Nursing & Midwifery Council

A public consultation on changes to our fitness to practise function

Ensuring patient safety, enabling professionalism

About us

We exist to protect the public by regulating nurses and midwives in the UK.

We do this by setting standards of education, training, practice and behaviour so that nurses and midwives can deliver high quality healthcare throughout their careers.

We maintain a register of nurses and midwives who meet these standards, and we have clear and transparent processes to investigate nurses and midwives who fall short of our standards.

Foreword

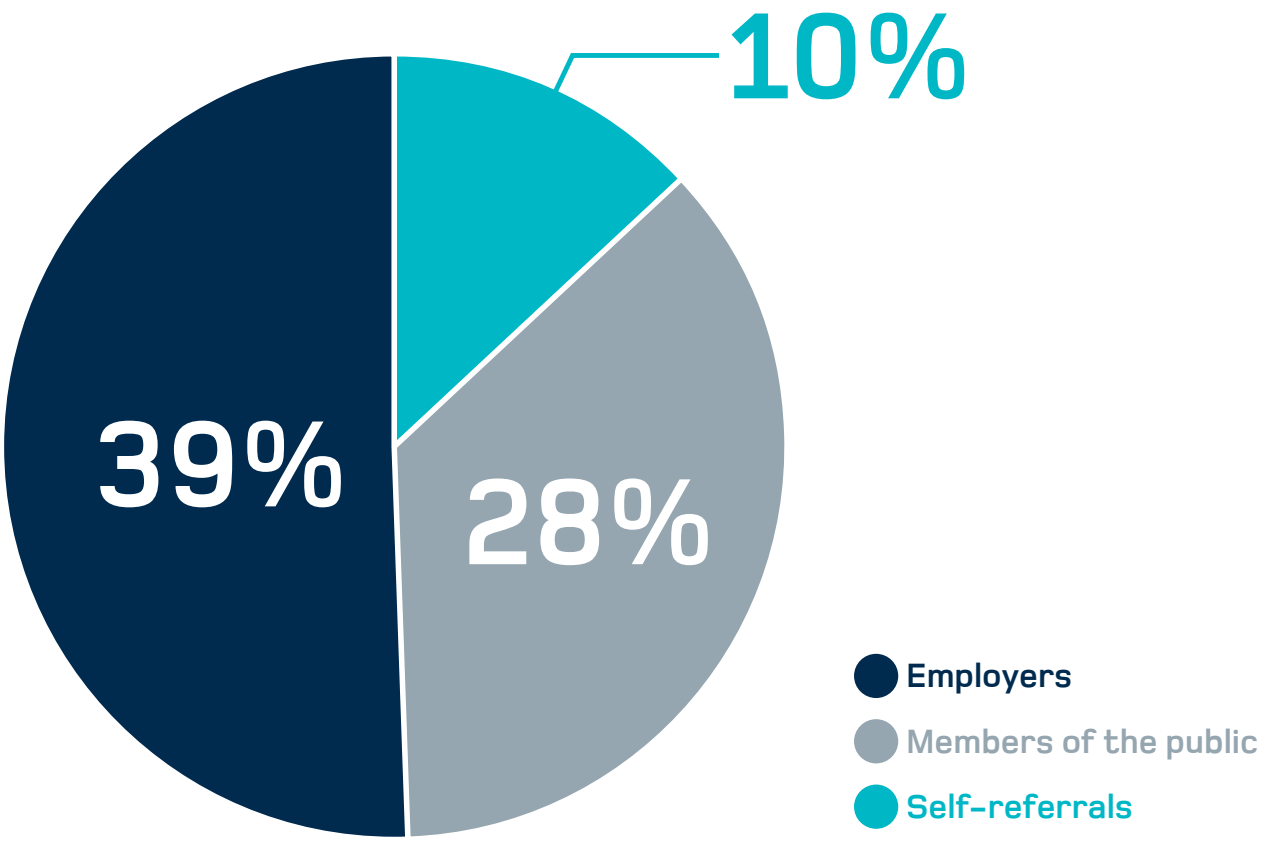
Our Strategy 2015–2020 commits us to becoming a dynamic, innovative and leading regulator. We have made significant strides in achieving that aim, including:

- In 2015, we launched a new Code for registrants, developed in collaboration with many who care about good nursing and midwifery. The Code reflects the world in which we live and work today, and the changing roles and expectations of registrants.
- In the same year, in collaboration with the General Medical Council we published joint guidance for registrants on the professional duty of candour, which builds on the requirements in the Code for registrants to be open and honest when things go wrong.
- In 2016, we launched revalidation, meaning that every registrant on our register must now demonstrate on a regular basis that they are able to deliver care in a safe, effective and professional way. The continuing commitment of the professions and support of our stakeholders across the UK has contributed to the success of revalidation.
- In 2017 we supported the UK's four chief nursing officers to publish Enabling professionalism in nursing and midwifery practice. Enabling professionalism sets out how good health and care outcomes are highly dependent on the professional practice and behaviours of nurses and midwives.
- We have initiated an ambitious programme of reform to our education functions. In March 2018, following a public consultation we have agreed new standards of proficiency for nurses and changes to the way nurses and midwives will be educated in the future. We have also started reviewing the standards of proficiency for midwives.

Our fitness to practise function helps us to protect patients and the public. We investigate concerns about registrants who fall short of our standards. If someone registered with us presents a risk to patients or the public, we can take action to restrict or remove their right to work as a nurse or midwife.

We receive around 5,500 complaints a year about nursing and midwifery professionals, which we call referrals. Referrals are often about incidents or things that go wrong in a clinical setting, but they can also involve registrants' conduct away from the workplace, for example if they have been involved criminal offending. We also investigate registrants who don't appear to have the skill or knowledge to provide safe care, or who present risks to patients because they are unwell, or unable to communicate clearly in English.

The majority of referrals come from three sources:



Patients and members of the public play a key role in our process. Where they have been directly affected, they can tell us about their experience and we can act on it. We expect them to continue to play an important role in our process in the future.

We conclude around **80 percent** of cases in 15 months.

In 2016/17, our independent panels imposed more than **1,200 sanctions**, around half of which involved removing a professional from our register permanently or temporarily.

In recent years, we have made significant improvements to our process to make sure we are focussing our resources on the right cases and providing the right support. We have:

- introduced voluntary removal and consensual panel determination to reduce the need for unnecessary full hearings
- introduced case examiners to improve the efficiency, quality and consistency of decision-making at the end of the investigation stage
- set up the Employer Link Service (ELS), which is an important tool in employer engagement, supporting healthcare providers with referrals, providing learning and induction for fitness to practise and sharing information
- set up a risk intelligence unit to help us understand risk factors and deliver evidence-informed regulation, and to share information with others
- set up the Witness Liaison Team to support witnesses during investigations and hearings
- secured additional powers for case examiners, allowing them to conclude certain types of cases at an earlier stage, ensuring that the public is protected without the need for a full hearing.

In addition, we are in the process of setting up our Public Support Service which will anticipate and meet the needs of patients and members of the public who are involved in cases.

There remains an urgent need for reform in healthcare regulation. The UK Government's recent consultation on regulatory reform was a welcome step in the right direction. However, now is the right time for us to think more radically about how we undertake fitness to practise without waiting for new legislation. This consultation paper is about how we can do that. In essence, it comes down to:

- **ensuring patient safety:** using our regulatory powers to encourage fairness, openness and learning; taking regulatory action where it is 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.

We want to hear from members of the professions, the public and our stakeholders, and to encourage as much participation in this debate as possible.

What is this consultation about?

The nature and context of nursing and midwifery practice are shifting rapidly. The way we regulate is evolving, as we respond to a changing landscape.

We consider that effective and proportionate fitness to practise means putting patient safety first, and that an open, transparent and learning culture will best achieve this. We are not alone[1] in thinking that a culture of blame and punishment is likely to encourage cover-up, fear and disengagement. 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.

We need to build on recent reforms, to make sure our fitness to practise process encourages this approach. We know our process can be adversarial and lengthy. It doesn't always provide enough incentive to registrants to engage early in the process. By continuing to evolve, we can better protect the public, but we need to be clearer on what we want to get out of the fitness to practise process.

How fitness to practise currently works

Being fit to practise means that a registrant has the skills, knowledge, health and character to do their job safely and effectively. If someone has concerns about a registrant's fitness to practise, they can raise them with us and we will decide what action we need to take to protect the public. In every case, we aim to reach the outcome that best protects the public interest at the earliest opportunity.

Anyone can tell us at any time if they have concerns about a registrant's fitness to practise. We can also open cases ourselves if we consider it necessary. We will make initial enquiries about the concern. If we decide that it isn't serious enough for us to take action, we usually won't investigate the matter further. If we have investigated the concern, our case examiners or Investigating Committee will decide whether there is a 'case to answer'.

If there is a case to answer, we will hold a hearing or a meeting to reach a final decision and determine what action, if any, to take.

Before a hearing or meeting is held, registrants can apply to be voluntarily removed from the register. We use voluntary removal in cases where a registrant admits the allegation and doesn't intend to continue practising. A registrant can also ask for a consensual panel determination. This is where we reach an agreed position about how the concern should be dealt with, without the need for a full hearing.

At a final hearing or meeting, a panel of the Fitness to Practise Committee will decide whether a registrant's fitness to practise is impaired and if it needs to take action to protect the public.

To find out more about how fitness to practise currently works and how we make decisions, please see our website.

Our proposed strategy

We believe that we need to rethink how fitness to practise operates, and ensure that we are always placing public protection at the heart of what we do. We need to be clear how promoting or maintaining public safety, public confidence in the professions and professional standards and conduct protects the public.

We know that there are some cases where a registrant will have to be removed from the register. This still includes cases where a registrant is unable to remediate or chooses not to remediate the concern. However, we also propose that this should happen when the conduct complained about so seriously damages public trust in the professions or undermines public safety that it can't be remediated.

We recognise that we need to secure and maintain the confidence of the public. However, we don't think this means that we need to take regulatory action every time a registrant does something that a member of the public may not approve of.

We believe that if we act in accordance with the Professional Standards Authority (PSA) right-touch regulation principles the public[2] will have confidence in us as a regulator.

This consultation sets out our proposed strategy in this area. It defines our desired regulatory outcomes as:

- 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.

To achieve these aims, we need to take a consistent and proportionate approach to fitness to practise. We also need to be fully transparent and accountable. We

want to build on the changes we've already made to our processes and continue to strengthen partnerships with employers, so that they feel able to manage concerns appropriately at a local level. We will support employers to incorporate the principles of equality, diversity and inclusion when considering making referrals, so that our fitness to practise proceedings contribute to a healthcare culture that values diversity, equality and inclusion.

We will need to deal with concerns when they are serious enough that we need to take regulatory action to ensure patient safety, or because they cannot be managed locally. In these types of cases we should take into account the context in which patient safety incidents occur and also enable registrants to remediate concerns at the earliest opportunity. Then we should only hold hearings where there are real areas of dispute to be resolved.

We've developed ten policy principles that encapsulate our approach.

Strategic policy principles

1. 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.
2. We can best protect patients and members of the public by making final fitness to practise decisions swiftly and publishing the reasons openly.
3. Employers should act first to deal with concerns about a registrant's practice, unless the risk to patients and the public is so serious that we need to take immediate action.
4. We will always take regulatory action when there is a risk to patient safety which is not being effectively managed by an employer.
5. We will 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.
6. 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.
7. Deliberately covering up when things go wrong seriously undermines patient safety and damages public trust in the professions. A registrant who does so should be removed from the register.
8. We will only take regulatory action to uphold public confidence if the regulatory concern is so serious that otherwise the public would be discouraged from using the services of registrants.

9. Some regulatory concerns, particularly if they raise fundamental concerns about the registrant's professionalism, can't be remedied and require removal from the register.

10. 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.

An illustrative example

Figure 1 is a typical example of how we might handle a case under our current approach to fitness to practise. In part 2, we've used this scenario as an example, to show how our proposed new model of fitness to practise would work.

Figure 1, Example scenario

A nurse was referred to us by a relative of a patient who died following a catastrophic medication error. The patient was receiving end of life care in a care home. On the day the error took place, the patient was due insulin at 09:00, after breakfast. The nurse needed to check the patient's blood sugar levels before administering insulin, but was distracted by a care assistant and a call from another patient. She was the only nurse on duty and the home had 20 residents.

Following the distraction, the nurse forgot to do the checks before giving the resident the insulin. Having not had breakfast, the patient fell into a hypoglycaemic state and died shortly afterwards. The nurse realised her error as soon as she had given the patient the injection, and immediately summoned emergency assistance. The nurse was dismissed immediately after the incident.

The nurse has attended a course on diabetes care and secured a new post.

After we investigate the matter the case examiners find that there is a case to answer as the nurse has not remediated in the areas of medicines administration and working in a challenging environment. Also, the nurse didn't provide any information about what happened on the day of the incident.

The case is scheduled for a hearing. At the hearing, the nurse admits the allegation and the new employer attends the hearing to provide a positive reference.

The panel decides that the nurse's fitness to practise is impaired, because there is still a risk to patient safety. The panel makes a conditions of practice order. The order states that the nurse should only administer medicines under direct supervision.

How to respond to this consultation

The consultation is presented in six parts and sets out our intended strategic direction for our fitness to practise function.

In **part one** we open the discussion about public protection and public confidence in the regulatory process. We consider this in light of the wider discussions on patient safety and regulatory reform. We introduce and define our regulatory outcomes.

In **part two** we set out how we intend to achieve our regulatory outcomes using our existing regulatory powers.

Part three explains changes we are making to the way we operate.

Part four asks questions about equality, diversity and inclusion.

Part five is a chance for you to tell us about you.

Part six is our glossary.

You can respond via the following link: **www.surveymonkey.co.uk/r/76785T2**

If you can't submit your response using the online survey, please contact us at **consultations@nmc-uk.org** for an alternative format. You can also use this email address if you have any questions.

All consultation questions are optional except for the 'About you' questions. This shows us if we have engaged with a diverse and broad range of people. Responses on behalf of organisations will be analysed separately from responses from individuals, so it's important that we know which capacity you are responding in.

If you're responding on behalf of an organisation we'll ask for your name and the organisation's name. However, you have the option to remain anonymous if you wish.

If you're responding as an individual we won't ask for your name. Therefore you won't be able to change your responses after you have submitted them. We also won't be able to provide a record of your responses.

The consultation will run from 4 April to 30 May 2018. Any responses received after this time won't be included in the analysis of the consultation responses.

Part one

Our regulatory outcomes

Rethinking how we protect the public and what the public expect from us

We are clear that our focus is protecting the public. What does this require in terms of fitness to practise activity?

A small but significant part of our current caseload is made up of registrants who don't pose any ongoing patient safety risks. We take these cases forward on a 'wider public interest' basis to uphold professional standards and maintain confidence in the professions.

There is no defined threshold for which cases should be taken forward purely to uphold public confidence. The decision is made on a case-by-case basis, with reference to the particular facts of the case. This can lead to the criticism that our fitness to practise process is inconsistent, with us acting as a 'moral guardian', and unduly punitive. This approach becomes harder to justify for regulatory concerns that would result in less serious sanctions or case disposal. Why are we taking regulatory action in these cases? Is it proportionate?

Public protection

One potential criticism of how we do fitness to practise is that our regulatory remit has widened beyond pure public protection issues and into a world where we are undertaking regulatory activity that may not be essential. We do it on the basis that we have believed that it's expected of us by others. This can have a significant impact on our resources and confidence in us.

We propose to reconsider how we undertake fitness to practise by refocusing on public protection.

We consider that public safety, public confidence in the professions and the need to promote and maintain proper professional standards and conduct should be interpreted from a public protection viewpoint. Where there are public safety concerns, there will always be a clear link to public protection. But in cases concerning the promotion and maintenance of professional standards and public confidence, there won't always be that link, for example, where a registrant has been convicted of a minor criminal offence. In those cases, we don't think that we should promote and maintain professional standards and public confidence in

the professions unless there is a clear link to our overarching objective of public protection.

We believe that public protection is best achieved through reducing the risk of harm. When looking at harm, we need to differentiate carefully between accidental errors or failures in the system, and deliberate or reckless behaviour and those who conceal patient safety concerns.

We know the importance of keeping our decision-making process transparent, and so where we decide not to take formal regulatory action, we will provide the person or employer raising the concern with our reasons for not taking action.

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.

Public safety

For us to take action on the basis of maintaining the health, safety and wellbeing of the public we need to be very clear as to why we say that there is an ongoing public protection risk presented by the registrant.

Maintaining public confidence in the professions

We are aware that there can be a difference between what the people or organisation raising the concern expects us to do and the purpose of fitness to practise. But the fact that a member of the public disapproves of a registrant's behaviour doesn't necessarily mean that we should take action. There may be a desire to see the registrant punished, and this can create some dissatisfaction with those raising concerns, especially if we choose not to take any regulatory action. Maintaining public confidence in the professions doesn't mean that we need to punish people when something goes wrong. Making a registrant go through a lengthy fitness to practise process just to punish them would be counterproductive, given that a blame culture undermines patient safety.

To link public confidence to our overarching objective of public protection, the regulatory concern needs to involve something that is so serious that it would have a material impact on the likelihood of a member of public using the services provided by registrants in the future. If the public avoids using those services, because they lack confidence in registrants, the risk of harm to the public increases.

Maintaining professional standards

We want to promote and maintain professional standards in order to reduce future risk to patient safety. However, the need to maintain professional standards should not, on its own, justify us taking fitness to practise action. The Fitness to Practise Committee may take it into account when deciding whether a registrant's fitness to practise is impaired. But, it is not enough on its own to establish that a registrant's fitness to practise is impaired.

We think that we can best reduce patient risk by ensuring that we've the correct standards in place, and enabling registrants to promote and uphold high standards. We can achieve this through working with the professions, employers and the public to promote a clear vision of professionalism.

Q1 **We think 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. Do you agree?**

Q2 **We don't think fitness to practise is about punishing people for past events. Do you agree?**

Q3 **We propose that we will 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. Do you agree?**

Q4 **Some clinical conduct, such as deliberately covering up when things go wrong, seriously damages public trust in the professions and undermines patient safety. Do you agree?**

Q5 **In those types of cases, the registrant should be removed from the register. Do you agree?**

Public confidence in the regulatory process

Public confidence in the regulatory process goes beyond public confidence in fitness to practise. Our other functions, including registration, revalidation, education and standards, are a large part of ensuring patient safety and enabling professionalism. We need to consider how fitness to practise can maintain the confidence established by those functions.

When a concern is raised, we believe that if it's possible to enable the registrant to practise safely and effectively, we should do so. This involves working with employers and registrants to enable reflection and remediation.

We believe that the public can have confidence in us as a regulator if we follow the PSA principles of good regulation:

- proportionate
- consistent
- targeted
- transparent
- accountable
- agile.

Being transparent and accountable doesn't mean we need to take every concern we receive through the entire fitness to practise process (ending in a fully contested public hearing). We won't need to do this, and may not even need to send the case to our investigators, if we know that the registrant has already put any risk to patient safety right, and the concern isn't one which means they need to be removed from our register.

Even where there is still a risk to safety, or the concern is so serious that removal is required, we may not need to go through the entire fitness to practise process. Where there is no disagreement about the issues in the case, we don't need to hold costly and time-consuming public hearings. We can resolve cases at an early stage in the process by using our existing powers for case examiners to agree undertakings, issue warnings, or give advice if the registrant accepts our concerns. We already have the power to ask the Fitness to Practise Committee to decide cases on paper at a private meeting without the parties attending at a private meeting. We want to extend this to every case where the registrant does not disagree with our assessment of the case. We can remain transparent and accountable by publishing the panel's reasons. This will allow the public to see the concerns raised and how they have been dealt with.

Currently we don't publish the details of voluntary removal decisions that are granted by the Registrar before a hearing. Under the new strategy, to be fully transparent and accountable, we propose that we should publish all decisions to grant a registrant voluntary removal, taking out any private information, such as information about a health condition.

Q6 **We propose 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. Do you agree?**

Q7 **We propose that every decision that relates to a restriction being placed on a registrant's practice (including voluntary removal) should be published. Do you agree?**

Regulatory outcomes

In every fitness to practise case we seek to protect the public. We also believe that we should consider more broadly what regulatory outcomes we expect to see as a result of our fitness to practise process. We are proposing two regulatory outcomes that reflect our distinctive role as part of a wider system to ensure patient safety and enable professionalism.

Regulatory outcome one

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

To achieve a learning and inclusive culture within the healthcare sector we need to look at how employers deal with concerns at a local level and the context in which patient safety incidents occur.

We believe that fitness to practise should be about managing the risk that a registrant poses to patients or members of the public in the future. We don't think it's about punishing people for past events. 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[3] about how fitness to practise affects professionals have found that if people think their regulator is punitive or focused on blame, they are 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[4] has found that cultures of blame are 'pervasive' in healthcare. We are aware of this problem, and we want the way we regulate to be focused on helping to solve it.

Research also tells us that our current fitness to practise processes don't contribute to a healthcare culture that values diversity, equality and inclusion. There is an overrepresentation of registrants from outside the EU and from

black and minority ethnic (BME) backgrounds in fitness to practise proceedings, driven by disproportionate referrals from employers.[5] This is a concern in other parts of the regulatory sector. General Medical Council research found that BME and non-UK doctors are overrepresented in investigations,[6] 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.[7]

Q8 **We propose that fitness to practise should support a professional culture that values equality, diversity and inclusion and prioritises openness and learning in the interests of patient safety. Do you think this is the right regulatory outcome?**

Regulatory outcome two

Registrants who are fit to practise safely and professionally.

In recent years, we've markedly improved our ability to protect the public through legislative changes and improvements to our operations. However, our processes focus on restricting a registrant's practice, are complex and take a long time. Many cases are resolved at full hearings which are adversarial in nature and can have a negative impact on people involved in the process, such as witnesses, employers, and registrants.

To ensure that registrants who are referred to us can practise safely and effectively, we should enable registrants to remediate regulatory concerns at the earliest opportunity and, if needed, reach an agreed position with us as to how the concern should be dealt with. This means that we would only hold full hearings in exceptional circumstances.

If we do this, there would be fewer cases going through the full fitness to practise process. Those matters which do, will be dealt with in a way which is designed to prompt openness and remediation from the registrants and encourages engagement.

Q9 **We propose that fitness to practise should ensure that registrants are fit to practise safely and professionally. Do you think this is the right regulatory outcome?**

Q10 **Please tell us your views on our regulatory outcomes as we've set them out in this consultation.**

Part two

How we regulate

Achieving our regulatory outcomes

We've identified four different ways in which we can achieve our regulatory outcomes using our current regulatory powers:

Prioritising effective local action by employers

When something goes wrong, members of the public generally want to know that it will be dealt with quickly and effectively so that it doesn't happen again. Employers are usually in the best position to address concerns immediately before they escalate into more serious issues.

Employers usually have established systems and processes for investigating incidents and complaints from members of the public. If they decide that a registrant presents a risk to patients they can address this quickly and effectively through training or supervision. If disciplinary action is needed, they can restrict registrants to non-patient work, or suspend them.

We would expect employers take these steps before they make a referral to us. They can also consider wider systems problems if they need to. We can look at whether a registrant is meeting our professional standards; we can't resolve complaints from members of the public, or address systems issues within employers.

By prioritising effective local action by employers we will:

- Ask employers to investigate locally first if we receive a referral from a member of the public that the employer has not had a chance to look at first. We will expect the employer to deal with the concern under their local procedures first, unless we think there need to be an immediate interim restriction on the registrant's practice.

- Set out very clearly for employers what we expect from a referral. All referrals will need to be signed off by a senior manager responsible for clinical governance.

- Work with our Regulatory Intelligence Unit to collect information from the referrals we receive and use that information when we investigate concerns.

This will improve the quality of referrals as we will be able to assess them when we receive them. We won't require additional initial information.

We will ensure transparency by working with employers on local complaints handling processes, to make sure that the process adopted is transparent, user friendly and communicated to members of the public.

Where employers haven't, can't, or won't deal with a patient safety issue (or if the registrant is self-employed), we will consider what regulatory action we need to take ourselves. We may also refer the issue to another regulator if we think is necessary so that issues are not left unresolved.

Q11 We think 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. Do you agree?

In our scenario, the nurse was dismissed by her employers immediately. By prioritising local action, the employer in this scenario could have managed this situation, investigating fully and training the nurse in medications administration. The investigation would also have highlighted any problems in the care home and the environment the nurse was working in, making the home safer for all patients.

Taking the context into account

The context in which patient safety incidents occur is extremely important. By considering the context we are asking what caused an incident, rather than who is to blame. Although we currently take account of context on a case-by-case basis, we don't have a consistent methodology for doing so.

By taking into account the context, 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
- share intelligence about context with employers and other regulators.

This will support us in developing an open and learning culture in the workplace, and make sure that we focus only on matters that raise genuine regulatory concerns.

Q12 Do you agree that we should always take the context in which a patient safety incident occurs into account when deciding what regulatory action is appropriate?

If the employer, having addressed the issue locally, still referred the matter to us, we'd look at the context in which the nurse operated. The nurse was working as the only registered adult nurse in a 20 bed care home. She was called away to care for another resident. We'd want to take into account the staffing levels at the home and the support the nurse was given. It won't be misconduct if we decide that the nurse was working in a system which might have caused any professional to make the same mistake. We wouldn't take the case any further. We may instead refer the home to a systems regulator.

Enabling registrants to remediate regulatory concerns at the earliest opportunity

It's clearly in the interests of patient safety for registrants to remediate areas of weakness in their practice as soon as possible. But we note that there are some types of conduct that are so serious as to be fundamentally incompatible with registration – they can't be remediated.

Our decision-makers take remediation into account throughout our process. Remediation often determines whether a case requires regulatory action.

By enabling registrants to remediate regulatory concerns at the earliest opportunity, we will:

- encourage early remediation by engaging more with the registrant at the beginning of the process
- provide employers and registrants with guidance on remediation that is specific to the registrant
- refer all non-remediable cases directly to the Fitness to Practise Committee.

Q13 Do you agree that we should be exploring other ways to enable registrants to remediate at the earliest opportunity?

If we decide that we should deal with the concern, we would contact the nurse and set out what we think the regulatory concern is. We would then advise them on how their concern could be remediated. If, following the advice, the nurse shows us that they've remediated, the case would go no further as there would be no outstanding public protection concerns.

Holding full hearings only in exceptional circumstances

Currently, once case examiners have found a case to answer, most cases go to a full hearing. Around 25 percent of cases are resolved by alternative means: meetings (i.e. hearings on the papers), consensual panel disposal, and voluntary removal.

We do not believe that full public hearings are always required to reach a decision that protects the public. Their adversarial nature often has a negative impact on referrers, witnesses and registrants, and they are slow and resource intensive.

By holding full hearings only in exceptional circumstances, we will:

- As early as possible, produce a draft determination, including provisional findings on charges, impairment, and sanction. We will use this as the basis for engaging with the registrant and seeking to resolving as many aspects as possible of the case by consent.

- Use hearings to adjudicate the outstanding matters in dispute. None of this would prevent a registrant from requesting a full hearing at the appropriate point.

- Make more use of meetings (i.e. hearings on the papers), as opposed to full hearings, where issues are not in dispute or where the registrant is not engaging with us.

This will improve the way we work, so that the principal function of hearings is to resolve outstanding areas of dispute with a focus on reaching an agreed position with the registrant.

Q14 We propose 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. Do you agree?

Q15 Please tell us what you think about our proposals and if there are any other approaches we could take.

Having engaged with us at the earliest opportunity, we know that the regulatory concern has been remediated and that there are no areas of dispute. A hearing would not be necessary as it would not achieve anything.

If there is remediation outstanding, we could use the alternative disposal of a CPD agreement, agreeing conditions of practice.

Part three

How we operate

We've identified three areas where we can improve how we operate. We've focused on these areas as they're aligned to issues we know about in our current process, lessons we have learned from past events, and the proposed changes to how we regulate.

Managing public expectations and supporting vulnerable stakeholders better

We've improved the information that we provide to members of the public. We've also significantly improved the support we provide to witnesses who attend our hearings.

Many people engaging with our process have been involved in distressing and traumatic incidents, and so require a greater degree of support than we provide at the moment.

It's also the case that some members of the public are not clear about what the fitness to practise process can and can't achieve. At the moment, we don't have a system that allows us to proactively manage their expectations. This can lead to further distress for them and damage confidence in us as regulator.

We are setting up a public support service that aims to anticipate and meet the needs of members of the public who are involved in cases. It will also support vulnerable people, including people who have experienced bereavement or trauma, or who need support because of a disability, or age. We will seek input from patient groups and other relevant stakeholders to inform the development of the service.

We will improve further by:

- introducing a strategy for proactively contacting members of the public at the point we open an investigation
- explaining better how our process works and set expectations more effectively
- improving how we communicate with members of the public
- explaining key decisions to members of the public who have an interest in the case and seeking their input where it is appropriate to do so.

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

Over the last few years, we've improved the way in which we work and share information with regulators and other key stakeholders in the interests of public protection. We routinely share information with the Disclosure and Barring Service, Disclosure Scotland, and with system and professional regulators across the UK.

We will improve further by:

- defining 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
- referring concerns to other organisations where they are better placed to deal with them than we are
- exploring opportunities for joint working where they're in the interests of public protection.

Continuously improving

We could get more from improvements by using a consistent quality improvement methodology and embedding it in the way we design and run our processes. Learning from the way we currently handle cases tells us that we should seize the opportunity to take a more systematic view of process improvement.

We will improve further by:

- adopting a consistent quality improvement methodology and embedding it in our management culture
- reviewing our processes to identify opportunities to improve quality and efficiency
- developing an improvement plan that is in line with our organisation-wide plan to replace our information technology systems.

Q16 Tell us what you think about our proposals to improve our processes. Are there any other ways we could give more support to members of the public, or improve how we work with other organisations, including other regulators?

Part four

Impact on equality, diversity and inclusion

Q17 **Do you agree that having a fitness to practise process that values equality, diversity and inclusion could result in fairer outcomes?**

Q18 **Do you agree that we should support employers to incorporate the principles of equality, diversity and inclusion when considering making referrals?**

Q19 **The protected characteristics are:**

- age
- disability
- gender reassignment
- marriage and civil partnership
- race
- religion or belief
- sex
- sexual orientation
- pregnancy and maternity.

Will any of these proposals have a particular impact on people who share these protected characteristics (including nurses, midwives, patients and the public)?

- Mainly positive impacts anticipated
- Mainly negative impacts anticipated
- No impacts anticipated
- I don't know

Please give a reason for your answer.

Q20 **How can we amend our proposals to advance equality of opportunity and foster good relations between groups?**

Please give a reason for your answer

Part five

About you

We are committed to treating everyone fairly and meeting our legal responsibilities under the Equality Act 2010 and related legislation (such as the Human Rights Act 1998) and we will use this information to better understand if we are engaging with a diverse and broad range of people.

Q1 Are you responding as an individual or on behalf of a group or organisation?

- As an individual (please complete questions 2-9)
- On behalf of a group or organisation (please complete questions 10-16)

Individual:

Q2 Are you a:

- UK-registered nurse
- UK-registered midwife
- Overseas registered nurse and/or midwife
- Other healthcare professional
- Employer or manager
- Educator
- Nursing or midwifery student
- Nursing associate trainee
- Member of the public, service user or carer
- Other – please specify
- Prefer not to say

Q3 **In your main job do you work:**

- Full time (30 or more hours per week)
- Part time (below 30 hours per week)
- Prefer not to say

Q4 **Gender**

- Female
- Male
- Non-binary
- Prefer not to say

Q5 **Age**

- Under 25
- 25-34
- 35-44
- 45-54
- 55-64
- 65 and over
- Prefer not to say

Q6 **Disability – Please select one option to indicate whether you consider yourself to have a disability or long term health condition.**

The Equality Act 2010 defines disability as a physical or mental impairment which has a substantial long-term effect (at least 12 months) on a person's ability to carry out normal day to day activities.

- Yes
- No
- Prefer not to say

Q7 Ethnicity

A: White

- British, English, Northern Irish, Scottish or Welsh
- Irish
- Gypsy or Irish traveller
- Any other white background, please specify

B: Mixed or multiple ethnic groups

- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed or multiple ethnic background

C: Asian or Asian British

- Indian
- Pakistani
- Bangladeshi
- Chinese
- Any other Asian background

D: Black, African, Caribbean or black British

- Caribbean
- African
- Any other black, African, or Caribbean background

E: Other ethnic group

- Arab
- Any other ethnic group

F: Prefer not to say

- Prefer not to say

Q8 **Religion**

- No religion
- Buddhist
- Christian
- Hindu
- Jewish
- Muslim
- Sikh
- Any other religion
- Prefer not to say

Q9 **Sexual orientation**

- Bisexual
- Gay man
- Gay woman or lesbian
- Heterosexual or straight
- Prefer not to say

Group or organisation:

Q10 **Which best describes the type of organisation you work for?**

- Government or public body
- Regulator
- Professional organisation or trade union
- NHS employer of nurses or midwives
- Independent sector employer of, or agency for, nurses and midwives
- Education provider
- Consumer or patient organisation
- Charity/voluntary sector
- Other – please specify

Q11 Please give the name of your organisation.

Q12 Would you be happy for your comments to be attributed to your organisation in reporting?

- Yes. I am happy for my comments to be attributed to my organisation.
- No. Please keep my responses anonymous.

Q13 Please state your name.

Q14 Please state your job title.

Q15 Please state where your organisation mainly operates.

- Across the UK
- Great Britain
- England
- Northern Ireland
- Scotland
- Wales
- Other – please specify

Q16 Does your organisation officially represent the views of nurses/midwives and/or the public that share any of the following protected characteristics?

- Older
- Younger
- Disabled
- Ethnic minorities
- Gender
- Lesbian, Gay and Bisexual
- Transgender
- Pregnancy/maternity
- Religion or belief

Part six

Glossary

Adjudicate: to make an independent and binding decision about something that we and a nurse or midwife disagree about.

Advice: private guidance we can give to a nurse or midwife to help them keep their practice safe when they admit making a minor breach of the Code.

Candour: being open and honest with patients when things go wrong.

Case examiners: decision makers who work in pairs to look at the evidence in a case and decide what should happen at the end of our investigation. In every case one member of the pair will be a nurse or midwife, and one will not.

Charges: the allegations that show why a nurse or midwife may pose a risk to patients, members of the public, or undermine public confidence in the professions.

The Code: the professional standards that nurses and midwives must uphold in order to be registered to practise in the UK.

Conditions of practice order: an order which allows someone to continue to work as a nurse or midwife, but subject to conditions. The conditions could, for example, prevent the nurse or midwife from doing certain tasks, or could be requirements like supervision, training, or reporting to us.

Consensual panel determination: a way of dealing with a case by coming to an agreement with the nurse or midwife. We agree a sanction and a statement of facts, then ask the Fitness to Practise Committee panel to approve the agreement.

Fitness to practise: having the skills, knowledge, good health and good character to work as a nurse or midwife safely and effectively.

Fitness to Practise Committee: one of our two independent practice committees. It makes decisions at hearings about whether a nurse or midwife is fit to practise. Panels are made up of three members. One member must always be a nurse or midwife, and one member must be a lay person.

Human factors: environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety.

Hearing: when the Fitness to Practise Committee panel meets to hear a disputed case about a nurse or midwife's fitness to practise. The hearing is made up of three stages: the facts stage, the impairment stage, and the sanction stage. The panel needs to make a fully reasoned decision at each stage. The nurse or midwife has a right to attend. Our case is explained by a case presenter, and the panel has a legal assessor to help them with points of law.

Impairment: a nurse or midwife's fitness to practise is impaired if they aren't able to do their job safely and effectively, or if they have acted in a way which has undermined public confidence in the professions.

Investigating Committee: one of our two independent practice committees. It decides what should happen at the end of an investigation if the case examiners can't agree. It can also make interim orders restricting someone's practice while we investigate allegations about them.

Meeting: when a panel decides a case in private using the documents in the case. The nurse or midwife doesn't attend but can send us submissions in advance. We will always publish the outcome on our website. Unless the case involved the nurse or midwife's health, we will normally publish the panel's reasons too.

People: individuals or groups who receive services from nurses and midwives, healthy and sick people, parents, children, families, carers and representatives.

Professional Standards Authority (PSA): an organisation that oversees the work of the regulators of health and care professionals.

Registrant: a nurse or midwife who's registered with us.

Regulatory concern: something about a nurse or midwife's practice or conduct which could present a risk to patients or affect public confidence in the professions.

Regulatory outcomes: what we think the regulation of nurses and midwives should be achieving across the professions.

Remediation: when nurses and midwives put right concerns about their conduct, performance, health or language through training, supervised practice, reflection, or other work.

Sanction: an order the Fitness to Practise Committee makes against a nurse or midwife after a full hearing. This could be a caution, conditions of practice, suspension, or a striking-off order.

Standards of proficiency: standards that set out the skills and knowledge nurses and midwives need to have before they can join our register.

Undertakings: measures agreed between us and the nurse or midwife to address the problems in their practice that pose a current risk to patients.

Voluntary removal: when a nurse or midwife who is the subject of a fitness to practise case applies to be removed from the register. This brings the case to an end if we approve it.

Warning: a way of publicly recording that a nurse or midwife's past conduct was unacceptable, without the need to hold a hearing.

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] PSA, right-touch regulation principles, 2015 and Better Regulation Executive, principles of good regulation, 2000.

[3] 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).

[4] 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.

[5] 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).

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

[7] 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