

Council meeting, 22 September 2011

Reports of the Health Committee annual accountability hearings of the General Medical Council and the Nursing and Midwifery Council

Executive summary and recommendations

### **Introduction**

In June 2011, the General Medical Council and the Nursing and Midwifery Council (NMC) attended hearings of the House of Commons Health Committee which inquired into their performance. The Committee published reports as a result of these hearings in July 2011.

The attached paper summarises the key findings in the report that are particularly relevant to the HPC. The paper also includes observations and comments from the HPC Executive, including any actions.

### **Decision**

The Council is invited to discuss the attached paper; no specific decision is required.

### **Background information**

Outlined in paper

### **Resource implications**

The actions identified in the paper are already included or will be included within department resource planning for 2010/2011 and 2011/2012.

### **Financial implications**

The actions identified in the paper do not have any direct financial implications, with the exception of the review of the standards of conduct, performance and ethics which will be accounted for within Policy and Standards Department budgeting for 2011/2012. The scope and structure of the review would also be subject to separate scrutiny by the Council.

**Appendices**

None

**Date of paper**

12 September 2011

## **Reports of the Health Committee annual accountability hearings of the General Medical Council and the Nursing and Midwifery Council**

### **1. Introduction**

- 1.1 The General Medical Council (GMC) and Nursing and Midwifery Council (NMC) have recently attended hearings of the House of Commons Health Committee which has inquired into their performance.<sup>1</sup>
- 1.2 The issue of whether the regulators should be the subject to greater parliamentary scrutiny was raised in the Command Paper 'Enabling Excellence', with the following action: 'The Government will discuss with the Parliamentary authorities what formal mechanisms might be established to enable Parliament to hold the regulators to account.' (page 13; paragraph 3.8) Although the Health Committee has held hearings in relation to the performance of the GMC and the NMC, and has said that it will do so every year, there has not currently been an indication that it wishes to extend this role to the other regulators, including the HPC.
- 1.3 This paper looks at the conclusions and recommendations made by the Health Committee in their reports on the GMC and the NMC. As some of the conclusions and recommendations are very specific to these organisations, the main body of the paper looks at those areas which are common across the reports. The observations and comments of the Executive are included in each area, including an indication of any relevant ongoing work being undertaken and any proposed actions as a result of the Committee's report.
- 1.4 The Council is invited to discuss this paper and to suggest any further actions that may be necessary.

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<sup>1</sup> Health Committee - Seventh Report  
Annual accountability hearing with the Nursing and Midwifery Council  
<http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1429/142902.htm>  
Health Committee - Eighth Report  
Annual accountability hearing with the General Medical Council  
<http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1429/142902.htm>

## 2. Revalidation

2.1 The GMC and the NMC are both at very different stages of developing their arrangements for revalidation. Some of the conclusions and recommendations are organisation specific and therefore not of direct relevance to the HPC, although, overall, they do indicate that there is still a high level of scrutiny on the regulators plans in this area. There are, however, some conclusions and recommendations across the reports which have general applicability, including the following.

- The responsibility for developing an effective system of revalidation rests with the regulator and this represents a significant amount of work.
- The regulators need to ensure that the likelihood that some registrants will fail revalidation is fed back to employers to be captured in workforce planning.
- The burden on registrants in terms of time and effort in meeting requirements for revalidation needs to be considered.
- The effectiveness of processes in gathering information to meet the revalidation standard needs to be considered.

2.2 Whereas the GMC is currently involved in a number of pilots of revalidation, the NMC is at an earlier stage of development. The NMC does not currently systematically or randomly audit CPD portfolios. Instead, the NMC has hours-based practice and CPD requirements for re-registration and looks at some registrants' CPD records as part of a 'risk based' approach - this might be when a nurse or midwife declares a conviction or caution at re-registration. The NMC indicated that it intended that a 'revamped' form of its re-registration and CPD arrangements would form the basis of its revalidation arrangements, which would be 'online' and 'risk based'. The Committee expressed concern that there are 'nurses and midwives who could be failing to meet the already acceptably low standards for re-registration but who do not come to the attention of the NMC and are therefore re-registered unchallenged'. They suggested that the NMC should undertake an 'annual random audit of the registration renewal evidence supplied by a sample of registrants'.

## HPC observations / comments

- 2.3 The HPC is currently undertaking a stage one research project to look at revalidation. A number of reports are due to be presented to the Council over the coming months, including a paper looking at the learning that can be derived from the other regulators' existing approaches to revalidation.<sup>2</sup>
- 2.4 The Command Paper 'Enabling excellence' published in February 2011 has refocused the agenda in this area on proportionality, cost-effectiveness and added value. The regulators are asked to continue to work to develop an evidence base for revalidation but legislative change will only be considered 'where there is evidence to suggest significant added value in terms of increased safety or quality of care for users of health care' (page 19; paragraph 5.3).
- 2.5 There now appears to be a renewed focus amongst the 'non-medical' regulators to closely scrutinise whether there is a justification for a new revalidation process or whether introducing or augmenting (existing) CPD processes would be sufficient. For example, the General Chiropractic Council (GCC) recently decided, having undertaken a consultation on a proposed revalidation model, that it could not demonstrate added value and therefore would not be undertaking any further work on revalidation. However, it indicated that it might wish to review its approach to CPD.
- 2.6 In terms of the comments made about the NMC in this area, differences between the HPC and the NMC's current arrangements mean that they are not completely applicable to the HPC. The HPC would not ask for evidence of CPD from a registrant as a result of a declaration of a conviction or caution and consideration of such health and character issues is functionally separate from CPD. Random audits to check compliance with the CPD standards have taken place since 2008, with 2.5% of registrants in every profession randomly audited every two years.
- 2.7 However, they do highlight that revalidation remains firmly on the political agenda and that in developing its approach the HPC will need to ensure that it has robust evidence and a clear argument for its chosen approach.
- 2.8 **Action:** The Executive will present a paper looking at the revalidation approaches of the other regulators for consideration at a future Council meeting.

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<sup>2</sup> Revalidation update, Council meeting, 7 July 2011  
<http://www.hpc-uk.org/aboutus/committees/archive/index.asp?id=535>  
(click on enclosure 23)

2.9 **Action:** The Executive will ensure that the themes in this area in the Committee's conclusions and recommendations are included in the report to the Council on revalidation currently planned in December 2011 or February 2012.

### **3. Fitness to practise**

#### **Case management**

- 3.1 Both organisations have experienced increases in the number of cases they are handling. The GMC reported a 25% increase in referrals to them in 2010, leading to a 19% increase in the number of fitness to practise cases it handles. The NMC reported a 102% increase in 3 years. The GMC is undertaking research to help explain this trend and is commended by the Committee for doing so. The Committee concluded that it was 'surprised' that the NMC could not provide a 'satisfactory reason' for this trend and urged them to undertake similar research.
- 3.2 The Committee noted that the GMC had achieved its target of concluding 90% of fitness to practise cases within 15 months. The GMC indicated that it considered this still to be too long a period, a view that was endorsed by the Committee who suggested that the CHRE should set it a more ambitious target. The NMC's recent difficulties in this area were also examined by the Committee, with the Committee noting that although improvements had been made, a third of fitness to practise cases still took longer than 15 months to complete.

#### **HPC observations / comments**

- 3.3 The HPC has experienced similar trends in the overall numbers of cases.<sup>3</sup> There has been a 135% increase in the number of cases between 2006/2007 and 2010/2011. In the same period the size of the Register has increased by 21%. The proportion of registrants subject to a fitness to practise allegations has increased in this period from 0.19% to 0.35% but still remains far lower than the NMC's figure of 0.6% of nurses and midwives.<sup>4</sup>
- 3.4 The HPC figures seem to be driven by an increase in allegations received from members of the public – between 2006/2007 and 2010/2011 there has been a 10% increase in the proportion of allegations from this complainant group. In 2009/2010 four professions, chiropodists /podiatrists, hearing aid dispensers, paramedics, and practitioner psychologists were subject to more complaints than might be expected by

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<sup>3</sup> Fitness to practise data taken from the Draft Fitness to Practise Annual report 2010/2011 Council meeting, 7 July 2011

<http://www.hpc-uk.org/aboutus/committees/archive/index.asp?id=535>  
(click on enclosure 10)

<sup>4</sup> Nursing and Midwifery Council: Annual Fitness to Practise Report 2010-2011  
<http://www.nmc-uk.org/Press-and-media/Latest-news/NMC-annual-report-and-accounts-2010-2011-and-annual-fitness-to-practise-report-2010-2011/>

their proportion in the Register and in all but one of these professions members of the public were the largest complainant group. Two of these professions recently joined the register – practitioner psychologists (July 2009) and hearing aid dispensers (April 2010), so the number of allegations received in this period includes cases that were transferred to the HPC from the British Psychological Society and the Hearing Aid Council. We might also link this increase to increased awareness of the HPC through employer events and other communications activity and the increased accessibility of the fitness to practise process.

- 3.5 With regards to the length of time take to conclude cases, it is unclear from the report whether this is the length of time from receipt of allegation to conclusion of the final hearing or whether this is the length of time from a case to answer decision to final hearing. In 2010/2011, the length of time taken from receipt of allegation for a hearing to conclude was a mean of 15 and a median of 14 months, a reduction from 18 and 16 months from the previous year. The length of time take from a case to answer decision for a hearing to conclude was a mean and median of 9 months in 2010-11 compared to a mean and median of 11 and 9 months the previous year. Analysis undertaken by the Executive and considered by the Fitness to Practise Committee in February 2010 indicates that the minimum time a case can take to conclude from receipt to final hearing is 11 months.<sup>5</sup>
- 3.6 Although the Committee refers to CHRE targets, the CHRE does not set express targets for the length of time taken to conclude fitness to practise cases as part of its performance review. In its 2009/2010 performance review, the CHRE particularly commended the fitness to practise department in the areas of communication, employer engagement and its focus on continuous improvement, and raised no concerns about the length of time taken to conclude cases.<sup>6</sup>

### **Voluntary erasure**

- 3.7 The ability of individuals who are subject to fitness to practise action to remove themselves from the Register is referred to in both reports – the GMC refers to this as ‘voluntary erasure’. The NMC reported to the Committee that it was seeking legislative amendments to gain powers to consider applications for voluntary erasure from those undergoing fitness to practise cases.

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<sup>5</sup> Audit of final fitness to practise decisions, Fitness to Practise Committee, 16 February 2011

<http://www.hpc-uk.org/aboutus/committees/archive/index.asp?id=527>

(click on enclosure 6)

<sup>6</sup> CHRE performance review 2009/2010 <https://www.chre.org.uk/satellite/311/>



- 3.8 Where a doctor is subject to fitness to practise action but wishes to remove themselves from the medical register, a GMC panel or case examiner can grant voluntary erasure if this would protect the public interest; the private interest of the complainant; and the private interest of the doctor. The GMC outlined to the Committee how this process can provide a quicker outcome that protects the public, avoiding the risk of a sanction less than erasure (striking-off) at a hearing.
- 3.9 The Committee's scrutiny of this area was because of criticism of the GMC's decision to grant voluntary erasure in some cases where the complainant and/or other interested parties (such as insurers) were dissatisfied with the decision and/or were not given sufficient notice and opportunity to raise objections. The Committee concluded that the GMC should not grant an application 'unless interested parties have been given adequate notice...and have been offered an opportunity to voice an opinion on the matter'. The Committee's conclusion in relation to the NMC was more directive: '...erasure must only take place with the consent of the complainant.'
- 3.10 The availability of information of the circumstances giving rise to voluntary erasure was also considered by the Committee. The GMC reported that they were seeking powers to publish the circumstances of voluntary erasure in fitness to practise cases, and this was endorsed by the Committee. Similarly, the Committee concluded with reference to the NMC that erasure should involve 'publication of the full details of the case against the registrant'.

### **HPC observations / comments**

- 3.11 The HPC does not have powers for considering applications for 'voluntary erasure' from individuals subject to fitness to practise allegations. The HPC uses the similar term 'voluntary removal' to refer to the process by which a registrant can ask us mid-registration cycle to remove their name from the register. However, this is not open to those who are the subject of allegations.<sup>7</sup>

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<sup>7</sup> Article 11(3) of the Order and Rule 12(3) of the Health Professions Council (Registration and Fees) Rules 2003 prevent a registrant from seeking to resign from the register whilst the registrant is the subject of an allegation or a conditions of practice order or suspension order made by a Panel.

3.12 The HPC does have arrangements to dispose of cases that have been referred to final hearing by consent, as a means to quickly and effectively protect the public without the need for a contested hearing.<sup>8</sup> The HPC only considers agreeing to dispose of a case by consent where it is content that the proposed outcome would protect the public and that it would not be detrimental to the wider public interest to proceed in this way.

3.13 The HPC will only consider resolving a case via consent:

- after an Investigating Committee has found that there is a “case to answer”, so that a proper assessment has been made of the nature, extent and viability of the allegation;
- where the registrant is willing to admit the allegation in full. A registrant’s insight into, and willingness to address, failings are key elements in the fitness to practise process and it would be inappropriate to dispose of a case via consent where the registrant denies liability; and
- where any remedial action agreed by the registrant and the HPC is consistent with the expected outcome if the case was to proceed to a contested hearing.

3.14 This process may also be used when existing conditions of practice orders or suspension orders are reviewed. This enables orders to be varied, replaced or revoked without the need for a contested hearing.

3.15 Although the HPC and the registrant can agree to dispose of a case via the consent regime, this has to be considered and approved by a panel and panels retain the option to reject such a request. An agreed statement of facts is also published on the HPC website setting out the decision in such cases. Furthermore, CHRE retains its section 29 powers to review such cases. In 2010/2011, 17 cases were concluded by the HPC’s consent arrangements.

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<sup>8</sup> HPC Practice Note: Disposal of cases by consent  
<http://www.hpc-uk.org/publications/practicenotes/index.asp?id=172>

## 4. Proactive regulation

- 4.1 A theme across both reports is 'proactive regulation', with a focus on the regulators' role in taking proactive action where possible, pre-empting poor practice and joining-up information from different sources to identify systemic issues.
- 4.2 One specific area is around taking forward complaints relating to standards at Mid Staffordshire NHS Foundation Trust, which is currently the subject of a public inquiry. The Committee criticised the GMC's decision to put 'on hold' cases relating to registrants working at this Trust until the outcome of the public inquiry, commending the NMC for its approach.
- 4.3 Another is the NMC's approach in this area. The Committee notes that it has undertaken two 'extra-ordinary reviews' of the pre-registration education environment in two NHS Trusts, one of which was precipitated by concerns raised by the Care Quality Commission (CQC) and Monitor. Since the publication of the Committee's report, the NMC has asked three education providers to remove students from the Pilgrim Hospital in Lincolnshire following concerns about the learning environment. This follows a recent CQC report which raised concerns about the standard of care.<sup>9</sup>
- 4.4 The NMC has recently undertaken a project looking at 'critical standards intervention' – looking at ways in which the NMC could be 'more proactive in its protection of the public, within existing powers'. The NMC is establishing a 'critical standards intervention' team which will lead this work, which will aim to bring together information received from fitness to practise, education and other areas of the NMC in order to identify 'failures of critical standards' and to work in partnership with other organisations to identify where it is necessary to intervene.<sup>10</sup>

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<sup>9</sup> 'Pilgrim Hospital Student Nurses Removed Over 'Concerns'', BBC News Online 29 July 2011  
<http://www.bbc.co.uk/news/uk-england-lincolnshire-14339185>

<sup>10</sup> Nursing and Midwifery Council, Critical Standards Intervention, September 2010  
<http://www.nmc-uk.org/About-us/The-Council/Meetings-of-the-Council/16-September-2010/>

## **HPC observations / comments**

- 4.5 The topic of the relationship between systems and professional regulators has received some attention recently in light of the Mid Staffordshire NHS Foundation Trust public inquiry and the Winterbourne view case.
- 4.6 The HPC recently entered into a memorandum of understanding with the Care Quality Commission about sharing information. We are currently reviewing how we might routinely identify trends in fitness to practise data and cases which might be of interest to the CQC. Similarly, the Education Department is also reviewing how we might routinely identify trends in practice placement learning environments.
- 4.7 Like the other professional regulators, the HPC does not have powers to intervene in organisations. In the area of education, the HPC's powers are limited to approving and monitoring programmes of education and training which lead to registration or annotation of the Register. The HPC does not have wider powers to undertake reviews or to intervene in other ways in practice learning environments. However, the HPC can and has acted on information it has received from external sources in order to assure itself that the standards of education and training continue to be met. The HPC has also been in contact with the CQC in light of the NMC's decision to assure itself that there are no concerns with regards the practice learning environment for those professions regulated by the HPC.
- 4.8 The Executive does not ask the Council to agree any specific actions in this area at this time. However, this will need to be kept under review by the Council and by the Executive and in light of the forthcoming publication of the outcomes of the public inquiry into poor care at Mid Staffordshire Hospital NHS Foundation Trust.

## **5. Language proficiency and competence of internationally qualified professionals**

- 5.1 In both the NMC and GMC reports, the Committee addresses the issue of the regulators' ability to test the competence and English language proficiency of doctors, nurses and midwives coming to the UK from a country in the European Economic Area (EEA) and Switzerland.
- 5.2 This area has recently received press attention in the light of the case of Dr Ubani, a German doctor who gave a patient a fatal overdose of medicine whilst undertaking a locum appointment in the UK. The Committee concludes that the inability of these regulators to routinely test language proficiency and competence is 'unsatisfactory', 'unacceptable' and 'at odds with good clinical practice' and urges the regulators to work with government to resolve the situation.

### **HPC observations / comments**

- 5.3 Some professions, including doctors, nurses and midwives are subject to 'sectoral' arrangements which mandate 'automatic recognition'. This means that registration with a competent authority (normally another regulator) in another EEA state has to be recognised in the UK, meaning that knowledge and competence cannot be assessed.
- 5.4 The professions regulated by the HPC are not subject to automatic recognition. The HPC is able to assess individuals from the EEA to establish whether the combination of their training and experience meets the standards of proficiency for entry. In cases where the HPC has identified a substantial shortfall in the standards required for practise in the UK, the applicant can choose between undertaking a period of adaptation (a period of further training and experience) or sitting a test of competence (a test of knowledge and/or skills).
- 5.5 All of the regulators, including the HPC, are prohibited from routinely language testing applicants exercising mutual recognition rights. The HPC therefore does not require evidence of a completed language test for these applicants. The only exception to this is for speech and language therapists where language proficiency is a core professional skill.
- 5.6 The European Commission is currently reviewing the Professional Qualifications Directive and this topic has recently been scrutinised by the House of Lords European Union Committee. In its responses to the Commission and to the House of Lords we have indicated that the current requirements are workable in practice and that we are unable to point to

any robust evidence that the requirements are problematic. However, we also noted that importance of employers putting in place rigorous selection and induction procedures.<sup>11</sup>

- 5.7 The European Commission has recently published a Green Paper as the next stage in its review. The paper asserts the Commission's view that 'systematic language testing can become a means of unfairly preventing foreign professionals from accessing the right to perform a professional activity, if applied disproportionately' (paragraph 35: page 14). Two options are suggested – clarifying the code of conduct that accompanies the Directive; or introducing a one-off exemption applicable to health professionals with direct contact with patients to allow language testing.<sup>12</sup>
- 5.8 **Action:** The Executive will continue to engage in the review of the Professional Qualifications Directive and update the Council as appropriate.

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<sup>11</sup> Health Professions Council response to the European Commission consultation on the Professional Qualifications Directive, March 2011

<http://www.hpc-uk.org/aboutus/consultations/external/index.asp?id=119>

Health Professions Council response to the House of Lords European Union Committee call for evidence on the Professional Qualifications Directive, June 2011

<http://www.hpc-uk.org/aboutus/consultations/external/index.asp?id=121>

<sup>12</sup> Modernising the Professional Qualifications Directive (Green Paper), June 2011

[http://ec.europa.eu/internal\\_market/consultations/2011/professional\\_qualifications\\_directive\\_en.htm](http://ec.europa.eu/internal_market/consultations/2011/professional_qualifications_directive_en.htm)

## 6. Reporting concerns and 'whistleblowing'

- 6.1 In both reports the Committee references the ongoing public inquiry into poor care at Mid Staffordshire Hospital NHS Trust and the investigation into abuse at the Winterbourne View private hospital. The reports note the action that each regulator has taken in respect of the doctors and nurses involved, particularly those that were aware of poor practice but did not act appropriately to raise their concern.
- 6.2 The Committee has concluded that both regulators should 'send a clear signal' to their registrants that they are at 'as much risk of being investigated by their regulator for failing to report concerns about a fellow registrant as they are from poor practice on their own part'. The Committee also acknowledges reported occasions where whistleblowers have been unfairly disciplined by their employers for raising concerns.

### HPC observations / comments

- 6.3 The standards of conduct, performance and ethics ('SCPE') are clear that registrants are responsible for their actions and omissions. In particular: 'You must protect service users if you believe that any situation puts them in danger... This includes the conduct, performance or health of a colleague.' (paragraph 1) However, it is suggested that consideration might be given to strengthening this area further when the standards are next reviewed. The Executive plans that the next review should commence early in 2011/2012 with republication of the standards by the end of 2012/2013 in line with the previously agreed timetable.
- 6.4 In December 2010, an article was published in the HPC In Focus newsletter looking at raising and escalating concerns in the workplace. At the same time, more information was published on the HPC website, including links to sources of further help and a flow diagram which covers raising concerns informally as well as the more formal process of 'whistleblowing'.<sup>13</sup>
- 6.5 **Action:** The issue of reporting concerns should be considered in the next review of the SCPE. The Executive plans to bring a proposal for this work to the Council in May 2012.

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<sup>13</sup> Raising and escalating concerns in the workplace  
<http://www.nmc-uk.org/Press-and-media/Latest-news/NMC-annual-report-and-accounts-2010-2011-and-annual-fitness-to-practise-report-2010-2011/>  
Raising and escalating concerns in the workplace, HPC In Focus, December 2010  
<http://www.hpc-uk.org/publications/newsletter/index.asp?id=428>

## **7. Equality and diversity and internationally qualified registrants**

- 7.1 The GMC has observed that black and ethnic minority doctors are overrepresented in its fitness to practise hearings. However, its research has indicated that where a doctor is trained is a more important factor. The research showed that ethnicity was not linked to outcome in cases, but that there was a clear link between whether a doctor qualified outside of the UK and fitness to practise outcomes. In its evidence, the GMC noted that a greater proportion of overseas doctors are likely to be employed in peripatetic locum positions without the levels of support associated with working for one organisation / in one setting.
- 7.2 The Committee suggested that the GMC should do more to understand the risks of these practitioners and to work to ensure that these doctors are supervised and supported.
- 7.3 No such trend was reported in the NMC's report. However, the Committee expressed concern that the NMC has yet to publish an analysis of ethnicity data on the nursing and midwifery register. In addition, the Committee concluded that the NMC needed to start collecting equality and diversity monitoring data in fitness to practise cases so that the public can have 'confidence that the NMC discharges its functions in a manner that is fair and equitable to minorities'.

### **HPC comments / observations**

- 7.4 The HPC has not to date identified any significant trend in the numbers of allegations from registrants who qualified outside of the UK. Instead the data has consistently shown, year-on-year, that registrants who qualified outside of the UK are not overrepresented in fitness to practise proceedings.
- 7.5 Some of the regulators, including the NMC and the GMC have been subject to 'specific duties' under equality legislation which means that they are required to publish a scheme setting out how they will ensure that in their functions they do not discriminate on the basis of disability, age, gender, transgender, sexual orientation, race and religion. This includes requirements around collecting equality and diversity data. The separate legislation in these areas has now been replaced by the Equality Act 2010. In its 2009/2010 performance review, the CHRE noted that there was variation in the demographic data collected by the regulators and recommended that 'all the regulators should be subject to the same duties and expectations under all equality and diversity legislation'.



- 7.6 The HPC has not been subject to the specific duties but, in 2008, published an equality and diversity scheme as part of good practice. Our approach in this area is currently being reviewed in light of the Equality Act 2010.<sup>14</sup> In 2008, the Council considered its approach to demographic data collection and the Council agreed that it would begin to collect data from applicants for registration, before considering at a future point whether it might collect data from registrants.<sup>15</sup>
- 7.7 One particular issue was about the usability and meaningfulness of the data, and legal advice sought by the Executive indicated that, as the HPC was not included in the specific duties, it was highly limited as to how it could collect and store any data. In particular, the data could only be collected on an anonymised basis, which meant that, even with certain safeguards, the data could not be stored alongside other registration data or linked in any way to registrant or applicant records. This very much limits the usability of any data as it would not be possible, for example, to run a report that might indicate trends in ethnicity referenced against fitness to practise outcomes.
- 7.8 The HPC currently collects some data as part of routine registration work (for example, gender and age). The HPC also collects equality and diversity data from applicants for registration on a voluntary and anonymised basis. The HPC also collects equality and diversity data from registrants and complainants involved in fitness to practise cases on a voluntary and anonymised basis. For both of these areas, in particular for applicants, the take-up rate has been low. The HPC also collects data from applicants for employment and from existing employees.
- 7.9 The Executive suggests that it would be timely to review this area again, following the receipt of advice about necessary changes and updates to the equality and diversity scheme.
- 7.10 **ACTION:** The Executive will produce a paper looking at the HPC's existing approach to demographic data collection and present this to the Council in 2012/2013.

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<sup>14</sup> Equality Act 2010, HPC Council meeting, 31 March 2011  
<http://www.hpc-uk.org/aboutus/committees/archive/index.asp?id=533>  
(enclosure 13)

<sup>15</sup> Equality and Diversity demographic data collection, HPC Council meeting, 3 July 2008  
<http://www.hpc-uk.org/aboutus/committees/archive/index.asp?id=338>  
(enclosure 10)

## **Appendix 1: General Medical Council**

The conclusions / recommendations reached by the Committee in their final report are reproduced below for completeness. The structure mirrors the sections in the main paper, where possible, therefore some conclusions / recommendations may appear in different sections in the Committee's published report.

### **Introduction**

- Although the Committee recognises that the GMC achieves a high level of operational competence, it remains concerned that the leadership function of the GMC within the medical profession, and within the wider health community, remains underdeveloped particularly in the areas of fitness to practise, revalidation, education and training and voluntary erasure. We hope that the GMC will embrace more ambitious objectives for professional leadership, some of which are described in this report.

### **Revalidation**

- The work undertaken by the Society of Cardiothoracic Surgery of Great Britain and Ireland in setting standards for that part of the medical profession is commendable. Its transparency will be welcomed by patients and should be a template (where clinically relevant) for further refinement of the revalidation process.
- The GMC clearly has a considerable amount of work to undertake between now and the implementation of revalidation in 2012. Although we agree that all disciplines will not have developed their standards to an advanced level by that date, the GMC needs to accelerate its work with the medical royal colleges to further refine the standards for revalidation in specialist areas and to ensure that the process is meaningful to clinicians and transparent to the public.
- As the GMC states, some doctors may decide to retire rather than undergo the process of revalidation; of those who pursue revalidation, some may require retraining and some may fail to meet the required standards. The GMC needs to ensure that it monitors the number of doctors who retire, leave the profession, have conditions placed on their practice or fail revalidation. It must develop and share this evidence with employers to ensure that future workforce planning includes the developing outcome of the revalidation process.
- Of the Officers who will have to make recommendations about revalidating doctors, only a minority feel that the process will help with the early identification of doctors with performance issues. Early identification of

problem doctors is a core task of the professional regulatory system, and the GMC needs to ensure that its systems of appraisal and revalidation achieve this task.

- The Committee notes the negative media reports about the time taken to undertake revalidation and hopes that the GMC will ensure that lessons are learned from the revalidation pilots, particularly in how it can support locum doctors. It also needs to ensure that the underlying processes that doctors are expected to undertake are not unwieldy and overly time-consuming, and that they are an effective means of gathering the required evidence.

### **Fitness to practise**

- The Committee notes that there is an increase in referrals of doctors to the GMC, and of nurses to the NMC, as well as an increase in the number of general NHS complaints. The Committee welcomes the fact the GMC has commissioned research into this phenomenon in order to better understand what is driving this increase, and to ensure that their systems and processes are adequate for meeting the future needs of the public. We look forward to reviewing the preliminary findings of this with the GMC at our next accountability hearing.
- The Committee welcomes the ongoing good performance of the General Medical Council (GMC) in resolving 90% fitness to practise cases within fifteen months. However, we agree with the GMC that fifteen months is indeed too long to conclude such cases and we recommend that the Council for Healthcare Regulatory Excellence (CHRE) their regulatory body, should set the GMC a more demanding target for future years.
- Some of the decisions made by fitness to practise panels of the GMC defy logic and go against the core task of the GMC in maintaining the confidence of its stakeholders. Furthermore, they put the public at risk of poor medical practice.
- The GMC holds the dual but potentially conflicting roles of prosecutor and adjudicator in fitness to practise cases. The GMC proposes to establish an Independent Medical Practitioner Tribunal Service to create a greater separation between these functions, and the Committee supports this proposal. We also urge that performance management of fitness to practise panellists commence as soon as is practicable.
- The GMC currently has no right of appeal over decisions made by independent fitness to practise panels. The Committee does not seek to undermine the existing power of appeal held by the Commission for Healthcare Regulatory Excellence, but agrees that the GMC needs also to have a right of appeal in cases where it thinks panellists have been too

lenient. We urge the Government to move quickly to make the necessary legislative amendments.

- Several cases have been brought to the attention of the Committee of doctors applying to remove themselves from the register during an ongoing investigation into their practice by the GMC (so called voluntary erasure). The Committee has no objection to the principle of voluntary erasure as it can be a useful tool to protect the public. However, in some cases, interested parties have been given little or no time to raise an objection to applications for voluntary erasure, and the GMC was not able to offer a clear explanation of this.
- Applications for voluntary erasure must not be granted by the GMC unless interested parties have been given adequate notice of an application and have been offered an opportunity to voice an opinion on the matter.
- The Committee fully supports the publication of the facts of any case of voluntary erasure where there is a fitness to practise allegation about the doctor concerned. The GMC needs to ensure that turning voluntary erasure into an admission of guilt does not have a perverse impact in reducing the numbers seeking it and therefore erode public protection.

### **Proactive regulation**

- In contrast to the approach of the Nursing and Midwifery Council, the GMC has put its fitness to practise cases relating to Mid Staffordshire "on hold" until the inquiry has concluded. The Committee believes that this is neither fair to the public, or to the registrants under investigation. We urge the GMC to set out its rationale for this, publically and clearly.
- We suggest that the GMC further considers risk-based approaches to proactive regulation and how these could be developed with its employer liaison services.

### **Language proficiency and competency of internationally qualified professionals**

- Doctors from the European Economic Area and Switzerland seeking to practice in the UK cannot routinely be language and competence tested by the GMC.
- The GMC along with the Government is working towards resolution of this with partner organisations across Europe. The Committee takes the view that current legal framework is at odds with good clinical practice, which is clearly unacceptable. The GMC has plans, within the boundaries of UK law and the EU Directive, to manage the constraints on language and competence testing by using the Responsible Officer role to establish that EEA (the EU plus several other European countries) doctors are fit to

practise in the UK. The Committee accepts this way forward as a short term measure.

- Although this short term measure is welcome, the Committee believes that public confidence in the medical profession requires the issue to be addressed authoritatively. It is clearly unsatisfactory that the competence to practise of health professionals should be assured by a work-around, and we look to the Government, GMC and the relevant European bodies to work as a matter of urgency to produce a long-term solution to this problem. (Paragraph 23)

### **Reporting concerns and 'whistleblowing'**

- Doctors from Mid Staffordshire NHS Foundation Trust whose practice was in itself blameless but who failed to act and raise concerns about colleagues are now also under investigation by the GMC. A clear signal needs to be sent by the GMC to doctors that they are at as much risk of being investigated by their regulator for failing to report concerns about a fellow registrant as they are from poor practice on their own part.
- The Committee recognises, however that doctors and other practitioners who have raised concerns by other staff have sometimes been subject to suspension, dismissal or other sanctions. The Committee therefore intends to examine this issue in more detail in due course.

### **Equality and diversity and internationally qualified registrants**

- The Committee appreciates the seriousness with which the GMC has treated the suggestion that doctors from black and minority ethnic backgrounds are over-represented in fitness to practise cases. The finding that this relates to overseas trained doctors and not ethnicity per se does not alter the fact that a problem exists.
- The GMC needs, as matter of urgency, to do more to understand the risks associated with overseas-qualified doctors. It should offer timely induction and needs to assure itself that those doctors in peripatetic locum positions are adequately supervised and supported. If a doctor is not safe to practise in the UK then the GMC must ensure that they do not do so.

## **Appendix 2: Nursing and Midwifery Council**

The conclusions / recommendations reached by the Committee in their final report are listed below for completeness. The structure mirrors the sections in the main paper, where possible, therefore some conclusions / recommendations may appear in different sections in the Committee's published report.

### **Introduction**

- The NMC has requested Department of Health support for further amendments to the legislation that governs its operation. The Committee broadly supports this request, as improvement to the performance of the NMC in some key areas is hampered by its current legal framework. The Government must prioritise this work if it wishes to see further improvement in the performance of the NMC.
- The Committee welcomes the improved financial performance of the NMC in recent years, but is concerned about the affordability of the registration fee for many lower paid registrants. We would urge the NMC to avoid further fee rises and to consider fee reductions for new entrants to the register.
- The NMC is now leaving behind its previous organisational and financial instability, and is improving in many areas of its work. There remains however a significant amount of work to be done in order for it to be an effective regulator that has public protection as its principal concern.
- Although, therefore, the Committee recognises that the NMC is developing a higher level of operational competence, it remains concerned that the leadership function of the NMC remains underdeveloped, particularly in the areas of fitness to practise, revalidation, education and training and proactive regulation. The Committee hopes that the NMC will embrace more ambitious objectives for professional leadership, some of which are described in this report.

### **Revalidation**

- The current standard for re-registration—completing 450 hours of practice and 35 hours of professional development—is wholly inadequate, as this tells patients and the public nothing about the quality of nursing and midwifery practice undertaken by the registrant. There is also no routine assessment of whether nurses and midwives have even met this minimal standard. The NMC instead relies on honesty within the profession and "whistle-blowing" when registrants are dishonest. For many nurses and midwives this may well be adequate, but for a significant minority,

including those most at risk of manifesting low professional standards, it may not be.

- The Committee supports the NMC's risk-based approach to the current re-registration process. However, we are concerned that there are nurses and midwives who could be failing to meet the already unacceptably low standards for re-registration but who do not come to the attention of the NMC and are therefore re-registered unchallenged. Registrants must feel that their regulator could call in their re-registration evidence at any time and as such the NMC should undertake an annual random audit of the registration renewal evidence supplied by a sample of registrants.
- The Committee will monitor progress against the 2014 deadline for the introduction of revalidation by the NMC at subsequent accountability hearings.
- Revalidation of nurses and midwives is a significant undertaking that the NMC is progressing with due caution. The Committee notes that statutory supervision of midwives is a tried and trusted means of assuring the quality of midwifery practice. The NMC should consider the costs and benefits of extending the statutory supervision framework as a potential means of delivering an effective revalidation process for all registrants.
- The NMC needs to ensure that it monitors the number of nurses and midwives who retire, leave the profession, have conditions placed on their practice or fail revalidation. It must develop and share this evidence with employers to ensure that the future workforce planning includes the developing outcome of the revalidation process.
- The Department of Health must clarify how it will maintain the continuity of statutory supervision of midwives through Local Supervising Authorities once Strategic Health Authorities are abolished.

### **Fitness to practise**

- The Committee is very concerned about the recent dramatic rise in the numbers of NMC referrals of nurses and midwives, and that NMC reports make it difficult to distinguish between referrals made about nurses or midwives. We are surprised that the NMC has no clear answer to why referrals are increasing, and recommend that the NMC undertakes urgent research to establish the reasons for this increase. This data could and should be used to support the development of revalidation and a more proactive approach to regulation.

- The Government is proposing to have one Act of Parliament that establishes the core functions of professional regulators, leaving them to decide how they discharge these. The Committee welcome the Governments plans for simplification of the legislation that underpins professional regulation in the UK.
- However, in the light of criticisms by the CHRE about "significant weaknesses" with the process, the Committee urges the Government to bring forward amendments as soon as possible to the Nursing and Midwifery Order 2001 so that the NMC can streamline its fitness to practise procedures.
- The Committee supports the proposal that nurses and midwives be able to voluntarily remove themselves from the register. However, where concerns have been raised about a nurse or midwife seeking erasure, or where an investigation is taking place into fitness to practise, erasure must only take place with the consent of the complainant and on publication of the full details of the case against the registrant.

### **Proactive regulation**

- The NMC's plans for investigation of and intervention in a healthcare organisation where concerns are being raised is a creative and interesting approach to regulating what is a large group of professionals working across a variety of settings. It offers the NMC another tool to strengthen public protection.
- We do feel however that whilst the power to look at the quality of educational environments gives the NMC "a foot in the door", clear power must be established in law for further expansion of this role, and we encourage the Government and the NMC to work together to develop this approach. The Committee would particularly like to see the NMC responding to trends in outcome and complaints data from NHS and social care providers.

### **Language proficiency and competence of internationally qualified professionals**

- Nurses and midwives from the European Economic Area and Switzerland seeking to practice in the UK cannot routinely be language and competence tested by the NMC. The NMC, along with other professional regulators and the Government is working towards resolution of this with partner organisations across Europe. The Committee takes the view that the current legal framework is at odds with good clinical practice, which is clearly unacceptable.



- The Government, the NMC and the other health professions regulators must now grasp this as a significant risk to patients and dramatically pick up the pace in resolving or mitigating it.
- The Committee is concerned that waiting for regulatory action at a European level will expose patients to a high risk over an unacceptably long period of time. We would like to see prompt action on this matter along the lines taken by the GMC where Responsible Officers sign off a doctor as competent and fit to practise.

### **Reporting concerns and 'whistleblowing'**

- Following our earlier report into complaints and litigation, the Committee remains very concerned about the existence of low standards of basic nursing care in our acute hospitals and care homes, which appear to be in breach of the code of conduct for nurses and midwives. We are particularly concerned about this in light of the ongoing inquiry into Mid Staffordshire NHS Foundation Trust, the Winterbourne View scandal and the recent Health Service Ombudsman report into care of the elderly in hospital.
- This evidence presents a challenge to the NMC which is responsible for professional standards in the nursing and midwifery professions. Based on its existing guidance on care of the elderly, we propose that the NMC should develop a programme of action to deliver a demonstrable improvement in outcomes for this vulnerable group.
- Furthermore, the NMC needs to send a clear signal to nurses and midwives that they are at as much risk of being investigated by their regulator for failing to report concerns about a fellow registrant as they are from poor practice on their own part.

### **Equality and diversity and internationally qualified registrants**

- The Committee is also concerned that an analysis of ethnicity data on the nursing and midwifery register is still not available despite having made assurances that this would take place in 2010. Of more concern is the fact that, according to its own records, the NMC is still not recording ethnicity or other diversity monitoring in fitness to practise cases. Without this, neither the professions nor the public can have confidence that the NMC discharges its functions in a manner that is fair and equitable to minorities.

## **Regulation of healthcare support workers**

- As previously mentioned, the Committee has ongoing concerns about the care and treatment of older people both in hospitals and care homes. Of particular concern to the Committee is the lack of regulation of a range of groups who undertake many basic nursing care tasks.
- The Committee endorses mandatory statutory regulation of healthcare assistants and support workers and we believe that this is the only approach which maximises public protection. The Committee notes that the Government intends to give powers to the relevant regulators to establish voluntary registers for non-regulated professionals and workers, but would urge it to see healthcare assistants, support workers and assistant practitioners as exceptions to this approach who should be subject to mandatory statutory regulation. However, the NMC needs to make significant improvements in the conduct of its existing core functions (such as in how it manages fitness to practise cases) before powers to register these groups are handed to it.