

Response to the Nursing and Midwifery Council consultation on a draft revised Code and proposed approach to revalidation

August 2014

1. Introduction

- 1.1 The Professional Standards Authority for Health and Social Care promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament. More information about our work and the approach we take is available at www.professionalstandards.org.uk.
- 1.2 As part of our work we:
- Oversee nine health and care professional regulators and report annually to Parliament on their performance
 - Conduct research and advise the four UK governments on improvements in regulation
 - Promote right-touch regulation and publish papers on regulatory policy and practice.
- 1.3 We responded to the first part of this consultation in March 2014 (our response can be found at Annex 1). We were supportive of the use of the Code as a basis for the continuing fitness to practise scheme, because this means it will focus both on competence and on conduct. However, we had concerns about the basis on which these proposals had been developed and the lack of detail in the documents made available for this consultation.
- 1.4 We therefore welcome the opportunity to respond to the follow-up consultation which covers further proposals for revalidation as well as the new draft Code.
- 1.5 We have not used the online form for this response as we found the questions too restrictive for our purposes. In general, we consider it good practice to include more open questions for a consultation of this type than were available here. This encourages more comprehensive feedback and enables those consulting to get the full benefits of the views and expertise of respondents.

2. Comments on the draft *Standards of conduct, performance and ethics for nurses and midwives*

- 2.1 In July 2013, the Nursing and Midwifery Council (NMC) commented in its response to the Francis Report¹ that it would be revising its *Standards of conduct, performance and ethics*, and we support this decision. Nurses were

¹ NMC, July 2013. *NMC response to the Francis Report*. Available at: <http://www.nmc-uk.org/Documents/Francis%20report/NMC%20response%20to%20the%20Francis%20report%2018%20July.pdf>. Accessed 13/08/14

found to have been deeply implicated in some of the recent high-profile failings in health and social care, including at Mid-Staffordshire NHS Foundation Trust and Winterbourne View. The current Code, which has been in use since May 2008, undoubtedly needs reviewing to address some of the professional deficiencies identified in these events.

- 2.2 It would have been helpful if the NMC had provided more background information as part of the consultation documents, as currently the consultation materials give only a very brief explanation of how the Francis findings and recommendations may have influenced this new draft.
- 2.3 We agree that the Code needs to be revised to support revalidation, but precisely how this draft will do this is not clearly explained.

Length and tone of the Code

- 2.4 In our view, one of the strong points of the current Code is its conciseness: the shorter it is, the easier it should be to memorise and follow. NHS staff are required to work within a plethora of guidelines and codes, as evidenced by research by *Carthey et al* published in 2011. They found over 3,000 guidelines on the Department of Health website and a further 1,000 on the NICE website, and concluded that: “[the] extraordinary and uncoordinated proliferation [of clinical guidelines] in the NHS confuses staff, causes inefficiencies and delay, and is becoming a threat to patient safety.”²
- 2.5 In light of this, we question the rationale for replacing the current eight pages with a twenty-page code and a further seven pieces of guidance. This is a significant change to the nature of the Code, which we feel should at the very least be explicitly acknowledged and explained.
- 2.6 Inevitably, in a code of this length, the requirements are numerous and detailed: in our view, this draft is too prescriptive. The risk inherent in providing such a detailed set of standards is that gaps are likely to become apparent over time, and they will therefore require constant updating. A code based on more high-level statements can more easily address all the relevant areas, and is more resilient to future changes in policy focus.
- 2.7 In addition, a very prescriptive set of statements leaves little room for a nurse or midwife to exercise professional judgement, thereby reducing the opportunities for professionalism to thrive.
- 2.8 This problem is exacerbated by the tone of the document with the repetition of the phrase ‘you must’ at the start of each statement. It is important that nurses and midwives take ownership of this Code, and we suggest that a different tone could encourage greater engagement by registrants. *Good Medical Practice*³ uses both ‘you must’ and ‘you should’. The former expresses an overriding principle; the latter is used to explain how this duty should be met, or if the duty does not apply in all situations. Another way to change the tone could be to use

² Carthey J, Walker S, Deelchand V et al. 2011. *Breaking the rules: understanding non-compliance with policies and guidelines*. 2011; 343: d5283.

³ General Medical Council. April 2013. *Good Medical Practice*. Available at: http://www.gmc-uk.org/guidance/good_medical_practice.asp. Accessed 13/08/14

the first person: 'I will' (instead of 'you must') expresses a clear personal commitment to the code.

Focus on patients and structure of the Code

- 2.9 We welcome the renewed emphasis on patients and the public. Sir Robert Francis QC, in his report on the failings at Mid-Staffordshire NHS Foundation Trust, identified the lack of focus on patients and their welfare as one of the main causes of the tragedy.
- 2.10 We do, however have some queries about the way in which this emphasis takes shape in the draft. Firstly, we were unclear about the status of the opening section on patient and public expectations. Its structure is not echoed elsewhere in the document and it is not clear whether or how registrants would be expected to comply with it. Perhaps the Code in its entirety could serve to illustrate to the public what they can expect of a nurse or midwife. Another option would be to link each patient expectation to a section of the Code. In this way, the opening section could be used to introduce the structure of the rest of the document.
- 2.11 Building on these suggestions, the Code could perhaps be presented as a commitment by registrants to their patients – rather than to the regulator, with patients referred to mainly as passive recipients, which is how it reads at present.
- 2.12 Given the intention to bring patients to the fore, it is also disappointing to us that '[upholding] the reputation of your profession' comes before '[making] the care and safety of people in your care your first concern' in the list of objectives on page 8, and again in the sections on pages 9 and 10. We see the value of a reference to 'upholding the reputation of the profession', which is well established as one of the three objectives of professional regulation, however we are aware that this term could be misconstrued by members of the public as a requirement to maintain the reputation to the detriment of everything else, including patient welfare. As the draft code already suggests, the welfare of patients *must* be the primary concern for all healthcare professionals, and this should be more clearly reflected in the document's structure.
- 2.13 Page 8 refers to a 'principal duty' and five underpinning 'aspirations'. The term aspiration is defined in the Oxford English Dictionary⁴ as 'a hope or ambition' – we are puzzled by its use in a regulatory Code, which sets the minimum standards which all registrants should be in a position to meet. Perhaps a more appropriate term might be 'duty', or 'commitment'.
- 2.14 These aspirations are then used as the headings for the rest of the code with various sub-headings under them. This structure implies that the purpose of each of the paragraphs or standards is to achieve the aspiration under which they are listed. We found however, that many of the paragraphs were relevant to several of the 'aspirations', in particular to '[making] the care and safety of people in your care your first concern' – suggesting, perhaps, that this should be the principal duty. We also found that the headings resulted in a certain

⁴ 'Aspiration'. In Catherine Soanes and Angus Stevenson (ed). 2006. *Concise Oxford English Dictionary, 11th Edition*. Oxford University Press.

amount of repetition of themes across the individual standards. For example the topic of raising concerns appears within both the 'Raising concerns' (paras 63-67) and 'Managing risk' (para 68) sections under 'Work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community'; and in 'the Duty of Candour' (para 4) section under 'Uphold the reputation of your profession'. The language used differs across these different paragraphs, which could lead to confusion about what is expected of registrants.

Specific comments

2.15 While we do not have the technical expertise to comment in detail on the content as it relates to nursing and midwifery, we do have a number of comments and questions about the clarity and consistency of specific parts of the Code, to add to the points from the previous paragraphs.

- **Title:** we note that the term 'good' has been used in the title at the top of page 8 (but not on the front cover of the draft). What is the purpose of this addition?
- **Duty of Candour:** last year the Department of Health sought the Authority's advice on what more professional regulators could do to encourage health and care professionals to be candid with patients. The advice we provided identified that there were four aspects to a professional's candour responsibilities:
 - Recognising that harm has occurred or may have occurred
 - Proactively informing the patient or service user about what has happened (regardless of whether a complaint has been made or a question asked about it)
 - Offering an appropriate remedy and support
 - Supporting peers when they need to be candid and to play an active role in creating a climate where professionals feel able and supported to be candid.⁵

Only some of these are reflected within the draft NMC Code: the second is addressed by both paragraphs 4 and 105, and the third aspect is partially covered by paragraph 104. We suggest that consideration is given to how the Code could better reflect all of the above. Paragraphs 4, 104 and 105 could perhaps be improved by clearer drafting and combining them into one.

Also, if the word 'candour' is retained in paragraph 4 we suggest it would be clearer and carry more weight if its intended meaning in this context were defined within the main text, rather than in the glossary as it is at present. Paragraph 4 currently reads as if the professional duty of candour requires professionals to be open and apologise only when a complaint is made,

⁵ Professional Standards Authority. October 2013. *Can professional regulation do more to encourage professionals to be candid when healthcare or social work goes wrong? Advice to the Secretary of State for Health, paras 7.1-7.3.* <http://www.professionalstandards.org.uk/library/document-detail?id=c376579e-2ce2-6f4b-9ceb-ff0000b2236b>

whereas the Francis definitions of candour⁶ refer to the ‘volunteering of relevant information’ and ‘an appropriate remedy being offered’ (which may well include an apology).

- **The fundamentals of basic care:** this terminology, which is used in paragraph 27, may suggest to some a link with the Care Quality Commission’s fundamental standards of quality and safety⁷. The NMC may wish to amend the wording or make any intended links explicit.

As lay commentators, we would like to see a greater emphasis on patients’ emotional and mental health needs, as separate from psychological needs, in paragraphs 25 and 27. In the events at Stafford Hospital, a disregard for emotional wellbeing went hand-in-hand with the failure to look after people’s basic physical needs.

- **Conscientious objection:** paragraphs 32 and 34 appear to us to be contradictory. Conscientious objection is a complex and controversial topic. A balance needs to be struck between the duty to provide care without discrimination and a professional’s right to exercise conscience by refusing to provide certain treatments or services (such as contraception or abortion). Perhaps the overarching principle here should be that the personal views of a health professional should never interfere with the availability of healthcare services for a particular patient.
- **Maintaining financial boundaries:** we suggest that paragraph 41 could be brought into 40. In addition, paragraph 42 could include a reference to financial boundaries.
- **Ending a professional relationship:** (para 43) when professional (including sexual) boundaries have been violated, it is entirely possible for a nurse or midwife to continue to administer good and safe *clinical* care while causing other types of harm, particularly emotional. It may also be necessary to end a professional relationship when the nurse or midwife is at risk.
- **Raising concerns:** in paragraph 63, it might be helpful to describe what type of action is expected of registrants – perhaps by merging this statement with paragraph 66. Paragraphs 64 and 67 could be matched with a more positive statement about supporting colleagues and patients to raise concerns.

In paragraph 65, what is meant by ‘if it is within your remit’? Perhaps the phrase ‘within your powers’ would be more fitting.

- **Managing risk:** paragraph 68 appears to duplicate some of the statements under the ‘Raising Concerns’ section on pages 14 and 15. In addition, we do not consider paragraph 71 to be a necessary addition to the Code. We would expect a Code to include a general statement about practising within

⁶ *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, chaired by Robert Francis QC 2013. (see paragraph 1.176 of the Executive Summary and paragraph 22.2 of Volume III). Available at: <http://www.midstaffpublicinquiry.com/report>. Accessed 13/08/14

⁷ For more information see <http://www.cqc.org.uk/content/our-fundamental-standards>. Accessed 13/08/14

the limits of one's skills and knowledge, but this statement seems overly cautious and may deter some registrants from taking appropriate, and perhaps essential, action in an emergency.

- **Keeping knowledge and skills up to date:** we understand that this section (p16) needs to include reference to the forthcoming revalidation scheme. However, we question whether the Code needs to include the detail relating to the proposed revalidation requirements that are covered in paragraph 77 – the statements in paragraph 76 seem to us to address this requirement. Not only does 77 add unnecessary detail, it also ties the NMC to a revision of the Code if it should seek to change its revalidation requirements.
- **Acting with integrity:** (p18) we recommend that this section includes a reference to dealing with conflicts of interest. This has become particularly relevant since the introduction of Clinical Commissioning Groups, the governing bodies of which must include a registered nurse. This person may have a vested personal and/or financial interest in a particular provider.

3. Comments on the proposed revalidation model

- 3.1 In our response to part 1 of the revalidation consultation (Annex 1), we expressed concerns about the lack of detail made available about the revalidation proposals. The information published as part of this consultation addresses a small number of these concerns, mainly in relation to the requirements on the registrant (paragraphs 4.4 and 4.5 of our response), however most remain.
- 3.2 We would like to raise some further queries about confirmation, appraisal, feedback, and continuing professional development (CPD), based on this new information.
- 3.3 One of the key challenges for the NMC is to design requirements that everyone on the register is in a position to meet. How will the proposals for confirmation and feedback work for non-clinical and/or non patient-facing roles? How will they apply to locum and bank staff? We understand that the consultation itself may help the NMC to answer these questions, however, it might have been helpful to include an acknowledgement of these challenges in the consultation document.
- 3.4 Further comments relate to specific aspects of the proposals.
 - **Confirmation:** perhaps the NMC could clarify what constitutes *familiarity* with a person's practise – how much exposure to a registrant's practice, and of what kind, does a person need in order to be able to comment on their compliance with the Code?

Under what circumstances might a confirmer be liable for a problematic confirmation? What would this mean for them?
 - **Appraisal:** we welcome the use of external mechanisms for confirmation, but we caution against placing too much reliance on existing appraisal systems – the NMC can no doubt learn from the GMC's experience in this

area. We would expect the consultation document to include some information about the quality and spread of existing appraisal systems. Employers will need to be supported to develop robust appraisal systems that focus on continuing compliance with the NMC Code, as this will undoubtedly require a shift from the current use of appraisals as a performance management tool.

- **Feedback:** as mentioned in our response to part 1 of the consultation (paragraph 4.5), the NMC could look to the work carried out by other regulators on how registrants can provide evidence of reflection and improvement. The General Dental Council and General Osteopathic Council have both done work on learning cycles that could be useful here.

We would like to know how the NMC proposes to verify (in audit) a registrant's feedback portfolio if feedback is received verbally.

Finally, we suggest that the NMC could take a stronger line on patient input, which is a valuable, if not essential source of feedback: it is reasonable for the NMC to expect the large majority of its registrants to have some patient contact and therefore to be able to provide patient feedback. Registrants who are not in patient-facing roles could be asked to explain any deviations from this.

- **CPD:** again, the work by other regulators on learning cycles could be of use here, as a way for registrants to demonstrate the value of their CPD activities. We are encouraged to see a requirement for participatory learning to combat professional isolation. We would be interested to know more about how the NMC would want CPD to be evidenced, particularly for these participatory learning activities.

3.5 For further comments, we refer to our response to part 1 of the consultation on revalidation which appears at the end of this document.

4. Further information

4.1 Please get in touch if you would like to discuss any aspect of this response in further detail. You can contact us at:

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ANNEX 1: Response to the NMC consultation on revalidation

March 2014

1. Introduction

- 1.1 The Professional Standards Authority for Health and Social Care promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament. More information about our work and the approach we take is available at www.professionalstandards.org.uk.
- 1.2 As part of our work we:
- Oversee nine health and care professional regulators and report annually to Parliament on their performance
 - Conduct research and advise the four UK governments on improvements in regulation
 - Promote right-touch regulation and publish papers on regulatory policy and practice.
- 1.3 We welcome the opportunity to respond to this consultation on the NMC's plans for revalidating nursing and midwives. This is an important aspect of the regulator's role that we have consistently recommended the NMC needs to develop in our annual Performance Reviews.⁸ Our *Standards of Good Regulation* stipulate that '*through the regulator's continuing professional development/revalidation systems, registrants maintain the standards required to stay fit to practise*'.⁹ Good regulation should assure the public that '*those who are registered have and/or continue to meet the regulator's standards*'.
- 1.4 Because of the current uncertainty over the future of the legislative framework underpinning the regulation of health professionals in the UK and social workers in England, now is a difficult time for any of the regulators we oversee to be planning major regulatory change.¹⁰ We therefore understand the need for the NMC to consider two distinct phases of reform in which the first could be introduced without having to amend legislation. The proposals on which the NMC is consulting here form the first part of a two-phase process of reform and would operate within the organisation's current legislation, while the second

⁸ See <http://www.professionalstandards.org.uk/search-results?indexCatalogue=site%2Dindex&searchQuery=%22performance+review%22&wordsMode=0>

⁹ Professional Standards Authority, June 2010. *The Performance Review Standards, Standards of Good Regulation*. Available at: <http://www.professionalstandards.org.uk/docs/scrutiny-quality/120720-the-performance-review-standards-%28updated%29-psa-version.pdf?sfvrsn=0>

¹⁰ The Law Commission is currently reviewing the legislation underpinning the nine regulators we oversee, and is due to publish a draft Bill on 2 April 2014:

http://lawcommission.justice.gov.uk/areas/Healthcare_professions.htm

phase, which is not discussed in any detail in the consultation documents, would require legislative change. In its consideration of the revalidation strategy in September 2013¹¹, the NMC's Council determined that options for this phase should be reconsidered following the implementation of Phase 1.

- 1.5 We note that the NMC has used the term 'revalidation' to describe their proposals. In our paper on the subject¹², we explain that the term 'revalidation' describes just one of many possible ways of assuring the continuing fitness to practise of health and care professionals. Further consideration may need to be given as to whether this process is proportionate and risk-based, and meets public and employer expectations around revalidation, which are likely to have been shaped by the GMC's model.
- 1.6 We support the use of the NMC Code as a basis for the continuing fitness to practise scheme, as this should result in a focus not only on competence but also on conduct, which is an important aspect of professional standards. This is in line with the recommendations we made in our report.¹³
- 1.7 However, we have concerns about the basis on which these proposals have been developed and the lack of detail in the documents made available for this consultation.

2. Questions about risk analysis

- 2.1 In *Enabling Excellence*¹⁴, the Government explained that the non-medical regulators should '*continue to develop the evidence base that will inform their proposals for revalidation*'. Our own paper on continuing fitness to practise¹⁵ put forward as a general principle that regulators should develop '*a clear understanding of what professionals do, and of the context in which they do it*' so that they can design their regulatory response to mitigate the risks presented. We also stated in this report that in the interests of transparency, regulators should be clear about what lies behind a decision about how much and what type of regulatory force is needed to mitigate identified risks.
- 2.2 We note that the Department of Health provided a grant of £189,000 to the NMC in 2010-11 to develop a risk-based framework, in addition to other monies. Our 2011-12 and 2012-13 Performance Review reports urged the NMC to look more closely at the risk profile of its own registrant base with respect to revalidation, so we would have expected to see some evidence that the NMC's

¹¹ Minutes of NMC Council meeting 12 September 2013, available at [http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2013/Council%20papers%20-%20OPEN%20November%202013%20\(PDF\).PDF](http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2013/Council%20papers%20-%20OPEN%20November%202013%20(PDF).PDF)

¹² CHRE, November 2012. *An approach to assuring continuing fitness to practise based on right-touch regulation principles*. Available at: <http://www.professionalstandards.org.uk/library/document-detail?id=69393f02-d5a3-4ae0-a1bb-a7b437dc3485>

¹³ See footnote 5.

¹⁴ HM Government, February 2011. *Enabling Excellence: Autonomy and Accountability for Health and Social Care Staff*. Available at: <https://www.gov.uk/government/publications/enabling-excellence-autonomy-and-accountability-for-health-and-social-care-staff>

¹⁵ See footnote 5.

proposals were based on an analysis of the types, severity and prevalence of the risks presented by nurses and midwives.

- 2.3 The single model the NMC is proposing does not take account of the diversity of the register, despite this diversity having been highlighted in an NMC Council paper as a risk: '*revalidation not [being] fit for purpose due to the great diversity of NMC register, great size and complexity in settings and scope of practice*'.¹⁶ In our view, not only is a risk-based approach necessary to ensure the proposals are fit for purpose, it would also allow the NMC to target more of their resources on groups who present higher risks, such as midwives.
- 2.4 This type of risk analysis might also have provided a sense of the NMC's aims for revalidation, and therefore of the part that each of the two phases in the implementation model might play in achieving those aims. As such it is difficult to understand how the NMC will evaluate the success of its proposals.

3. Questions about resources and impact

- 3.1 The consultation documents predict that the direct financial cost to the NMC of the proposals will reach £4.413 million for the introduction of the scheme, with a further £1 million per year of ongoing costs. It would have been helpful to see a breakdown of the calculations underpinning these figures.
- 3.2 The impact of introducing revalidation on the NMC's operations – how resources might need reallocating across different regulatory functions, and what additional work the introduction of revalidation might create for the NMC – merits serious consideration. We anticipate that the registration team will be under increased pressure not only with tasks relating directly to revalidation, but also with re-registration applications from those who have 'lapsed' from the register through revalidation.
- 3.3 In addition, evidence from the GMC¹⁷ suggests that the number of fitness to practise referrals from employers increased in the run-up to the introduction of revalidation for doctors – a similar increase could be anticipated for nurses and midwives, and be planned for. The NMC's scrutiny of revalidation evidence submitted by registrants could also lead to a more sustained increase in the number of fitness to practise (FtP) referrals, putting further demands on the FtP function. It would be helpful to understand how the NMC will prepare for such an impact on their operations. The FtP function is already under much pressure,

¹⁶ NMC Council Paper, 12 September 2013. *Draft Revalidation Strategy*. Available at: <http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2013/Council%20papers%2012%20September.pdf>

¹⁷ In *The State of Medical Education and Practice in the UK 2013* (General Medical Council, October 2013), the GMC reported an increase by two-thirds, between 2007 and 2012, of complaints from employers leading to a GMC investigation, which they suggested could be attributed in part to employers anticipating the introduction of revalidation. This report is available at: <http://www.gmc-uk.org/publications/23435.asp>. Accessed 18/03/14.

as illustrated by the Health Committee's statements about the backlog of cases in its report of the NMC Accountability Hearing in 2013.¹⁸

- 3.4 The consultation paper lacks any consideration of the compliance costs or broader impact on employers, the workforce, and the provision of care. The resources required for nurses and midwives to complete their own revalidation activity, in addition to the work involved in third party confirmation and feedback, should be carefully evaluated and costed. It is worth noting that recent research published by the Department of Health Revalidation Support Team found that revalidation was taking doctors longer than had been anticipated.
- 3.5 A further impact will come from those who, under the proposals, are '*not able to revalidate*'¹⁹ and therefore lapse from the register. This could make large numbers of nurses and midwives unable to practise because they are no longer registered. This wider risk, which is directly linked to the proposal to allow those who 'fail' revalidation to lapse from the register, needs to be carefully evaluated and planned for by employers and service providers.

4. Questions about the revalidation process

- 4.1 In addition to the above, we are concerned that some vital questions about this scheme remain unanswered at this stage of the development process.
- 4.2 We have attempted in the figure at Annex A to represent, in the form of a graphic, a generic continuing fitness to practise model. This is based on the various models that have been developed or are currently in development among the regulators we oversee. The following points in our response are made with reference to the numbers in this graphic.

Length of cycle (1)

- 4.3 The NMC is proposing a three-year cycle. While we understand that this cycle has been chosen to fit with the current renewal legislation, the absence of any proper discussion of the optimal cycle length based on an evaluation of risk makes it difficult to comment. It also opens the NMC up to criticism and inevitable comparisons with the GMC, whose cycle is two years longer for a profession that is arguably higher risk.

Continuing fitness to practise requirements on the registrant (2)

- 4.4 These requirements are set out in the consultation documents but they lack detail. The NMC will require the nurse or midwife to have sought and received third party feedback (from '*patients or peers, etc*'), which should have informed their reflection on their practice, and third party confirmation (from '*employers where applicable*') that they are fit to practise. This raises a number of key questions:

¹⁸ House of Commons Health Committee, December 2013. *2013 Accountability hearing with the Nursing and Midwifery Council*. TSO.

¹⁹ We discuss the question of what might constitute 'failure to revalidate' in paragraph 4.14 below.

- Who will be eligible to provide third party feedback and third party confirmation?
- How will the NMC make sure that the system functions for all job settings while providing comparable evidence of continuing fitness to practise for all registrants?
- How will the NMC ensure that feedback and confirmation are reliable? For example, a line manager may be reluctant to provide negative feedback for their own staff for fear that it might call into question their own competence as a manager. Peers may also be unwilling to be critical of each other
- Will registrants be required to demonstrate that the third party feedback has informed reflection on their practice (as is suggested in the description)? If so, how? If not, what is the value of the third party feedback?

4.5 Without answers to these important questions, it is difficult to comment further. The NMC could perhaps turn to some of the work carried out by the other regulators to help with the detail. For example, some (GDC, GOsC) are looking at the learning cycle (practice, analysis/feedback, reflection, application, improved practice) as a tool for self-reflection and self-reporting for continuing fitness to practise. This could perhaps be of use to the NMC in thinking about how registrants might demonstrate that third party feedback has informed their practice.

Submission requirements and method of submission (3)

- 4.6 It is not clear from the NMC proposals what information it will require registrants to submit for the revalidation audit, nor how they will be required to submit it.
- 4.7 As we commented in our paper on lapsed registration²⁰, the NMC is one of the few regulators not to offer online renewal of registration. Confirmation by the registrant that they have met the continuing fitness to practise requirements, which will be included as part of the renewal process, and subsequent submission of evidence will presumably have to be made via a new process. The NMC is working to a relatively ambitious timetable, and the operational details needs to be considered at an early stage in order to assess the viability of the proposals.
- 4.8 There is also the question of how long registrants will be given to submit their evidence once they have been selected. The system will need to allow for the possibility that registrants may, for entirely legitimate reasons, such as being away on holiday or not in work, not be in a position to respond immediately to the request for further information.

Sampling (A)

- 4.9 The NMC is proposing only to require evidence that the revalidation requirements have been met from a sample of registrants. Although the

²⁰ Professional Standards Authority for Health and Social Care, August 2013. *Lapses in professional registration: Impact, issues, and ideas for improvement*. Available at: <http://www.professionalstandards.org.uk/docs/psa-library/130802-lapsed-registration-final.pdf?sfvrsn=0>

consultation documents explain that the sampling will be partly random and partly risk-based, questions about how the risk-based sample will be chosen, what the ratio of random to risk-based will be, and how large the overall sample will be remain unanswered (see section 2 above).

Scrutiny process and threshold for pass, pass with remediation and fail (4)

- 4.10 The consultation documents contain little detail about how submissions will be scrutinised, in particular we would have liked to understand:
- a) What standards submissions will be assessed against
 - b) What will constitute a pass (renewal) and a fail (lapse)
 - c) The procedure for making decisions about a registrant's continuing fitness to practise, and
 - d) How these decisions will be quality assured.
- 4.11 The Code is currently being revised, and we understand that as a result the NMC is unable to set out in any detail which standards registrants will be assessed against. It is difficult to comment on the overall value of the proposals when such a core component is yet to be determined. It would be helpful to understand more about, and have the opportunity to comment on (a) and (b) above.
- 4.12 The effectiveness of the framework for decision making will determine whether or not the procedure picks out those registrants who are failing to meet the standards – again we would have liked to see more detail on this element of the framework ((c) and (d)) which, unlike (a) and (b), is not dependent on the content of the Code.

Response to non-submission (5) and failure to meet the standards of continuing fitness to practise (6)

- 4.13 Once the NMC has requested the submission of a portfolio by a registrant, there are two possible negative outcomes:
- The registrant fails to engage with revalidation (5), or
 - The registrant engages but does not meet the standards (6).
- 4.14 The consultation paper states that *'if a nurse or midwife is not able to revalidate, they will lapse from the register'*, but is not clear whether this is intended to capture scenario 5, scenario 6, or both. We would hope to see different responses to each of these to ensure that:
- The reason for which a registrant is no longer registered is properly recorded and publicly available where appropriate
 - The regulatory action taken is proportionate to the risks presented, while ensuring that the public is protected.
- 4.15 The GMC, for example, will defer a doctor who has not met the standards, but will not renew the licence of a doctor who has not engaged in the revalidation process.

- 4.16 The NMC's proposed approach presents a particular problem for situations in which registrants show signs of falling just short of the standards expected of them, but do not meet the threshold for a fitness to practise referral. In these situations, the NMC can either keep them on the register and take no further action or allow them to lapse. The former fails to protect the public while the latter is disproportionate and could have a serious impact on the workforce and provision of care (as discussed in paragraph 3.5 above). There is no third option of continued registration with remediation (8). It is also unclear what the NMC's policy would be for registrants applying to return to the register having lapsed under these circumstances.
- 4.17 The NMC may be constrained by its legislation at present, but an indication that it is aware of the problem and working towards both short and longer-term solutions would be helpful.

Opportunities and criteria for fitness to practise referral (7)

- 4.18 There are several points in the revalidation process when the NMC could identify concerns about a registrant that meet the threshold for referral to the fitness to practise function. While the criteria for referral through revalidation should be no different to the criteria for concerns that arise from other routes, it would have been helpful if the NMC had explained the points at which such concerns will be likely to arise and the sorts of situations that might trigger a referral.

Appeals (9)

- 4.19 The consultation document is silent on the matter of appeals for registrants who have been removed through the revalidation process. We assume that there will be no change to the right to appeal against a decision made about renewal of registration, nor to the procedure in place. However, the introduction of the revalidation process, which involves subjective, judgement-led decision making on the part of the NMC, may result in a qualitative change to the grounds on which renewal appeals are based. The number of appeals is also likely to increase significantly, and we would like to hear more from the NMC about how they are preparing for these changes.

5. Conclusion

- 5.1 Through our *Standards of Good Regulation*, we seek assurance that the regulators we oversee have the means of ensuring their registrants remain fit to practise.²¹ As the NMC's proposals stand, we feel they raise more questions than answers, and as a result we cannot state with any confidence that they will provide this assurance. There is much still to be done to fill in the essential detail of the plans, and the NMC has set itself a challenging timetable, which we

²¹ Professional Standards Authority, June 2010. *The Performance Review Standards, Standards of Good Regulation*. Available at: <http://www.professionalstandards.org.uk/docs/scrutiny-quality/120720-the-performance-review-standards-%28updated%29-psa-version.pdf?sfvrsn=0>

hope will not impede the quality of either the development work or implementation.

- 5.2 The consultation survey will collect the views of a range of stakeholders, but we hope that the NMC will also develop the robust evidence base, particularly around risk, which appears to be lacking currently. If developing this evidence base is not possible within the timescales set for Phase 1, it should become the cornerstone of the strategy for Phase 2.
- 5.3 In addition, there is a lot to be learnt from the sizable body of research and development work carried out by the other regulators we oversee on the topic of continuing fitness to practise, and we feel that the NMC could benefit from exploring this valuable resource.

6. Further information

- 6.1 Please get in touch if you would like to discuss any aspect of this response in further detail. You can contact us at:

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ANNEX A: Figure – a graphic representation of the continuing fitness to practise (CFtP) process

