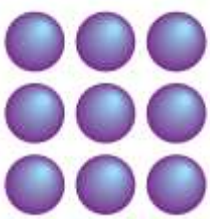
A review conducted for the Nursing Council of New Zealand

October 2012



council for healthcare regulatory excellence

About CHRE

The Council for Healthcare Regulatory Excellence promotes the health and well-being of patients and the public in the regulation of health professionals. We scrutinise and oversee the work of the nine regulatory bodies[1] that set standards for training and conduct of health professionals.

We share good practice and knowledge with the regulatory bodies, conduct research and introduce new ideas about regulation to the sector. We monitor policy in the UK and Europe and advise the four UK government health departments on issues relating to the regulation of health professionals. We are an independent body accountable to the UK Parliament.

Our aims

CHRE aims to promote the health, safety and well-being of patients and other members of the public and to be a strong, independent voice for patients in the regulation of health professionals throughout the UK.

Our values and principles

Our values and principles act as a framework for our decision making. They are at the heart of who we are and how we would like to be seen by our stakeholders.

Our values are:

- Patient and public centred
- Independent
- Fair
- Transparent
- Proportionate
- Outcome focused

Our principles are:

- Proportionality
- Accountability
- Consistency
- Targeting
- Transparency
- Agility

Right-touch regulation

Right-touch regulation means always asking what risk we are trying to regulate, being proportionate and targeted in regulating that risk or finding ways other than regulation to promote good practice and high-quality healthcare. It is the minimum regulatory force required to achieve the desired result.

CHRE will become the Professional Standards Authority for Health and Social Care in the autumn of 2012

1 General Chiropractic Council (GCC), General Dental Council (GDC), General Medical Council (GMC), General Optical Council (GOC), General Osteopathic Council (GOsC), General Pharmaceutical Council (GPhC), Health and Care Professions Council (HCPC), Nursing and Midwifery Council (NMC), Pharmaceutical Society of Northern Ireland (PSNI)

Contents

1. Introduction

1.1 This report follows a request in 2010 from the Nursing Council of New Zealand (NCNZ) for CHRE to undertake a review of the effectiveness of its:

- Governance arrangements
- Conduct, competence and health functions.

1.2 The review was carried out in March and April 2012.

1.3 CHRE undertakes annual performance reviews of the nine health professional regulatory bodies in the UK as part of our statutory responsibilities. We publish the outcome of those reviews annually to the UK Parliament and the devolved administrations. We have also, following requests from the organisations, conducted reviews for the Medical Council of New Zealand, the General Teaching Council for England, the General Social Care Council in England and for the UK's Nursing and Midwifery Council.

1.4 Although CHRE has no statutory oversight of the NCNZ, we consider that there are mutual benefits in this review. There are benefits to the NCNZ in having an independent assessment which benchmarks its performance in relation to other regulators. At the same time we have the opportunity to learn about different approaches to professional regulation and regulatory practice, which, following publication of this report will be shared with regulatory bodies in the UK, New Zealand and internationally.

1.5 We are grateful to the Council and staff of the NCNZ for their positive engagement with this review, for their readiness to provide us with the background information, paperwork and case files we needed and for the hours they spent between them answering our questions and explaining their processes. This report has depended greatly on their openness and cooperation.

2. Scope of review and methodology

2.1 CHRE has an established process for undertaking performance reviews. This is based on a set of standards, which we developed in liaison with the UK health professional regulators and other stakeholders including patients and the public. These are called the Standards of Good Regulation[2]. In undertaking this review we used our procedure and standards for undertaking performance reviews of the health professional regulators in the UK as a framework to guide our review of the NCNZ.

2.2 To carry out an audit of 21 NCNZ case files closed between 2010 and 2012 we used our audit process[3]. In March 2010 CHRE led a meeting of representatives from all of the nine health professional regulators to agree a 'Casework Framework'. This was a description of the key elements that should be present in

[2] http://www.chre.org.uk/_img/pics/library/100601_The_Performance_Review_Standards_1.pdf

[3] https://www.chre.org.uk/_img/pics/library/110831_Audit_Process_and_Guidelines_Revised.pdf

the different stages of a good fitness to practise process. When auditing the NCNZ case files, we assessed the handling of a case against the elements of the Casework Framework.

2.3 In brief, the procedure followed in this review involved preparation and consideration of the written evidence which the NCNZ provided in March 2012 prior to the Review Team working at the NCNZ in Wellington between 16-27 April 2012. During this period we:

- Reviewed documentary evidence provided by the NCNZ
- Audited 21 NCNZ case files (this included conduct cases, competence cases, health cases, cases where no further action was taken and those cases referred to either the Health and Disability Commissioner (HDC) or the Health Practitioners' Disciplinary Tribunal (HPDT))
- Observed a complaints and notifications meeting
- Observed a Council meeting at NCNZ
- Met with the Chief Executive (CE) and individually with members of the management team
- Met with the Chair, Deputy Chair and individually with all members of Council
- Met with a sample of Professional Conduct Committee (PCC), Competence Review Panel (CRP) and Health Committee (HC) members
- Met with stakeholders of the NCNZ.

2.4 We also had the opportunity while in Wellington to meet with representatives of Health Workforce New Zealand at the Ministry of Health, and with colleagues at the Medical Council of New Zealand who provided us with valuable background information and context.

2.5 We have set out our approach to effective regulation in our paper *Right-touch regulation*[4]. Right-touch regulation means using only the regulatory force necessary to achieve the desired effect. It sees regulation as only one of many tools for ensuring safety and quality and therefore that it must be used judiciously. Professional regulation exists not to promote or protect the interests of professional groups but to enhance patient safety and protect the public. The general approach to regulation set out in that paper underlies our Principles of Good Regulation and our judgement about the performance of the NCNZ.

2.6 This report sets out our findings in relation to the NCNZ's governance arrangements and its conduct, health and competence processes. It then moves on to discuss our views on what aspects of their legislation the NCNZ could consider commenting on under the current review of the legislation and the matters it could consider as part of the work being undertaken by the New Zealand government on its plans to merge regulatory authorities.

[4] *Right-touch regulation* CHRE 2010

3. Executive summary

3.1 We consider that overall the NCNZ has satisfactory governance arrangements in place and that it generally has effective processes for handling cases under the conduct, health and competence procedures, reaches appropriate decisions which protect the public and provides a good level of service to those who are involved. We also consider that it has a reflective approach to its work generally and regularly seeks the views of its stakeholders to ensure that its policies and processes are as effective and efficient as they can be.

3.2 Whilst we have made a number of recommendations to the NCNZ, this does not mean that we consider its performance is inadequate. Our recommendations are aimed at improvement and best practice generally not at addressing failures. We have reviewed the performance of the NCNZ with the benefit of knowledge gained from our oversight of the nine UK health professional regulators. We make our recommendations based on our knowledge of best practice in UK health professional regulation and so that the NCNZ is able to continually improve its performance.

3.3 We set out our findings in full at section five and six but below is a summary of our findings.

Governance

- Leadership – we consider that there are good working relationships based on trust between the Chair, Chief Executive and Council. In our view this is an essential component for an effective health professional regulator.
- The Council – we consider that the Council works effectively as a group. However, we are concerned that there is not a shared understanding of the role of a Council member. We consider that this is then reflected in the discussions which take place during Council meetings which we believe could have a greater focus on public protection.
- Information provided to the Council –whilst the Council receives a wealth of information at each Council meeting we consider that this information should be refocused. The Council should receive clearer information relating to risk to the organisation, financial matters and the performance of the NCNZ in each of its regulatory functions.
- Governance policies – we saw evidence of good clear governance policies which provide a framework in which decisions can be made transparently. We consider that the NCNZ would benefit from two additional policies relating to the management and investigation of complaints about itself and complaints about its Chair and Council members.
- Stakeholder engagement – we saw evidence of good stakeholder engagement with the nursing professional associations, employers and educators. However, we consider that further work could be carried out to more effectively engage with the public and patients, and with the Ministry of Health. Stakeholder engagement would be enhanced by great transparency

in the business of the NCNZ including the publication of Council agendas, papers and minutes.

Conduct, health and competence processes

- Publicly available literature on the complaints process – we consider that the information available is generally clear and helpful. Although there are some areas where the documentation would benefit from further clarity.
- Initial handling of complaints – we consider that the NCNZ has good processes in place for handling complaints on their receipt.
- Risk assessment – the NCNZ has recently introduced a process whereby each case is risk assessed on receipt. However, it does not yet have a process for assessing risk throughout the lifetime of a case. The lack of such a process means that appropriate action may not necessarily be taken once new information comes to the attention of the NCNZ.
- Gathering information – we consider that the NCNZ generally collects an adequate amount of information so that its committees can reach robust decisions.
- Decision-making – we consider that generally the NCNZ made good decisions in relation to the cases that we audited. We note that its decision letters and determinations would benefit from the inclusion of greater detail so it is clearer to the reader how decisions have been reached.
- Timeliness – we found evidence of delays in the progression of some of the cases which we audited. The reasons for these delays were unclear from the casefiles. These delays had the potential to impact on patient safety, and also to damage public confidence in the NCNZ.
- Record-keeping – we found evidence of inconsistent record keeping which meant that it could be difficult to identify an accurate and comprehensive audit trail in some cases.
- Customer service – we found that the NCNZ has a culture of providing good customer service. This was exhibited by its leadership and by staff throughout the organisation.
- Case management system – currently the NCNZ does not have an electronic case management system. We are pleased that such a system is in development as it should help it to address some of the areas for improvement we have identified.
- Guidance for staff and committee members – we consider that the NCNZ guidance which is available for staff and committee members is satisfactory but have identified additional guidance documents which could be developed.
- Recruitment, training and appraisal of committee members – we consider that committee members should be recruited through open competition and against defined job specific competencies. Committee members should also receive a formal induction training programme and ongoing refresher training thereafter. We also consider that Committee members should undergo at least bi-annual performance appraisals.

- Quality assurance – currently the NCNZ does not have a system of quality assurance for its conduct, health and competence processes. We consider that such a system should be introduced as it drives continuous improvement and enables the NCNZ to be assured about its own performance.

4. The role of Nursing Council of New Zealand and the regulatory environment in New Zealand

The role of the Nursing Council of New Zealand

4.1 The NCNZ regulates nurse practitioners (expert nurses who work within a specific area of practice incorporating advanced knowledge and skills), registered nurses (who utilise knowledge and complex nursing judgment to assess health needs, to advise and support and to provide care) and enrolled nurses (those who work under the direction of a registered nurse to deliver nursing care to people across the life span in community, hospital and residential settings). There are currently some 50,000 nurses with annual practising certificates registered with the NCNZ.

4.2 The NCNZ's role and responsibilities are similar to those of the Nursing and Midwifery Council and other UK healthcare professional regulators. In brief, it has five main functions, which are to:

- Set and promote standards that nurses must meet before and after they are admitted to the register
- Maintain a register of those nurses who meet the NCNZ's standards. Only registered practitioners with a current practising certificate are allowed to work as nurses
- Take appropriate action where a nurse's conduct, competence or health has been called into question
- Accredit and monitor educational institutions and degrees, course of studies, or programmes
- Recognise, accredit and set programmes to develop the competence of nurses.

4.3 The NCNZ is a statutory organisation, which is accountable to the New Zealand Parliament. It is funded entirely by nurses' annual practising certificates ($110) and registration application fees ($70-$3,000). The Council is made up of nine members, six of whom are professionals and three of whom are public (lay) members. Three of the professional members are elected by the profession and the rest of the members are chosen by the Minister of Health. The New Zealand legislation (Health Practitioners Competence Assurance Act 2003 (HPCA Act)) specifies that there should be a majority of nurses on the Council of the NCNZ.

The regulatory environment

4.4 Despite the similar roles set out above healthcare regulation in New Zealand is markedly different from the UK in both philosophy and organisation and we set out basic details of this approach and structure below.

4.5 The NCNZ works closely with the HDC and the HPDT. All three organisations have different but complementary roles in regulating nurses. The Health and Disability Commissioner Act 1994 and the Medical Practitioners Act 1995 set in motion this multi-layered process for receiving and dealing with complaints about nurses and other health professionals. Further refinements were achieved by the introduction of the HPCA Act 2003. This separation of roles and powers between the three bodies is an important aspect of the New Zealand system of regulation.

4.6 New Zealand also has a no-fault compensation scheme administered by the Accident Compensation Corporation (ACC). This scheme also plays a part in establishing the consensual style of regulation.

4.7 The HDC is responsible for the initial consideration and investigation of all complaints about nurses where a patient has been affected and when appropriate refers them on to the NCNZ. The HDC generally settles most complaints (including many that lead to an investigation and breach finding) through an apology from the nurse or hospital. The HDC will also note changes the nurse has made in their practice and recommend any further improvements, for example re-education.

4.8 In the event of a finding that the provider breached the Code of Health and Disability Consumers' Rights, the Commissioner may refer that provider to his independent Director of Proceedings, to decide whether to bring disciplinary and/or Human Rights Review Tribunal proceedings. The Commissioner weighs the complainant's wishes, the provider's submissions and the overall public interest in deciding whether to refer a provider found in breach of the Code to the Director of Proceedings. As a general rule, cases must be considered to be wilful, reckless, unethical or criminal before they are seen as so serious as to warrant referral. The Director then decides whether to issue proceedings taking into account the public interest and the likelihood of success. For registered health professionals the usual avenue is proceedings before the HPDT rather than a Human Rights Review Tribunal.

4.9 The HPDT, was set up in 2004, it adjudicates on final conduct cases of all of the health professional regulatory authorities in New Zealand. It is rare for competence cases to be referred to the HPDT although it does have jurisdiction to hear such cases and it has no remit to consider health cases.

4.10 The HPDT can impose the following range of sanctions, which the nurse can appeal to the High Court:

- Fines
- Conditions
- Suspensions
- Cancellation of registration (we refer to this as striking off the register).

4.11 The NCNZ can initiate immediate action in respect of complaints about the competence of individual nurses and does not have to await the outcome of the

HDC's consideration. Under the competence process, the nurse can be required to undertake a performance assessment. Where a nurse is found to be working below the required standards of competence the usual outcome is for the NCNZ to order the nurse to go through a structured educational programme. This may include supervision and some form of retraining. If the NCNZ consider there are reasonable grounds for believing the nurse poses a serious risk of harm to the public the NCNZ can order an interim suspension of their practising certificate.

4.12 The NCNZ also has powers to initiate immediate action in respect of complaints about the health of individual nurses. Under the health process the NCNZ can request that the nurse undergo a medical assessment to ascertain whether they have a health condition which is not temporary in nature and does impact on their ability to practice safely. If the nurse is found to have a health condition which affects their fitness to practise the NCNZ can suspend the nurse or require them to work under a conditions of practice order.

4.13 If the HDC refers a conduct matter to the NCNZ for its consideration or if a complaint about a nurse's conduct is made directly to the NCNZ and there is no evidence that a patient has been affected the NCNZ can undertake an investigation into a nurse's conduct. The outcome of which can be one of the following: no further action; charges being laid with the HPDT, conciliation, a letter of counsel being sent or the conduct, competence or health of the nurse being reviewed.

4.14 In addition, the ACC provides no fault compensation for people who have suffered harm or unintended consequences of medical treatment. On occasions the ACC refers cases to the HDC and the NCNZ for further consideration.

4.15 The NCNZ also works closely with the Health Workforce New Zealand (HWNZ), which is a government agency, whose role includes ensuring that the country has sufficient nurses with the necessary skills.

5. Governance

5.1 The NCNZ's Council is established by the HPCA Act 2003. There are nine members appointed by the Minister of Health. Six members are professionals, of which three are elected by the profession and three members are members of the public (lay members). The appointment of the elected members is confirmed by the Minister of Health. The Chair and Deputy Chair are elected on an annual basis by the Council from amongst their own members.

5.2 The Act gives the Council a range of statutory duties but it has some considerable discretion as to how it fulfils these. Its overall responsibilities are set out in paragraph 3.2 above. The NCNZ has good clear governance policies in place. The current Council has delegated a significant proportion of these tasks to the CE and the staff team and to its committees: the Finance and Audit Committee; the Remuneration Committee; the Education and Registration Committee; and the Professional Conduct Committee; Competence Review Panel; and Health Committee.

5.3 Decision-making is supported by a comprehensive scheme of delegation. This allows decisions to be made quickly and effectively at an appropriate level in the organisation with a clear accountability structure around them. The Council also

has a clear and comprehensive Code of Conduct which in particular addresses the issue of individual and corporate responsibility.

5.4 We commend the approach the Council is taking to separate itself from both operational and statutory decision-making. In well run organisations operational decisions are clearly the preserve of the executive staff team, while in separating statutory decisions about conduct, health and competence from the Council an important element of independence has been introduced. Furthermore by making these changes the Council has enabled itself to focus on the three elements of good governance: strategic direction; holding the executive to account; and the proper use of resources. We comment on the extent to which the Council has achieved these objectives later in this section.

5.5 We interviewed the Chair, Deputy Chair and all seven other members of Council. All members showed an appropriate understanding of the role of Council as a governing body and of the CE and staff team as the executive although there was less shared understanding of the individual responsibilities of council members. All Council members also demonstrated a real commitment to improvement and to reflection on their performance as individuals and as a group. This gives us confidence that both the process and the outcome of this review will be useful to them.

5.6 The Chair is highly respected by everyone we spoke to. The Council, the staff and the external people we met shared an admiration for her good judgement, her thoroughness, her patience and her skill as a Chair. Similarly the CE is widely regarded as having transformed the effectiveness of the organisation in providing leadership for the staff team and for communicating openly with the nursing and health community. As we have observed in a recent report[5] good working relationships between Chair, CE, Council and staff are essential for high performance. In this regard the NCNZ is in a strong position.

5.7 We have some concern that the current good balance and working relationships within the Council are despite rather than because of the constitutional arrangements of the NCNZ. We comment in paragraphs 7.9 – 7.14 on our concerns with the legislative requirements regarding the appointment process for the Chair, Deputy Chair and the Council members. We note that these appointment processes are consistent across all the health professional regulatory authorities in New Zealand rather than being unique to the NCNZ.

5.8 We observed one Council meeting in full and read the papers and minutes for a number of other Council meetings. The Council meeting lasted a full day and a half and had an agenda with 24 items; this was supported by 540 pages of documentation. The minutes in contrast were only a few pages long. Overwhelming Council members with information is not a good way to support strategic decision-making. We consider that improvements to the agendas, reporting of the Council meetings, papers for consideration and background material would enable Council meetings to be shorter and members to focus better on strategy and good decision-making.

5.9 We are therefore glad that the NCNZ, in line with its move to electronic version of meeting papers, has accepted our suggestion that the number and volume of

[5] CHRE, 2012. The Strategic Review of the Nursing and Midwifery Council, Interim Report. CHRE: London.

background papers for Council should be reduced significantly. It has introduced a system whereby that the papers submitted to Council for discussion or decision set out the objective, summarise the reasons for the decision being proposed, explain the benefit to patients and refer to background papers where necessary. The background papers are then be made available separately to Council members who wish to see them.

5.10 The primary purpose of the Council is public protection. The theory of this is clearly understood by all the members. However, meetings take place in private and there is little attempt to explain the work of the Council to patients and the public. We recommend that Council papers, agendas and minutes should be published so that the public and registrants can have confidence in the conduct of the NCNZ's business.

5.11 New Zealand has a relatively small population, therefore people in healthcare and public life are bound to know each other and nurses know other nurses so conflicts of interest are inevitable. Council members and Committee members are mindful of this and good procedures are in place to avoid inappropriate engagement in decisions about conduct, competence and health. The avoidance of conflicts of interests is somewhat less clear in the Council itself, where two thirds of the members are nurses and indeed one of the three public members also has a role in healthcare. We noted the frequency with which Council members referred to their personal experiences of nursing in assessing a policy and the impact of decisions or changes in practice on nurses. In contrast patients and the impact of decisions or changes on patients were very rarely mentioned during the Council's discussions. We think Council members would be helped to achieve their intention if each paper for discussion or decision had a statement of patient impact included in it.

5.12 We consider that the NCNZ has satisfactory polices to take account of cultural sensitivities in New Zealand and that it demonstrated serious commitment to equalities and diversity.

5.13 Regulation is about the management of risk. The Council in its work pays proper attention to the risks inherent in nursing and is now turning its attention to the risks associated with its own performance as a regulator. The CE and Council are aware that developing a better risk register linked to a defined set of key performance indicators is desirable and we encourage them to make progress with this. We recommend that the Council discusses and decides on the high level strategic risks and that the executive team produces a risk matrix allowing them to be reported on regularly to the Finance and Audit Committee and periodically to the full Council.

5.14 The Council has a strategic plan and a business plan but has not agreed a set of key performance indicators with the executive staff team through which it can hold them to account. We recommend that this is done and that the performance indicators measure outcomes and impact of the regulatory functions. There should be performance indicators for the key areas of activity; standards, education, registration and public protection through the conduct, competence and health processes, and for the efficient management of the Council's business. The CE's report to Council should shift its emphasis to reporting on the organisation's progress against the business plan.

5.15 Responsibility for financial management is delegated by Council to the Finance and Audit Committee. This is appropriate and minutes of the Finance and Audit Committee are seen by Council. One Council member we spoke to felt they did not receive sufficient information about the finances of the NCNZ although others had no concerns about this. However the minutes are not detailed and we do not consider them an adequate basis for Council assurance. Since effective use and stewardship of resources is a key responsibility of Council we think some more formalised financial reporting to Council should be in place, this could be linked to the new risk register.

5.16 One of the declared values of the NCNZ is transparency but we do not find this clearly demonstrated in the way it conducts and reports on its business. We have already commented on the lack of public reporting of meetings. The NCNZ is doing a good job but it seems to be doing it mostly in private. One of its roles is to maintain public confidence in regulation. It cannot do this if the public does not know what it is doing. External partners have reported to us how much communication with the profession has improved in recent years. In particular they praised the efforts of the Chief Executive in listening to stakeholders and explaining the NCNZ's role. It now seems time for the Council to turn its attention to communication with patients and the public. We note that it has already started a programme of consultations with patients and service users and we commend this. We think however the Council's role and decisions could be better communicated to patients and the public on whose behalf they are made.

5.17 Reflective practice is a hallmark of professionalism. We commend the commitment of the Council individually and as a whole to reflecting on its own performance and to continuous improvement. We hope it will consider the recommendations below and use them to improve its practice and clarify individual and corporate roles.

Recommendations

5.18 We recommend that the NCNZ:

- Continues with its programme of delegations and the separation of the role of Council from operational and statutory decisions.
- Makes its Council meetings more focussed and directed to strategic issues, effective decision-making, holding the executive to account and stewardship of its resources. At Council meetings greater attention should be paid to risk and performance measurement and more explicit consideration of patient safety and public protection should be given when policy decisions are made.
- Introduces shorter Council meeting agendas which are focused on strategic issues.
- Prepares Council papers which include clear recommendations for decisions and only the necessary information for a decision to be reached.
- Prepares Council meeting minutes which are a more complete record of the Council meeting. The minutes should report the Council's decisions clearly and be supported by an action table. Consideration should be given to Council meeting papers and minutes being put on the NCNZ's website.

- Restructures the CE's report so that it is focused on the delivery of the business plan, Council policies and decisions and key performance indicators.
- Introduces key performance indicators detailing the performance of NCNZ in each of its regulatory functions which are regularly reported to Council.
- Introduces a revised risk register which is focused on strategic matters and uses a RAG rating system.
- Strengthens financial reporting to its Council to ensure the Council is corporately responsible for the stewardship of its resources.
- Engages more actively with patients and the public and promotes transparency and openness. Considers how its commitment to transparency can be put in to practice in the conduct and reporting of its business and in its communication with patients and the public as well as the profession and the health service.
- Ensures that Council members have a shared understanding of their role and that a role brief is drawn up for both the Chair and Deputy Chair to assist with succession planning.

6. Conduct, competence and health

6.1 The NCNZ manages three processes which are used when a registered nurse's ability to practise safely is called into question. These processes are:

- Conduct – action can be taken by the NCNZ when it believes that questions have been raised about the conduct or the safety of the practice of a nurse (this includes when nurses have been convicted of certain criminal offences) (section 68(3) of the HCPA 2003).
- Health – action can be taken by the NCNZ when it is believed that a nurse may be unable to perform the functions required for their practice because of some mental or physical condition (section 45(3) of the HCPA 2003).
- Competence – action can be taken by the NCNZ when it is believed that a nurse may pose a risk of harm to the public by practising below the required standard of competence (section 34(1) of the HCPA 2003).

6.2 The role of the NCNZ is to protect the public by making sure that the individual health professionals they regulate are fit to practise their profession or, in the most serious cases, to stop them from practising if they are not. Whilst we have used the term 'complaints process' in the report as it is easily understood by all, it is important to note that the conduct, competence and health processes are not the same as a complaints-handling process. They are not designed to achieve a satisfactory outcome for the complainant.

6.3 From our review we identified that the NCNZ generally has effective processes in place for handling cases under the three processes, reaches appropriate decisions which protect the public and provides a good level of service to those who are involved with the processes. We also consider that it has demonstrated a reflective

approach to its work and seeks the views of its stakeholders to ensure its processes are as effective and efficient as they can be.

6.4 We do not include everything that we looked at and considered during our review in this report but we do set out below our main findings including the areas of practice where we consider that NCNZ could improve its systems and processes. This is done under the following headings:

- Publicly available literature on the complaints process
- Initial handling of complaints
- Risk assessment
- Gathering information
- Decision-making
- Timeliness
- Record-keeping
- Customer service
- Case management system
- Guidance for staff and Committee members
- Recruitment, training and appraisal of Committee members
- Quality assurance

Publicly available literature on the complaints process

6.5 We consider that any process used to ensure the ability of nurses to practise safely will only work effectively if complainants are able to make complaints without encountering unnecessary tasks or obstacles and if there is clear guidance to those who wish to complain about how and when they should do this.

6.6 We consider that the NCNZ has a process which enables complaints to be raised about nurses' ability to practise safely without undue difficulty and where concerns are raised about non-compliance with the complaints process action is taken promptly. In one case that we audited, we saw that the NCNZ had followed up a concern raised by a registrant on a survey response (which was an entirely separate activity to the conduct, competence and health processes) that a referral she had made had not been dealt with. The NCNZ contacted the registrant and asked for more information on their comments which led to a further referral being made and action being taken. However, we do think that the publicly available documentation on making complaints could be strengthened and we set out further information on this below.

6.7 Nurses in NZ have a legal responsibility to report other nurses where they feel that they are suffering from a health condition; this does not apply where they have such concerns regarding a colleague's conduct or competence. Until the legislation is changed (as further discussed in the next section of the report), we consider the guidance provided by the NCNZ publicly should be strengthened in this respect. At present the NCNZ website says only that nurses 'may' notify the NCNZ about a competence issue and offers no advice to nurses with regards to conduct issues.

However, there is a professional obligation on nurses as set out in its recently revised Code of Conduct to report conduct and competence issues, the Code states 'You must intervene to stop unsafe, incompetent, unethical or unlawful practice. Report to an appropriate person and take other actions necessary to safeguard health consumers'. It would be helpful to nurses and other stakeholders if the professional obligation of nurses to report such concerns was stated clearly on the NCNZ's website.

6.8 The guidance that has been developed by the regulatory authorities in NZ for employers on how and when to make a competency referral contains clear and helpful advice. We consider that this guidance should help employers understand when they should make a referral as it explains the differences between employment and regulator concerns and the threshold that has to be met in terms of the risk of harm that might justify a referral. We also consider that it then goes on to offer practical advice on how the risk associated with the nurse can be managed whilst awaiting a regulatory authorities' response to a referral e.g. by placing conditions on their working practices. We suggest to the NCNZ that it considers the benefits of developing similar guidance (with or without the involvement of the other regulatory authorities) for employers in relation to health and conduct referrals.

6.9 We consider that the three information booklets published by the NCNZ (one for each of the fitness to practise processes) are useful documents for those who wish to complain. The booklets contain an overview of each stage of the process from initial receipt of a complaint/referral to potential avenues of appeals for nurses against a final decision by the NCNZ. However, we consider that the documents would be more user-friendly and easier to follow if they were written in plain English with less of a focus on ensuring that the text reflects the order and content of the HCPA 2003. We also consider that the three booklets would benefit from a review to ensure there is consistency in the presentation of the information and in the language used. In carrying out this review work, we would suggest that the NCNZ seek the views of its stakeholders on how the three booklets could be improved.

6.10 NCNZ currently publish three separate complaint forms, one for each of the fitness to practise processes. The forms essentially ask the same questions of the complainant but are attached to a covering note about either the conduct, competence or health processes. We consider that having a single complaint form that could be used for raising conduct, competence or health concerns would make it easier for a complainant to make a complaint. We also consider it would be more appropriate for the NCNZ to make the decision about which process should be used to manage the complaint that has been made rather than the complainant making that decision for it. This links to our views which are set out at paragraph 7.21 on the benefits of having a single process to deal with all conduct, competence and health concerns.

Initial handling of complaints

6.11 All new complaints received, either from the HDC, employers or other complainants are considered at a weekly complaints and notifications meeting of the senior management team and a nursing adviser. This means that all cases receive prompt consideration, with input from a clinical specialist. We consider this is good practice. From our observation of one such meeting we felt assured that cases

were given proper consideration and in particular that attention was paid to two areas of risk: the risk of harm the nurse posed to patients (ie whether an interim order application should be considered) and the risk associated with the investigation of the case (ie do the circumstances of the case mean that this case should be investigated within the shortest possible timeframe). We would suggest however, as we did to the Medical Council of New Zealand[6], that to ensure the patient perspective is always properly considered one member of the team is charged with putting that point of view across in each case.

6.12 Following consideration of a complaint at the complaints and notifications meeting, one of the following outcomes are achieved: a referral to one of the conduct, competence and health processes, a referral to the HDC, or a request can be made for further information to be obtained. We are confident that appropriate action is taken to progress the outcomes of the complaints and notifications meetings. However, we consider that the initial handling of a complaint could be strengthened if a system was introduced to monitor the progress of those cases referred to the HDC. This would prevent instances like the one we were made aware of during our visit: a referral that was made by the NCNZ did not reach or was misplaced by the HDC and this was not identified until several months later, when a dissatisfied complainant contacted the NCNZ to ask what progress had been made on their complaint. Such a system would also enable the NCNZ to actively monitor the risks associated with the cases referred so it could consider whether it needed to take an action in the interim (eg the imposition of an interim order) if new information came to light during the HDC's investigation.

Risk assessment

6.13 Robust risk assessment both on receipt of a new case and on receipt of further information is necessary to enable the regulator to assess: what action should be taken; and the priority with which the case should be treated. In some circumstances the regulator may need to take immediate action on receipt of a complaint/further information. Such action could mean applying for an interim order to prevent the registrant from practising unrestricted while the matter is under investigation, or it could mean the regulator sending information to another interested body (e.g. the registrant's employer).

6.14 Interim orders can be imposed by the NCNZ in conduct, competence and health cases. However, the timeframes in which the interim orders apply, who makes the decision to impose an interim order and the tests used to impose the orders differs across the three processes. We consider that there is scope for some harmonisation of approach to the imposition of interim orders and a widening of the circumstances in which an interim order can be imposed. We discuss our views in section seven of this report in the context of the Government's review of the HCPA 2003.

6.15 In August 2011, the NCNZ introduced a process of risk assessing complaints when they are received. Whilst we consider that this process should have been in place earlier than 2011, we are pleased that the NCNZ is now working towards embedding risk assessments into its processes. The risk assessment occurs as part of the complaints and notifications meeting as explained at paragraph 6.11.

[6] CHRE, 2010. Performance Review of the Medical Council of New Zealand. CHRE: London.

This process is in its infancy and we are confident that it will be kept under review to ensure that it remains effective. At the time of the visit we recommended that the NCNZ ensures that all records from the complaints and notifications meetings are saved onto the relevant casefile. This was implemented immediately.

6.16 Whilst the NCNZ has a process for risk assessing complaints when they are received, there is no formalised system for assessing risk throughout the lifetime of a complaint. We would expect there to be a process for assessing risk when new information is received and at each key decision point in the conduct, competence and health processes. This would enable the NCNZ to ensure that it was taking appropriate action to mitigate against any new risks associated with the case, for example reconsidering whether an interim order was necessary. In one case that we audited we identified that the nurse under investigation had raised quite serious concerns during the progress of the case about the conduct of other nurses. However, there was no record of whether any action had been taken against those nurses or even if the NCNZ had considered whether this was necessary. We consider that this is not good practice and could have potential implications for public protection. It is important that the risk associated with a case is under regular review to ensure that the public is protected.

Gathering information

6.17 Gathering the right information in the conduct, competence and health processes is essential to enabling the regulator to assess the risks that a registrant may pose to patient safety, and to ensuring that appropriate action can be taken promptly to protect the public (including, where necessary, applying for an interim order).

6.18 The NCNZ has the power to demand information from any person under section 77 of its legislation. This means that those involved in the complaints process can be ordered to provide information, we note that this is not a power open to all UK regulators. There is also the potential for a criminal sanction if the demand is not complied with (a summary conviction and fine not exceeding $10,000). The NCNZ has told us it does not need to use that power very often as individuals and organisations usually comply with its demand. In relation to medical records it sometimes includes in its letters that it is requiring those documents under section 77 of the legislation as it provides some protection to witnesses and district health boards (equivalent to NHS Trusts in the UK) who may be reluctant to release this information. We consider that this is a pragmatic approach and note that this is one which is used by some of the UK regulators.

6.19 The NCNZ has developed guidelines on the action that PCCs can take following a notification of a court conviction for drink-driving convictions. These guidelines do not follow our recommended good practice. We recommend to the UK regulators that a registrant who has been convicted or cautioned for a drink or drug related offence should be required to undergo a routine medical examination, in order to establish whether or not their fitness to practise is impaired as a result of an underlying drink or drug dependency. We recommend that the NCNZ should consider adopting this practice as such information is key to the PCCs making robust decisions in such cases.

6.20 In competence cases, a CRP reaches its view on the competence of a nurse referred to it following a competence assessment. We are concerned that such assessments do not adequately focus on the actions that resulted in the referral in the first place. For example in one case we audited, it was not clear from the file what medication errors had occurred or what had led to the errors being made. This was as a result of no employer investigation being carried out (the nurse left their job before this could be carried out) and because the NCNZ do not focus on the reason for the referral but instead carry out a general competence review of the nurse. We are concerned that as of result of this approach the NCNZ may not be addressing those areas where there are potential public protection issues. We are also concerned that the tools used by the CRP have not been refreshed for some time and therefore may no longer be fit for purpose. We note that the NCNZ themselves has concerns about this process and that it has initiated a review of the competence process which is underway. We recommend that the following should be considered as part of this work:

- The approach to competence cases to ensure that the competence review process tackles the concerns raised as part of the complaint rather than just reviewing the registrant's general competence
- The assessments used to carry out the competence reviews to ensure that they are still fit for purpose and sufficiently robust.

Decision-making

6.21 Providing detailed reasons for the decisions that are taken either by NCNZ staff or by the Committees, and ensuring that those reasons clearly demonstrate that all the relevant issues have been addressed, is essential to maintaining public confidence in the regulatory process. Requiring decision-makers to provide detailed reasons also acts as a check to ensure that the decisions themselves are robust.

6.22 We are pleased that the NCNZ has moved away from having Council members sitting as Committee members. Separation of the governance and operational functions of regulatory authorities is in place in the UK and is considered to be good practice.

6.23 Whilst the template letters developed by the NCNZ are generally of a good quality we consider that its letters to complainants where it decides it will take no further action could be more detailed. As it stands the letters state that the NCNZ can take no action and give a brief reason such as 'the nurse has retired' or 'we are referring it to the HDC as required under section 64(1) of the Act'. We consider it would be helpful if the letters explained why the retirement of the nurse meant no action could be taken or why the legislation requires that a referral has to be made to the HDC. This would aid the understanding of the reader of the letter.

6.24 We are also concerned that decisions in competence cases were not clearly articulated in those casefiles which we audited. In three of the five competence cases audited, we could not find a clear evaluation by the nursing adviser as to why the papers provided in relation to the nurse meant that either the nurse was now competent following actions taken after the CRP or they were competent because of the actions they have taken since the referral and did not require a competence review. We consider that the rationale for such decisions should be clearly set out

and documented and that these decisions should be reviewed by another nursing adviser. This should ensure that a robust decision has been made.

6.25 Additionally, we consider that the determinations drafted by the Committees could be improved. We have published a learning points bulletin which highlights our views on how a determination should be written[7]. In our view a good determination should be a stand-alone document which can be clearly understood by all audiences. It should set out a description of the allegations, an explanation of why particular allegations were or were not found proved, an explanation of any important background facts which led the panel to reach its conclusion, and an explanation of why that specific decision was reached. Currently, we consider that the NCNZ determinations are lacking sufficiently detailed reasons for the decision reached by the Committee and do not include information about the oral evidence heard from the nurse or complainant nor any panel questioning that took place. These are key details which should be included in the determination so that the reader can understand why a decision has been reached. We recommend that the NCNZ should review its template decision letters and determinations templates to ensure that they are 'stand alone' documents which include details of all the information considered by the Committee when reaching the decision and the reasons for the decision reached. The NCNZ should take account of our learning points bulletin when carrying out this review.

6.26 One of the decisions that the committee can reach is the issuing of a letter of censure. Currently Committee members will give staff a general indication of what the letter should say. We consider that the Committee should draft the content of the letter of censure at the time of its meeting as it is their decision to issue such a letter and therefore they have a responsibility to ensure that it reflects the areas of concern that they had. We recommend that the Committee members decide and agree the text to be included in letters of censure.

6.27 We consider that the NCNZ has introduced a pragmatic approach to managing the risks associated with nurses who have health problems and are working under conditions of practice. They have introduced a standard condition of practice which is that the nurse 'must work with an approved employer'. This condition is placed on the public register and on the nurse's APC. As a result, employers are required to contact the NCNZ and request further information on the nurse and her history. This acts as an additional safeguard to the employee taking responsibility for telling any prospective employer of her conditions of practice. We would suggest to our UK regulators that they consider whether introducing such a condition of practice would be useful to them.

Case management

6.28 Effective case management is a key element of a good fitness to practise process. We consider that this includes having processes in place to ensure:

- The timely progression of cases
- Comprehensive and accurate record keeping
- The provision of good customer service.

[7] https://www.chre.org.uk/_img/pics/library/090817_Learning_Points_Bulletin.pdf

Timeliness

6.29 Delays in the progression of cases are not in the interests of complainants, registrants, employers or the public. Whilst we recognise that in some cases some delays are unavoidable (e.g. because of ongoing criminal investigations or difficulties in obtaining evidence) we are unclear about the reasons for the delays we identified in the NCNZ cases we audited due to a lack of recorded reasons for them. Therefore we are unclear about whether these delays could have been avoided by better case management.

6.30 The delays identified occurred during the investigation of cases, for example in one case there was a period between 13 October 2008 and January 2010 where no activity occurred on the case but the reasons for this were not clear. We also identified cases where the NCNZ had failed to take prompt action when nurses failed to comply with conditions of practice for example in one case no action was taken for 10 months following the nurse failing to comply with the conditions of practice in the time required. Generally as a matter of pragmatism the NCNZ allow time between an order being made by a Committee and the order coming into force. We were told that this was to give the nurse time to put in place arrangements for their compliance with the order eg organising training courses or a supervisor at their place of work. We do not think that this is appropriate and the NCNZ should consider ensuring that such arrangements are made prior to a final decision being made.

6.31 We were also concerned with the amount of time generally taken by the NCNZ to investigate cases. Some cases appeared to be straightforward but took 11 months or longer to resolve.

6.32 We are concerned about the timeliness of the conduct, competence and health processes because delays in the process have significant implications for:

- The public, as there could be patient safety implications in relation to the failure to resolve cases quickly, the failure to put interim orders in place promptly where serious allegations are made and because there can be increased difficulties in reaching a decision on a case if the quality of the evidence before the relevant committee is lessened because of the length of time that has elapsed
- Registrants, as it is unfair for them to have unresolved cases against them for long periods of time
- Witnesses, who have to make arrangements to be involved including time off work and may have difficulty recalling events as time passes
- Employers, who may have to support those involved with the process including financial support
- Complainants, who may not be able to move on from the event they have complained about until it is resolved.

6.33 We therefore recommend that the NCNZ reviews its approach to case management to ensure that cases are progressed without undue delay both prior to and after a committee hearing.

Record keeping

6.34 Maintenance of a single comprehensive record of all actions and information on a case is essential for proper management of cases and for good quality decision-making.

6.35 The results of our audit of 21 casefiles showed that this was an area where the NCNZ's performance was inconsistent. We found several examples where the casefiles did not appear to include a complete record of all the actions, information and decisions related to cases. For example:

- As mentioned at paragraph 6.15, the casefiles did not include the outcomes of the complaints and notifications meetings. This means that the outcome of the initial risk assessment is not recorded on the paper file. The NCNZ has addressed this area for improvement as mentioned earlier in the report.
- As mentioned at paragraph 6.24, some of the casefiles we audited which related to competence cases did not clearly record the rationale for the decision that a nurse did not have to undergo a competence review.
- In two casefiles we noted that there was no a record of all the telephone conversations that appeared to have taken place during the life of the case.
- In four of the casefiles we noted that there was some documentation missing from the file such as letters to and from the registrant regarding the return of their annual practising certificate, letters informing the nurse of the biographies of those who will be sitting on her CRP/PCC so that the nurse could identify any conflicts of interests and responses to requests for information from third parties.

6.36 The inconsistent record-keeping had an affect on our confidence in the casefiles and made us question whether we had seen all the relevant information related to some of the cases. We therefore recommend to the NCNZ that it introduces a standardised approach to record-keeping so that all staff are clear about what documents must be contained within the casefiles and the ordering of those documents within the file. We also recommend that record-keeping is reviewed as part of any quality assurance system which is introduced by the NCNZ, we discuss this further at paragraphs 6.53 and 6.54.

Customer service

6.37 Good customer service is important to maintaining professional and public confidence in a regulator. It also helps to facilitate the smooth progression of a case as it enables good working relationships to develop between the regulatory authority and the parties to a case.

6.38 We consider that the NCNZ has a clear organisational understanding of the importance of providing good customer service. This is exhibited by the NCNZ leadership and throughout the organisation. It appeared to us that providing good customer service was a result of the NCNZ leadership cascading the importance of this to staff as well as an inherent understanding within the organisation of its importance. There is a culture of being open and helpful with stakeholders such as nursing unions and those involved in a conduct, competence or health case. This is to be commended.

6.39 Generally we considered the letters sent to those involved in the conduct, health and competence processes set out each stage of the process clearly, in way that could be easily understood and in an appropriate tone of voice. However, we have a concern about the tone of one of the standard letters sent by the NCNZ in competence cases. The letter includes 'The Council will endeavour to make the process fair and if there are insufficient grounds for the concern, a review will not proceed' and it includes '…the Council will endeavour to work with you in a facilitative and supportive manner.' Whilst it is correct that the processes managed by the NCNZ are fair, we do not think this letter gives appropriate weight to the need for the competence review process to ensure that the public is protected from incompetent nurses. We are aware that the NCNZ is conducting an internal review of its competence process and would suggest that it reviews its standard letters associated with this process to ensure that the role of the NCNZ in protecting the public is clearly stated.

6.40 We also have a concern that on one occasion that the will to provide good customer service resulted in a transgression of the role of the regulator. In a competence case where a referral was made some time after the events complained about occurred, the nurse was advised during a telephone call of a possible way that she could defend herself in a case. She was advised that section 34 of the Act referred to an employer 'promptly notifying the Council' of their concerns and that she should take advice from her professional organisation regarding whether or not such a late referral could be made by her employer and therefore action taken by the NCNZ. We consider that it was inappropriate for such advice to have been offered by the NCNZ. The NCNZ's role is to protect the public and one of the ways that it does this is by taking action when a nurse's fitness to practise is called into question. It is not the role of the NCNZ to act as an advocate for the nurse, this is the responsibility of the nursing unions. Such actions could damage confidence in the NCNZ if repeated and lead to a perception of bias towards registrants.

6.41 We consider that the actions noted above may be due to the fact that currently a nurse adviser has to provide advice on the capabilities of the nurse under investigation as well as manage the progression of a case in competence and health cases. Given the NCNZ is currently reviewing its competence processes, it should consider whether it would be beneficial to introduce two distinct roles of case officer and nurse adviser for the management of competence and health cases. The case officer should be responsible for the administration and management of the cases including responding to queries from the nurse under investigation and the nurse advisor should be responsible for providing expert advice on the clinical matters of the case. We consider that such separation of the functions should enable a more efficient process as well as enabling those in the roles to focus on their areas of expertise.

Case management system

6.42 An effective case management system is key to the maintenance of an efficient fitness to practise process. Currently the NCNZ does not use a formal electronic case management system. It relies on a system of excel spreadsheets. It is our view, that this is not an effective or efficient way to manage a relatively large caseload.

6.43 We are therefore pleased that the NCNZ is in the process of developing an electronic case management system. The system will enable one record to be maintained for each case and the record will cover initial receipt of complaint to the case being closed. The system will facilitate prompts for case owners so that they are reminded when tasks need to be completed and it will lead staff step by step through the process. The system will also enable management data to be easily extracted so that performance can be monitored by the Council and areas where there are timeliness issues with case progression to be identified and addressed. We also consider that the action it is taking to ensure that staff are involved in the development of such a system is good practice. This is because it helps to ensure that the resulting system is fit for purpose, user-friendly and has staff support/'buy in'. Whilst being mindful of the possible merger of regulatory authorities in NZ, we consider that the NCNZ should continue to take steps to develop and implement a case management system.

Guidance for staff and Committee members

6.44 We would expect a regulatory authority to have as a minimum the following documentation:

- An internal operational manual for staff responsible for managing the conduct, health and competence processes
- Guidance for decision makers to include the PCC, HC and CRP and Registrar on their roles and responsibilities
- Guidance for those who carry out investigations on the part of the PCC or medical assessments on behalf of the HC
- Guidance on how to:
    - Make and record decisions
    - Treat drink-driving/drug related offences
    - Respond to anonymous complaints
    - Carry out initial and on-going risk assessments

6.45 We have seen that the NCNZ has a series of detailed and comprehensive process maps for each part of the conduct, competence and health processes. These maps detail each step of the process, who is responsible for each action to be taken and they also highlight the relevant template letter that should be sent at each point in the process. Whilst these are very useful tools we consider that the NCNZ would benefit from an internal operational manual for staff. We consider that a manual which covers each stage of the processes from initial receipt of a complaint to a final decision should be developed; it should include case management processes, business support arrangements (such as administrative tasks and financial payments), scheduling arrangements for committees, liaison with the legal team and other experts and processes related to cases when they are referred onto the HPDT.

6.46 The NCNZ does have guidance documents for decision-makers on their roles and responsibilities which we consider are sufficient. However, it does not have any formal guidance for those who carry out investigations on behalf of the PCC or

those who undertake medical assessments for the HC. In order to ensure consistency, fairness and that the decisions reached are robust in the conduct and health processes, we consider that such guidance should be available to those individuals.

6.47 The NCNZ does have limited guidance on making and recording decisions, dealing with drink-driving/drug related offences, responding to anonymous complaints and carrying out initial risk assessments. However, we consider that these could benefit from further development so that what is expected of staff and decision-makers is clearer. This should enhance consistency in performance and improve transparency for complainants, registrants and others.

6.48 Some of the UK regulators publish the guidance that they use when processing fitness to practise complaints on their websites. We consider that this is good practice as it enables greater transparency of their processes. We recommend to the NCNZ that it considers whether it should also publish its key guidance documents on its website.

Recruitment, training and assessment of committee members

6.49 We are concerned that the PCC, CRP and HC do not have a majority of public members as the fitness to practise committees of the UK based health and care professional regulators do. Instead they are comprised of two nurses and one public member. Whilst we did not see evidence that the committee composition affected the quality of decision-making, we consider that the current composition could result in a perception that the profession is looking after its peers, rather than focusing on the protection of patients and the public. We consider that the NCNZ should review the composition of its committees as their absolute focus on patient safety and public protection are essential to effective professional regulation. It is also important to recognise that public confidence is essential to the NCNZ's effectiveness as a regulator and that any perception of bias towards registrants will adversely affect such confidence.

6.50 Regardless of whether the members of these Committees should be predominantly members of the public or nurses, we are concerned that the members are not recruited against defined competencies and through open competition which is contrary to good practice. Instead members are appointed against qualifications and employment experience and are invited to apply for the position. Whilst employment experience and qualifications are useful indicators for the ability of individuals to carry out a role, competency based recruitment enables an employer to consider the behaviours, technical attributes and attitudes of an applicant in relation to the specific role advertised. Competency based recruitment is considered to be an effective way to identify the right person for the job. We recommend that the NCNZ should review its approach to the recruitment of Committee members.

6.51 Following the appointment of Committee members there is an informal induction programme and for the PCC members only there is refresher training approximately every two years. We consider that this approach is insufficient and that all committee members would benefit from a formal structured induction training programme and at least annual refresher training thereafter. This would

ensure that members have the appropriate knowledge and skills to carry out their role effectively on an ongoing basis. We consider that the induction training should cover the role of the NCNZ, the regulatory environment, the conduct, health and competence processes, good decision-making and include shadowing of current Committee members. The ongoing training should cover learning identified from reviews or appeals of decisions, cases considered and concluded by the HPDT, any new caselaw and learning identified from any quality assurance process for the conduct, competence and health processes which are introduced by the NCNZ (see paragraph 6.53 and 6.54).

6.52 We also consider that Committee members would benefit from at least annual performance assessments. This would provide the NCNZ and the Committee member with a formal opportunity to discuss the member's strengths, areas for improvement and training needs. In conjunction with the formal structured training programme, this should help to ensure that members have the appropriate knowledge and skills to carry out their role effectively on an ongoing basis. It also provides an opportunity for the NCNZ to gather feedback on its performance from those involved in a key area of its work. It would also be beneficial to the development of committee members' experience if there was an objective and transparent system for allocating members to conduct, competence and health committees. We were told that currently it can be the case that the same committee members are picked to work with staff on cases because of well-developed working relationships meaning that others do not develop a good level of experience.

Quality assurance

6.53 At this time the NCNZ does not have a system which enables it to quality assure the conduct, competence and health processes and associated case decisions. We consider that having such a system of quality assurance is good practice. We have recommended to the UK health and care professional regulators that they should ensure that they have a proportionate system of quality assurance in place that enables the review of cases that have reached key decision points (such as decisions about whether to impose an interim order, decisions taken at the end of the investigation stage and decisions taken about the formulation of allegations prior to a hearing) to ensure that procedures are being followed consistently and that appropriate decisions are being made. We believe that such quality assurance drives continuous improvement and provides assurance to the Council and others about the quality of the regulators' work. This can only be beneficial to public protection and to public confidence in professional regulation. We therefore make the same recommendation to the NCNZ.

6.54 We also recommend that the NCNZ should consider introducing a committee comprised of Council members who will review, monitor and report on the work of the NCNZ's conduct, competence and health processes. We have a similar committee – the Scrutiny Committee – which is responsible for assuring on behalf of the Council the operational work of the Scrutiny and Quality team (the team responsible for scrutinising the work of the regulatory bodies). We consider that a similar committee at the NCNZ could provide the assurance its Council is seeking about the quality of the executive's and PCC's, CRP's and HC's work now that Council members are now longer members of those Committees. Once established

and the Council is assured about the quality of the work of the executive and the fitness to practise committees, the requirement for the Registrar (the position of which is held by the CE) to approve and sign off the decisions of the three Committees could be removed. This would enable the decision-making of the three Committees to be completely independent of the executive and Council which we consider to be good practice.

A further area for improvement

6.55 Currently the NCNZ's register does not include nurses who have been suspended or struck off the register. The rationale for this is that those nurses do not have current annual practising certificate and the public facing register is only meant to reflect nurses with current registration. Whilst we understand this, we recommended in our report *Maximising the contribution of regulatory bodies' registers to public protection*[8] that the health professional regulators' registers should include information about all current fitness to practise sanctions and should include information about health professionals who have been struck off on their online register for at least five years. We consider that the public are entitled to access this information so that they can make informed choices about the health professionals they engage with. We therefore recommend that the NCNZ includes on its register or its website details of those registrants who have been suspended or struck off the register and links to any associated determinations published by the HPDT.

Recommendations

6.56 We recommend that the NCNZ:

- Reviews its publicly available literature on the conduct, competence and health processes to ensure that it is easy to understand, are consistently presented and are up to date.
- Combines the complaints forms available for each of the conduct, competence and health processes into one form to remove the potential for unnecessary confusion for those who wish to complain.
- Introduces a monitoring system for those cases referred to the Health and Disability Commissioner to ensure that the risks associated with these cases are appropriately managed.
- Introduces a system whereby risk is assessed throughout the lifetime of a complaint, for example, when new information is received and at each key decision point.
- Considers adopting the practice of requiring a registrant who has been convicted or cautioned for a drink or drug related offence to undergo a routine medical examination, in order to establish whether or not their fitness to practise is impaired as a result of an underlying drink or drug dependency

[8] The report can be found here: https://www.chre.org.uk/satellite/146/

- As part of the current review of the competence review process, the following should be considered:
    - The approach to competence cases to ensure that the competence review process tackles the concerns raised as part of the complaint rather than just reviewing the registrant's general competence.
    - The assessments used to carry out the competence reviews to ensure that they are still fit for purpose and sufficiently robust.
- Reviews its template decision letters and determinations templates to ensure that they are 'stand alone' documents which include details of all the information considered by the committee when reaching the decision and the reasons for the decision reached. The Council should take account of our learning points bulletin when carrying out this review.
- Ensures that the Committee members decide and agree the text to be included in letters of censure.
- Reviews its approach to case management to ensure that cases are progressed without undue delay both prior to and after a committee hearing.
- Reviews its approach to record keeping so that its case files include all the documentation from the initial complaint to the final piece of correspondence, include each decision made on the case and the rationale for that decision and are consistent in their layout.
- Considers introducing two distinct roles of Case Officer and Nurse Adviser for the management of competence and health cases. The Case Officer should be responsible for the administration and management of the cases and the Nurse Advisor should be responsible for providing expert advice on the clinical matters of the case.
- Reviews it standard letters in competence cases to ensure that the role of the NCNZ in protecting the public is clearly stated.
- Introduces:
    - A competency based appointments process for all committee members
    - Annual refresher training for all committee members which should cover amongst other things learning from any reviews or appeals of decisions, writing good determinations and legal updates
    - A formal appraisal system for all committee members so that any training needs are identified and performance of committee members can be reviewed at regular intervals.
- Reviews its current guidance to evaluate whether it is sufficiently robust, detailed and clear for all of its intended audiences. Considers whether its key guidance documents should be published on its website.
- Introduces a proportionate system of quality assurance which enables it to review cases that have reached key decision points in the fitness to practise process, to ensure that processes are being followed consistently and that appropriate decisions are being made.

- Considers introducing a committee of Council members who review, monitor and report on the work of the NCNZ's conduct, competence and health processes.
- Includes on its register or website details of those registrants who have been suspended or removed from the register.

7. Context in healthcare regulation

7.1 Healthcare systems across the world are facing a combination of challenges; aging populations, an increase in co-morbidities, an epidemic of non-communicable diseases, the ever rising cost of health technologies and a global shortage of healthcare workers. New Zealand is not immune from these pressures.

7.2 In New Zealand some 600,000 people are aged over 65 (Statistics New Zealand 2012), obesity affects 28 per cent of the population against a regional average of 7 per cent, diabetes is a particular problem in Maori and some Pacific Island populations. Cancer accounts for 29 per cent of deaths, cardio-vascular disease 37 per cent. Overall non-communicable diseases account for 91 per cent of all deaths. New Zealand also has a relatively large healthcare workforce with 24 physicians and 109 nurses per 10000 population compared with a regional average of 15 and 20 respectively (for a more direct comparison Australia has 96/10000 nurses (source WHO Country Health Reports)). The combination of high levels of cancer, heart disease and obesity with high numbers of health professionals is characteristic of high income countries.

7.3 Mobility of health professionals is a particular issue in New Zealand. Up to 25 per cent of New Zealand medical and nursing graduates leave to work abroad, although many of them subsequently return. Their positions are filled by international graduates; In 2010-11 1304 nurses who qualified elsewhere were admitted to the register by the NCNZ, just under half the total number of new registrants. A high proportion of this group do not stay permanently. The movement of health professionals in and out of New Zealand, which is greater than in many other countries, presents particular challenges to regulation. Regulators need to be sure that overseas education programmes and qualifications are equivalent in content and level. They need to check the identity of individuals applying, their past professional record and their language competence. Regulatory frameworks and standards differ from country to country so even obtaining validation data from a competent authority in the registrant's home country may be difficult.

7.4 Regulation has a vital role to play in ensuring the quality of the workforce and thus patient safety. But good patient care also depends on a supply of competent professionals and regulation inevitably affects supply. We considered the link between work force planning and regulation in our Performance Review of the Medical Council of New Zealand (2010). It is important in our view that regulators are able to remain independently focused on patient safety and the competence of health professionals and must not be required to compromise quality to support workforce needs.

7.5 At the same time we have argued that agility is one of the requirements of modern regulation. Agility is the ability of the regulator to foresee and respond to changes in clinical knowledge and practice so that innovation is not hampered, new ways of

working not restricted but patient safety maintained. The approach that the NCNZ is taking to nurse prescribing is an example of good practice in this regard. In response to a request from the Minister of Health to support more convenient healthcare the Council is examining the case for increased nurse prescribing which is focussed always on keeping patients safe but at the same time develops a scope of practice for nurses which is forward-thinking, flexible and sustainable.

7.6 Health Workforce New Zealand has a desire to create greater flexibility around roles and responsibilities in healthcare. This is clearly of benefit. However, we consider that solutions to the availability of competent health professionals in a global market where there is a shortage of supply cannot be at the expense of reduced quality or increased risk to patient safety. Since this is a global problem with whole country consequences the long-term solutions must lie with greater international coordination and improvement of regulation rather than with increasingly diverse local arrangements or a reduction in the effectiveness of regulation. The recent report from the Global Health Policy Summit *A Neglected Resource: Transforming Healthcare through Human Capital* may be of interest here[9].

7.7 Two recent initiatives by the New Zealand Ministry of Health provide important challenges to regulatory authorities. The Ministry has announced a review of the legislation which covers health professional regulation and also Health Workforce New Zealand has published a consultation paper (which includes a number of options) on merging the health professional regulatory authorities. We do not consider it appropriate for us to comment directly on New Zealand Government policy. However the proposals that are under consideration will have a significant impact on regulation in New Zealand and consequently on patient safety so we feel it appropriate to raise some questions which the NCNZ may wish to consider. Our report *A Review of the cost Effectiveness and Efficiency of the Health Professional Regulators* should provide some useful comparative data.[10]

7.8 Our first area of interest covers those matters in the NCNZ's legislation which might be improved as part of the legislation review. These include arrangements for the appointment of the Council and it's Chair, procedures for interim orders, and powers to strike off nurses who remain continually incompetent.

Appointment of Council and it's Chair

7.9 We have some concern that the current good balance and working relationships within the NCNZ Council are despite rather than because of the constitutional arrangements of the NCNZ. As is the case for all health professional regulators in New Zealand, Council members are not appointed in an open and transparent manner. Vacancies are not publicly advertised but nominations invited from a closed list of interested organisations, even nominations for lay members are invited not from community or patient organisations but from professional bodies and associations. We also understand that the Minister of Health invites people to put their names forward. For the latest round of Council appointments, the NCNZ

[9] *A Neglected Resource: Transforming Healthcare Though Human Capital*, Dzau, Victor J et al. Global Health Policy Summit 2012

[10] *A Review of the Cost Effectiveness and Efficiency of the Health Professional Regulators,* Professional Standards Authority, 2012

prepared competencies for the role of Council member which it submitted to the Ministry of Health but it is not clear if these were taken into account in the selection of individuals. There are no interviews for Council member appointments and apart from the members elected by the profession, appointments are made personally by the Minister. Regulators exist to protect the public but the public in New Zealand appears to have no role and little influence in the appointment of the Nursing Council.

7.10 Amongst the regulators covered by the HPCA only the NCNZ and the MCNZ have elected members. The reason for this is not clear. Regulators exist to protect the public not to represent professionals so while it is necessary for a regulator to understand the profession it is not appropriate for nurses or doctors to be appointed on the basis of an appeal for support from their professional colleagues as opposed to meeting a published set of competences and being committed to protecting the public.

7.11 In 2011 22 nurses stood for election and 6156 voting papers were received, a turnout of only 11 per cent. The election cost the NCNZ $90000 and it is now seeking a change in the rules to reduce the cost. Notwithstanding the personal quality and commitment of the individuals elected it is hard to see what value this process brings to effective governance.

7.12 Competency based appointments are in our view an essential element in the modernisation of professional regulation. The election of members of boards from the professions means that people are appointed as representatives of their profession not guardians of patient safety. They may or may not be capable of fulfilling the governance and public protection role which they must take on. Good governance requires both open competition for appointment and selection against defined role description and competencies.

7.13 We do not find the process of ministerial appointments either transparent or fair. It does not accord with our understanding of best practice in public appointments. While we understand that it is the New Zealand practice for appointments to be made by ministers we believe this should be done following open recruitment and interview against published competencies.

7.14 In accordance with the HCPA the election of the Chair and Deputy Chair is on an annual basis from within the Council. We consider that this is also not good practice. The skills and competencies required of a Chair are not the same as those required of a Council member and good practice is increasingly that Chairs should be appointed separately. We consider that there should be defined role descriptions and competencies for the Chair and Deputy Chair. The one year period of office for the Chair is also quite inadequate as it hinders their ability to become fully effective and limits their ability to provide strategic leadership. We consider that chairs should have a period of office of three years. Additionally, the possibility that the Deputy Chair might be elected Chair in the future also introduces unhelpful rivalries and risks creating cliques within the Council. The combination of election with very short terms of office does not allow for proper succession planning. Quite where the patient and public interest lies in this model is unclear to us.

Interim orders

7.15 Interim orders can be imposed in conduct, competence and health cases. However, as noted earlier in the report, there are differences in the timeframes in which the interim orders apply, who makes the decision to impose an interim order and the tests used to impose the orders. The circumstances for each of the processes are set out below:

- Health cases - interim orders are imposed by the Registrar without the nurse being given notice, last 20 working days (which can be extended for a further period of 20 working days if a medical report has not been received) and the test set out in the HPCA is 'the authority considers that the health practitioner may be unable to perform the functions required for the practice of his or her profession because of some mental or physical condition'.
- Conduct cases – interim orders are imposed by the PCC, can be put in place until the PCC has reached its final decision on the nurse's behaviour and the test set out in the HPCA is that if the conduct casts doubt on the appropriateness of the nurse's conduct in his or her professional capacity, a suspension or conditions of practice order can be imposed. The nurse has an opportunity to present her views (orally or in writing) before the PCC reaches a decision on whether to impose an interim order.
- Competence cases – interim orders are imposed by the CRP, can be put in place until the nurse has successfully passed a competence programme and the test set out in the HPCA which is applied is 'are there reasonable grounds for believing that the health practitioner poses a risk of serious harm to the public by practising below the required standard of competence.' The nurse has an opportunity to respond, (either orally or in writing), and meet with the CRP before it makes any such order.

7.16 Whilst the NCNZ has reported to us that the short timeframe of a maximum of 40 working days for the imposition of interim orders in health cases has not hindered its ability to protect the public, from our experience of overseeing the UK regulators, we consider that such a limited timeframe has the potential to do so. As such we consider that the NCNZ should reflect on the benefits of suggesting, as part of the legislation review, that it is given powers to impose an interim order in health cases which last until the HC has reached a final decision on the nurse's ability to practise safely. This would enable the NCNZ to ensure that the public is protected throughout the lifetime of a complaint which is dealt with under the health process regardless of whether there are any delays in the progression of the complaint.

7.17 In conduct and competence cases, a nurse is able to submit her views either orally or in writing prior to the relevant Committee reaching a decision on whether to impose an interim order. We are unclear as to the rationale for nurses being denied such an opportunity in health cases. We consider that this is not fair to the nurse as they are in effect being denied an opportunity to defend themselves. Such a position also seems to be contrary to the rehabilitative and consensual approach to health professional regulation in NZ. We would suggest that the NCNZ reflect on whether it should suggest that the health interim order process should be made consistent with the conduct and competence processes.

7.18 In the UK, a single test is used when considering applications for interim orders. We consider that the use of three separate tests when considering interim order applications is confusing and unnecessary. As we have not seen a clear rationale for the differences, we consider that the NCNZ should reflect on whether it should suggest that a single test is used across the three processes. Associated with this we note that most UK regulators have a three limbed test which is used when considering interim order applications. Interim orders can be imposed when it is necessary for the protection of the public; necessary in the registrant's own interests and otherwise in the public interest. However in NZ the tests used to impose interim orders do not include an option for an interim order to be imposed where it is necessary in the registrant's own interest or in the public interest. We consider that by omitting those two further grounds the NCNZ is hindered from maintaining public confidence in the profession and in the regulation of nurses as well as taking action to ensure the safety of nurses. As such, we consider that the NCNZ should reflect on whether it should suggest that the circumstances in which an interim order can be imposed should be widened.

Powers to review suspension and conditions of practice orders

7.19 Currently when the HPDT suspends or places a conditions of practice order on a nurse, a nurse can re-join the register once the order has expired without any review of their ability to practise safely. This is concerning to us as there are real implications for public protection if a nurse remains unsafe to practise and is allowed to re-join the register. In the UK, we expect final fitness to practise committees' determinations (where a suspension or conditions of practices order has been imposed) to include a request for a review hearing to held and an explanation of the sort of evidence the registrant would be expected to provide at a resumed hearing to prove that they are safe to practise. The review hearing then assesses whether the registrant has met the requirements of the final fitness to practise committee. This provides an assurance to the public, employers and others that only those who have met the regulators' standards are allowed to join the register. We consider that the NCNZ should reflect on whether it should ask for the power to review suspensions and conditions of practice orders imposed by the HPDT.

Powers to strike off continually incompetent nurses

7.20 When a CRP has concluded that a nurse is incompetent and required them to undergo a competence programme the NCNZ currently has no power to remove them from its register if they are continually unable to pass the competence programme. We have been told that in a small number of cases some nurses have continually been deemed incompetent for a number of years. We consider that the lack of such powers to take appropriate action in such cases leads to the NCNZ resources being diverted from those cases where its involvement is likely to have a positive effect on the nurse's ability to return to practise. As such we consider that the NCNZ should reflect on whether it should ask for powers to strike off continually incompetent nurses when contributing its views on the review of the legislation.

A single process for dealing with conduct, health and competence concerns

7.21 As described earlier in this report, the NCNZ has three separate processes for managing conduct, competence and health cases. These processes are set out in the HCPA. We consider that there are benefits to a holistic single fitness to practise committee being used to deal with conduct, competence and health cases. For example, it would remove the risk that cases where it could be considered that there are both conduct and competence concerns are being dealt with under only one process which may not enable all the concerns about the nurses to be addressed. Having one process to deal with all concerns facilitates the consideration of different factors which may underlie a nurse's failure to practise in line with their standards. It enables a fuller picture to be gained on that nurse's practice so that the appropriate action can be taken to protect the public. We consider that the NCNZ should reflect on whether it should ask for a single process to be introduced in which conduct, health and competence concerns could be dealt with.

Effectiveness and efficiency

7.22 Regulation needs to be effective as well as efficient. We understand that the New Zealand government is seeking the sharing of back office functions by all the professional regulators in New Zealand. There are sixteen separate regulators which vary greatly in the size of their register, the level of public risk they manage and the complexity of their operations. Our recent study of the Effectiveness and Efficiency of Health Professional Regulators in the UK suggests that economies of scale are the most significant way of reducing cost and increasing efficiencies[11]. The merging of several smaller regulators into a single body is likely to have greater impact on cost without reducing effectiveness, than a shared services model. In the latter there is a risk that cost is increased since merged systems would default to the most complex. We suggest that consideration is given to the findings our report in reviewing how regulators in New Zealand could be more cost effective

Recommendations:

7.23 In summary, in submitting views to the Government's review of the legislation the NCNZ considers asking for:

- The standards and process for appointments to the Council, including the appointment of the Chair and Deputy Chair, to be made more transparent and competency based
- The test for imposition of interim orders to be consistent across conduct, competence and health processes and for the power to impose interim orders where it is necessary for the protection of the public; necessary in the registrant's own interests and otherwise in the public interests

[11] http://www.chre.org.uk/satellite/414/

- The powers to impose interim orders in health cases for the duration of the lifetime of a complaint and for nurses to have an opportunity to respond to the NCNZ's intention to impose an interim order in a health case
- The powers to review suspension orders and conditions of practice orders imposed by the HPDT before they expire to ensure that public protection and confidence in health professional regulation is maintained
- The power to strike off nurses who are found to be continually incompetent
- The power to use a single system to consider conduct, competence and health cases.
- A full cost and risk assessment to take place in relation to proposals for all regulators to share back office functions and consideration of alternative ways of saving costs such as the merger off all small regulators in to one.

8. Conclusions

8.1 The NCNZ is an effective regulator with strong leadership and a commitment to improvement.

8.2 Governance is appropriate and Council members are diligent and serious in their approach to their responsibilities. Governance policies are in place and are generally followed. The relationship between Council and staff is one of mutual respect and is well balanced.

8.3 There are a number of areas in which governance could be improved; greater focus on public protection, more efficient management of meeting papers and agendas, clearer oversight of financial matters by council and changes in the selection and appointment of council members.

8.4 The NCNZ is protecting the public through its conduct, competence and health processes. Overall we found sound decision-making within the context of the New Zealand approach to regulation with its strong focus on rehabilitation.

8.5 There are two areas which need particular attention because of their bearing on protection of the public. These are the brevity of interim suspension orders available in health cases and the separate processes for conduct, competence and health.

8.6 There are a number of improvements which the NCNZ could make to its procedures to ensure greater consistency of outcome. These include better record keeping, an overall quality assurance framework, more detailed and comprehensive recording of decisions.

8.7 Public confidence could also be promoted by greater transparency, better communication with the public, improved letters and more information on the register.

8.8 We are grateful to the Council and staff of the NCNZ for inviting us to undertake this review and for their co-operation, openness and honesty throughout.

9. Annex 1: People who contributed to the review

9.1 The following individuals contributed to the review:

Staff members

- Carolyn Reed, Chief Executive
- Lindsay Hiener, Business Development and Support Manager
- Pam Doole, Director of Strategic Policy
- Maureen Kelly, Education Manager
- Clare Prendergast, Health and Conduct Manager
- Ana Shanks, Registration Manager
- Sue McDonald, Professional Standards Manager

Council members

- Dr Margaret Southwick, Chair of the Council
- Lesley Going, Deputy Chair of the Council
- Katherine Townsend
- Catherine Byrne
- Catherine Abel-Patterson
- Barry Ayling
- Deborah Rowe
- Patricia Seymour
- Dr Jo Ann Walton

Committee members and panellists

- Beverley Burns
- Julia Ebett
- Gail Harrison
- Marie Keily

Stakeholders

- Geoff Annals, Chief Executive of New Zealand Nurses Organisation
- Professor Jenny Carryer, Chair of College of Nurses
- Jane O'Mally, Chief Nurse, Ministry of Health Executive

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