusion

9 We will continue to embed the Welsh language scheme in our day to day activities and raise awareness of our scheme with staff as our work evolves.

10 We will also engage closely and regularly with the Welsh Language Commissioner to ensure the smooth transition of the new set of Welsh language standards.

Annexe one: Summary report of the implementation of the Welsh language scheme from 1 April 2014 to 31 March 2015

New policies and initiatives Number and percentage of new policies and initiatives that were subject to a language impact assessment.	12
Contact with the public Number of publications available to the public. Number of publications available to the public in Welsh.	We usually define documents as being 'for' one audience. We have a small number of publications the primary audience for which is the public, but they are also of use to other audiences. We also have publications which may primarily be of interest to nurses and midwives, but will likely be viewed by the public too, such as the Code. The figure depends on how we define 'the public' as all our publications are available to all audiences. However, we have translated 32 key documents into Welsh.
Complaints Number of all complaints received about the conduct of practitioners in Wales. Number of complaints received in Welsh about the conduct of practitioners in Wales. Number of complaints received about the operation of the Welsh language scheme.	246 The data produced is based on a nurse or midwife who is registered with an address in Wales with the NMC. 0 1
Information technology Percentage of the organisation's website that is available in Welsh. Evidence relating to any plans to	Less than 1 percent. We currently have 1,785 webpages in English. We anticipate to review and improve our

improve or increase the Welsh Language provision on the website. Evidence relating to the process used to ensure that existing content, updates and new content, complies with the requirements of the Welsh language scheme.	Welsh Language provision on a regular basis as we recently launched our new website. As we update the content of our new website, we assess whether documents need to be translated in Welsh and placed visibly on our website.
Publicity Evidence of the methods used to promote the organisation's Welsh language services e.g. telephone services, website, providing evidence etc.	We are committed to offering services in both English and Welsh and promote our Welsh language services through the following methods: **Website** The services offered in Welsh are stated clearly in Welsh on our website. **Telephone services and written communications** We do not have any Welsh-speaking staff members at present, so telephone calls will be offered in English. If nurses, midwives and members of the public wish to communicate in Welsh, they are given the option of continuing the call in English or writing to us in Welsh. Alternatively, nurses, midwives and members of the public can write to us in Welsh, by letter or email. **Complaints** Nurses, midwives and members of the public can make a complaint to us in Welsh, by letter or email. **Meetings** Members of the public who intend to attend our public meetings in Wales are welcome to speak in Welsh, provided that prior notice is given.

	Notices of public meetings in Wales will be bilingual, along with any agendas or minutes. **Hearings** A person will be able to speak at a hearing in Welsh. When we are informed that a registrant or someone connected with their case such as a witness, wishes to speak Welsh, we provide the use of suitably qualified translators. We require 28 days' notice to enable us to do this effectively. **Corporate identity** We have Welsh versions of our logo, corporate identity and letterhead. **Publications** Publications aimed at members of the public are available in Welsh. Our professional standards and guidance are translated upon request. For example, our Code of Practice and the Revalidation guidance are available in Welsh. **Press and advertising** We issue bilingual press releases and statements to the media in Wales where relevant. Translations are provided on request.
Fitness to practise cases Number of hearings held in Wales. Number of hearings where a request was made by the witness to speak Welsh. Number of hearings in which evidence was presented in Welsh.	96 We do not hold definitive records on this and we have no knowledge of any requests being made between 1 April 2014 and 31 March 2015. 1
Language awareness training Number and percentage of the	60%

organisation's new staff (i.e. new since 1 April 2014) who have received training to raise awareness of the Welsh language scheme's commitments. Number and percentage of the organisation's entire workforce who have received training to raise awareness of the Welsh language scheme's commitments.	96 employees attended Equality & Diversity (E&D) training. 159 new starters (permanent) in the period 1 April 2014 and 31 March 2015. 96/159 = 60% 17% 96 employees attended E&D training in period 1 April 2014 and 31 March 2015. 577 employees according to the Individual Personal Development Plan headcount from 1 April and 31 March 2015. 96/577 = 17%

Item 16: **Annexe 2**
NMC/15/101
25 November 2015

The proposed schedule for the implementation of the new Welsh Language Standards

The Welsh Language Commissioner (The Commissioner) will carry out a "Standards Investigation" which will determine what standards should apply to organisations. When carrying out the standards investigation, the Commissioner must consider whether the standards are not unreasonable or disproportionate.

The proposed schedule for the implementation of the Welsh Language Standards being set is:

Standards investigation ends (January 2015) (STAGE HAS BEEN COMPLETED)
The Standards investigation will last for three months.

↓

Standards investigation report to be presented to the Welsh government (May/June 2015) (STAGE HAS BEEN COMPLETED)
After the Standards investigation is complete, the Commissioner will produce a standards investigation report.

↓

Draft regulations and associated document produced (October-November 2015)
During autumn 2015, Welsh ministers will be drafting regulations for participants within round 2 of the standards investigations.

↓

Debate and vote an approval of regulations in National Assembly plenary session (December 2015)

↓

Consult with organisations before giving compliance notice (January –February 2016)
The consultation period will allow the participants to provide information, evidence and/or feedback in regards to the contents of the draft compliance notice, before issuing the final compliance notice to the participants.

↓

Compliance notice to be issued to the organisation (March–April 2016)
The compliance notice will contain information such as confirming the organisation's name, details and the Welsh Language Standards to be complied with.

Item 17
NMC/15/102
25 November 2015

Council

Audit Committee Report

Action: For information.

Issue: Reports on the work of the Audit Committee.

Core regulatory function: Supporting functions.

Strategic priority: Strategic priority 4: An effective organisation.

Decision required: No decision is required.

Annexes: There are no annexes attached to this paper.

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

Secretary: Fionnuala Gill
Phone: 020 7681 5842
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Chair: Louise Scull

Context

1 Reports on the work of the Audit Committee. The Committee met on 28 October 2015.

Audit Committee terms of reference

2 As requested, the Committee reviewed its' existing terms of reference. The Committee is satisfied that these remain appropriate and that no adjustments are needed at this time.

Annual report and accounts 2014-2015

3 The Committee reviewed minor amendments to the letters of representation to the external auditors and National Audit Office (NAO) in relation to the accounts for the year to 31 March 2015. The changes were necessary following confirmation of lower than expected dilapidation charges on vacation of Old Bailey. External auditors were satisfied that the amount was not sufficiently material to re-open the accounts. The Committee agreed to recommend that the Chair and Chief Executive sign the amended letters of representation.

Review of accounting policies and adoption of FRS 102

4 The Committee considered a report on the impact of the new accounting standard FRS 102 on the NMC's accounting policies and the accounts for the year ending 31 March 2016. Key changes include:

4.1 A requirement to disclose the pension deficit in the accounts. The Committee asked management to ensure that a consistent approach is taken to reporting the pension deficit in financial management reports and statutory accounts going forward.

4.2 A requirement to disclose the remuneration of 'key management personnel'. In the interests of full transparency, the Committee considers that disclosure should include remuneration of both permanent and interim Directors.

Fitness to Practise

5 The Committee received an update on work in FTP to look at ways of optimising the various change initiatives underway and inform scoping of an end to end review. The Committee felt that identification of gaps and grouping of key themes were useful steps forward, which, supported by strong management focus should assist in driving forward further efficiencies.

Internal audit annual effectiveness review 2014-2015

6 The Committee discussed the outcomes of the annual review of internal audit effectiveness. The Committee welcomed assurances from both internal auditors and the Executive that issues raised in the review were being addressed, including improved scoping of internal audit reviews to produce more meaningful results for the organisation.

7 The Committee welcomed the proposal by the Executive to extend the contract of the existing internal audit providers for a further 12 months.

Internal audit work programme 2015-2016: progress update

8 The Committee approved revisions to the internal audit programme for 2015-2016 to take account of the further discussions about the focus of internal audit work in finance, procurement and IT. The Committee reviewed and was comfortable with the terms of reference of a proposed thematic review of operational governance processes in these areas. The Committee noted the progress update on work to date and noted that the bulk of the internal audit work will now be conducted in the final two quarters of the financial year.

Corporate Quality Assurance

9 The Committee considered an internal audit review of Corporate Quality Assurance and was disappointed that not as much progress had been made as expected.

10 The Committee also considered a report on a possible change to the future direction of the Corporate Quality Assurance Strategy. In the light of the internal audit findings, the Committee's view is that the organisation is not yet ready for this but should focus first on ensuring the basics of quality assurance are well embedded before considering more ambitious approaches.

Public protection implications:

11 No public protection implications arising directly from this report.

Resource implications:

12 No resource implications arising directly from this report.

Equality and diversity implications:

13 There are no direct equality and diversity implications resulting from this paper.

Stakeholder engagement:	14	None.
Risk implications:	15	There are no risk implications arising directly from this report.
Legal implications:	16	None identified.

Item 18
NMC/15/103
25 November 2015

Council

Midwifery Committee report

Action: For information.

Issue: This paper provides Council with an overview of the work of the Midwifery Committee since the last report in July 2015.

Core regulatory function: All regulatory functions

Strategic priority: Strategic priority 1: An effective regulator.

Decision required: No decision is required.

Annexes: None.

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

Secretary to the Midwifery Committee: Jennifer Turner
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Chair: Dr Anne Wright

Context:

30 September 2015 Extraordinary meeting

Report on the North Wales Extraordinary Review

1. The Committee discussed the draft reports produced as a result of the review, and was satisfied that they had captured the concerns in detail. Many of the themes arising from the review were not within the NMC's control such as the culture and behaviours displayed in the organisations under review.

2. At the date of the meeting, the NMC was still developing the actions required for change. The Committee requested that the NMC escalate the issues to an appropriate level in the University to ensure that priority was being given to the improvement of the education programmes. This is being addressed with the Vice Chancellor of the University.

3. The reports were published by the NMC on 26 October 2015.

29 October 2015 meeting

Midwifery regulation change: Update paper

4. The Committee considered the first progress report on the work done towards midwifery regulation change. The Committee received a detailed presentation which covered the proposed route map, a preliminary timeframe, the consultation which had taken place with partners and stakeholders, and an outline of the communication and engagement plan. The Committee noted that the timeframe was dependent on other stakeholders, particularly the Department of Health.

5. The Committee individually reviewed each of the proposed amendments to the Nursing and Midwifery Order 2001, and the Midwives Rules and Standards 2012.

6. In particular, the Committee noted that the protected title and function of a midwife, and the scope of practice, would not change.

7. The Committee was clear that this picture needs to be effectively communicated to the midwifery community, and noted that a communication plan and engagement strategy is being developed.

8. The Committee is aware that midwives are concerned about their functions being delegated to other workers, but the Committee noted that this is not a result of the proposed legislative changes.

9. The Committee will monitor the risks associated with this transition through a risk register which will be discussed at future meetings.

The context for pre-registration midwifery education standards

10. The Committee is supportive of the proposals to separate the standards into those for education institutions, and those for student nurses and midwives. The Committee provided suggestions for concepts of particular importance which should be considered for inclusion in the new standards, such as those relating to flexibility, values, communication skills, and new models of care.

Draft Annual Report on the quality assurance of education and local supervising authorities (2014-2015)

11. The Committee discussed the draft annual report (which is on the Council open meeting agenda). In relation to education, the Committee noted that in some cases the learning environment was found to be inadequate due to a lack of resources, mentorship, and placement capacity.

12. Regarding the Local Supervising Authorities, the Committee noted some issues around failure of midwives to escalate concerns and a shortage of supervisors of midwives, and the importance of ensuring compliance during the legislative change transition period.

13. The Committee endorsed the content of the report for the Council's approval.

Schedule of business for 2016-2017

14. The Committee agreed that the focus of future meetings would be in four main areas:
    - 14.1. Midwifery regulation change
    - 14.2. Data relating to midwifery issues that may help to inform the Committee
    - 14.3. Update on revalidation
    - 14.4. The context for pre-registration midwifery education standards

Public protection implications:

15. No public protection implications.

Resource implications:

16. No resource implications.

Equality and diversity implications:

17. No direct equality and diversity implications.

Stakeholder engagement:

18. None.

Risk implications:	19.	None.
Legal implications:	20.	None identified.