Nursing & Midwifery Council

Consultation report: Ensuring patient safety, enabling professionalism

July 2018

Consultation report: Ensuring patient safety, enabling professionalism

Introduction

1. From 4 April to 8 June 2018 we consulted on changes to our fitness to practise function. We proposed reforming fitness to practice with a new strategy: *Ensuring patient safety, enabling professionalism.*

    - **ensuring patient safety**: using our regulatory powers to encourage fairness, openness and learning, taking regulatory action where it's warranted, 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 defend high standards.

2. We proposed ten strategic policy principles for fitness to practise, to inform the expectations of those who are involved in the process. We revisit those principles in this report.

3. We received a significant number of responses to our consultation: 892 responses, of which 809 were from individuals and 83 from organisations. Of the 747 respondents who told us more about themselves, 48 identified as being a 'member of the public, service user or carer' and 573 said they were a UK registered nurse or midwife.

4. The number of responses compares very favourably to other consultations concerning fitness to practise. We thank everyone who took the opportunity to respond and in doing so has helped shape our strategy.

5. During the same period we commissioned ICE[1] to carry out qualitative research with key stakeholders including employers, registrants, members of the public and members of the public who have been involved in the fitness to practise process. This was to understand current perceptions of fitness to practise and the acceptability of our proposed strategy.

6. ICE conducted the research[2] across the four UK countries and engaged with a diverse sample of participants. The final sample of 206 included:

    - 49 members of the public who had used the service of registrants in the last six months and three members of the public who had been involved in fitness to

[1] ICE Creates Ltd, www.icecreates.com.

[2] We have published this on our consultation webpage at www.nmc.org.uk/about-us/consultations/past-consultations/2018-consultations/ensuring-patient-safety-enabling-professionalism/

practise in the last three months. This included representation from male and females and a wide range of age groups. 14 percent were from black and minority ethnic groups (BME).

- 113 registrants from a range of practice areas and work settings, who were representative of the ethnicity and gender of the registrants who interact with fitness to practise.

- 41 employers from a range of work settings including private and NHS, and from varied levels of authority.

7. This document sets out a summary of the responses we received to the consultation and research analysis. You can find further detailed analysis on how organisations and individuals responded to our consultation and our full qualitative research report on the consultation page of our website at: www.nmc.org.uk/about-us/consultations/past-consultations/2018-consultations/ensuring-patient-safety-enabling-professionalism/

The changes we are making

8. We have used the responses and research to inform the changes we have made to our strategy. The main changes are:

- Introducing a new strategic policy principle to reflect a person-centred approach to fitness to practise and the importance of engaging effectively with patients and families.

- Clarifying when we will take action to maintain public confidence or uphold standards.

- No longer suggesting that deliberately covering up when things go wrong will result in automatic removal from the register. We now say this conduct is likely to result in restrictive regulatory action.

9. We deal with these changes in more detail throughout the relevant sections of our report.

Background

10. We've made several improvements to our processes in recent years. We made some of these through legislative change, such as the introduction of case examiners. Other reforms involved changes to how we operate, such as supporting employers and improving the quality of referrals with the Employer Link Service.

11. In January 2017 the General Dental Council (GDC) published *Shifting the balance: a better, fairer system of dental regulation*. This discussion document set out the GDC's views on reforming dental regulation without relying upon legislative change. For fitness to practise, it outlined a refocus: being clear about the serious nature of 'impaired fitness to practise' and taking action to ensure that anything short of that is dealt with using alternative tools with the right touch, and providing support to patients to find the best mechanism for resolving their issue.

12. In October 2017, the Department of Health published *Promoting professionalism, reforming regulation, a paper for consultation*. This consultation recognised that regulation needs to change. From the perspective of patients and the public, the current system of regulation can be confusing, inconsistent and slow, and the adversarial nature of fitness to practise proceedings does not support the early identification and resolution of concerns. To meet the challenge of changing healthcare systems, it proposed that regulators should be given greater autonomy to innovate, without having to wait for legislation, while working with other groups to better support professionalism.

13. In November 2017 the Professional Standards Authority for Health and Social Care (the PSA) published a report, *Right-touch reform: A new framework for assurance of professions*. This report proposed a number of guiding principles for reform. For fitness to practise, it proposed only using fitness to practise measures when necessary and seeking early resolution and remediation where appropriate. The report also proposed 'a more radical principle' of only using formal adjudication when a registrant disputes the case.[3]

14. The common theme in all these publications is that the current model of regulation needs to change. The fitness to practise model needs to be flexible and proportionate, and foster professionalism. Regulators have a key role to play in this.

15. It's against this backdrop that we commissioned research, engaged with stakeholders and developed our proposed strategy for reforming fitness to practise that puts patient safety first, and supports an open, transparent and learning culture that values equality, diversity and inclusion.

The evidence base for our strategy

16. In developing our strategy we reviewed the literature, reviews of fitness to practise and healthcare, and research already undertaken by other regulators and the PSA. It's clear that a culture of blame and punishment is likely to encourage cover-up, fear

[3] The PSA deemed this as radical in light of what case law suggests. However, in the PSA's view there would be value in re-evaluating this assertion. Right Touch Reform, paragraph 3.216.

and disengagement.[4] From our review, we found that if people think that 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 patent safety.

Research

17. In January 2017, we commissioned research into the *Progress and Outcomes of Black and Minority Ethnic (BME) Nurses and Midwives through the Nursing and Midwifery Council's Fitness to Practise.*[5] The research tells us that individuals in the black and unknown ethnic categories are referred to us with greater frequency than would be expected given the proportion of BME nurses and midwives on our register.

18. Males are referred to us at around twice the rate than would be expected given the number of male nurses and midwives registered with us. So, male registrants from a BME background may experience a double disadvantage in that they are a minority in society by virtue of their ethnicity and a minority in the profession by virtue of their gender.

19. Employers and members of the public are the most frequent sources of referrals. Employers refer more BME registrants than we would expect given the proportion of BME registrants on our register. Conversely, members of the public refer mainly white registrants and are less likely to refer any of the other ethnic groups.

20. However, when we hold final hearings, BME registrants are the least likely to receive a penalty that prevents them from working. This suggests that the fitness to practise process does not discriminate against BME registrants, but that there is some evidence of discrimination in terms of the disproportionate number of referrals by employers.

21. This identifies support for gearing our regulatory processes towards supporting a professional culture that values equality, diversity and inclusion.

[4] 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.

[5] West et al (2017), The Progress and Outcomes of Black and Minority Ethnic (BME) Nurses and Midwives through the Nursing and Midwifery Council's Fitness to Practise Process; Ice Creates Ltd research (2018), NMC: Fitness to Practise Insight [Published at https://www.nmc.org.uk/about-us/governance/the-council/council-meetings/council-meeting-25-july-2018/]

Just Culture

22. Organisations across the healthcare sector have been working to embed a just culture approach to investigations for a number of years. A just culture involves avoiding blame and punishment when things go wrong, if a reasonable professional would have acted similarly in the circumstances. Above all it focuses on learning from mistakes to make systems safer. Some of the more recent developments in this direction include:

    - the establishment of a Just Culture Taskforce for England by the Department of Health in January 2017
    - Healthcare Safety Investigation Branch (HSIB) becoming operational as an independent investigation body for serious safety incidents in the NHS in England in April 2017
    - publication of the Health Service Safety Investigations Bill, establishing the Health Service Safety Investigations Body (HSSIB) to build on the work done by HSIB in September 2017
    - NHS Improvement adopting a Just Culture tool for the NHS in England at the end of March 2018.

23. We welcomed these developments. HSSIB is part of an ambition to create a more open, learning culture across the NHS and represents, 'a landmark moment for patient safety across our NHS, and is a historic opportunity to achieve widespread cultural change in learning from mistakes'.[6]

24. We think that changing our approach to fitness to practise gives us the chance to be part of the solution. We have engaged with the organisations at the forefront of this approach and think that our role can help to underline that a just culture approach is the one most likely to keep patients and the public safe.

Stakeholder engagement

25. During our consultation we communicated with our stakeholders, setting out our proposed strategy, listening to their views and encouraging them to respond to our consultation. Our stakeholder base spanned the four nations and sought to include all the groups we interact with. It included registrants, employers, healthcare bodies and charities, people with first hand experiences of fitness to practise, such as patients and patient organisations, and registrants who had been referred to us and who had gone through the fitness to practise process.

26. As well as email and telephone conversations, we held roundtable events and webinars. We spoke with panel members and our staff. After our consultation closed, we continued to speak with interested people and organisations.

---

[6] Secretary of State for Health, Jeremy Hunt, https://www.gov.uk/government/news/new-bill-to-improve-patient-safety

Lessons learned review

27. During our consultation period the PSA published the *Lessons Learned Review*.[7] The review considered our handling of concerns about midwives at the University Hospitals of Morecambe Bay NHS Foundation Trust.

28. We welcomed the review and agree with its recommendations. Our approach to the Morecambe Bay cases, in particular the way we engaged with the families, was unacceptable. We missed opportunities to deal with concerns sooner and this put the public at higher risk. We are sorry for this. We take the findings of the review extremely seriously and we're committed to change and improvement.

29. Our strategy recognises this and is part of the significant changes we have made to the way we work. The views of families and patients are central to everything we do and this is now encapsulated in our policy principles, which set out the aims of our strategy and the approach we will take. Our principles state that taking a person-centred approach to fitness to practise can help us to properly understand what went wrong, and make sure concerns raised by patients and families are properly addressed. It helps us to make sure they understand what is happening in our process.

30. We haven't always appreciated that what patients, their families and loved ones tell us about their experiences helps us understand the regulatory concerns about registrants. But we are learning from our mistakes. Our full Public Support Service will be up and running by autumn 2018. It will provide tailored support to make sure patients, families and the public are protected, valued and respected, specifically when we consider whether a nurse or midwife is fit to practise.

31. We won't stop there. We know we have a lot more to do. In the past, we haven't been open with people when things went wrong. We are improving our approach to transparency through the training we give to staff and the information we make available. This is also a key feature of improving how we operate, outlined in our strategy.

32. We revisit these lessons throughout this report.

The consultation

33. Our consultation was set out over six parts. Parts one to four set out our strategy.

34. Part one introduced our regulatory outcomes:

- a professional culture that values equality, diversity and inclusion and prioritises openness and learning in the interests of patient safety
- registrants who are fit to practise safely and professionally

[7] PSA, May 2018, Lessons Learned Review: The Nursing and Midwifery Council's handling of concerns about midwives' fitness to practise at the Furness General Hospital

35. We also asked what the public expected from us as a regulator, in terms of public protection and the wider public interest. The aim was to identify a threshold for when we should take cases forward purely to uphold public confidence or proper professional standards, and to gather evidence, through the questions we asked, as to when the public think we should take action.

36. Part two discussed how we regulate. We identified four different ways in which we can achieve our regulatory outcomes using our current regulatory powers: prioritising effective local action by employers; taking the context into account; enabling registrants to remediate regulatory concerns at the earliest opportunity; and holding full hearings only in exceptional circumstances.

37. Part three focused on how we operate. We identified three areas where we can improve how we operate. Area one dealt with managing public expectations and supporting vulnerable stakeholders better. This is an important focus for us and part of our commitment to ensuring that the views of families and patients are central to everything we do. Area two outlined how we will continue to work with regulators and other key stakeholders and share information in the interests of public protection. Area three explained how we will continuously improve how we operate by using and embedding a consistent quality improvement methodology.

38. In part four we asked specific questions about equality, diversity and inclusion. Our first regulatory outcome identifies that we aim to achieve a professional culture that values equality, diversity and inclusion. We envisage that a fitness to practise process that does value equality, diversity and inclusion and supports employers to incorporate these principles, could result in fairer outcomes.

Policy principles

39. To achieve the aims of our strategy we know that we need to take a consistent and proportionate approach to fitness to practise. By identifying ten policy principles in our consultation, we sought to identify our aims and inform the expectations of people involved in our fitness to practise process. We've considered them further in light of our research and the responses we've received to the consultation.

40. The responses to principle seven told us that automatic removal from the register in cases such as deliberately covering up when things go wrong is considered too restrictive. On reflection, we agree that other factors and context may mean that automatic removal won't always be the right result. We've amended this principle to reflect this.

41. We have added a further two principles, which incorporate our approach to patients and members of the public, and clarify our position on when we will take action to uphold public confidence in the professions. We set out our revised principles at the end of this report.

Qualitative research

42. The overall objective of the separate qualitative research was to gain feedback from stakeholders on our proposed changes. However, we also wanted to understand the current perceptions and expectations of fitness to practise.

43. We asked ICE to:
    - understand stakeholders' expectations of us with respect to fitness to practise
    - understand perceptions of the current fitness to practise process
    - understand the acceptability of the potential change to our regulatory focus
    - understand the acceptability of the four different ways in which we propose that we can achieve our regulatory outcomes
    - explore stakeholders' perceptions regarding the potential benefits and challenges associated with the proposed changes – including whether or not the proposed changes would be expected to improve processes and outcomes in fitness to practise.

44. The research methods included workshops, face-to-face interviews and telephone interviews. A quarter of the participants were members of the public who had used a registrant's service in the last six months. Our strategy takes a person-centred approach to fitness to practise. The voice of patients, families and members of the public help us understand the fitness to practise concerns about registrants. So it was important for us to understand what members of the public expect from the fitness to practise process, and what they expect from us.

A summary of responses

Consultation

45. In our consultation we asked 19 questions about the changes arising out of our proposed strategy. The questions fell into six categories:

    1. Public protection
    2. Public confidence in the regulatory process
    3. Our regulatory outcomes
    4. Achieving our regulatory outcomes
    5. How we operate
    6. Impact on equality, diversity and inclusion

46. We asked respondents whether they agreed or disagreed with each question. They had the option of stating 'don't know'. All respondents had the option to provide additional commentary in relation to the proposals. Respondents we able to reply through our online survey platform or in writing.

47. A total of 892 respondents answered some or all of the questions in the full consultation document. These included 83 organisations and 809 individuals. Of organisations, the strongest support for our proposals came from NHS employers of doctors, nurses and midwives.

48. We had a low number of responses from ethnic minorities, who made up 5 percent of responses. This is significantly below the number we'd expect given people from an ethnic minority make up 22 percent of our register, and 13 percent of the general population in the UK. Therefore, the responses of this consultation may not reflect the wider views of diverse communities, and more engagement is required to understand the equality, diversity and inclusion impacts of the strategy on minority groups.

49. The detailed analysis of responses to each question can be found on the consultation pages of our website at https://www.nmc.org.uk/about-us/consultations/past-consultations/2018-consultations/ensuring-patient-safety-enabling-professionalism/. It does not include an analysis of responses received outside of the consultation period. However, we have taken them into account in preparing this response.

Research

50. Our qualitative research findings focus on seven sections:

1. Stakeholders' expectations of the NMC regarding the fitness to practise process
2. Stakeholders' perceptions of the current fitness to practise process
3. Feedback on public confidence policy statement
4. Prioritising effective local action by employers
5. Taking context into account
6. Enabling registrants to remediate regulatory concerns at the earliest opportunity
7. Holding full hearings only in exceptional circumstances

51. The key findings of the research for sections one and two identified that people expect us, through fitness to practise, to protect patients and the public and uphold the standards of the professions.

52. We asked researchers to make sure that the groups in our qualitative research were diverse. Although we know the groups were made up of people with a range of protected characteristics, we don't have an analysis of the research by protected characteristic, which would give us insight into the impact of the strategy on specific groups and individuals.

Expectations

53. Across all stakeholder groups, participants said that they would expect us to uphold standards and make judgements on registrants' practice by applying standards and policies in a consistent manner. There was also an expectation for fair, proportionate regulatory action based on the severity of the concern regarding a registrant's fitness to practise in the future, as opposed to the severity of the outcome of the incident. Groups also said that they would expect us to be transparent about the process and the process to be efficient.

54. Members of the public said that if they were making a referral, they would expect us to appreciate that the process may be distressing for them as a referrer, particularly if the case took a long time to resolve and concerned a family member. We

recognise that people don't take the decision to refer to us lightly, and it can be a very stressful experience.

55. The research tells is that the public expect us to be supportive. We know that we must listen to the voices of the public and keep them informed, to make sure that we have all the vital information we need to properly scrutinise the concern referred to us, so that we meet our overarching objective of protecting the public and maintain confidence is us as a regulator.

56. This approach is also in line with the PSA's recommendation from the Lessons Learned Review that we engage with patients and service users, make sure they are informed of the process and progress, and analyse and take their evidence seriously.

Perceptions

57. Similar themes emerged from the stakeholder groups. Participants agreed that the fitness to practise process is time-consuming and longer than they expected, and it needs to be more efficient. Employers were concerned by the time initial screening of cases can take. They believed that it became more challenging to provide investigations with quality fact-based evidence the longer the time window between them raising a concern and a full investigation being opened.

58. Members of the public who had been involved in a fitness to practise case found it 'extremely distressing', a feeling that was increased by the length of time it took to resolve a case. It was discussed that, in order to reduce the negative impact of fitness to practise cases, we would be expected to provide appropriate support and guidance to the registrant, referrer, employer and others concerned.

59. We've incorporated the results from sections three to seven (above) into the relevant categories of the consultation responses (below).

Public protection (questions 1-5)

60. Our overarching objective is protection of the public. Linked to this are the three sub-objectives of public safety, public confidence in the professions and the need to promote and maintain proper professional standards and conduct.

61. We proposed changes to how we undertake fitness to practise by refocusing public protection and by moving away from a culture of blame and punishment. This would mean that we would always need to interpret public safety, public confidence in the professions and the need to promote and maintain proper professional standards from a public protection viewpoint.

62. We proposed that we wouldn't take action to promote and maintain professional standards and public confidence in the professions unless there was a clear link to our overarching objective of public protection. To make this link, the regulatory concern would need to involve something that is so serious that it would have an impact on the likelihood of a member of the public using the services provided by registrants in the future.

Supportive responses

63. 89 percent of respondents agreed that fitness to practise should primarily be about managing the risk that a registrant poses to patients or members of the public in the future.

64. 77 percent of respondents agreed that fitness to practise is not about punishing people for past events. The key theme, from 20 percent who provided additional comments, was that registrants should be supported rather than punished and part of this support should be a culture of openness, so that individuals have opportunities to learn from their mistakes

65. Overall, 74 percent of respondents agreed that we should only take action to uphold public confidence when the conduct is so serious, that if we did not take action, the public wouldn't want to use the services of registrants. A lower proportion or organisations agreed (61 percent), compared to 75 percent of individuals. Others said that this proposal would reduce the time spent on issues that do not pose a risk to the public and would allow time to be spent on issues that do present a risk.

66. One organisation, which represents registrants, said:
"*We welcome the attempt to identify a meaningful criteria for maintaining public confidence in the register*"

67. 94 percent of respondents agreed that some clinical conduct, such as deliberately covering up when things go wrong, seriously damages public trust in the professions and undermines patient safety. 52 percent of respondents agreed that in these types of cases, the registrants should be removed from the register.

68. Those respondents agreed that patient or public safety should always be the primary aim and that risk management is the right way to ensure a proportionate and fair approach. The context in which incidents happen was also clearly important. There was support for an open culture, so that registrants can learn from their mistakes, or for mistakes to be used as learning opportunities by others.

Unsupportive, neutral or other responses

69. 9 percent of respondents disagreed that fitness to practise should primarily be about managing the risk that a registrant poses to patients or members of the public in the future.

70. 16 percent of respondents disagreed that fitness to practise shouldn't be about punishing people for past events, with comments that there may be occasions when it's necessary to consider past events, or that past events may have relevance to the current issue or that a past event that has had a negative impact upon safety or the quality of care should be considered. Those that disagreed cited the negative perceptions of the punitive nature of the fitness to practise process or us as an organisation.

71. 18 percent of respondents, 24 percent organisations and 17 percent individuals, disagreed with the proposal that we should only take actions to uphold public confidence when the conduct is so serious, that if we did not take action, the public wouldn't want to use the services of registrants.

72. The PSA noted:
"*We do not agree with the NMC's attempt to link public confidence to whether misconduct would have a 'material impact on the likelihood of a member of the public using the services provided by registrant in the future'… we also do not agree with the NMC's statement that there is a need to link public confidence to a direct risk to public safety in order to justify taking action…fitness to practise should give equal weight to all three limbs of public protection and 'willingness to see' as a concept may divert focus away from this principle which is well established in existing case law (GMC v Chaudhary 2017, para 53)… it also risks side-lining the importance of the regulator's role in upholding professional standards*"

73. Additionally, the ability of members of the public to be able to decide whether or not to use the services of a specific registrant was queried by 3 percent, and 1 percent of respondents noted that what constitutes a serious concern may differ significantly between the general public and organisations.

74. Overall, only 3 percent of respondents disagreed that some clinical conduct, such as deliberately covering up when things go wrong, seriously damages public trust in the professions and undermines patient safety. However, 25 percent of the total respondents disagreed that in those types of cases, the registrant should be removed from the register. This was higher among organisations. The key theme emerging, cited by 33 percent of respondents was of a need to consider the context and any mitigating circumstances. Again, this position was higher among organisations.

Research responses

75. The research also tells us that 'public confidence' was perceived as hard to quantify and possibly changeable, making it particularly difficult to understand when and how the NMC would act. This indicates support for an identifiable threshold for when we will act to uphold and promote public confidence.

76. The research did suggest that participants felt the kinds of misconduct that could call into question a registrant's trustworthiness would usually involve major breaches of professional standards. Participants also noted that revalidation is now seen the established process for registrants to ensure they continue to meet professional standards.

Conclusion

77. We agree that when relevant we should consider the three sub-objectives of the overarching objective of public protection. Our strategy isn't about a focus on one and ignoring the others. It's about understanding what we mean by public confidence and defining when we will take action to promote and maintain it. It separately involves us trying to understand how fitness to practise, alongside our

other regulatory functions, works to promote and maintain proper professional standards and conduct for registrants.

78. Our research and consultation responses indicate that there is confusion and misunderstanding of what public confidence means, what kinds of conduct actually affect the public's confidence in registrants, and how a regulator can measure what public confidence needs in any particular case. So we think that we can set our own threshold for when we say a case raises public confidence issues:

    - 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.

    - 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.

79. We've changed this threshold because we recognise that respondents are concerned about how decision-makers could assess what sorts of conduct would discourage people from seeking treatment or care. Our new approach depends on whether or not the initial concern was about clinical practice. With this approach, decision makers will be able to focus more clearly on the nature of the conduct. It recognises that there are a small number of cases of very serious clinical harm that can't be remedied. It also reflects the evidence from our qualitative research that we should take action to uphold professional standards when registrants do things that could affect their trustworthiness as a registered professional. We think these thresholds will help us adopt a consistent and proportionate approach in how we regulate. We'll publish them as part of new guidance later in the year.

80. Our research also suggests that the kinds of misconduct which are seen as major breaches of professional standards are often those that could affect a registrant's trustworthiness. It also confirms that fitness to practise is not our only means of promoting and maintaining proper professional standards and conduct. We've reflected these findings in how our amended policy principles now deal with promoting and maintaining proper professional standards and conduct.

81. We agree that automatic removal from the register in cases, such as deliberately covering up when things go wrong, is too restrictive and that removal will not always be appropriate in all circumstances. We agree that there may be other factors and context to consider. We've amended our policy principles to reflect this feedback and our position.

82. Having reviewed and considered the evidence base in the form of consultation responses, research and engagement, we intend to proceed with our proposals, but with modifications to our policy principles. We've changed how we want to set the thresholds for when we should take regulatory action against a registrant to promote and maintain public confidence or proper professional standards. We believe it is vital that we play our part in making sure that people have confidence in using the services of all the people on our register but we agree that using this as a threshold

for taking action could cause confusion. For this reason, we have instead focused the thresholds on whether the concern can be remedied.

Public confidence in the regulatory process (questions 6 and 7)

83. We proposed that public confidence in the regulatory process goes beyond public confidence in our fitness to practise function. Our registration, revalidation, education and standards functions are a large part of ensuring patient safety and enabling professionalism. Fitness to practise can maintain the confidence established by those functions. If we follow the PSA principles of good regulation the public can have confidence in us a regulator.

Supportive responses

84. 82 percent of the total respondents agreed that cases should be resolved at an early stage in the process if a registrant has fully remediated their clinical failings, even where those clinical failings have led to serious patient harm. The key theme was reiteration of the need for registrants to demonstrate insight, remorse and remediation to reduce any future risk and to show that lessons have been learnt. This had the highest level of support from those who agreed with this proposal (30 percent compared to 5 percent who did not agree).

85. 65 percent of respondents agreed that every decision relating to a restriction being placed on a registrant's practice (including voluntary removal) should be published. Significantly, a higher proportion of organisations were more supportive than individuals (cited by 80 percent of organisations compared to 64 percent of individuals). The key theme emerging, and cited by a quarter of respondents, was of a need for openness and transparency within the professions. 16 percent of respondents who provided a comment noted the need for honesty and openness, specifically in reference to the public having confidence and trust in the professions.

Unsupportive, neutral or other responses

86. 9 percent of respondents disagreed that cases should be resolved at an early stage in the process if a registrant has fully remediated their clinical failings, even where those clinical failings have led to serious patient harm. There were general concerns that the employer investigation process is not robust enough to make sure that the public is properly protected. A small number of organisations noted concerns over what checks would be in place for a registrant who changes employers, or how we could regulate the workplace to ensure remediation is taking place and being effective.

87. One organisation queried:
"*What is meant by resolved at an early stage…and what sort of cases could be considered remediable*?"

88. 24 percent of total respondents disagreed that every decision that relates to a restriction being placed on a registrant's practice (including voluntary removal) should be published. Those disagreeing highlighted the impact of publication,

namely the stress this can cause to a registrant or that it can damage a career. There were also comments from some respondents that a culture of 'naming and shaming' is not helpful.

Conclusion

89. We intend to proceed with our proposals. It's in the interests of patient safety that cases should be resolved as early on in the process as possible. This means either the employer takes action, or if the matter has been referred to us, dealing with the issue without any formal fitness to practise action. We know that delay and lengthy and adversarial fitness to practise proceedings can cause defensive practice among professionals, or cause professionals to disengage from their profession.[8]

90. Our processes and guidance will be designed to support registrants and employers to resolve cases at an early stage in the process and to encourage registrants to engage with us early on in the fitness to practise process. Our guidance will clearly set out the types of case we consider the hardest to remediate.

91. Openness and transparency in regulation is vital. We appreciate the concerns regarding privacy of registrants and it was never our intention to publish information relating to a registrant's physical or mental health. However, we're confident that the need to be fully transparent and accountable outweighs any concerns expressed in the responses we have received. The PSA, in the *Lessons Learned Review*, recommended that regulators should publish as much as they legitimately can, to improve public confidence through transparency.

Our regulatory outcomes (questions 8-10)

92. We proposed two regulatory outcomes that reflect our distinctive role as part of a wider system to ensure patient safety and enable professionalism:

- a professional culture that values equality, diversity and inclusion and prioritises openness and learning in the interests of patient safety
- registrants who are fit to practise safely and professionally.

Supportive responses

93. 95 percent of respondents agreed that a professional culture that values equality, diversity and inclusion and prioritises openness and learning in the interests of patient safety is the right regulatory outcome

94. 98 percent of respondents agreed that registrants who are fit to practise safely and professionally is the right regulatory outcome.

95. One in ten respondents focused on the support this gives to public confidence in nursing and midwifery and the reputation of the profession as a whole, and that registrants need to be professional and work to their professional standards.

[8] See footnote 1, above.

Unsupportive, neutral or other responses

96. 3 percent of respondents disagreed that a professional culture that values equality, diversity and inclusion and prioritises openness and learning in the interests of patient safety is the right regulatory outcome

97. Respondents did have concerns over the implementation of this proposal and our ability to move forward with this and monitor this.

98. The PSA responded:
"*We are unclear how this regulatory objective interacts with the NMC's overarching objective and the three limbs of public protection and what happens if there is a conflict between these…*"

99. Only 1 percent of respondents disagreed that fitness to practise should ensure that registrants are fit to practise safely and professionally is the right regulatory outcome.

100. Respondents did comment that we would to need make sure that registrants and employers have the necessary support, training, skills and ongoing learning to meet required levels of safe practise and professionalism, and the need for standardised approaches to measure outcomes, for example, improved quality assurance, formal recording and monitoring.

Conclusion

101. We received overwhelming support for these regulatory outcomes and intend to proceed with them.

102. We agree with one NHS employer of nurses and midwives that:
"*Professional regulation is about delivering safe and effective care through helping the registrant to be the best that they can be. If they are fearful of their regulator, we cannot achieve this*."

103. We accept that we can't change institutional cultures overnight. It will require communication, collaboration and cooperation. We can achieve this through our proposals to prioritise effective local action by employers, by taking the context in which patient safety incidents occur into account, enabling registrants to remediate regulatory concerns at the earliest opportunity and holding full hearings only in exceptional circumstances.

104. We don't think that our proposals conflict with our overarching objective. The NMC has duties under the public sector equality duty, as well as under the Human Rights Act 1998

105. Our strategy doesn't mean that we may decide not to take action against registrants on equality grounds or that our threshold for regulatory action is being lowered by having regard to equality considerations or the public sector equality duty.

106. We also plan to follow up on the research we have undertaken in to the overrepresentation of minority ethnic groups in fitness to practise proceedings, once the first cycle of revalidation is concluded in 2019.

Achieving our regulatory outcomes (Questions 11-15)

Prioritising effective local action by employers (Question 11)

Supportive responses

107. 75 percent of respondents agreed that employers are usually in the best position to resolve concerns immediately, and we should only take regulatory action if the concern has already been raised with and investigated by the employer (where there is one), unless there is an immediate risk to patient safety that we have to deal with.

108. Supportive responses noted that local resolution should be explored in the first instance, and that employers need to take on more responsibility, and they are in the best position to make judgements.

Unsupportive, neutral or other responses

109. 16 percent of respondents disagreed with the proposal that employers are usually in the best position to resolve concerns immediately.

110. Respondents noted concerns about the impartiality of some employers, or the lack of robust in-house policies.

111. A professional trade union noted:
"Again the concept is a good one but [we are] concerned about how this will work in practice. In particular how the NMC will determine whether the employer is effectively managing the risk or requires support to do so."

112. While overall support for this proposal was relatively high, respondents still perceived us as having a role in a number of instances, with some respondents noting a need for employers to be given guidance and support on how to resolve concerns and clarity regarding their responsibilities, or for employers and managers to be monitored and audited by the NMC.

Research responses

113. 96 percent of participants agreed that by prioritising effective local action, the fitness to practise process will be improved. Participants agreed that for most cases, the employer is best placed to conduct a thorough investigation and take action if required to protect patient safety and remediate concerns regarding a registrant's practice.

114. A number of members of the public considered that a clear and transparent feedback loop between us, the employer, referrer and registrant is essential. They considered this an essential part of making sure that members of the public who

refer to us are confident that we take their concerns seriously and so that it will guard against employers being able to “sweep things under the carpet”.

Conclusion

115. Prioritising effective local action by employers is vital if we’re going to be a more proportionate and efficient regulator. When something goes wrong, our evidence tells us that members of the public generally want to know that it will be dealt with quickly and effectively so that it doesn’t happen again.

116. It will not be acceptable for us to accept the conclusions of an employer investigation when something calls into question the validity of an investigation, or the ability of an employer to conduct a full and fair investigation.

117. We intend to proceed with this proposal, but we will be producing very clear guidance for employers setting out what we expect from a referral so that they have a clear understanding of the matters that they can and should deal with. In assessing whether we accept the conclusions of an employer we will understand what the patient and referrer concerns are in the context of the investigation as part of a person-centred approach.

118. This is supportive of the PSA’s recommendation[9] that we should work closely with employers and stakeholders to deal with concerns that can be remedied without fitness to practise procedure, while not compromising patient safety.

Taking the context into account (Question 12)

Supportive responses

119. 94 percent of the total of respondents agreed that we should always take the context in which a patient safety incident occurs into account when deciding what regulatory action is appropriate.

120. The workplace environment was cited as a contributory factor by a significant number of respondents, with 20 percent of respondents noting that the work environment and culture can be stressful and pressured, with heavy workloads and busy shifts. A further 15 percent noted that that the processes and resourcing also need to be examined, for example, looking for possible system failures.

121. One regulator, while agreeing, warned:
“…*However, context is relevant, rather than determinative when deciding what regulatory action is required*”

Unsupportive, neutral or other responses

122. 3 percent of respondents disagreed with the proposal commenting that context has limits as a mitigating factor and cannot be used in many incidents, or that lower

[9] Lessons Learned Review 2018

standards should not be accepted because of the context and that registrants should be accountable for their actions.

123. One organisational response said:
"*…Context may mitigate particular errors in certain circumstances but it should not distract from looking at the individual actions of the registrant. For example, we consider that those professionals with management responsibility should be held to account for their failings in allowing a context where patient safety incidents can occur.*"

Research responses

124. 91 percent agreed that the fitness to practise process will be improved by taking context into account. Across the stakeholder groups, most participants agreed with the principle of looking at the 'whole picture' when determining whether or not to take regulatory action. They believed patient safety incidents rarely happen in isolation of other contributing factors. It was discussed that taking context into account would make sure our investigation is fair and leaves 'no stone unturned'.

125. Although the participants agreed that the proposed changes would improve our process, they identified some challenges. Participants were concerned that registrants may excuse their behaviour by blaming a patient safety incident on wider contextual factors. Others felt that the organisational culture and leadership may make it hard for us to investigate the context, and others were concerned with how we would monitor that the feedback that we provided resulted in meaningful action.

Conclusion (Question 13)

126. Taking the context into account is an important step in moving away from a blame culture and adopting a more holistic approach. We intend to proceed with this proposal. The PSA[10] has told us that we need to make sure that our processes allow us to take account of all the available and relevant information about cases and that we share intelligence properly. We already take context into account in our approach to cases. We will now work towards developing a tool to standardise the way we assess context, and build this into our decision making. We're also committed to improving how we communicate and share information with other organisations (see 'How we operate' later on in this report).

127. We agree that registrants with management responsibility should be answerable if it was their failings that allowed a culture to develop where patients and members of the public were put at risk of suffering harm. We will identify this type of conduct in the guidance we produce on seriousness factors.

[10] Lessons Learned Review 2018

Enabling registrants to remediate concerns at the earliest opportunity

Supportive responses

128. 90 percent or respondents agreed that we should be exploring other ways to enable registrants to remediate at the earliest opportunity.

129. One employer organisation stated:
"Shifting towards a more proactive approach which enables registrants to remediate at the earliest opportunity by supporting professionalism and raising standards is much supported by employers."

130. The key themes emerging related to the benefits of remediation, with 17 percent of respondents noting this will help to remedy problems and that everyone should be given the opportunity to correct, and learn from, their mistakes. 14 percent commented that early remediation is in everybody's interests.

Unsupportive, neutral or other responses

131. Only 3 percent disagreed with the proposal. While many respondents were positive about the impact of remediation, small proportions of respondents noted that it depended on the severity of the incident (7 percent) or that some staff will not learn from their mistakes (3 percent).

132. One regulator expressed concerns over how we would assess remediation and advised that we shouldn't go too far with guidance for registrants, as this would lessen the significance of the remediation and any insight expressed.

133. One senior nursing professional, while supportive of the proposal, commented:
"*The NMC should not lose sight of the need for registrants to take responsibility themselves as well for improving their practice…but this is not about spoon feeding. It is about giving honest feedback and direction…"*

Research responses

134. 94 percent of participants agreed that our fitness to practise process will be improved by enabling nurses and midwives to remediate regulatory concerns at the earliest opportunity. This rose to 100 percent for employers when the results were broken down into subgroups.

135. For each group, the acceptance of responsibility, openness about what happened, willingness to remediate concerns and the number of times a registrant had been involved in similar instances were considered important factors in determining whether remediation would be appropriate. Registrants believed that this change would encourage registrants to "open up" about honest mistakes if they understand that the issue can be remediated without serious sanctions from us.

136. Participants were clear that for issues such as competency and clinical mistakes, it would be appropriate for the registrant to undergo training to improve a specific skill and improve their competence and remediate the concern. However, participants

were less clear on how conduct involving misconduct or character issues that would call into question a person's trustworthiness could be remediated. So participants felt that it was less acceptable for such concerns to be remediated when a registrant's attitude or character was called into question.

Conclusion

137. We intend to proceed with this proposal as it's clearly in the interests of patient safety for registrants to remediate areas of weakness in their practice as soon as possible. However, we accept that there is conduct that is so serious that it cannot be remediated. We will identify this type of conduct in the guidance we produce on seriousness factors.

138. We assess remediation at all stages of the process, so don't believe that we will have difficulty in assessing remediation that occurs 'at the earliest opportunity'. Our remediation guidance will be specific to the registrant but not bespoke. We accept that, ultimately, we can guide and assist but the onus is on individual registrants to take responsibility for their practice.

Holding full hearings only in exceptional circumstances (Question 14)

Supportive responses

139. There was majority support for this proposal, with 79 **percent** of respondents agreeing that unless there is a serious dispute about the facts or disposal of a case, or a registrant has requested a hearing, all cases should be dealt with at a meeting.

140. Respondents noted the advantages of the proposal:
- it will enable quicker processing of cases
- it will be less stressful for registrants and witnesses
- it will save money and costs
- it will encourage openness and transparency
- it is a more humane way to deal with a case.

Unsupportive, neutral or other responses

141. 11 percent of the respondents disagreed with the proposal. They outlined concerns about a lack of fairness and openness at meetings, commenting that public scrutiny is vital and allows for transparency. There was also a concern that issues would not be explored in enough detail at a meeting and a full hearing is needed to enable the case to be properly judged by an independent panel.

142. An organisation that represented registrants at fitness to practise hearings said: *"If implemented, the proposals would unfairly tilt the balance of the fitness to practise process away from the interests of registrants, leaving them under pressure to admit mistakes they have not made and with less recourse to a process that allows the proper testing of evidence against them."*

143. The PSA said:

"…*we would highlight that the current case law suggests that in certain cases a hearing may be necessary to maintain public confidence, for example where there is a strong public interest element.*"

144. In a related response to another question, the same organisation said:
"…*we note that under its Order the NMC is required to refer any cases which meet the realistic prospect test to be dealt with in a public forum and to do otherwise is likely to require a change of legislation*."

145. Respondents who were supportive or neutral outlined some provisos in relation to the proposal:
- meetings to be structured properly and in a fair way so that all parties can put their case forward
- they need to include support and advice for registrants
- registrants need to be properly represented.

Research responses

146. 92 percent of participants agreed with our proposal to only hold a full hearing in exceptional circumstances. Participants believed that this proposal would improve the fitness to practise process for several reasons:

- speed up the fitness to practise process and require less resources
- avoid the negative impact full hearings can often have on referrers, witnesses and registrants
- avoid duplication of effort where criminal proceedings have produced clear outcomes.

147. The research highlighted that there is poor understanding of the regulatory process and participants wanted us to clearly communicate what the different stages involve and what the range of sanctions are at each stage. Employers and registrants suggested that registrants who have been referred may be less likely to request a hearing if they knew the potential sanctions beforehand, and in particular if they knew that being removed from the register wasn't a potential outcome.

148. There was a misunderstanding by members of the public as to what a meeting involves. Some thought that different and lesser sanctions were available at a meeting. This linked back to the idea of fitness to practise as some form of punishment.

Conclusion

149. We maintain that any registrant who wishes to have a hearing will always be able to have a hearing. Where there is a material dispute, a panel plays an important inquisitorial role in properly scrutinising and testing the evidence. However, there is no public interest in holding a hearing where there is no material dispute between us and the registrant. In this situation, the public interest is in making sure that the meeting decision is published and accessible. We think this will be clearer to people if we change how we describe this new approach. Rather than say we will only hold

hearings in exceptional circumstances, we will now say that we will only hold hearings if there is a material dispute.

150. We do not agree that our legislation requires us to refer any case where the realistic prospect test is met to be dealt with in a public forum and that to do otherwise would need a change to our legislation. In fact, if that test is met, our legislation requires our case examiners to either recommend undertakings to be agreed with the registrant, or refer the case to the Fitness to Practise Committee.

151. The Fitness to Practise Committee already has the power to deal with cases at meetings without members of the public, witnesses, registrants or our case presenter attending. A meeting is a hearing on the papers. So, the Committee has all the same powers of sanction as it would have if it were sitting in public. There is an independent legal assessor present and the Committee will assess the written evidence as carefully as it would in a public hearing.

152. We will publish a full record of all decisions made at meetings. This will include the panel's reasons, so that anyone who wants to know what happened can find it on our website. The only exception to this will be matters concerning private information, such as information about a registrant's health condition.

153. We do not agree that any case law interpreting our current legislation, or that of any comparable healthcare regulator, requires us to hold hearings in these circumstances. Our rules are clear: if the case has been referred to the Fitness to Practise Committee, the Committee has the choice to hold a hearing or a meeting, unless the registrant asks for a hearing. We are confident that previous case law which does not directly address how regulators should exercise that choice, and was largely decided before we were able to hold Fitness to Practise Committee meetings in private, cannot override the discretion given to us by Parliament in our legislation.

154. Whether the matter is dealt with at a hearing or meeting, we will continue to listen to the voices of the patients or members of the public concerned and clearly communicate to them our decisions and the outcomes in the case.

155. For these reasons, we intend to proceed with this proposal.

How we operate (Question 16)

156. We know that from listening to our stakeholders, from the Lessons learned review and our own internal quality assurance processes that we can continue to improve how we operate.

157. We proposed that we would:

- manage public expectations and support vulnerable stakeholders better
- work effectively with regulators and other key stakeholders within clearly defined boundaries
- continuously improve.

158. We have identified that the change in how we communicate with members of the public must come from all our members of staff, at all levels. The newly established

Public Support Service aims to anticipate and meet the needs of members of the public who are involved in cases.

159. We are exploring joined up working with other regulators and developing written agreements. We're setting out the information we'll share with other organisations in the interests of public protection.

160. To effectively continuously improve we proposed that we take a more systematic view of process improvement.

161. We asked respondents to tell us what they thought about our proposals to improve our processes. We asked if there were any other ways we could give more support to members of the public, or improve how we work with other organisations, including other regulators.

Improving processes

162. Respondents' comments included:
- Ensuring processes are completed in a timely fashion
- Better communication.
- More support for witnesses.
- Obtaining feedback from registrants who have been through the fitness to practise process.
- Greater use of technology.

Support to the public

163. Respondents' comments included:
- Being more open and transparent.
- Increase the public awareness of the role of the NMC.
- Publish fitness to practise decisions.
- Manage expectations of the public.

Improving work with other organisations

164. Respondents' comments included:
- Support and do more work with voluntary professional nursing bodies.
- Closer working with Care Quality Commission.
- Shared approaches to incidents involving more than one type of healthcare professional.
- Strengthened links with local providers and closer working with employers.

Conclusion

165. We intend to continue with the proposals we have outlined to improve how we operate. We also intend to consider all the suggestions made by respondents, and where appropriate review how we can incorporate them. One charity that provides support to vulnerable people told us:

"*Expertise within the fitness to practise function will be of great help when things go wrong, however, we also need the NMC to pay attention to how to get things right for people with a learning disability across all of its functions, including revalidation and education and training.*

"A family member told us: 'We want people to recognise that people like our son matter, that what happened was wrong and how it will be stopped from happening again'. The nurse in this case, accused of physical assault 'carried on practicing throughout the investigation and no action was taken against them, but other people were getting struck off for meds errors'."

166. We have shared this charity's entire response with our Public Support Service, so that we can learn from it.

Impact on equality, diversity and inclusion

167. We have completed an equality assessment for our proposals, to assess against the potential impacts on the protected characteristics set out in the Equality Act 2010. In addition, in our consultation respondents were invited to comment on or evidence any equality impacts the proposed changes may have.

168. A culture that values equality, diversity and inclusion is one of our regulatory outcomes. We proposed that this could result in fairer outcomes. We also proposed that we should support employers to incorporate the principles of equality, diversity and inclusion when considering making referrals.

Supportive responses

169. 77 percent of respondents agreed that having a fitness to practise process that values equality, diversity and inclusion could result in fairer outcomes. Slightly higher proportions of organisations agreed (86 percent) than individuals (76 percent).

170. An equalities advisory group for nurses responded:
"*In theory outcomes should be fairer, however discriminatory practices continue to disproportionately affect BME staff and other registrants that demonstrate the 9 protected characteristics.*

"Employers need to be supported by the NMC outlining clearly what its expectations are in relation to equality, diversity and inclusion. Cases should not be accepted where thorough investigation by an employer would have not resulted in a referral and clear evidence of remediation where appropriate has occurred.

"Every NMC panel should have a panellist that represents the depth and breadth of diversity including 9 protected characteristics and who is also up to date with clinical elements, possesses expertise and who fully understands the professional, discriminatory impacts for the public and registrants."

171. 83 percent of respondents agreed that we should support employers to incorporate the principles of equality, diversity and inclusion when considering making referrals,

although higher levels of agreement came from organisations (92 percent) than individuals (82 percent).

172. One registrant representative body commented:

"*Yes, we would expect to see this in response to the NMC's findings relating to the overrepresentation of registrants from black and ethnic minority backgrounds in fitness to practise proceedings driven by disproportionate referrals from employers.*"

Unsupportive, neutral or other responses

173. 7 percent of respondents disagreed with the proposal that having a fitness to practise process that values equality, diversity and inclusion could result in fairer outcomes.

174. 12 percent of the respondents who provided additional comments noted that overtly valuing equality, diversity and inclusion should not be required if the fitness to practise process is fair and transparent as these values are implicitly addressed within the process and that the same standards are required irrespective of a registrant's background. This comment was higher among those who disagreed with the proposal (39 percent of respondents who disagreed, compared to 1 percent who agreed).

175. 8 percent of respondents disagreed with the proposal that we should support employers to incorporate the principles of equality, diversity and inclusion when considering making referrals.

176. Of the respondents that provided additional comments, 10 percent noted that a registrant's background should be irrelevant to referrals as these should be dependent on unsafe or poor practice, and slightly fewer respondents (8 percent) noted concerns that this could lead to positive discrimination, for example, because of fears of accusations of racism. That said, a very small proportion (5 percent) of respondents felt that the number of BME referrals is disproportionate.

Conclusion

177. We recognise that we have more do in this area. We have taken on board the recommendations of the Williams Review,[11] and will continue our work and research. We will collaborate with registrants, representatives and valued stakeholders to properly understand and tackle the issues causing an overrepresentation of minority ethnic nurses and midwives in fitness to practise to make sure that our referrals and outcomes are fairer.

[11] Williams review into gross negligence manslaughter in healthcare, see recommendation 8.

Conclusion

178. We have received not only a high level of response to our consultation, but also a high level of support for our proposals from members of the public, registrants and organisations.

179. We have decided to implement our proposals as consulted upon, except where we have identified changes to our strategy in light of the responses we received or the findings of our research. We have reviewed and modified our policy principles to reflect this, as follows:

Strategic policy principles

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 addressed, and to explain to them what action we can take and why.

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.

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

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.

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

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.

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.

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.

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.

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.

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

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.