



Health Committee

Oral evidence: 2013 accountability hearing with the Nursing and Midwifery Council

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Written evidence from witnesses:

- [Nursing and Midwifery Council](#)

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Members present: Mr Stephen Dorrell (Chair); Rosie Cooper; Andrew George; Barbara Keeley; David Tredinnick; Valerie Vaz; Dr Sarah Wollaston

Questions 1–100

Witnesses: **Mark Addison CB**, Chair, and **Jackie Smith**, Chief Executive and Registrar, Nursing and Midwifery Council, gave evidence.

Q1 Chair: Good afternoon and thank you for coming. We are somewhat depleted this afternoon because some of my colleagues want to participate in question and answer on the Floor of the House on press self-regulation—says he, choosing his words carefully—so would ask to present their apologies. Could you very briefly introduce yourselves? I think you have both been before the Committee before.

Mark Addison: Indeed. My name is Mark Addison. I am the chair of the NMC and this is Jackie Smith, the chief executive.

Q2 Chair: Thank you very much. You are probably aware that we saw the Professional Standards Authority in July and their assessment suggested that the NMC was making some progress towards an improved registration/regulation service, which gives you some external view of progress being made, but I wondered how you rate your own progress. Self-assessment might be more demanding than external assessment.

Mark Addison: Thank you. That gives me a good cue to say the first few words I thought I might say—to do a bit of scene setting—at the beginning. Then, if it is acceptable to the Committee, there are two specific areas I think it would be helpful if Jackie could flag up initially and then we can move on to the more specific areas you may want to cover. It will be very brief.

Chair: Please, yes.

Mark Addison: The first piece does play exactly to that, I think, Chair.

The points I want to make are about the progress we have made, which will play to the news I hope that you have heard from the PSA, and the challenges in the year to come and beyond. It also might be sensible to clear up right at the outset my own and indeed Jackie's position. It was a specific recommendation that the Committee made last year and I thought it might be useful to get that out on the table up front.

On progress we are just over halfway through the two-year timetable, effectively, that the PSA, as it is now, gave us to get our act together. We are 14 months into that period. My view is that we have delivered some sound and solid progress against all the recommendations in that initial report. The areas I would highlight particularly that the PSA dealt with concern clarity of purpose, the governance of the organisation—we have, of course, a new slimmed-down council—the performance on some aspects but by no means all aspects of fitness to practise, which we will no doubt come on to in more detail, financial stability and capacity. The culture of the organisation and the mood of the staff I think have improved—Jackie will say a word about that—and we have also strengthened relationships with external stakeholders. Those are all things that the PSA mentioned where we have made some solid and sound progress. That has enabled us to begin to think about getting beyond the engine-room fixing stage that I described last year to thinking more generally about the protection of the public and how that can be strengthened and what our role is in that.

The “challenges ahead” moves on absolutely seamlessly from that analysis, I think. First of all there is still very clearly unfinished business around some aspects of performance. On the FTP front that is essentially around the adjudication timetable. We have a target of getting that down to six months, as you know, by the end of the next calendar year; that remains a big challenge. There is still a mountain to climb in relation to adjudication. We also have work to do to complete the review, and the development of new policy on and ensuring compliance with registration processes, which we are well advanced on but there is still further work to do.

More substantively, beyond that, we have a big agenda around public protection, which is linked to the Francis report. So in the coming year we will be focusing very much on revalidation, the review of the code and the standards, the strengthening of collaboration with other regulators and on developing a more proactive presence across the four countries out there, closer to the front line and to employers. That agenda, I think, will not just occupy us for the following year but a good deal beyond that.

If I may, I will finally say a word about my own and Jackie's position, to set out where we have got to. My original appointment was for 18 months, which would have taken me up to the middle of March next year. Following a discussion with the council and then with the Department, the current intention is that my appointment would be extended until the end of the next calendar year, so until the end of 2014. There would then be an open competition to find a successor, which would start up effectively in the second half of next year, to complete and find a successor by the close of the calendar year. As to Jackie's position, when we were last before you she was the substantive chief executive. She is now the permanently appointed substantive chief executive of the NMC, I am delighted to say. If Jackie could have a couple of minutes of your time on two items—

Jackie Smith: I promise not to take up too much time, Chair, if I can just raise two points. As Mark said, the Committee understandably probed us last year on the culture of the organisation. We have done quite a bit in the last year. We carried out a staff survey which I think underlines that the organisation understands its purpose: 94% of staff responded saying they understood the aims and objectives of the NMC.

The second thing is in relation to revalidation. I hope the Committee will have seen that council approved the proposals for the model for validation in September. Obviously we will answer questions.

Q3 Chair: We will certainly come on to revalidation. I want to start, if I may, by going back to some of the discussion of last year about the fitness-to-practise process. The Royal College of Nursing has talked to individual members of the Committee and submitted evidence to the effect that some cases are still taking up to five years to resolve. I am not suggesting there are large numbers, but any number that takes that long I assume you would agree is unacceptable.

Jackie Smith: I think we said in evidence previously that we had 1,589 cases that were opened before January 2011. We had a target to complete those by December 2014. We currently have 44 left, 41 of which have been scheduled for a hearing. The case load, aside from that, came into existence after January 2011. The cases that we have been dealing with in recent months have been the most difficult because they are the oldest and I completely accept that is too long, but I think we can demonstrate that we have improved significantly in clearing the historic case load.

Q4 Chair: Apart from that 44, you have no case from before the beginning of 2012.

Jackie Smith: Except where there are third-party investigations. If there is a police investigation being carried out, we will wait until that concludes. There will be some cases, but not very many.

Q5 Chair: Do you know how many?

Jackie Smith: I can certainly update the Committee afterwards with that figure.

Q6 Chair: Given the history, in terms of confidence building, apart from anything else, as well as performance management, it would be helpful to be able to say, "We know every single case that exists from before 2012," which is now nearly two years away.

Jackie Smith: I can certainly update the Committee afterwards on that figure, but I assure you it is small.

Q7 Chair: Then we go on to what is acceptable for the future. Could you clarify to the Committee your current thinking about acceptable performance for both investigation and decision, because if you are an individual registrant the key thing is the length of time to a decision?

Jackie Smith: Absolutely. At the moment, on average, it takes us just over eight months to investigate a complaint. Two years ago it was taking us 22 months. On average, at the

moment it is taking us just over seven months to adjudicate a case. That has not changed hugely, although it has come down. That partly reflects the sheer volume that we have in the adjudication stage. On average at the moment it is taking us just over 15 months. With the introduction of case examiners, thanks to the Department of Health helping us with our legal framework, the investigation stage should be quicker, but I am afraid that, until we get the Law Commission at the table and are able to dispose of cases other than at a hearing, we are not going to do a great deal to shorten the adjudication part.

Q8 Chair: Taking the two stages separately, what do you think is a reasonable objective in terms of an adjudication time scale?

Jackie Smith: A reasonable objective is six months. We would like to get it down from that position, but we cannot bring it down until we have alternative methods of disposing of cases.

Q9 Chair: Focusing for a second on that small word you used, “average”, averages conceal a lot of evils. What is the maximum period of time that it should take you to investigate a case?

Jackie Smith: We want to get to 15 months by the end of 2015.

Q10 Chair: That is the maximum for investigation.

Jackie Smith: And adjudication—from start to finish.

Q11 Chair: Maximum, not average? The reason I am pushing you is that some of the papers that have been presented to us, I think, have confused “maximum” and “average”.

Jackie Smith: Yes.

Mark Addison: Absolutely. We were rather conscious of that. The Committee’s recommendations last year were couched largely in terms of timetables in terms of averages, with the important proviso that no case should take longer than a certain amount, which is one way of doing it. In fact, the way we have set targets is a combination of those two notions and requires us to complete 90% of cases within a certain time frame. These averages and 90% figures are quite hard to compare. Jackie has been using the language that the Committee used around averages, but it does leave open the risk that you can have a very long tail, which is why, in a sense, it is quite helpful to think of the target that Jackie mentioned of 90%, or the vast majority of cases, being within 15 months, which we think is achievable—perhaps I could just clarify this—with the benefit of the section 60 changes that we have been promised by the Department, which will allow us to introduce case examiners as well as the right to review investigation decisions. That is what we think we can achieve with the current policy commitments. What we can achieve with the other changes that may come with the Law Commission is a different matter and will enable us to get within striking distance, if not achieve, the sort of average timetable that the Committee was talking about last year.

Q12 Chair: What I would find helpful—and I hope my colleagues on the Committee would—is to receive from you a statement of what you think is a reasonable definition of

key performance indicators for fitness-to-practise procedures, given the state of the current law and recommendations for the future, how you think that KPI should be formulated, reflecting what I think would be the Committee's view that it is one thing to have an average or a 90% indicator but if you are an individual nurse the thing that matters most is the guarantee that the case will be disposed of, on a worst case, within a given time scale.

Mark Addison: Yes, understood. We are very happy to do that and we will try and make it clear when we are talking about averages, when we are talking about 90%, when we are talking about everything, and we will also try and be clear about what is achievable under different policy environments currently planned and, aspirationally, with the Law Commission.

Chair: Thank you very much. That would be very helpful.

Q13 David Tredinnick: Can we move on to the Francis report? Your organisation published a full response in July 2012, including a series of actions and time scales: "To evaluate our education standards," "To raise our profile," and, thirdly, "To strengthen our collaborative work with other regulators." Which of Francis's recommendations are you implementing, please?

Jackie Smith: We are implementing the ones that directly impact on the NMC. You have touched on those—profile and proactivity particularly. We will evaluate our pre-registration nursing standards, which we launched in 2010, in 2014, and we are reviewing the code in readiness for our revalidation proposals.

Q14 David Tredinnick: But do you feel you have addressed those three basic points—education standards, getting your profile up so that people know you exist and the strengthening of collaborative work with other regulators?

Jackie Smith: I think we have started to address them. I do not—

Q15 David Tredinnick: You talked about nursing standards.

Jackie Smith: I am sorry, I did not hear that.

Q16 David Tredinnick: You referred to some other points, but I wondered if you had managed yet to tackle the core points that were in your response in 2012.

Jackie Smith: Yes. We responded in July this year—2013. That was the response that went to council. We have just started to scope what improved profile and proactivity would look like and we have set out a timetable for the code and our standards.

Q17 David Tredinnick: Do you think you can deliver within the resources you have? Is there a resources issue? Do you feel you have enough money to do the work? Surely you are going to say no; everyone always does.

Mark Addison: It is a very big question.

Jackie Smith: We have evaluated the cost of the Francis recommendations that impact directly on the NMC. We have been clear about the cost of revalidation to the NMC.

There is a different discussion around fees. I have no doubt that this Committee will want to come back to that, but we are happy to remind the Committee of the decision that council took last October when it made the very difficult decision to increase fees from £76 to £100 with, obviously, support from the Government. Our current priorities—what we have said we will set out to do—are affordable.

Q18 David Tredinnick: You have set out your stall and the various actions you are taking, but what overall can the NMC do to prevent another Mid Staffs?

Jackie Smith: I think there are many things that we can do better. We have to work alongside nurse directors. One of the proposals we are making is to have regional officers. We have to work better with the CQC in England, and the system regulators in the other countries too. We need to make better use of our data and we need to identify areas that represent a high risk. All those things will help us identify if there is another Mid Staffs. There is plenty the NMC can do, is doing or is working towards doing.

Mark Addison: Can I add to that list one thing that we have been addressing recently, which is other registrants being prepared to raise concerns and encouraging them to come forward? One of the striking things for me about Mid Staffs was the number of cases that went through our fitness-to-practise regime that we ourselves referred rather than them coming from the trust or colleagues there. It is an interesting and concerning point, and we are trying to place a lot more emphasis on encouraging and enabling nurses and midwives to see that part of their responsibility is to alert employers and, if necessary, us to failures of practice out there. That should help resolve it.

Q19 David Tredinnick: Talking of failures of practice, how many cases from Mid Staffs do you still have ongoing?

Jackie Smith: The precise number I do not have to hand, but I can provide the Committee with it. We have a number that are in the queue for a hearing. There are some which have been adjourned and are coming back for a decision in November.

Mark Addison: There have been 55 in total.

Q20 David Tredinnick: With this new regime you have, how are you going to get the information out about the lessons that have been learned? Do you have a plan to disseminate the lessons that come out of these cases?

Jackie Smith: Recently we looked at our FTP data over the last 18 months, looked at the cases that were closed by an investigating committee and closed or dealt with at a final panel and said, “This needs to feed into the code. This is part of the code review.” If there are areas where our registrants are falling foul of the code, we need to strengthen the code and make it clear. That is part of the lessons learned work.

Q21 David Tredinnick: May I ask a question about revalidation? Plans for revalidation of nurses have been ongoing for a very long time. What are your plans for revalidation? Are you confident that delivering this model—I think there is a model, is there not, for revalidation—by 2015 will not jeopardise your ability to deliver your core function of regulating fitness to practise?

Jackie Smith: I would say that our core function is continuing fitness to practise, which in effect is what revalidation is proposing to deliver. We have proposed that we build on the existing structures—appraisal—as a way of assuring continuing fitness to practise, and I think that is a sensible model for the NMC, with the size of its register, to take forward.

Mark Addison: I would simply add the point that, essentially, your concern and the question you ask is a fair one for an organisation that is struggling to do some of its basic processes adequately and I quite understand why you raised it. The council's judgment, when it looked at the revalidation proposals, was that the organisation had got itself into a position—had achieved a sufficient degree of recovery, if you like—to begin to take on some new responsibilities as long as they were carefully prioritised and thought through. The council clearly will watch very carefully to see how that process rolls out to the end of 2015. But you are right—I think I made the point when I made my opening remarks: our capacity and capability need to be at a point where we can begin to take on new work, and there are new things now on our agenda.

Q22 David Tredinnick: Fine. But when I asked about resources, you certainly did not say, “Yes, we need more money.” You seemed—dare I say it?—almost complacent about your funding.

Mark Addison: I do not quite know what to say in response to that, given that—

David Tredinnick: Well, comment on what I have said.

Mark Addison: Resources are a huge and important issue for us. Maybe I could say a word about our financial strategy, which I think is the framework within which we work. The council last year agreed a financial strategy for three years, which was based on a certain level of income from fees. It factored in the £20 million grant from the Department and it made an assumption that the fee level would be such as to generate, effectively, £120-worth of fee income a year over the next three years. That is the assumption on which it is based. Within that envelope, every commitment we have made has been costed and added. Every time the council is asked to consider a proposal, the executive have to satisfy the council that it is affordable within that financial envelope. That is the discipline that we are working to at present and it is very clear. It is very well set out and very well understood, so you can be assured that any of the commitments that we have publicly committed to are affordable within that cost envelope. But that does only take us to 2015-16.

David Tredinnick: Thank you very much.

Q23 Chair: Can I jog you back a stage to when you were discussing your response to Francis—that you are going to evaluate your education standards? Do you have any comment to offer on the Government's view that before nurses go on a degree course they should have experience on the ward?

Jackie Smith: We know that most applicants or students who want to be nurses and midwives have prior experience, and we encourage universities to take account of prior

experience. I cannot produce evidence to say, “This is the number who have had prior experience,” but from what we know a good proportion do.

Q24 Chair: Are you engaged with the Government on the evolution of this policy?

Jackie Smith: Yes.

Q25 Chair: They are running pilots, as I understand it.

Jackie Smith: They are. That is right. We are a member of the steering group and we are very keen to see what develops.

Q26 Chair: You envisage being involved in the crystallisation of this proposal as part of your thinking about your own education requirements presumably.

Jackie Smith: Indeed. It is a statutory responsibility for us and we are very keen to play an active part.

Mark Addison: Could I add a “four country” point here because it is relevant? One of the things that we needed to address is that most of the reviews, of which there have been a large number in the last year, are England-based. We set standards across the UK and therefore we need to be very much aware that if we are to change our requirements or standards they are going to have to work in all of the four countries of the UK, not just England. That puts us in a slightly different position when we are evaluating pilots in relation to an England exercise from some of the other folk around the table.

Q27 Chair: Does it follow that you have to have exactly the same arrangements for education, fitness to practise, registration and revalidation in all the four home countries?

Mark Addison: It might be implemented and interpreted in different ways, but the basic standards are UK-wide.

Jackie Smith: Yes.

Q28 Andrew George: While we are on the Francis report, your role is to take up the individual cases, which David asked you about a moment ago, and you said you have 55 that are currently at various stages of investigation. Having looked at the report itself and recognising that in many cases nurses were reporting issues of concern, one of the themes you picked up is the need to make sure that, in their professional role, they should feel confident to be able to report to their employers. In terms of taking that forward, are you content that nurses have that confidence and—one of the outcomes of the work you have done on Francis—that they are reporting more than perhaps they have in the past? Are you picking that up where there are concerns?

Jackie Smith: That is very difficult to quantify. One of the reasons why we decided to relaunch our guidance on raising concerns was that we felt there was a need to remind nurses and midwives of their responsibility to raise concerns where they see them. We need to look at what comes our way, take stock and see if it does actually make a

difference. The guidance is very important and we need to continue talking about the important role that registrants play.

Q29 Andrew George: Taking that a stage further, if they are reporting those concerns, are you able to distinguish in your role as the NMC in maintaining and keeping watch on professional standards between where there is a failure of clinical practice of them as professionals and where—a clear theme running through the Francis report time and time again—it is a resource issue, in other words, where there are insufficient nurses on the ward? The complaint was that nurses felt they were being left unsupported—not that their colleagues were being unprofessional but that there were not enough of them in certain circumstances. Are you able to distinguish between them, and is it appropriate that you should keep an eye on, as it were, the resource itself rather than the failure to meet professional standards?

Jackie Smith: If I may say so, the whole issue of staffing levels and resources and what is an appropriate number is an interesting question. Our role, as you know, is protecting the public. The code says, “It is your duty to put the care of your patient first.” Where you are not able to do that, or where you feel you cannot do it or are not being listened to, we are encouraging those individuals to raise those concerns, for employers to take a look at what is acceptable locally. It is very difficult for us as a regulator to enter a territory where, frankly, we may be completely unsighted on what the issues are.

Q30 Barbara Keeley: This leads to my question; it is all running together, I think. You mentioned the guidance, but there is a balance to be achieved between cases that should be resolved locally and those which need regulatory action. Yet the guidance that you have just referred to is published on raising concerns mainly with employers rather than directly with yourselves. Going back to Francis, how can you help a nurse in Helene Donnelly’s position in Mid Staffs? She tried to raise concerns locally but she was not listened to. How is it helpful if you are putting out guidance to say to people in that position, as she was, “Complain to your employer,” and then your employer does not listen to you? There is a difficulty, isn’t there, if the failure extends to a failure to listen to people, as was the case? It is not enough, is it, to say, “Raise it first with your employer,” because people may be in a position of trying for months and failing to get anywhere with their employer, or they just give up. That is the worst case. They may think, “Nobody is listening to me and I am not going to persist with it.”

Jackie Smith: Absolutely, and that was the case in Helene Donnelly’s position. What we are trying to say is that there will be many situations where you can resolve it locally. It may not represent a patient safety issue but where it does and you feel you are not being listened to, escalate it. Where we come in is in supporting nurse directors.

Q31 Barbara Keeley: How do you do that? That is the point.

Jackie Smith: It is the regional adviser model, so working alongside, understanding where the low-level concerns are and tackling them before they become an issue that it is too late to deal with.

Q32 Barbara Keeley: If we take the other aspect of this, the public being involved—the public who Francis described as “the prime and most valuable source of information about the conduct of nurses,” clearly the people on the wards with their family members who can see failures in nursing—you are talking about relaunching your website next year with guidance for the public, but is that information about your role going to be made available to patients as well as it is to others? That is what Francis recommended. How are you going to measure whether you become more visible to patients and to the public? Otherwise, you are missing that valuable source of information, which he stressed was a good source of information about the conduct of nurses.

Jackie Smith: I do not think we are at the point where we could say that our visibility is such that members of the public would be aware of what our role is. I think we have a way to go.

Q33 Barbara Keeley: How will you measure it once you start? Obviously there are actions you are taking next year. How will you be able to measure it?

Jackie Smith: If we see an increase in referrals it will indicate that we are having an impact, and that is what I expect will happen. When we are based locally and we are supporting nurse directors and others, I think what you will find is that our visibility will be increased and it may well lead to an increase in referrals, as it did at the GMC when they rolled out affiliates locally. I think that is one measurement. I am sure there will be others, but it is in the early stages of our thinking at the moment.

Mark Addison: I suppose there will also be feedback from patient groups, and that could be valuable. I hope that the regional officers—they are a plan, by the way; they are not in place yet—would have access to local patient networks that would also provide us with softer intelligence about the effectiveness of that strategy. Maybe it is just worth saying that in two weeks’ time, on 24 October, the council will spend a day thinking about our forward strategy over the next five years: what we should be prioritising, how we should be beginning to put some measures around it and assessing our own progress. We have been focused on fixing the basics so far. We now need to start thinking a bit longer term about the forward direction for the organisation. Issues around how we determine what our priorities should be and how we assess and measure progress against them will be very much something that they will want to have in their sights on the 24th and beyond. We are aiming to come up with a product from all this work to coincide with the beginning of the next planning year.

Q34 Rosie Cooper: Before I ask my question, can I pose a question following on from what Barbara said about local resolution? What would you say to nurses, for example in Liverpool, complaining about the senior management of their trust and who, therefore, would be complaining—and have done—to the very people they are complaining about? I understand the Royal College of Nursing and Unison are taking a joint grievance. What would you say to those nurses who are very concerned? I will not go into the detailed medical bit, but, for example, they cannot get investments in certain wards, yet the trust have just moved into the most plush headquarters. We would be very envious of those and we will find how much they cost in due course. Using your regulatory purpose, these nurses

have concerns—the practice of the trust, the Liverpool community trust and their wards and everything else—so how would “just complain locally” sort that out?

Jackie Smith: If nurses are seeing a system operating that is impacting on patient safety, we would say that is an issue for us. We try to reflect in the guidance that there are different levels of concerns and we hope that the vast majority that a nurse or a midwife encounters can be resolved locally; where they cannot and patients are being put at risk, it is a regulatory matter.

Q35 Rosie Cooper: But we want nurses to speak up—

Jackie Smith: We do.

Q36 Rosie Cooper: And not just about “at risk” incidents. In fact, I was involved in what would have been an untoward incident, had it happened—it was that close. My dad spent a month in hospital this summer and they did not have his notes; they ended in 2007, so six years passed for an 88-year-old man and nobody knew. There were some serious things, but that did not become an untoward incident because I sorted it out. Where staff are concerned—what we now have too is the Royal College and other people—I think you have a role and I wonder how you are really connecting with the people out there, because they are not complaining about individual nurses; they are saying, “We are really worried.” Do you think you have a role there?

Jackie Smith: We have to encourage individuals to speak up. I think that is the point you are making. We have to do that. We cannot simply say that it is not a matter for us. If there are issues that impact on public protection, then we have a role to play and we have to work alongside the other players in the field. We need to do that, but fundamentally we cannot erode our primary function, which is protecting the public.

Q37 Rosie Cooper: I will stop on that, but let me tell you that some people have been moved on, some feel bullied and some feel that if they make further complaints their jobs will be in jeopardy and nobody once ever mentioned the NMC. I put it to you that that is something to be concerned about.

Jackie Smith: I agree.

Q38 Rosie Cooper: Now I can go to the question I should be asking—it almost impinges on that—which is the NMC “should not have to wait until a disaster has occurred to intervene.” You rejected that recommendation and I wonder why you did that. Do you think you need to be a more proactive regulator?

Jackie Smith: In fact we accepted entirely what Robert Francis said and that is a quote from his report. We entirely accept that we need to raise our profile and be more proactive in promoting what the NMC does. I am sorry if we have left you with the impression that we rejected that. It is absolutely not the position of the NMC.

Q39 Rosie Cooper: You rejected the recommendation that the NMC should be better equipped to investigate situations where concerns about nursing fitness to practise appear across the health system.

Jackie Smith: I think what we rejected was stepping into territory which is for the CQC, but that does not mean to say that we would not want to work alongside the CQC where we see systemic problems.

Q40 Rosie Cooper: Does the fact that the CQC does not have a director of nursing affect how you operate in the liaison with the CQC?

Jackie Smith: I do not think their personalities or positions affect the way in which we are operating with them. We are about to sign another MOU with the CQC. We are doing a significant amount of work with them. We are in the middle of visiting the trusts that are on the Keogh list, so our relationship with the CQC is better than it has been. I do not think their positions there affect our relationship.

Q41 Rosie Cooper: But in response to Francis you say that you will improve the memoranda of understanding between the regulators, but the Professional Standards Authority says that is not enough, and good communication across each level must exist—case managers and staff teams. How would you describe your main channels of day-to-day communication with the other regulators?

Jackie Smith: It is at various levels. Sometimes it is at the highest level, when Mark and I meet with the chair and chief executive of the CQC. But it operates at a local level and it is sometimes the regional inspectors; it is sometimes staff below that level. All sorts of different staff are involved in the CQC inspections and we have daily contact with them.

Rosie Cooper: What we are really looking for almost is that the information flow just happens automatically at each of those levels.

Q42 Chair: Can I develop that for a moment? The area that we are interested in is the extent to which the NMC is developing a proactive professional regulator role of the kind that the GMC is in the process of developing. I am not suggesting they have got it right or perfect, but for various reasons they seem further down the road of developing networks to give them the necessary information to be an effective preventative regulator rather than simply waiting till the case is presented for investigation.

Jackie Smith: That is exactly the position that we are in. The GMC are further down the road. They have been operating the model of affiliates for some time now. We are only just about to launch that next year, but it does not stop us having conversations with the CQC and sharing information, which is what we are doing. We are trying to move to the position that the GMC is in and has been in for a while, but we are not there yet.

Mark Addison: The relationship between the professional regulators and the systems regulators in the form of the CQC in England is clearly a critical one. To go back to the point about why we were reluctant to get drawn into assuming powers of inspection and so on, we think broadly there is a clear distinction between our own focus on individuals and the CQC focus on systems. We have to make sure between us that there are no gaps between the two and that, as you say, the collaborative arrangements work at every level.

My strong sense over the last year is that those linkages are getting stronger all the time and there are practical results now, as Jackie says, around the way we are visiting Keogh

sites and providing the CQC with intelligence and they are providing us with intelligence, which I do not think would have happened pre-Francis. So there are steps being taken in that direction. We will probably go rather more carefully and modestly initially around developing proactive capability simply because we are an organisation coming out of a troubled and challenged past and we do not want to start taking on remits and setting targets we think we might not be able to meet. We have been very clear that we are only going to adopt ambitions if we are confident they can be delivered. But there will be a serious programme of pilot activity, as Jackie says, for these regional offices with a view to completing the roll-out of that in 2015. That will be a significant development for us.

Q43 Chair: Linking that to the discussion we were just having with Andrew George, do you agree with the proposition that in a better developed world it simply is not a defence for a nurse, a doctor or any other registered professional to say, “The staffing here was inadequate,” if they knew the facts and did not raise the concern before the event?

Jackie Smith: Absolutely.

Mark Addison: Absolutely.

Q44 Chair: You said that quietly, but the word “absolutely” is very important—a fundamental part of what it means to be a professional in a modern hospital.

Mark Addison: Yes, and it goes back to the raising concerns point and the routes available to people to raise issues—if not with their employer, with us directly—and their willingness to do so.

Rosie Cooper: If I may come in, it is really important that I recount to you—not necessarily which executive—that I had a discussion with a chief executive of a hospital recently about Salford hospital’s record on saying whatever number of staff they need for the case mix on wards each day. I asked the chief executive about it and he said, “What do you want me to do—frighten everybody by letting them see”—this is the chief executive—“that we do not have enough nurses on each of those wards every day?” And there you are saying what you have just said and a chief executive can acknowledge to an MP that he knows those wards do not have enough nurses, he hasn’t got them and is not going to get them, saying, “Do you want me to actually tell everybody? I will only frighten them.” How many hospitals is that happening in today? I say that because it is very complacent to talk about what we think is going on when, on the ground, that is the reality. The absolute answer was, “So what do you want me to do? What?”

Chair: What the Committee said in its most recent report is, “Yes, it is his job to publish that information because, without it, nurses and doctors cannot discharge their professional obligations.” It is a very straightforward answer: yes.

Rosie Cooper: Absolutely, but the reality is that that is what is going on out there.

Q45 Andrew George: At the risk of us having a conversation among ourselves and not asking you a question, I would like to know this. You said “absolutely”, that of course nurses should be reporting their concerns about understaffing on wards, but you know that presupposes there is not a culture that actually discourages them from doing that. Do you

acknowledge that there may be a culture, in some hospital settings especially, which discourages them from raising those issues—indeed, the Francis report identified this as well—and where there is a culture of bullying for those nurses that in fact do attempt to do that?

Jackie Smith: I cannot sit here and say I know that a hospital there or there is doing that but Francis makes it absolutely clear that there are cultural problems that need to be tackled. Being open and transparent about those sorts of issues, which may well impact on patient safety, is very important, so I agree with the Chair that “yes” is the answer.

Andrew George: In a theoretical world, though.

Chair: No. It is real patients.

Q46 Rosie Cooper: Yes, but who is going to do it? Forgive me. You are the regulator.

Jackie Smith: We need to work alongside people. The point I am trying to make is that this is a serious problem. It is not just for the NMC. It is for everyone to say, “There is an issue here. What is it and what is the best way of tackling it?” Our remit is public protection. If that impacts on public protection, then obviously there are responsibilities at every level in that organisation to deal with it and that is what we would expect.

Rosie Cooper: But this is like when we had Jane Cummings sitting where you are and—I cannot remember which organisation—I think it was the CQC who said that 14 hospitals did not have enough nurses and I asked her what she, the chief nurse, was doing about it. She was waiting for reports. Hello? Waiting for reports? She is the chief nurse. Forgive me, you are the regulator and we are going to have lots of other different people. I have read this and I hear that you do not have a great financial base to do all this investigation, but—this is reality—when the next Francis comes, each of these regulators or people are going to be in the dock looking at each other waving flags and saying, “We all knew a little bit, but nobody knew it all.” That is what I am trying to get across. If a chief executive absolutely knows he needs to have that number of nurses but financially he cannot or will not, or whatever you want to say, and his view is, “Well, look, are you telling me that every nurse in that hospital does not know?”—of course they know—who is going to make that chief executive deliver the right number of nurses?

Q47 Chair: The question, therefore, for the NMC is how should the nurse who is working in that hospital react?

Mark Addison: Yes.

Q48 Chair: What is the answer?

Jackie Smith: I am going to sound like a broken record. The answer is if they see that patient safety is being compromised, we would expect them to raise it.

Rosie Cooper: Forgive me, when you say things like that, it is like the TSA in housing saying, “We have only got two options—nuclear or we will just keep a watchful eye on it.” What they would say is, “It is just the very fact that we are doing what we are doing,

trying to make sure that patient safety is maximised.” But if you said, “Itemise each incident,” and they say they are just short of staff, the end result is that they are not going to be able to write down a list. That is why people do not come forward; they cannot sit and itemise each of those untoward or potentially untoward incidents.

Q49 Andrew George: Can I put it as a question? Do you have a concept that there may be circumstances that make it difficult for nurses to report inadequate staffing levels and do you accept that in some circumstances nurses are not reporting when they should be reporting the understaffing of hospital wards, and why that may be?

Jackie Smith: As I said earlier, I think, I am not in a position—I do not have the evidence—to say that there is a problem here and a problem there.

Andrew George: No.

Jackie Smith: No. So I cannot say that that is my view. Staffing levels is clearly a very important issue but, fundamentally, it is not an issue for the NMC. The NMC’s role is protecting the public. If staffing levels impact on public protection and patient safety, then clearly there is an issue that we need to be concerned about. But we are not here to determine staffing levels.

Q50 Andrew George: I appreciate that, so you will purely take each case on its own professional merits, if that nurse fails in their duties.

Jackie Smith: Indeed.

Q51 Andrew George: Even if that failure in duty may be because they are overstretched because they could not fulfil all their requirements because there were insufficient staff.

Jackie Smith: It is about individuals and their responsibilities.

Q52 Chair: We can have a final shot on this otherwise we are going to get stuck.

Mark Addison: There is no escaping the fact that our entry point into this argument is around the nurse’s or midwife’s ability to comply with the code. If they find there are circumstances, whatever they may be—whether they are resource driven or something else—where they cannot comply with the code, then they have an obligation to raise it. That would be a relevant factor in any fitness-to-practise hearing. If you want to put it into a legal context, it would be a factor to surface in that context. The Helene Donnelly story is quite interesting. You may well have heard from her personally about her own story and how she actually did go home and itemise all the issues she had spotted on the wards that were preventing her and her colleagues from complying with the code. That was the basis on which she finally gave evidence to Francis and others. It also led her, in the end, in despair to leave the trust. But it is possible to itemise.

Q53 Chair: Your view, if I may put words into your mouth, is that the right way of doing that is to raise it locally first and if there is no response to raise it direct with you.

Mark Addison: Yes. “First” is a key word.

Q54 Andrew George: Do you mean in the Datex report on a daily basis then?

Mark Addison: I am sorry?

Q55 Andrew George: I said in the Datex report, which is what Helene Donnelly was doing on a regular, daily basis.

Mark Addison: Yes, okay.

Q56 Rosie Cooper: We will move on a little. Francis was clear in his view that no nurse should be “too posh to wash,” and repeatedly expressed concerns about the erosion of compassion and basic caring skills in nursing. You have stated that changes to nursing education and standards will address this, but, in essence, what do you do to audit whether that is translated into actual improvements on the ground? Francis also argues that being an observer or a supernumerary on the ward does not substitute for actual experience. To go back to the question the Chairman asked—tacking it on at the end—do you agree with the policy that people should be on the wards as part of that education process?

Jackie Smith: I think there is a misunderstanding about what our education standards actually deliver. The pre-registration nursing standards, which we launched in 2010, test for care and compassion. There are a number of points during the cycle that a student nurse has to go through, and care and compassion is tested as part of that process. That is set out in our standards. We need to evaluate those standards—which we are proposing to do next year—to try and deal with the issue that what is being produced at the end is a nurse or a midwife who fails to display the necessary care and compassion. The second point is that 50% of their learning is spent on wards. It is not 100% of the time in a classroom; 50% is spent delivering hands-on care. I think there is a misunderstanding as to what our standards deliver.

Q57 Andrew George: This is about the regulation of healthcare support workers, as a result of the Francis inquiry, and the potential future role of the NMC with regard to expanding its responsibility to cover those professions that are coming in. Supporting nurses is very critical in taking on a number of nursing roles. Where do you see your role in the future with regard to the potential regulation of healthcare support workers in hospital settings?

Mark Addison: Perhaps I could say a word about that. It was obviously an important recommendation in the Francis report, and it was not accepted initially by the Government. The Government’s position is that that is not the right way forward, as you know. Francis recommended registration rather than regulation, but, be that as it may, the position that we adopted in front of you last year remains our position: the decision on regulation or registration is one for the Government, and if the Government decided that they wanted to pursue regulation or registration of healthcare support workers, the NMC would not be in a position at present to take it on. That was what we said to you last year. We are grateful, by the way, for your recognition of the force of that argument.

So here we are a year on and where are we on those issues? It remains the case that that is a decision for the Government and they are producing their final response to Francis, I think, in November. My own view—and I have not put this to the council—and Jackie’s

view is that, as things stand at present, the absorption of that additional responsibility, which would be for at least the registration of several hundred thousand support workers, would be a step too far for the NMC given where it is on the recovery curve. However, we are on a strengthening trend. We are a year on. We have more confidence in ourselves and the outside world has more confidence in us as a regulator who is able to at least get on top of the basic responsibilities, and we are beginning to look more broadly, for all the reasons we have talked about, at the forward agenda.

So I do not think that would be our position for ever—that we would never be in a position to absorb that responsibility—but it remains the case that we are not there yet. We would like to leave the possibility open at some future date, if that policy decision were taken by the Government, to have a good practical conversation with them about whether we were yet in a position to absorb that extra work or not.

Q58 Andrew George: Does it concern you, nevertheless, that registered nurses, whether from professional choice or as a result of the circumstances they find themselves in, are—admittedly, in a supervisory role with regard to healthcare support workers—requiring or asking healthcare support workers to increasingly undertake functions that previously were solely undertaken by registered nurses? Do you not think that it is those functions that you should be looking at rather than necessarily those registered to perform those duties?

Jackie Smith: The code is clear about delegation, taking responsibility for delegating to someone who has the skills to do what you are asking them to do. On that front it is very clear. I am not sure there is much more we can add.

Mark Addison: We are, of course, looking at the code, as we have explained, next year in the context of revalidation but more generally following on from Francis and the standards alongside it. One of the issues that we will be thinking about when we review the code is to make sure that it is as clear as it needs to be about delegation responsibilities and approaches. There are a number of other things we will want to look at carefully post-Francis as well, but that will be one of them. We are not expecting to want to make major changes, but that would be a focus of the council's attention when it comes to looking at the code.

Q59 Andrew George: On that—and it does play out to other themes—a lot of your answers are based on seeing your role as policing the regulated sector and those who are registered. To what extent is there a theme developing here in the same way as we were discussing staffing levels earlier? Given the fact that you are looking at a system when it fails—or at least allegedly fails and, therefore, a complaint is made and it reaches the NMC, so it must be quite significant—do you not pick up themes you feel that you can then convey? You are in a far better position than many other people—

Mark Addison: Absolutely, yes.

Q60 Andrew George: You can convey patterns or developments that are happening within the nursing profession or across hospital settings, for example, but it seems that you are kind of standing away from that and simply seeing your role as the policeman or woman for those registered nurses.

Mark Addison: Can I say a couple of things in response and then Jackie will want to come in? First of all, as to the policing role, it is important to look beyond fitness to practise. Fitness to practise was described as our core function earlier. I think we have a number of core functions, one of which is the setting of education standards.

Andrew George: Yes, of course.

Mark Addison: We are working with the HEE in that territory to make sure that those responsibilities are clearly understood, as well as registration. Policing is, if you like, the FTP bit of that tripod. On the point about intelligence and analysis and making the best use of the information we have, which I think is the general territory your question was in—

Andrew George: Absolutely, yes.

Mark Addison: It is a big question for the NMC. It is a big question for all the regulators, but it is a big question for us. It is fair to say that we have lagged behind some of our fellow regulators in taking that seriously. We do have access to information and intelligence, and we can commission focused work to bolster that intelligence. We have not done a lot of that in the past. We have done some of it, but we have not done a lot. Jackie and I certainly share a view that there is more we can do to use the information we have intelligently to inform our policy and practice into the future. It will be something that the council will want to think about on the 24 October strategy day that I referred to earlier. I'd be a bit surprised if one of their major preoccupations over the next few years was not to strengthen our capacity to analyse information and make informed decisions using the information, as I say, that we have ourselves—and only we can have—and also is available out there more generally, in order to make sure we set the right priorities and get the right results. I would accept the general point but I have probably made it a little wider than the original question.

Andrew George: Okay, yes. That is helpful. I can see you have taken on the point about gathering intelligence for your own purposes. I was thinking more of gathering intelligence and providing an annual commentary, or whatever, in terms of themes that are developing. Where you see a pattern of activity going on—obviously it is very much a debating point about whether staffing levels are an issue or not, and whether the interface between nurses and healthcare workers is a potential risky fault line emerging in the healthcare system—it would be an important role of the NMC, if you have identified that as a theme developing, to then report it to other policy makers, including Ministers. I really am urging you to see your role as reporting back not just intelligence to yourself to help you develop your work but also reporting to us.

Chair: But do not write the report for them, Andrew.

Andrew George: I am walking the tightrope about whether there is an issue there or not.

Jackie Smith: Can I say—

Q61 Barbara Keeley: Before you do that, I want to strengthen that point because it goes back to the discussion about once you become more visible to the public. You made the

point that you might start getting referrals, but you could possibly see a stressed organisation in those reforms.

Jackie Smith: Absolutely.

Q62 Barbara Keeley: You could possibly see the public saying to you, “The nurses on this ward were run off their feet and never had time to talk or breathe,” and that sort of thing. You would see that first and that is pretty important.

Jackie Smith: I want to say in response that I hope we have created the impression here—because it is absolutely the case—that we are with you. That is where we want to be, but, as Mark said earlier, we are an organisation that has emerged from a crisis. We have stabilised, we are making progress and we want to do the things you are saying—absolutely.

Q63 Chair: Can I bring you on to talk again about revalidation and how you see that working? You are committed to a process of revalidation by the end of 2015, which is a year of some significance to Members of this House. Do you envisage that you will be able to implement revalidation without impacting on the political world?

Jackie Smith: Yes. I am confident that we can deliver the form—the model—that council has agreed to by the end of 2015. As I hope is clear, we are building on existing systems so we are using appraisal. I know that there is a view that appraisal is not consistent, that it is patchy, but that is not a reason not to do revalidation: it is a reason to do it.

Q64 Chair: We have heard a very similar argument from the GMC. I want to probe what the concept of confirmation by a third party means in the context of your view of revalidation and how that is different from the report of the responsible officer.

Jackie Smith: It can be given by a number of individuals in different positions. The confirmation is that that individual is up to date and fit to practise.

Q65 Chair: The confirming individual does not have to be a registrant.

Jackie Smith: That is right.

Q66 Chair: So it can be the local solicitor or family and friends.

Jackie Smith: It needs to be in the employment setting.

Q67 Chair: What is the definition? Who is an acceptable confirmer?

Jackie Smith: That is something we want to try and tease out during the early pilots.

Q68 Chair: What is the purpose of the confirmation?

Jackie Smith: That they have had an appraisal, that they have talked to the individual, that they have—

Q69 Chair: That it is a formal appraisal process.

Jackie Smith: Yes, absolutely.

Q70 Chair: In which case, why would it not be the person who has done the nurse's appraisal?

Jackie Smith: The expectation is that it will be the person who has done the appraisal, but we need to test this out because nurses and midwives work in a very diverse environment and we need to make sure that this is something that will work for the vast majority of the nurses and midwives on our register. We need to tease that out with the early adopters.

Q71 Chair: If it is normally the appraiser, that individual is taking a significant responsibility, are they not, when they sign the certificate that says, "I confirm this nurse has done what they say they have done"?

Jackie Smith: Yes. We are suggesting that appraisal and revalidation is owned by that individual—the person who is being appraised. They are taking responsibility for ensuring, according to the guidance and the standards that we set, that they have kept themselves up to date, that they are continuing to demonstrate they are fit to practise, and the person conducting that appraisal has the information to be able to say that is a suitable registrant to be on the NMC's register, and thereafter we will conduct random audits.

Q72 Chair: How much of this has been road-tested?

Jackie Smith: It will be road-tested through the review of the code, the review of our standards, and the early pilots. At the moment it has not been road-tested.

Q73 Chair: I am mindful that it took the GMC 10 years to get to a workable model. You are saying you are going to have a full process of revalidation, presumably starting over a rolling three-year period.

Jackie Smith: Indeed. We are not saying that at the end of 2015 we will have revalidated 674,000 registrants, no.

Mark Addison: You said it will start by the end of 2015.

Q74 Chair: Okay, fine. It starts, effectively, on 1 January 2016.

Jackie Smith: On 31 December 2015.

Chair: Okay. We are not going to quibble.

Mark Addison: I agree with the general proposition that there is a huge amount to do in order to get to that point and there will be a number of consultations. The first consultation exercise is now gearing up, and at every point some questions will be answered and more questions will be raised. The next phase of work will be designed to address those questions and take the whole project further on. Some people have criticised us for taking too long and some people have criticised us for doing it too quickly. We think the end of 2015 is deliverable on the model that we have adopted. It is a "no legislative change" model. It would not be possible if legislative change were a requirement.

Q75 Chair: It is no legislative change. The current law, you are saying, allows you to remove somebody from the register if you are not satisfied.

Jackie Smith: Yes. At the renewal point, they would lapse.

Mark Addison: We have a renewal process already. It just does not work very well.

Q76 Chair: Who pays the £1.50 per nurse?

Jackie Smith: Sorry?

Chair: A witness has told us that the GMC revalidation process costs £6 per registrant, and your process is intended to cost £1.50. You do not recognise either of these numbers.

Mark Addison: I have not come across that number myself.

Jackie Smith: No, I am sorry.

Mark Addison: If the general question is who is going to pay, the costs fall on two parties. Essentially, they fall on the system and they fall on the NMC. Part of the whole process of working up these proposals will allow us to be clearer and sharper about what both those costs are. We have made an allowance in our financial strategy for the initial costs to the NMC which are affordable within that envelope, and they are not very great. The more significant cost is likely to fall on the system, but given, as Jackie says, that we have come up with proposals that are essentially with the grain—with the existing regime that good employers will already be providing—we hope the additional costs will be acceptable. But clearly that is an issue. It is an issue for employers and it is an issue for the Government as we go forward, which is why we will be working very closely with the employers and, indeed, with the Government to identify what those costs are, to produce a fully worked-up business case and to make sure it stacks up and is acceptable before we put final proposals to the council for endorsement.

Q77 Chair: But you do not intend that there would be a cost on the registrant.

Mark Addison: No. We have said that this will be within the current fee plans—I forget our exact words. This would be funded, and it will be funded essentially because there will be an additional cost to the NMC, but it will be funded as part of the savings and cost reductions that Jackie and her team are making at present and over the next few years. That is how we intend to fund quite a bit of the work that we are embarking on.

Q78 David Tredinnick: I would like to change tack and ask you about some of the remarks that the Professional Standards Authority made about you. The PSA state that it is likely that different groups on your register present different types and levels of risk, but that your proposals “lack a robust evidence base...around risk.” How will your risk-based targeting system work to identify nurses for early audit?

Jackie Smith: We can draw on existing data. We can draw on fitness-to-practise data that we already have at our disposal. We can take account of high-risk settings. We can use the

information and intelligence that we are gathering through visits and the work that we are doing with the CQC in England and the other systems regulators, so we are not starting from a zero base.

Q79 David Tredinnick: Are you going to have some model—perhaps a computer model—to assess risk on a points system?

Jackie Smith: We were not proposing a computer model, no. We are proposing to build on data that we already have at our disposal, and using the intelligence that we are gathering and taking account of practice settings. That gives us a pretty good starting point. Clearly the risk model will develop and evolve once we roll out revalidation; it will change over time. But I think that is a pretty good starting point.

Q80 David Tredinnick: I have one other question. What safeguards can you introduce to stop this being perceived as discriminatory—for example, if you are identifying all nurses of a certain age, or from a certain area? How do you avoid discrimination in assessing the risk? That is the key question.

Jackie Smith: I probably would go back to my earlier answer. We need to look at the data that we already have available to us and identify from that where the highest risk groups are. It is not intended to be discriminatory, but it is intended to target areas of risk.

Q81 David Tredinnick: Do you think there is a danger that you might end up making policy in how you assess different groups? Rather than trying to follow guidelines, is there not a danger that you might be tempted into policy decisions on risk with different groups?

Mark Addison: What we are talking about is probably the way in which the audit process would be targeted. The commitment we have made is that there would be a random component to the audit and there would be a risk-based component to the audit. That is a fairly standard way of making sure that you cover the right territory with a sample audit of this sort. As we drew up the risk framework for that audit we would clearly need to be sure that it was properly equality-proofed and did not have any obvious discriminatory components. I am not sure that that would involve setting policy in some way. That does not strike me as a risk with the approach. The bigger issues with the audit approach are, “Will we have our risk framework sufficiently developed at the point of launch? Will we have been able to invest enough in it and have we got a clear enough idea of how the sample frame should be drawn?” Secondly, “How big a sample should it be and how much will that cost?” A lot of the cost of this exercise for us will be driven by the size of the audit sample, and the bigger the audit sample the more reliable and effective it will be. There will be a balancing act that the council has to undertake in order to determine what scale of audit to embark on.

Q82 David Tredinnick: You will take advice to make sure that the sample you have is statistically sound.

Mark Addison: Absolutely, yes, we must do that.

Q83 Dr Wollaston: Still on the point of revalidation, the GMC has five-yearly cycles of revalidation, and the point has been made by some nurses that it seems unduly onerous that they have to revalidate every three years.

Jackie Smith: That is the renewal point.

Q84 Dr Wollaston: But you wanted to link it in; it is the renewal point. Do you think that, over time, if this becomes onerous you would shift to six-yearly?

Jackie Smith: We would certainly want to evaluate the first phase of revalidation before we made any decisions on that, but I absolutely take the point that we would need a change to our legal framework to be able to do it differently, and we would hope that that would be part of the Law Commission Bill.

Chair: Barbara wants to ask about fees.

Q85 Barbara Keeley: It is about the level of the fees and whether it would be possible to allow phased payments. We recommended that, and you understood that it would be too costly while you processed registrations manually, so will you be moving to an online process? We still feel that phased payments should be introduced, as people have been finding it tough.

Jackie Smith: Yes, I have two responses to that. We are moving to online services, which we hope to launch in April of next year for a small group initially. We do not want to launch online services for 674,000. That will be one thing that I think will definitely improve customer service and make it easier for nurses and midwives. The second is that we have not completely ruled out phased payments but it needs to form part of our ICT strategy, which will go to the council in November. Our intention is to replace the registration database in 2014. Once we do that and we have a new system in place, it will make it easier to look at phased payments. We have not ruled it out completely. We will return to it.

Mark Addison: It will be a factor that we want to consider in the design of that longer-term ICT strategy.

Q86 Barbara Keeley: That does not sound very positive. It is a recommendation from us.

Jackie Smith: I know. It is simply that we are not in a position to do it within the current systems.

Q87 Barbara Keeley: Indeed, but the words you just used do not sound like you want to make it part of a new system. If you are replacing the database, surely you are going to have to decide about IT requirements, so you could say, "We can do it from the point that we replace the database," but what you said sounded a lot weaker than that.

Jackie Smith: There are added complications, one of which is that not a huge number of nurses and midwives pay by direct debit at the moment, so the percentage for take-up is pretty low. It is around 20%. We would need to do quite a bit of work to improve that first

of all before we could get into a suitable position. It is not that I am not enthusiastic. It is just that—

Q88 Chair: You might find this will encourage them.

Jackie Smith: It may well do.

Q89 Chair: Can you give the Committee an assurance that the ICT system will be designed in a way that is compatible with this option?

Mark Addison: Yes. That was, I hope, the gist of my earlier remark: one of the things that we will be building into the consideration of that forward design is your recommendation about phased payments.

Q90 Chair: Yes. “Building it into the consideration” might be building into a phase you do not—

Mark Addison: I do not want to make a commitment that we will not embark on any IT strategy unless it has that capability because I do not know what I would be committing myself to. But I do take the message that it is a serious recommendation from you, that you would like us to think about it very carefully and only reject a system if it is absolutely impossible or disproportionately expensive to do. I will take away that message and convey it to the council when they look at the strategy in November.

Q91 Rosie Cooper: But surely—forgive me—the smallest organisation to the largest can manage to collect their subs weekly, monthly or whatever. You could just nip down to your local organisation and ask them how they do it, because it seems that you cannot be in the 21st century and it would be too hard to take money off people in 12 monthly instalments, or whatever. If that is seen to be really difficult, how do you deal with the really difficult questions? It scares me when I hear stuff like that, honestly.

Mark Addison: I understand the point.

Chair: Sarah wants to ask a final question, though I have a final question as well, I am afraid. We are on No. 26.

Q92 Dr Wollaston: We have fast forwarded. I am sorry, Chair. I want to ask a question about the draft legislation about language-testing. Under current proposals, language assessments will only take place after applicants from the EU have actually been accepted on to the register, in other words not proactively assessed. How are you addressing this?

Mark Addison: Perhaps I can say a word or two. We are as frustrated as everybody else about this. As you know, we would like to have been in a position to move more quickly, and the GMC is in a slightly different place. Perhaps I could just explain why. There are three fundamental issues that affect a regulator’s ability to test for language, as I see it. One is the European directive. The second is the way that directive is transposed into UK law. The third is the legal framework that the regulator has. The GMC happened to have a legal framework which has, I think, the “licence to practise” component to it, which allows them, with the right kind of signals from the Commission, if their legislation is tweaked, to

move to be able to language-test. We are not in that position. First of all, the current directive is generally quite hostile. Second, the way it is transposed makes things difficult for us. Third, and most importantly, we do not have that distinction, so we cannot introduce a point in the process between registration and the right to practise that will allow us to introduce a language test. That is the current position unless there is a willingness on the Government's side to introduce legislation that would advance us to the point where we could make that distinction. That would be a very big thing to ask in advance of the Law Commission coming through and in advance of the transposition of the new directive, which will help, which is under negotiation in Brussels.

Q93 Dr Wollaston: Perhaps it would be helpful for the Committee to understand what you would like to see in place. If you were actually drafting a change to the legislation, where would you see that sitting?

Mark Addison: We can let you have a detailed note if that would be helpful.

Q94 Chair: A draft amendment for us to put down to the Care Bill might be helpful.

Mark Addison: We will take that away too. The new directive explicitly addresses the issue of language-testing, so it is much friendlier to the notion that there should be the capacity for regulators to language-test. That is a big step forward. If the transposition of that directive into UK law is managed correctly and if we achieve, either through the Law Commission or through the transposition of the directive, a change to our legal framework that will allow us to make that distinction, then we can introduce language-testing, not asking employers to do it but actually ourselves making that decision, as the GMC are hoping to. We would welcome support for the transposition of the directive in a way that fully involves us and makes sure that we are clear that the way it is put into UK law will help us to get to the result we want—that would be extremely helpful—and, secondly, support for the change to our legal framework at that critical moment, which also allows us to make the change.

Q95 Chair: It would be very helpful to the Committee to know precisely what is required to be changed in all three of the headings you describe, and what the constraints are on the timetable. The Government has now moved—partly, I think we feel, because of the opinions expressed here—on language-testing for doctors, and it is regrettable that we are in a position where we cannot do it for nurses as well.

Mark Addison: We agree.

Jackie Smith: We can certainly submit that as a matter of urgency.

Q96 Dr Wollaston: We understand that the new legislation would take two years to come into force, so what would you recommend can be done to protect patients in the meantime?

Jackie Smith: We still urge employers to test language. That is what we continue to urge.

Q97 Dr Wollaston: Where someone has arrived and they recognise there is a problem, you urge them to test at an early stage.

Jackie Smith: Yes.

Q98 Dr Wollaston: The clear message should be to any employers who are not sure if they are able to do that—

Jackie Smith: Yes, “Please, test language.”

Q99 Dr Wollaston: Where they have concerns, they can test and they should do so at the earliest opportunity.

Jackie Smith: Yes, absolutely.

Mark Addison: It is a second best, but it is all we have.

Q100 Chair: Thank you very much. That has been a useful session and we will issue a report, but we would be grateful for the two bits of further evidence you said you would send to us.

Mark Addison: We will get them to you as soon as we can.

Chair: We can reflect on that and on our opinions. Thank you very much.