Nursing & Midwifery Council

New strategic direction

Ensuring public safety, enabling professionalism

Our commitment to change

We're at a turning point for fitness to practise. We're taking a new direction, signalling our commitment to moving away from a blame culture towards a just culture in health and social care.

We've already made some significant improvements to the way we work and we know there is much more we can do to change and improve.

Our focus is on reducing risks to patients and service users in the future by encouraging openness and learning, not on punishing nurses and midwives for past mistakes.

The changes we're making are about putting people at the centre of fitness to practise. This will make sure we treat patients, service-users, and families with compassion and respect, and properly listen to and resolve their concerns about nurses and midwives.

We'll work more closely with employers so that as many issues as possible can be resolved quickly and effectively at a local level. We'll give greater consideration to the context in which incidents occur, because we know that nurses and midwives face complex issues and pressures every day.

When concerns are raised with us, we strongly encourage nurses and midwives to be open and honest about what has happened and to talk to us as early as possible about what they have done to put things right. If more action is needed, we'll seek to agree with nurses and midwives what steps they need to take before they're fit to practise safely and effectively.

In many cases, a full public hearing may not be needed. This will reduce the burden on everyone involved, especially patients, service-users and families who

would otherwise have to relive distressing experiences. We'll continue to give full reasons for the decisions we take so there is transparency about what steps have been taken to protect the public and why.

Our new approach draws on the rich insights from our public consultation, our research and input from patients, service-users and families, nurses and midwives, employers and other stakeholders.

We've set out 12 key principles which underpin the changes we're making. These will form the basis of how we work and how we are held to account in the future. We're committed to pushing forward these improvements and shaping a new future for fitness to practise.

Philip Graf
Council Chair

New strategic direction

This sets out:

- why we're going in a new direction
- what we want fitness to practise to look like
- how we're making changes to get there.

Why are we going in a new direction?

Our *'Dynamic regulation for a changing world'* strategy (2015–2020) encouraged us to:

- 'Strike the right balance between the public interest and proportionate use of resources by making appropriate use of alternative means of disposal, in place of full hearings'
- 'Engage with employers to ensure our referral thresholds are understood and matters better handled locally do not result in referrals'
- 'Explore the benefits of other approaches to adjudication.'

We've made significant progress in each of these areas since 2015 and have improved our ability to protect the public. However, our processes remain complex, and we continue to spend a large part of our resources on resolving cases at hearings which are adversarial in nature and consequently have a negative impact on the people involved. We know that some patients and members of the public have felt distress at the length of time our process can take and how complex and impersonal it can seem.

We recognise that, in the continued absence of the wide-ranging regulatory reform which is required in fitness to practise, we have a responsibility to make sure that our fitness to practise function remains relevant and fit for purpose. This new strategic direction is the product of our thinking in this area.

A number of key sources of information have helped us to get to this point:

- the responses to our consultation on a proposed future direction for fitness to practise, which ran between April and June 2018
- qualitative research on public attitudes towards fitness to practise, undertaken by ICE Creates between April and June 2018
- a literature review on how fitness to practise processes and healthcare investigations promote professionalism and patient safety
- the Professional Standards Authority's Lessons Learned report into our handling of the cases relating to the Morecambe Bay maternity deaths, published in May 2018
- the findings of the report into patient deaths at Gosport Memorial Hospital, published in June 2018
- the Williams review into gross negligence manslaughter, published in June 2018.

What do we want fitness to practise to look like?

In short, we believe that two key factors apply:

- ensuring patient safety: using our regulatory powers to encourage fairness, openness and learning; taking regulatory action where it's needed; and avoiding punishing nursing and midwifery professionals for mistakes
- enabling professionalism: supporting nursing and midwifery professionals to address concerns about their practice, so that members of the public can continue to have confidence in the professions and confidence in us to promote and uphold high standards.

In order to properly explain this we need to set out our revised understanding of public protection, our desired regulatory outcomes and the policy principles that underpin them.

Public protection

Article 3(4) of the Nursing and Midwifery Order 2001 states:

'The over-arching objective of the Council in exercising its functions is the protection of the public.'

Article 3(4A) states:

'The pursuit by the Council of its over-arching objective involves the pursuit of the following objectives—

(a) to protect, promote and maintain the health, safety and wellbeing of the public;

(b) to promote and maintain public confidence in the professions regulated under this Order; and

(c) to promote and maintain proper professional standards and conduct for members of those professions.

We're required by law to make sure that public protection is at the forefront of our minds when we exercise any of our statutory functions. Within our fitness to practise process we're committed to identifying, investigating and, if necessary, restricting the practice of those individuals who pose an ongoing and serious risk.

We know that protecting the public means more than managing and mitigating immediate patient safety risks. It goes further than that. We need to play our part in making sure that people have confidence in using the services of nurses and midwives generally. This can involve taking regulatory action to maintain public confidence or uphold standards of the profession, even if the registrant in question doesn't pose a patient safety risk.

However, we recognise that taking regulatory action in these circumstances can have profound implications both for the individual registrant and the wider healthcare environment. Each and every time someone is seen to be 'punished' for their actions through the intervention of the regulator, there is the risk that this contributes to a culture where it becomes more – not less – likely that the actions will happen again. The potential for registrants to focus on avoiding blame rather than acknowledging errors or weaknesses in their practice is increased.

This contribution to an anti-learning culture is clearly an acceptable trade-off in situations where there is an ongoing and serious risk posed by an individual or the concern about their fitness to practise is of such severity that not taking regulatory action against them would be untenable. It has considerably less justification in cases where the nurse or midwife has already addressed the concern, or where it's of a less serious nature. Indeed, pursuing a case in such situations on the basis that it's necessary to maintain public confidence or uphold

standards has the potential to conflict with our patient safety responsibilities, if by so doing we undermine a culture of openness and learning.

In light of the above, we recognise that there is a need for us to be clear as to when we will take action under each part of our overarching objective and why. We have set out our thresholds for taking action later in this document.

Regulatory outcomes

Historically, fitness to practise has been viewed primarily as a vehicle for restricting the practice of registrants. We think this assumption needs to be challenged given that the nature and context of nursing and midwifery practice are shifting rapidly. We consider that effective and proportionate fitness to practise actually means putting patient safety first, and that an open, transparent and learning culture will best achieve this. We're not alone[1] in thinking that a culture of blame and punishment is likely to encourage cover-up, fear and disengagement, and we know that some people affected by things going wrong in the care of those close to them might expect that it's our role to discipline registrants for such incidents. We want registrants to engage with the fitness to practise process in a positive way and see it as an opportunity to learn and reflect on their practice, while increasing patient safety, and we want to better support the people who make complaints about care by explaining to them clearly that our purpose is to protect the public.

As the largest healthcare professional regulator in the world, we think we have a particular responsibility to lead in this area and that we need to be clear on what we want to come out of the fitness to practise process. We're calling these our regulatory outcomes.

A professional culture that values equality, diversity and inclusion and prioritises openness and learning in the interests of patient safety

We recognise that if people perceive there to be a culture of punishment in the profession, this could prevent an open, learning culture. It can lead to denial and cover-up and doesn't put patient safety first.

Academic studies[2] about how fitness to practise affects professionals have found that if people think their regulator is punitive or focused on blame, they're more likely to be anxious or even preoccupied about how their regulator might see their practice. This can lead to them being more likely to hide incidents that could affect patient safety. Recent work[3] has found that cultures of blame are 'pervasive' in healthcare.

Research also tells us that our current fitness to practise processes don't contribute to a healthcare culture that values diversity, equality and inclusion. Registrants from outside the EU and from black, Asian and minority ethnic (BME) backgrounds are overrepresented in fitness to practise proceedings, driven by disproportionate referrals from employers[4]. This is a concern in other parts of the regulatory sector. General Medical Council research found that BAME and non-UK doctors are overrepresented in investigations[5], while five years of General Dental Council hearings data reviewed by the British Dental Journal in 2009 showed that dentists trained outside the UK made up 42 percent of registrants charged[6].

We're aware of these problems, and we want the way we regulate to help solve them. This is why we have identified a professional culture as our first desired regulatory outcome.

Registrants who are fit to practise safely and professionally

Now, more than ever, we need a healthcare workforce which is able to respond to the complex and changing needs of an expanding population. The nurses and midwives on our register play a vital part in this. We think that our fitness to practise operation needs to support the maintenance and development of a skilled, safe and professional workforce and not hinder it.

With this in mind, we want fitness to practise to deliver improvements to the safe practice and professionalism of those who enter the process and not to curtail or restrict practice unnecessarily. We recognise that there will be situations where restrictions on or removal from practice are inevitable but we don't think that these cases are the norm. Most registrants who have difficulties in their practice are willing and able to remediate the problem. We want to break down the barriers that stop them from doing so as early as possible.

Policy principles

We've developed a number of key principles for fitness to practise. We want these to inform the expectations of those who are involved in the process, whether these are registrants, patients, members of the public, employers or decision-makers. We are happy to be judged by how well we keep to these principles and will be incorporating them into our own quality frameworks.

While these principles accord with our legislation and case law, they are also consistent with our underlying vision of a fitness to practise process that delivers our desired regulatory outcomes.

1

Taking a person-centred approach to fitness to practise helps us to properly understand what happened, to make sure concerns raised by patients and families are properly listened to and addressed, and to explain to them what action we can take and why.

A person-centred approach helps us to put patients, families and the public at the heart of what we do. What patients, their families and loved ones tell us about their experiences helps us understand the regulatory concerns about nurses and midwives. Sometimes, they provide vital information that shows we need to scrutinise the conclusions others have reached. Some patients and members of the public haven't felt supported or listened to in our fitness to practise proceedings. Putting patients, families and the public at the centre of what we do helps us to make sure we are in the best place to protect the public.

2

Fitness to practise is about managing the risk that a registrant poses to patients or members of the public in the future. It isn't about punishing people for past events.

If professionals see us as being punitive, those professionals are more likely to hide things going wrong or act defensively. This will make it difficult to achieve the kind of open and learning culture that's most likely to keep patients and members of the public safe. If we are seen by the people affected by unsafe care as being there to discipline the registrants involved, those people may be distressed if we don't take action against registrants who are no longer a risk.

3

We can best protect patients and members of the public by making final fitness to practise decisions swiftly and publishing the reasons openly.

Transparency is crucial to an effective fitness to practise process. All the people involved in a case, including patients, members of the public and registrants, expect fitness to practise processes to be efficient and joined up. They need to understand clearly and as quickly as possible what we have done about the concerns, and the reasons for our decisions. Those reasons may help others in similar situations make decisions that will help keep patients and members of the public safe.

4

Employers should act first to deal with concerns about a registrant's practice, unless the risk to patients or the public is so serious that we need to take immediate action.

Employers are closer to the sources of risk to patients and members of the public, and better able to recognise and manage them. If they need to, they can intervene directly and quickly in a registrant's practice, and do so in a targeted way dealing specifically with the risks. We are further away from the sources of possible harm, and have a more limited range of options to prevent it. We only need to become involved early on if the registrant poses a risk of harm to patients or the public that the employer can't manage effectively (perhaps because the registrant has left), meaning the registrant's right to practise needs to be withdrawn or restricted immediately.

5

We always take regulatory action when there is a risk to patient safety that is not being effectively managed by an employer.

In the small number of cases where employers can't put the right controls in place to keep patients and members of the public safe, then we will need to become involved. This can often happen when the registrant practises in more than one setting, or doesn't have an employer, although these aren't the only examples. We may need to consider putting conditions on the registrant's ability to practise, or remove it.

6

We take account of the context in which the registrant was practising when deciding whether there is a risk to patient safety that requires us to take regulatory action.

When incidents of poor practice actually happen because of underlying system failures, taking regulatory action against a registrant may not stop similar incidents happening again in the future. Regulatory action against an individual registrant may give false assurance, direct focus away from a wider problem and cause a future public protection gap.

7

We may not need to take regulatory action for a clinical mistake, even where there has been serious harm to a patient or service-user, if there is no longer a risk to patient safety and the registrant has been open about what went wrong and can demonstrate that they have learned from it.

Encouraging registrants to learn from mistakes, including mistakes with serious consequences, is more likely to promote a learning culture that keeps patients and members of the public safe than taking regulatory action to 'mark' the seriousness of the consequences. Negative stories about regulation have a harmful effect on registrants. We want to assure registrants that they won't be punished if they admit to, and show they have learned from, past mistakes because this will support them in positively engaging with their professional duty of candour and help promote, rather than discourage, the kind of professional culture that's been shown to keep people safe.

8

Deliberately covering up when things go wrong seriously undermines patient safety and damages public trust in the professions. Restrictive regulatory action is likely to be required in such cases.

The duty of candour requires registrants to be open and honest when things go wrong. It stops them from trying to prevent colleagues or former colleagues from raising concerns. We know that if professionals don't speak up when things go wrong, significant numbers of people can suffer harm, and have done in the past. Registrants who try to cover up problems in their own practice deny patients and members of the public the honest explanation and apology they deserve when they have been put at risk of harm. It can also put other people at risk of suffering harm if organisations are prevented from investigating wider problems.

9

In cases about clinical practice, taking action solely to maintain public confidence or uphold standards is only likely to be needed if the regulatory concern can't be remedied.

If the registrant has fully remedied the problem in their practice that led to the incident, and already poses no risk to patients, the case is unlikely to be serious enough to need us to take action to uphold public confidence in all registrants, or to declare standards for them. As our role is not to punish people for past events, only those cases that can't be remedied are likely to be serious enough for us to need to take regulatory action to promote public confidence or uphold standards.

10

In cases that aren't about clinical practice, taking action to maintain public confidence or uphold standards is only likely to be needed if the concerns raise fundamental questions about the trustworthiness of a registrant as a professional.

We know that the public take concerns which affect the trustworthiness of registrants particularly seriously. Our research told us that these cases are likely seen by the public as serious breaches of professional standards. Conduct that could affect trust in registrants and require action to uphold standards or public confidence include, where related to professional practice, dishonesty, bullying and harassment. Within a registrant's private life, convictions that relate to specified offences or result in custodial sentences are also likely to require regulatory action for the same reason.

11

Some regulatory concerns, particularly if they raise fundamental concerns about the registrant's professionalism, can't be remedied and require restrictive regulatory action.

Conduct that calls into question the basics of someone's professionalism raises concerns about whether they are a suitable person to remain on a register of professionals. It's more difficult for registrants to be able to remedy concerns of this kind, and where they cannot, it will be difficult to justify them keeping their registered status.

12

Hearings best protect patients and members of the public by resolving central aspects of a case that we and the registrant don't agree on.

Full public hearings are not always required to reach a decision that protects the public. Their adversarial nature often has a negative impact on people, and they are slow and resource intensive.

How are we making changes to get there?

The changes and improvements we intend to deliver in 2018/19 and 2019/20 are:

A person-centred approach

We will:

- launch a person-centred strategy
- complete the set-up of our Public Support Service, including:
- holding meetings with patients and family as part of the fitness to practise process
- delivering training to fitness to practise staff.
- explain better how our process works and set expectations more effectively
- improve how we engage members of the public
- explain key decisions to members of the public who have an interest in the case and seek their input where it is appropriate to do so.

Applying our policy principles to how we make decisions

Our decision-maker guidance will be updated in September 2018 to incorporate the 12 policy principles.

Prioritising effective local action by employers

In order to prioritise effective local action by employers we will:

- produce new referrals guidance and an online referrals system for employers
- introduce a new approach to handling referrals from members of the public.

Taking account of the context in which safety incidents occur

To make sure that we take context into account across our processes we will:

- introduce guidance that sets out why context is relevant and how we will take it into account when we make decisions
- introduce a tool to standardise the way we assess context, and build this into to our decision-making.

Enabling remediation

To help registrants to remediate regulatory concerns at the earliest opportunity, we will:

- engage more with the registrant at the beginning of the process
- provide a more tailored approach to remediation in respect of easily remediable cases.

Only holding full hearings to resolve material disputes

To make sure that we're only holding full hearings when there is a material dispute, we will:

- update our criteria for when a case needs to be heard at a hearing
- introduce a process for the use of statements of case in meetings.

Working effectively with regulators and other key stakeholders within clearly defined boundaries

We will:

- define more clearly the routine interactions we expect to have, and the information we expect to share, with other organisations in the interests of public protection
- refer concerns to other organisations where they are better placed to deal with them than we are
- explore opportunities for joint working where they're in the interests of public protection.

Continuous improvement

We will improve the way we operate by embedding continuous improvement in our culture.

Following an initial review of our processes, we will start to make changes and improvements in the following areas:

- preparing for and completing hearings
- managing cases involving third party investigations
- managing correspondence, documents, and evidence.

We will fundamentally review our processes more fundamentally in line with the plan to replace our case management system.

Footnotes

[1] See, for example, Berwick, D. (2013). A promise to learn–a commitment to act: improving the safety of patients in England. London: Department of Health, 6, Francis, R. (2013). Report of the Mid Staffordshire NHS Foundation Trust public inquiry: executive summary (Vol. 947). The Stationery Office. The Francis Report itself cited Professor Ian Kennedy's report into Bristol Royal Infirmary (Inquiry, B. R. I., & Kennedy, I. (2001). The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995. Stationery Office.) and Professor Sir Liam Donaldson's An organisation with a memory (Donaldson, L. (2002). Clinical Medicine, 2(5), 452-457) as reports well over a decade ago that called for a move away from a culture of blame, and which the evidence suggested healthcare has yet to achieve.

[2] McGivern, Gerry, and Michael Fischer. Medical regulation, spectacular transparency and the blame business. Journal of health organization and management 24.6 (2010): 597-610. McGivern, Gerry, et al. Exploring and explaining the dynamics of osteopathic regulation, professionalism and compliance with standards in practice. (2015).

[3] Armstrong, N., Brewster, L., Tarrant, C., Dixon, R., Willars, J., Power, M., & Dixon-Woods, M. (2018). Taking the heat or taking the temperature? A qualitative study of a large-scale exercise in seeking to measure for improvement, not blame. Social Science & Medicine.

[4] West, Elizabeth, and Shoba Nayar. A Review of the Literature on the Experiences of Black, Minority and Internationally Recruited Nurses and Midwives in the UK Healthcare system. (2016).

[5] General Medical Council: 'The state of medical education and practice in the UK 2015 **www.gmc-uk.org/SOMEP_2015.pdf_63501874.pdf** (pp. 58- 83)

[6] Singh et al 'A five-year review of cases appearing before the General Dental Council's Professional Conduct Committee' British Dental Journal vol 206 no. 4 Feb 28 2009