

## Meeting of the Midwifery Committee

to be held between 10:00 and 13:00 followed by lunch on 26 October 2016  
in the Council Chamber, 23 Portland Place, London W1B 1PZ.

### Agenda

Dr Anne Wright  
Chair of the Midwifery Committee

Jennifer Turner  
Secretary to the Committee

### Preliminary items

- |   |   |         |       |
|---|---|---------|-------|
| 1 | <b>Welcome from the Chair</b>                   | M/16/44 | 10:00 |
| 2 | <b>Apologies for absence</b>                    | M/16/45 |       |
| 3 | <b>Declarations of interest</b>                 | M/16/46 |       |
| 4 | <b>Minutes of the last meeting</b><br><br>Chair | M/16/47 |       |
| 5 | <b>Summary of actions</b><br><br>Secretary      | M/16/48 |       |

### Matters for discussion

- |   |  |                       |       |
|---|--|-----------------------|-------|
| 6 | <b>Fitness to Practise legislative change</b><br><br>Director of Fitness to Practise             | M/16/49               | 10:10 |
|   |  | <b>(Presentation)</b> |       |
| 7 | <b>Midwifery regulation change: Update paper</b><br><br>Assistant Director, Strategy and Insight | M/16/50               | 11:00 |
| 8 | <b>Education strategic programme update</b><br><br>Deputy Director, Education and Standards      | M/16/51               | 11:20 |
|   |  | <b>(Presentation)</b> |       |

### Matters for information

- |   |   |               |       |
|---|---|---------------|-------|
| 9 | <b>Revalidation update</b><br><br>Director, Registration and Revalidation | M/16/52       | 12:30 |
|   |   | <b>(Oral)</b> |       |

- |    |   |               |
|----|---|---------------|
| 10 | <b>Midwifery Panel Update</b>           | M/16/53       |
|    | Chief Executive and Registrar           | <b>(Oral)</b> |
| 11 | <b>Schedule of business 2016 – 2017</b> | M/16/54       |
|    | Chair / Secretary                       |               |
| 12 | <b>Any other business</b>               | M/16/55       |
|    | Chair                                   |               |

The next meeting will be held on Wednesday 22 February 2017 at 23 Portland Place, London.

Meeting of the Midwifery Committee  
Held at 10:00 on 26 July 2016  
at 23 Portland Place, London W1B 1PZ

## Minutes

### Present

#### Members:

Dr Anne Wright	Chair of the Midwifery Committee
Dr Patricia Gillen	Member
Dr Tina Harris	Member
Susanne Roff	Member
Lorna Tinsley	Member (joined during item M/16/35)

#### NMC officers:

Jackie Smith	Chief Executive and Registrar
Clare Padley	Deputy Director, Education, Standards and Policy
Anne Trotter	Assistant Director, Education and Standards
Emma Westcott	Assistant Director, Strategy and Insight
Jennifer Turner	Governance and Committee Manager (Secretary)
Sara Kovach-Clark	Revalidation Transition Lead

#### Observers:

David Foster	Department of Health
Jess Read	LSAMO Forum
Louise Silverton	Royal College of Midwives
Jayne Marshall	LME Forum
Verena Wallace	Department of Health, Northern Ireland
Prof Jacqueline Dunkley-Bent	NHS England

*Secretary's note: Some items were discussed out of order. The minutes reflect the order of the agenda.*

## **Minutes**

### **M/16/30 Welcome from the Chair**

1. The Chair welcomed members of the Committee, NMC staff and observers to the meeting.

### **M/16/31 Apologies**

1. Apologies were received from Pradeep Agrawal and Farrah Pradhan.

### **M/16/32 Declarations of Interest**

1. No declarations of interest were made.

### **M/16/33 Minutes of the previous meeting**

1. The minutes of the meeting of the Committee held on 27 April 2016 were confirmed as a correct record, subject to the following change:
  - a) M/16/29 (4): Correct the spelling of antenatal.

### **M/16/34 Summary of actions**

1. The Committee noted the summary of actions. All items were noted as not yet due and the Committee agreed to move the due date of M/16/23 to February 2017.

### **M/16/35 Midwifery regulation change: Update paper**

1. The Committee noted the paper which provided an update on the proposed regulation change since the April meeting of the Committee.
2. In discussion, the following points were noted:
  - a) The consultation had closed and the Department of Health was expected to publish the response in the Autumn.
  - b) While it was possible that the result of the European Union referendum could affect the government legislative process, the Department of Health remained optimistic that the proposed changes would go through according to the planned timetable.
  - c) The NMC continued to be involved in the group convened by the Department, which consisted of the Chief Nursing Officers, Local Supervising Authority Midwifery Officers, and representatives from the four countries. The group was looking at the future of supervision.

- d) The communication and engagement plan did contain an element of public and patient engagement. It was noted that the public may not have previously been aware of supervision arrangements, however there may be issues that will need to be communicated.

3. The Committee considered the annexe to the paper which was a document intended for the use of midwives after the proposed regulatory change, called *Practising as a midwife in the UK: An overview of midwifery regulation*.

4. The following specific comments were made:

- a) Paragraph 4: It was not correct to say midwives have a distinctive client group. The information on health conditions should be separated out.
- b) Paragraphs 7 and 8: Some rephrasing was needed in recognition of the fact that midwives' scope of practice may differ at various points in their career.
- c) Paragraph 12: Regarding the making of a declaration of a midwife's health and character, this has always been made by the Lead Midwife for Education (LME). It must be a named person. The information on indemnity insurance should clearly state that the responsibility is on the registrant, not the LME.
- d) Paragraph 13: The paragraph wording was awkward; especially the statement about English language requirements. Consider amending.
- e) The numbering started from one again after paragraph 13.
- f) Paragraph 5 (page 4): Consider changing the wording "...assessment of a midwife's fitness to practise...".
- g) Consider swapping paragraphs 25 and 26.
- h) Section 5: Consider adding the Criminal Justice Act 1945. Under the Human Fertilisation and Embryology Act 1990, state whether this applied to Northern Ireland.
- i) Paragraph 23: Items such as work records and practice diaries must be handed back to employers (where there is an employer).
- j) Review the document from the perspective of independent midwives, to make sure it gives clarity to that group.

**M/16/36 Midwifery regulation change: Risk register**

1. The Committee noted the risk register.
2. In particular, the Committee noted that the rating for the legislative risk had increased following the outcome of the European Union referendum.

**M/16/37 Revalidation update**

1. The Committee was presented with figures from the first quarter of activity since revalidation was introduced.
2. In discussion, the following points were made:
  - a) The first quarter report would be published shortly.
  - b) Exceptional circumstances applied to registrants who did not have time to meet the required practice hours if, for example, they were on maternity leave or extended sick leave.
  - c) Extensions were granted to 141 registrants who had not been able to complete a portion of the requirements – for example, sign off by their supervisor. All 141 registrants did successfully complete revalidation.
  - d) There was a plan to publish equality and diversity data annually, as quarterly data would not be statistically meaningful at this time.
  - e) The Committee asked for midwife-specific data. It was noted that, given the number of subtypes, it would be difficult to provide meaningful information. As data was accumulated over time, future reports would contain more detail.

**M/16/38 Education update**

1. The Committee received a verbal update on the education strategic programme.
2. In discussion, the following points were made:
  - a) As part of the programme, separate practice and education standards would be drafted, and there would be a review of materials relating to prescribing and medicines management.
  - b) An independent provider had been commissioned to look at quality assurance.
  - c) The following programme workstreams related to midwifery: the education framework; review of quality and assurance; review of prescribing standards; and, the review of standards for medicines management.

- d) Council would discuss the proposed timeline for the development of midwifery pre-registration standards at its September 2016 meeting.

**M/16/39 National maternity review**

1. The Committee noted the item on the national maternity review and discussed the recommendation specific to the NMC's work.
2. In discussion, the following points were noted:
  - a) The report recommended that the NMC and the Royal College of Obstetricians and Gynaecologists (RCOG) should review education to ensure that it promotes multi-professionalism and that there are shared elements where practical and sensible.
  - b) The Chief Executive had met with RCOG to discuss this recommendation, and RCOG had indicated its support.
  - c) Further work would take place to progress this initiative.

**M/16/40 Future midwifery input to Council**

1. The Committee considered a presentation on avenues for Council to receive midwifery advice in the future.
2. In discussion, the following points were made:
  - a) Based on a previous discussion of the Committee, the Council's needs were understood to fall into four areas: engagement and influence; expertise; four country perspective; and oversight of response to risks and concerns. The Committee was asked to consider these needs and provide further input and suggestions.
  - b) The gaps that may exist if the Committee was discontinued after the proposed regulatory changes were put in place, were agreed as follows:
    - i) Governance – the Midwifery Committee was part of the structure of Council. The Committee provided reports, gave advice, and had a direct relationship with Council.
    - ii) Regulatory – all instruments of regulation would remain but many would be changed.
    - iii) Communications and engagement – the voice of midwives was heard through the observers who attended the Council meetings, although the nature of the engagement between the observers and the Council was different to that with the

Midwifery Committee.

- iv) Strategic oversight – the Committee did consider and had oversight of reviews, reports and issues.
- v) Participatory – it was considered valuable that the participatory observers to the Committee were stakeholders with expertise in the midwifery community.
- vi) Legacy – members and observers believed the Committee had added value, and brought a depth of knowledge and understanding of the midwifery community.
- c) Various midwifery incidents had affected public confidence in the profession. Confidence would need to be restored through an outward message of public and patient protection.
- d) The Committee distils the information provided to it and presents a considered opinion to Council.
- e) Emphasis was placed on the Council having in place mechanisms to monitor the transition period resulting from the anticipated legislative change.

**M/16/41 Midwifery Panel update**

1. The Committee received a verbal update on the recent activity of the Midwifery Panel.
2. In discussion, the Committee noted the following:
  - a) The Panel held its fourth meeting on 21 July 2016.
  - b) A lay member had joined the Panel and Anne Wright, Chair of the Midwifery Committee, had also been invited to join the Panel.
  - c) Future discussions would include the landscape post the proposed legislative changes, any regulatory gaps that might exist, and making strategic recommendations to Council.
  - d) It was noted that David Foster, Deputy Director of Nursing and Midwifery Advisor, was leaving the Department of Health. The Chief Executive thanked him for his contribution to the Midwifery Panel.
  - e) Once the results from the consultation were published, the Panel would be clearer about what the future would hold.
  - f) The Chief Executive agreed to the notes from the Panel meeting

being shared with Committee members.

**M/16/42 Midwifery Committee schedule of business 2016-2017**

1. The Committee noted the forward schedule of business and asked that updates on the education strategic programme be included on the agendas of future meetings.

**M/16/43 Any Other Business**

1. The Chair noted that this would be the last meeting attended by David Foster, and she thanked him for his contribution to the Midwifery Committee.

There being no other business, the meeting was closed.

The date of the next meeting is 26 October 2016.

The meeting ended at 12:10.

**Confirmed by the Committee as a correct record and signed by the Chair:**

**SIGNATURE:** *DRAFT*  
\_\_\_\_\_

**DATE:** *DRAFT*  
\_\_\_\_\_



## Midwifery Committee

### Summary of actions

**Action:** For discussion.

**Issue:** Summarises the progress of actions agreed at previous meetings

**Core regulatory function:** Supporting functions.

**Strategic priority:** Strategic priority 4: An effective organisation.

**Decision required:** To note the progress on completing the actions agreed by the Midwifery Committee at previous meetings.

**Annexes:** There are no annexes attached to this paper.

**Further information:** If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

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### Summary of the actions arising out of the Midwifery Committee meeting on 27 April 2016

Minute	Action	For	Report back to: Date:	Progress
M/16/23	Update the Committee on progress of work on Annexe V of EU Directive 2005/35/EC.	Assistant Director, Strategy and Insight	22 February 2017	No progress to report. Work on Annexe V is expected to begin in 2017. Will report back to February meeting.

### Summary of the actions arising out of the Midwifery Committee meeting on 29 October 2015

Minute	Action	For	Report back to: Date:	Progress
M/15/48	Provide Midwifery Committee with an update on the maternity reviews in England and Scotland.	Assistant Director, Strategy and Insight		No progress to report. NMC is awaiting the opportunity to provide input into the Scottish review.

## Midwifery Committee briefing: FTP Undertakings, warnings and advice

### Purpose

1. To brief members on the proposed changes to our fitness to practise legislation, focussing in particular on the new early disposal powers for Case Examiners.
2. We have been seeking legislative changes for some considerable time to allow greater flexibility in our approach to fitness to practise cases, facilitating a more proportionate response to less serious cases as well as allowing a more sustainable approach. The proposed changes will provide new powers to dispose of certain cases without the need for a hearing, by issuing warnings, giving advice, or agreeing undertakings with the nurse or midwife. These changes support our strategic objective to adopt a proportionate approach to reach the outcome that best protects the public at the earliest opportunity by providing a wider range of options to address regulatory concerns in a transparent, targeted, and risk-focussed way. Several other regulators already have similar powers.
3. By way of context, the FTP annual report for 2015-2016 highlights that out of 960 hearings 152 cases resulted in a conditions of practice order and 119 cases resulted in a caution order. This amounts to almost 30% of cases, many of which may have been suitable for consideration of undertakings or warnings respectively, at a significantly earlier stage provided the nurse or midwife had engaged appropriately with us.

### Introduction

4. Between 21 April and 17 June 2016 the Department of Health (DH) ran a consultation on legislative change to reform midwifery regulation and improve our fitness to practise process. The consultation focused on changes to the Nursing and Midwifery Order 2001. The proposed changes to our fitness to practise process that we expect to be introduced by the section 60 order are summarised in annexe 1.
5. Colleagues at the Department of Health have indicated to that the progress of our legislation through the Parliamentary process should not be adversely affected by the result of the European Union referendum. Legal and policy liaison with DH colleagues has continued since the referendum, and work on the project appears to have continued as normal.

### Early disposal powers

6. Under our current process, at the end of an investigation the Case Examiners have two options open to them: either (a) if they find there is no case to answer, to close the case with no further action; or (b) if they find there is a case to answer, to refer the case for adjudication before a panel. The adjudication stage

has the greatest impact on the witnesses and registrants who attend hearings, and it is the most costly part of our process.

7. The proposed changes to our fitness to practise process would give our Case Examiners new powers to dispose of certain cases without the need for a hearing, by issuing warnings, giving advice, or agreeing undertakings with the nurse or midwife. As this would extend current Case Examiner powers the existing provisions to review decisions and promote quality and consistency would also be extended to apply in these cases.
8. The proposed approach as to how the new disposal powers could work was developed through research, internal workshops, and a series of engagement events that took place in July and August 2016.
9. The formal consultation will launch on 24 October 2016.
10. The key elements of each of the proposed new disposal powers are summarised below.

## **Undertakings**

11. Undertakings would be agreed measures between the Case Examiners and the nurse or midwife that would protect patients and allow the nurse or midwife to address deficiencies in their practice. The aim of undertakings would be to provide a pathway for the nurse or midwife to successfully remedy any risk to patients so that there is no longer any need to restrict their practice.
12. We anticipate that undertakings would be used in the types of case that currently result in conditions of practice being imposed by a panel at a hearing. Undertakings would not be appropriate where the case is so serious that there is any prospect that the nurse or midwife may need to be removed from our register.
13. The key elements of undertakings are:
  - a. The nurse or midwife must accept that there is a genuine regulatory concern about their practice and a need for measures to remedy that concern.
  - b. The Case Examiners would recommend specific measures (undertakings) which include clear steps the nurse or midwife must take, with defined time periods, to deal with the regulatory concerns.
  - c. The nurse or midwife would need to agree to the undertakings recommended by the Case Examiners. There would be an opportunity for the nurse or midwife to suggest variations where appropriate. If undertakings were not agreed, the case would be referred to a hearing.
  - d. The fact that a nurse or midwife is subject to undertakings would be published against their entry on the register in all cases. A brief summary of the regulatory concern and the undertakings themselves would also be published, except in cases involving the nurse's or midwife's health.

- e. Once they have been agreed, compliance with undertakings will be monitored by NMC staff, including regular contact with the nurse or midwife. Case Examiners would be responsible for (i) lifting undertakings once they have been discharged; (ii) varying undertakings where it is appropriate to do so; (iii) referring a case to a hearing where undertakings have not been complied with.

## Warnings

14. Warnings would provide a means for the Case Examiners to address certain types of regulatory concern without the need to refer the case for adjudication. The aim of warnings would be to publicly declare that past conduct was unacceptable, in order to promote and maintain professional standards and public confidence in the nurses and midwives we regulate.
15. We anticipate that warnings would be used in cases where, although past conduct has been unacceptable, the nurse or midwife poses no current risk to patients. Under our current process, only panels at a hearing can mark such conduct, often by issuing a caution order. Warnings would be not be appropriate in cases involving public confidence concerns (such as dishonesty or criminal convictions) that are so serious that a suspension or striking-off order may be required.
16. The executive summary of recent PSA sponsored research into dishonesty in healthcare professions and public perceptions is attached at **annexe 2**. This highlights that there is a range of dishonest behaviours and whether regulatory action would be required depends on the seriousness of the action and any aggravating elements as well as any mitigating circumstances which may apply.
17. The key elements of warnings include:
  - a. In all cases, when they receive the evidence at the end of their investigation, nurses and midwives would be made aware of the Case Examiners' ability to issue warnings and the criteria they will apply. The nurse or midwife would continue to be invited to respond at that stage.
  - b. Case Examiners would have the power to issue a warning on consideration of the material before them, including any response from the nurse or midwife.
  - c. For a case to be closed by the Case Examiners with a warning, the nurse or midwife would need to acknowledge the basis of our regulatory concern, and demonstrate necessary remediation and insight. The case would need to be serious enough to warrant a hearing, in the absence of admissions, remediation, and insight. However the effect of closing a case in this way would be that on agreement of the warning there would no longer be a case for the nurse or midwife to answer. This approach does not suggest warnings be issued in cases where there is not a case to answer, but rather that in reaching the agreement on warnings there is not value in pursuing the case further as the likely hearing out of a caution would effectively have been achieved in a more cost effective and timely manner.

- d. Warnings would be published in the nurse's or midwife's entry in our register for a period of 12 months, and would include a short summary of the regulatory concern as accepted by the nurse or midwife. Details of a warning would be retained as part of a nurse's or midwife's fitness to practise history, and (under existing rules) could be used in assessing future allegations received within three years.
- e. A nurse or midwife who has been issued a warning by the Case Examiners would have an opportunity to request an internal review of the decision.

## **Advice**

18. The aim of advice is to give a nurse or midwife private guidance to assist them in keeping their practice safe following a minor breach of the Code (where the issues are not serious enough to support an allegation of impaired fitness to practise).
19. We anticipate that the most likely use of advice as a Case Examiner disposal is where allegations which would have been serious enough to require restriction, or a declaration to protect public confidence, have fallen away during the course of our investigation. Advice would not be appropriate in cases where the nurse or midwife disputed the facts which formed the basis of the regulatory concern, or in cases involving the nurse's or midwife's health or knowledge of English.
20. The nurse or midwife would have a right to request an internal review of the decision to issue give of advice. Advice would not be disclosed to enquirers but would be retained as part of a nurse's or midwife's fitness to practise history, and (under existing rules) could be used in assessing future allegations received within three years.

## **Overview of Fitness to Practise changes**

The S.60 project is seeking various changes to Nursing and Midwifery Order 2001 and Fitness to Practise Rules 2004 to improve the efficiency and proportionality of our fitness to practise processes. A summary of these changes is provided below.

### **1. Case Examiner disposals**

Under the proposed changes Case Examiners would have new powers to give advice and issue warnings when making no case to answer determinations. Advice would be issued privately to the nurse and midwife concerned whereas warnings would be published alongside the nurse or midwife's entry on the register for a 12 month period.

Case Examiners would also have the power to recommend undertakings if they determine there is a case to answer and undertakings appear to be a proportionate disposal method to address the regulatory concerns.

### **2. Single Fitness to Practise Committee**

We are proposing to merge the Conduct and Competence Committee (CCC) and Health Committee (HC) into a single Fitness to Practise Committee. This will remove the need to transfer cases between Practice Committees if the nature of the allegation changes. For example, if a case is transferred from the CCC to the HC due to underlying health issues, this can lead to delays in the adjudication of the case and increase in stress for the nurse or midwife concerned. The Fitness to Practise Committee will avoid these types of delays in scheduling hearings.

This proposed change will also enhance public protection as it will allow panels to adjudicate upon all regulatory concerns relating to health and conduct as part of the same adjudication process.

### **3. Remove restrictions on appointment of panel members**

We are proposing to remove the statutory upper limit that restricts the number of panellists we can appoint to Practice Committees. This will allow the NMC to appoint new panel members according to operational need.

### **4. Location of Hearings**

We are proposing to remove the mandatory requirement that we must schedule substantive hearings in the UK country of the nurse or midwife's registered address. This will enable us to schedule hearings for certain cases in the location that would be most beneficial for the attendance of all parties involved in the hearing.

## **5. Discretionary substantive order reviews**

We are proposing to give panels imposing a conditions of practice order or suspension order the power to direct that the order does not need to be reviewed before it expires. The default position will be that a review is required unless a panel directs otherwise. The NMC will implement guidance to assist panels when exercising this discretion.

## **6. Interim order changes**

We are proposing to schedule all interim order reviews at six monthly intervals. Currently interim orders are reviewed initially after six months and subsequently every three months. This change will also apply to reviews of interim orders following extensions granted by the High Court. This would not affect nurses' and midwives' right to request an early review if new evidence is presented.

We are also seeking new powers for the High Court in England and Wales, the Court of Session in Scotland and the High Court of Justice of Northern Ireland to substitute an interim suspension order with interim conditions of practice order and vice versa when hearing interim order appeals, or applications for extension. Currently the courts can revoke or vary an order but cannot replace one type of interim order with another.

## **7. Notification requirements**

The NMC is currently required to notify specified persons, including the Secretary of State and governments of the four countries when an allegation is referred to the Conduct Competence Committee or Health Committee. We are proposing to remove this statutory requirement and instead rely upon our existing powers to disclose fitness to practise information to employers and when it is in the public interest as this is a more proportionate approach to disclosure of fitness to practise information.

# Dishonest behaviour by health and care professionals: Exploring the views of the general public and professionals

## Executive summary

Maintaining public confidence in health and care professionals is critical to the success of these sectors, not only in terms of quality standards and professional competencies but also in terms of standards of conduct and public faith in the integrity of professionals. The issue of dishonesty and dishonest behaviour cuts to the heart of public perceptions of integrity, not least because patients and service users are, by definition, vulnerable.

As the oversight body with responsibility for scrutinising nine UK health and social care regulators, The Professional Standards Authority (The Authority), commissioned Policis to undertake qualitative research both with the public and professionals with a view to:

- Understanding the views of the public and health and care professionals across the UK on how different types – and degrees of – dishonest behaviour are seen to influence fitness to practise and professionalism in different contexts and in a range of health and care professions.
- Drawing out any implications for regulators to inform thinking around the issues and best practice in addressing dishonesty in both the health and care professions and more widely.

The research method was entirely qualitative resting on eight extended focus groups held in each of the four nations of the UK.<sup>1</sup> Four groups were held with consumers, variously with ABs, C1C2s, DEs and heavy users of health and care services. All were structured to include a range of ages and life-stages. These were supplemented by eight depth interviews with residents in nursing homes or living at home and dependent on care and / or nursing support.

Four groups were held with professionals, variously non health and care professionals, frontline social workers and nurses and midwives working in hospitals and in the community, senior professionals and managers drawn from a range of health and care professions and registered professionals in complementary practice.

In each case research participants considered a range of scenarios largely drawn from real life Fitness to Practise (FtP) cases that had been appealed by the Authority, though in some cases scenarios were adapted to simplify presentation. Respondents were asked to consider, in the light of the regulators' remit and guiding principles, what disposals would be appropriate in each case and to respond both to initial FtP disposals and the outcome of appeals by the Authority.

Nine scenarios were considered involving:

- Dishonesty in relation to patient records
- Dishonesty in relation to qualifications or employment history
- Dishonesty in relation to registration status or indemnity insurance
- Dishonesty in relation to working at another job
- Dishonesty (tax fraud) outside the immediate context of professional practice
- Dishonesty in relation to convictions or previous identity
- Dishonesty in relation to patient interactions

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<sup>1</sup> Given that the research is fundamentally exploratory, an entirely qualitative approach was adopted as likely to deliver the richness and depth of insight required to fully understand views on a complex subject area. A qualitative approach will not however provide a sense of scale for how widely the views expressed by research participants are held by the public as a whole.

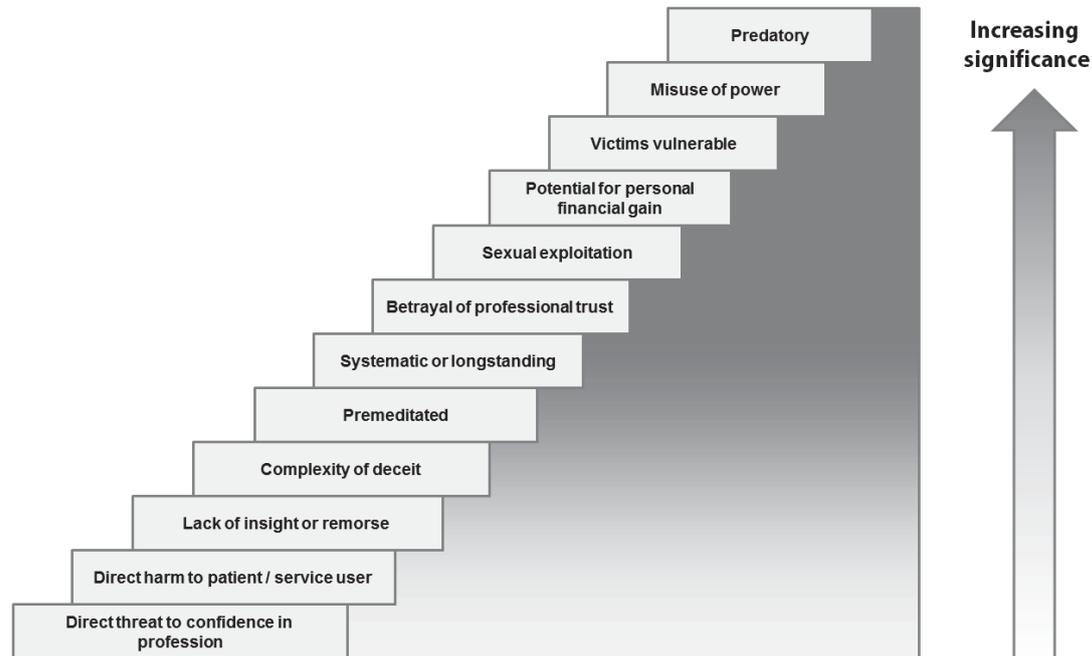
- Lying about relationships with colleagues or patients to conceal inappropriate practice
- Theft from patients or colleagues

We made the following observations in the course of the fieldwork:

- The public and professionals were agreed that attitudes to health and care professionals have undergone something of a sea change, with deference towards the professions having given way to a need to earn respect from a more empowered and demanding public. That said, there was a high degree of respect for health and care professionals among the public, with little or no awareness of cases of dishonesty within the professions. Professionals were more cynical, with health professionals conscious that fraud was an issue for the NHS.
- It would appear that both the public and professionals have a clear mental framework and a shared moral compass through which they view and conceptualise dishonesty by health and care professionals.
- Although there are some differences between professionals and the public, there are clear common elements, with both public and professionals having a shared view of what constitutes aggravating and mitigating factors in professional dishonesty.
- There was also remarkably little variation by socio-economic group or educational attainment in views on dishonesty and appropriate disposals among the public. Those most exposed to the health service and more dependent on health or care professionals felt more strongly than those who had less personal experience.
- There was a minority who saw issues in black and white and who judged any incidence of dishonesty as grounds for immediate expulsion from the profession. The great majority of both public and professionals took a more nuanced view with judgements more finely balanced around aggravating and mitigating factors.
- There was a consensus that premeditated, systematic or longstanding abuse of professional trust or dishonesty in the context of financial gain or sexual exploitation should be grounds for – rapid – deregistration.
- The majority however, with the exception of the most egregious cases, took a pragmatic and tolerant view on the appropriate disposals for dishonesty in FtP cases. The tendency was towards an emphasis on behaviour change and learning and rehabilitative and constructive outcomes, which allowed registrants to continue in the profession. This was particularly the case where individuals showed insight and remorse and seemed willing and capable of changing their behaviour.
- Predatory behaviour, misuse of power, abuse of vulnerable individuals, behaviour motivated by personal financial gain or sexual exploitation of patients were seen to lie at the extreme end of seriousness in terms of aggravating factors. Thus a psychiatrist who had lied about targeting ex-patients for sexual relationships and a nurse stealing from a care home resident were both seen as candidates for immediate and permanent deregistration.
- Dishonesty that involved pre-mediation, systematic or longstanding abuse or complex deceit was also seen as rendering dishonesty more serious, as was a lack of insight or remorse. These views on aggravating factors are captured in Figure 1 following.

### Figure 1. Aggravating factors in professional dishonesty

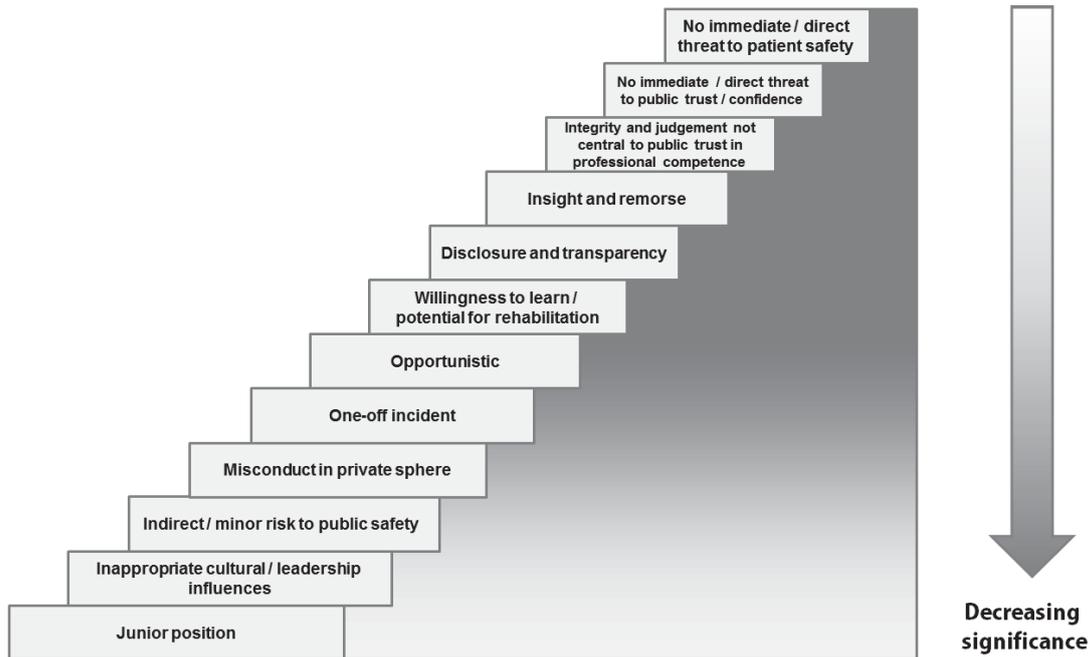
A stairway of significance within professional dishonesty



- By contrast, opportunistic and one-off incidents and dishonest behaviour by junior staff were seen as less serious. Full disclosure, remorse and insight as to why dishonest behaviour was unacceptable and willingness to learn and change were also seen as powerful mitigating factors.
- Dishonesty cases where public safety or confidence was not directly at risk were also seen as less serious, as were dishonest behaviours occurring outside the professional context – unless the dishonesty was so egregious as to raise clear issues of public trust. A conviction for theft was felt to disqualify a nurse for a role in caring for the vulnerable elderly, for example, while tax fraud on earnings from buy to let property was not seen as relevant to a dentist's fitness to practise.
- It was clear the importance of integrity to fitness to practise varied between professions. How far dishonesty influenced fitness to practise appeared to hinge on how far absolute integrity was believed to be critical to public trust or professional competence, being relatively unimportant for professions seen as "practical" (such as dentistry or osteopathy) but critical for professions (such as psychiatry or social work) involving either vulnerable individuals or momentous decisions with far reaching consequences. A social worker who had lied about having a second job and knowingly not complied with the terms of her (entirely separate) child-minding licence, was thought to lack the integrity essential to her profession and thus was not fit to practise as a social worker or care for children.

## Figure 2. Mitigating factors in professional dishonesty

A stairway of decreasing significance within professional dishonesty



- There were some clear gender and generational differences, particularly around cases involving professional boundaries or which contained a sexual element. Women of all ages were more conscious of boundaries, more suspicious of sexual intent and less tolerant of either sexism or inappropriate sexual behaviour. Older men were less aware of boundaries and more tolerant of sexualised relationships between professionals and patients. That said, both sexes and all ages had zero tolerance for predatory sexual behaviour or serial sexual misconduct.
- The public often did not appreciate how dishonesty in relation to insurances, registration status qualifications, experience or research results and similar might jeopardise public safety or public trust. Professionals by contrast were highly sensitive to the safety implications of breaches of codes of conduct and the requirements of registrants and deeply unforgiving of both failure to abide by codes of conduct, the rules for registration or any falsification of qualifications.
- The public, and to a lesser extent the professionals (who were more protective of the reputation of the professions), were also pragmatic in assessing the validity of any threat to public confidence in the professions. In thinking through appropriate disposals, the majority sought to balance any potential threat to public trust and the public interest with the rights of the registrant, registrants' investment in their careers and their ability to earn. Generally both public and professionals appear to take a more sceptical view than the regulators of threats to public confidence, unless impacts were clear and direct.
- Both public and professionals were highly sensitive to the cultural context in which dishonesty took place and were conscious of the potential for systemic failure in conduct standards (for example, the condoning or encouragement of the falsification of patient records). While respondents were aware that individuals were responsible for their own conduct, where dishonesty cases occurred in the context of perceived systemic, cultural or leadership failures, it was felt that there was a risk of individuals being "scapegoated" for the wider dysfunction. FtP hearings were seen as inappropriate in such cases. Instead, both public and

professionals rather put the emphasis on empowering individuals to act, escalate issues and challenge conduct standards.

- Broadly speaking, where the Authority had appealed FtP disposals as too lenient or as having put insufficient emphasis on the dishonesty element of the case, both public and professionals were largely supportive of the Authority's actions and of the typically more severe disposals that resulted. That said both public and professionals opined, on the basis of the cases shared with them, that there appeared to be a lack of organising principles or any coherent hierarchy of seriousness to underpin consistent treatment of dishonesty cases.
- Clearly in selecting cases to appeal, the Authority is bound by case law and the need to meet legal tests and must consider how far the appeal is likely to succeed. The research suggests that the Authority's actions are largely in line with the attitudes to dishonesty of both public and professions.
- Two areas would appear to arise for future thinking around how most effectively to handle dishonesty within FtP cases. Firstly there would appear to be a perception among both public and professionals that some instances, cases are being brought on confidence grounds where the link to public confidence is seen as too tenuous. This would seem to imply a potential use for a set of principles underpinning risks to public confidence and with it a more nuanced hierarchy of more or less serious risk.
- The other major implication of the findings for further development of thinking around the regulation of health and care professions may be the desire expressed by both public and professionals for a greater focus on rehabilitation, learning and behaviour change and managed re-entry to the professions in those dishonesty cases which are not so egregious as to merit immediate and permanent expulsion from the professions.



## Midwifery Committee

### Update on midwifery change

- Action:** For information.
- Issue:** This paper provides an update on progress with midwifery legislative change.
- Core regulatory function:** Fitness to Practise/Registrations/Education/Setting standards
- Strategic priority:** Strategic priority 1: Effective regulation
- Decision required:** None
- Annexe:** The following annexe is included with the paper:
- Annexe 1 – Midwifery change risk register
- Further information:** If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

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- Context:**
- 1 In January 2015 the Council accepted the recommendations of an independent review of midwifery regulation by the King's Fund and asked the government to legislate to amend our legislation. Following the election in May 2015, and responding to a further maternity review into failings at University Hospitals of Morecambe Bay NHS Foundation Trust, the Secretary of State said in a statement to the House of Commons that supervision would be removed from the NMC's statute and the additional tier of regulation applying to midwifery would be also be removed.
  - 2 The Department of Health consultation on the proposed changes to our midwifery framework (and improvements to our fitness to practise processes) closed on 17 June 2016. There were c1,400 responses including a high number of responses from individual midwives.
  - 3 At the time of writing we do not know what impact the EU referendum outcome will have on the Section 60. In the event of a formal decision to leave the EU, aspects of the domestic legislation programme may be deprioritised in order to create parliamentary time for EU exit related legislative change. If a further general election occurs within the timeframe for the passage of the Section 60 this could also have an impact.
  - 4 The Committee has received regular updates on the progress with the midwifery legislative change, and has kept Council informed about its oversight of the work.

**Discussion and options appraisal:**

**Progress with the Section 60**

- 5 The Section 60 went to the Regulatory Policy Committee, a government committee comprised of business representatives tasked with assessing the business impact of proposed legislation. It received a red RAG rating on the basis of further information sought concerning the FtP provisions. NMC colleagues have worked with officials to supply the required information.
- 6 At the time of writing the Department of Health has not published its response to the consultation on the Section 60. This response will confirm the proposals that will go to Parliament for debate. While the proposals may change as a consequence of the consultation, a Section 60 is debated for support in its entirety – it cannot be amended like a full Bill during its passage through Parliament.

**Sector developments**

- 7 The Department of Health convenes a group on the future of supervision 'decoupled' from regulation involving representatives of the four CNOs, the LSAMO Forum, and the RCM.

- 8 This group continues to meet fortnightly and, at the meeting on 31 July 2016, conducted a full stock take of progress with the new model of supervision and preparedness for changes to midwifery regulation. Progress is encouraging, with all four countries having advanced plans for supervision which are going through stages of sign off and moving towards implementation. A further four country meeting is planned in November 2016.
- 9 There is a consequential amendment arising from the Section 60 which relates to the regulatory framework under which midwives (and a number of other health professionals) can supply certain controlled drugs without a prescription. We will provide a verbal update on this at the meeting of the Committee.

### **Operational readiness – NMC**

- 10 The Section 60 Programme Board continues to meet regularly to oversee and co-ordinate activity in preparation for the legislative change.
- 11 A full audit of midwifery FtP cases has been undertaken to understand the profile of midwifery cases at the investigation and adjudication stages, as well as those midwives with a current sanction which may need to be monitored differently after the legislative change.
- 12 Registrations colleagues are planning to review the midwifery test of competence questions to ensure they are relevant to the practice of midwifery in the UK after the legislative change.

### **Communications and engagement**

- 13 Our next phase of communications and engagement work will begin when the government publishes its response to the Section 60 consultation. It will include work to inform Parliamentarians who will scrutinise the proposals in the parliamentary stages.
- 14 We continue to attend and speak at midwifery and maternity events in order to hear from midwifery stakeholders and communicate the forthcoming changes to midwifery regulation.

### **Risk register**

- 15 The Committee reviews the risk register at each meeting. The current risk register is included at annexe 1. There are no changes proposed to the RAG rating but some activity has moved from planned activity to mitigation in place.
- 16 We had planned to circulate our guidance document on the management of FtP case data, co-produced with LSAMOs, by this

stage in order to inform practice in the last six months of the current statutory framework. We have not yet done so because at the time of writing the government has yet to publish its response to the Section 60 consultation and we do not want to be seen to pre-empt the process towards change. We will keep this decision under active review and may have an update at the Committee meeting.

<b>Public protection implications:</b>	17	The change described in this paper is explicitly concerned with public protection. It is a consequence of three authoritative reviews into concerns about statutory midwifery supervision from a public protection and public confidence perspective.
<b>Resource implications:</b>	18	The Section 60 Programme is resourced within the 2016-2017 budget.
<b>Equality and diversity implications:</b>	19	An equality impact assessment of the midwifery legislation changes has been completed.
<b>Stakeholder engagement:</b>	20	This is covered in the paper.
<b>Risk implications:</b>	21	See paragraphs 15-16 and the annexe.
<b>Legal implications:</b>	22	This paper is concerned with a process of legislative change and the consequential changes that follow for our regulatory framework.

## Risk register

**Note:** The 'inherent risk scoring' column does not take into account any mitigation. The 'post-mitigation scoring' involves taking into account the mitigation in place but not the planned action.

Midwifery legislative change programme			Date updated: 10.10.16	Issue No: 3													
No.	Date of origin	Risk Scenario			Inherent risk scoring			Mitigation in place / Planned action			Post-mitigation scoring			Risk Owner (and Mitigation Owner)	Dates updated	Status (open / closed plus whether on track / not on track to reduce scoring)	Direction (of risk score)
		Root cause(s) (RC)	Potential situation	Consequences	Likelihood	Impact	Score	Likelihood	Impact	Score							
1	02.02.16	<b>Strategic communications risk: Communicating about the transition</b>			4	5	20	<b>Mitigation in place:</b> 1. Strategic level engagement across the four countries - ongoing since 2015 (RC 1,2,3). 2. Communications specialist partner engaged and a comprehensive communications plan has been finalised and is now being implemented (RC 1,2,3). 3. Draft transition document and draft future midwifery regulation reference document drafted and shared with Midwifery Committee (RC 2,3). 4. Transition document shared with the four country task groups so that sector is clear about impact of change on other roles and remits (RC1, 2)			3	4	12	AD Strategy	12/07/16 Updated to reflect corporate risk register post Brexit vote  Updated 10/10/16	Open and on track	No change
		1. The sector needs to plan for the transition 2. There could potentially be confusion around key roles and responsibilities of the regulator, employers and the wider system 3. There is uncertainty in the midwifery community about the effect of the changes	We may fail to engage and communicate effectively with the sector about the changes	1,2. Transition is not effective 1,2,3 Public protection is undermined  1,2,3 Negative impact on service users				<b>Planned action:</b> 1. Finalising and sharing a new reference document setting out the revised midwifery framework - April 2016 to March 2017 (RC 2,3).  3. Circulation of FtP case management guidance co-produced by NMC and LSAMOs (RC 1).									
2	02.02.16 (transfer from previous risk register)	<b>Legislative risk: Securing the right legislative change</b>			4	4	16	<b>Mitigation in place:</b> 1, 3. Create political momentum for change through evidence and work with strategic partners (RC 1, 2, 3) 2, 3. Establish and maintain close working relationship with the Department of Health's S.60 team (RC 1,2,3) 1,2. Obtaining timely legal advice to confirm approach (RC 1, 3)			3	4	12	AD Strategy	27/06/2016  Updated 10/10/16	Open and on track	No change
		1. Legislative change is not yet finalised 2. Consultation outcomes and parliamentary phase may influence content of section 60 order 3. EU referendum result diverting government and parliamentary time priorities, time and resources	We may fail to secure the legislative change to remove midwifery supervision from our legislation which might lead to increased uncertainty and challenge for the sector	1, 2. Current outdated arrangements continue to apply 1,2. Public protection is undermined				<b>Planned action:</b> 2. Public affairs work for Parliamentary phase (Jan 2017) and close working relationships with the Department of Health (RC 1, 2, 3) 3. We are seeking clarity from the Department of Health on available government and parliamentary time for the proposed s.60 changes in light of the advisory EU referendum result (RC 1, 3)									
3	02.02.16	<b>Operational risk: Operationalisation and implementation of change</b>			3	4	12	<b>Mitigation in place:</b> 1,2. Detailed impact assessment completed (February 2016-March 2016) and approved by programme Board (RC 1, 2, 3) 1, 2. Use of best practice policy development (RC 1, 2, 3) 1,2. Project board appointed and fully operational (April 2016) (RC 1, 2, 3) 3 Co-production work with LSAMO Forum to ensure 'right touch' oversight of LSA for 2016-17 (RC 1, 2) 1, 2 Initial full Equality Analysis completed and approved by project board (RC 1, 2, 3)			2	4	8	Sponsor Director	27/06/2016  Updated 10/10/16	Open and on track	No change
		1. There are a number of interdependencies between our regulatory processes and aspects of the current framework which require system and process changes(e.g. ItP, LSA investigations, data transfer) 2. Preparation for change is complex involving NMC staff, panellists and external stakeholders 3. Challenges of maintaining public protection during inevitable deterioration in the current infrastructure	1, 2 We might fail to handover operations effectively 1, 2. The operational approaches we develop for the future may be sub-optimal	1,2, 3 Public protection is undermined 1,2. Reputational damage with a negative impact on service users				<b>Planned action:</b> 1,2. Delivery plan of process and system changes (April 2016-March 2017) (RC 1, 2)									



## Midwifery Committee

### Education strategic programme update

<b>Action:</b>	For information.
<b>Issue:</b>	Provides an update on our progress towards delivering a review of our standards of proficiency for midwifery, as set out in our education strategic plan.
<b>Core regulatory function:</b>	Education Standards
<b>Strategic priority:</b>	Strategic priority 1: Effective regulation.
<b>Decision required:</b>	<p>The Committee will receive a presentation on evidence gathering for the review of midwifery pre-registration standards and will be invited to consider:</p> <ul style="list-style-type: none"> <li>• What works and what needs attention in the current pre-registration midwifery standards?</li> <li>• What sources of evidence should inform the new standards?</li> <li>• Are there any significant evidence gaps?</li> </ul>
<b>Annexes:</b>	None
<b>Further information:</b>	If you require clarification about any point in the paper or would like further information please contact the author or the deputy director named below.

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- Context:**
- 1 Our current education function involves the setting of standards for pre-registration education for nurses and midwives.
  - 2 The education strategic plan was developed in order to reflect the changing external healthcare environment outlined in the Council's Strategy for 2015-20, and in response to an independent evaluation of our current pre-registration nursing and midwifery standards which was undertaken in 2015 as part of our commitments in response to the Francis report.
  - 3 Our education strategic programme will ensure that the NMC leads the way in setting standards that prepare nurses and midwives to provide safe and effective care, both now and into the future. We will do so through the delivery of the following work streams:
    - 3.1 New standards of proficiency for the future graduate registered nurse at the point of entry to the register.
    - 3.2 New standards of proficiency for the future graduate registered midwife at the point of entry to the register.
    - 3.3 A new education framework that will support safe and effective learning.
    - 3.4 An independent review of our quality assurance (QA) function.
    - 3.5 A review of other related post-registration standards, including our standards of proficiency for nurse and midwife prescribers and standards for medicines management.
  - 4 While work in other work streams is well underway, there was reason to delay the delivery of the work to deliver the review of our standards of proficiency for midwifery, as described in paragraph 7.
  - 5 This work will be supported by a comprehensive stakeholder communications and engagement plan that puts our stakeholders at the heart of our education change agenda.

**Discussion: Standards of proficiency for the future graduate registered midwife**

- 6 In March 2016, the Council confirmed that it was committed to undertaking a similar approach to the development of new midwifery standards of proficiency to that of the approach taken for the development of new nursing standards of proficiency.
- 7 However, given the forthcoming regulatory changes in midwifery, it was decided at that time that it would not be appropriate to commence the work on the midwifery standards of proficiency within the same timeframe as the nursing standards given the scale of

change currently facing midwives in relation to the section 60 Order.

- 8 In September 2016 the Council approved our proposed timelines around the development of new midwifery standards of proficiency, key dates include:
- 2016/2017:** Developing an evidence base and early engagement with midwifery stakeholders alongside work on education framework
  - 2017/2018:** Drafting set of new standards with input from midwifery education stakeholders
  - Spring 2018:** Formal consultation on new midwifery standards
  - Early 2019:** Publishing our new midwifery standards
  - Sept 2019:** 'Early adoption' of new midwifery standards and new education framework in place
  - Sept 2020:** Deadline for adoption of new midwifery standards
- 9 This timeline means that the early engagement work on the midwifery standards will run in parallel with our engagement work on the education framework and new QA model which will apply to both nursing and midwifery programmes.
- 10 Since Council in September, initial research and evidence work has commenced; including an initial literature review and policy review, and analysis of FtP and QA data.
- 11 Many of the same concerns about our current pre-registration education standards apply to both the nursing and midwifery standards and many of the drivers for change are the same, including the need to separate the requirements for individuals and institutions and the need to establish the competencies required of the future graduate registered midwife in 2025.
- 12 In addition, there have been a significant number of high profile reviews in relation to the delivery of midwifery care in recent years. It is incumbent on us, as the regulator with responsibility for setting the midwifery education standards, to ensure that we reflect on these issues and consider any learning from these reviews that we need to take into account as we undertake this review of our education standards.
- 13 The new midwifery standards of proficiency will be outcome focused, accessible to the public, and open to objective assessment. They will build on the professional values set out in the Code, be informed by evidence of good midwifery practice both in the UK and internationally and will be unambiguous, transparent, and succinct.

- Public protection implications:** 14 Our education strategic programme is primarily driven by the need to protect the public, by ensuring that our standards equip future nurses and midwives for knowledgeable, safe and effective care both now and into the future.
- Resource implications:** 15 The resources for the education strategic programme have been factored into our corporate planning process and were agreed at the March 2016 Council meeting.
- Equality and diversity implications:** 16 An equality assessment being undertaken for the education programme as whole and will review the current available equality and diversity data from within the education team. It will also identify key external policy developments. The EA has not dealt with the standards of competence for midwifery as we have not yet commenced this work but initial planning and research is at an early stage.
- Stakeholder engagement:** 17 A full stakeholder communications and engagement plan has been developed and we intend to put stakeholders at the heart of our education strategic programme. Engagement work on the midwifery standards project not yet commenced, but we will be starting to engage with key stakeholder groups in late 2016, where we will be outlining our plans and gathering early feedback.
- 18 We are also establishing an education stakeholder forum from across the UK which will meet quarterly. We will also begin to cascade information about the education programme through our communications network, digital content and web development.
- Risk implications:** 19 Stakeholder expectations and the political and policy landscape that affects healthcare and education are some of the key areas of risk and opportunity. Risks of particular note include:
- 19.1 the changing policy landscape that affects the education and regulation of nurses and midwives in the future;
- 19.2 the scale of business transformation that the NMC is currently planning at the same time; and
- 19.3 the extent to which we can secure stakeholder buy in.
- Legal implications:** 20 The legal basis for the education standards and quality assurance function is set out in the NMC Nursing and Midwifery Order 2001, our education and registration rules, and requirements for the education of nurses and midwives as part of EU directives. We anticipate that the future nurse competencies, education framework and prescribing competencies will go to formal consultation in spring 2017 and the future midwife competencies in spring 2018.

## Midwifery Committee: Schedule of business 2016-2017

Midwifery Committee: standing items		
<ul style="list-style-type: none"> <li>• Minutes and summary actions from previous meetings</li> <li>• Changes to midwifery regulation. Including:               <ul style="list-style-type: none"> <li>○ Risk register for the midwifery legislative change programme</li> </ul> </li> <li>• Education strategic programme updates</li> <li>• Data and intelligence</li> <li>• Revalidation update (oral updates)</li> <li>• Midwifery Panel update</li> </ul>	For information	
	For discussion	
	For information	
	For discussion	
	For information	
	For information	
Next meeting		
Date	Time	Venue
Wed 22-Feb-17	10:00 – 13:00	London