Royal College of Nursing response to the Nursing and Midwifery Council consultation on changes to the Fitness to Practice function

The Royal College of Nursing supports these proposed changes and we consider that they have the potential to improve patient safety and the fairness of the Fitness to Practise process. Many of the cases currently heard by the NMC could be addressed more quickly and appropriately at a local level.

Regulators are best able to protect the public and maintain public confidence where they focus on learning from incidents and applying lessons to prevent recurrence. Incidents rarely occur simply as a result of human error. The related processes and organisational structures, as well as the particular context in which the incident occurred, all need to be considered in order to learn appropriate lessons and improve practices.

To help inform this response we sought the views of RCN staff and members from a variety of locations and specialisms. Although the timescale didn't allow for a full internal consultation we were able to invite views from a range of RCN executive and management committees, officials and various nurse networks. We also held open meetings at the recent RCN conference in Belfast, and invited comments from members through relevant closed Facebook groups. As a result of this engagement we have obtained views from members working in the NHS, care homes, and other parts of the community sector.

Our responses to the specific questions raised are set out below.

Questions

1. **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?**

   In the RCN we agree that FtP is primarily about managing risks to patient safety. We recognise the need for professionalism to be meaningful, and our registered members are proud about their professional status. However, we have seen FtP outcomes in the past that have concerned us that the NMC panel has been policing morality as opposed to professional behaviour, and we agree that public safety is the proper function of FtP.

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

   We agree that the focus of FtP should be about current risk and is not about punishment in any way. Sanctions should be purely to protect the public from possible harm that is likely to arise from future actions of registrants. We see

outcomes of FtP reported in the press in emotive terms that add to an atmosphere of blame, which is counter-productive for developing an open culture and improving patient safety, and we would like to see the regulators make efforts to steer away from a focus on blame and punishment to one of learning lessons to improve approaches and prevent future incidents arising.

3. **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?**

   We welcome the attempt to identify a meaningful criteria for maintaining public confidence in the register. We agree that the bar should be set very high so that panellists do not have to attempt to construct a moral arena for registrants to occupy based on their own world view.

   We have asked our members to try to identify behaviour that would not affect patient safety in itself, but should lead to sanction, and they have found it hard to do so. Some have spoken about convictions and dishonesty, but these can generally be included under the heading of presenting a continuing risk to patients. Others have talked about those who publicly express strongly racist or discriminatory views, which again could be categorised as a risk to patient safety. Many do not think that there is any behaviour that should preclude membership of the register providing that there is no risk to patient safety.

   We have represented members who have been struck off for undertaking sex work or participating in a swinger web site. Other members have not seen this as behaviour that should lead to sanction, and have expressed a view that nurses are entitled to a private life. There are clearly a range of views amongst the public and it is very difficult for a panel to reflect public opinion when that opinion is so divided.

   We hope that the NMC looks to other organisations (particularly the other health profession regulators) for a steer about what is fair in this respect, as there has been a sense at times that nurses are being held to a different standard. We would want any criteria to be focussed upon what is absolutely necessary for maintenance of confidence in a member of any professional register.

4. **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?**

   We agree, deliberately covering up incidents should be regarded as a serious breach.

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

   We do not necessarily think that the registrant should always be removed from the register in these circumstances, although we would agree that this would be the right outcome in some cases. The context, circumstances, impact and subsequent insight and actions of the individual should be taken into consideration alongside an understanding of the culture in which they were practising. Organisations who do not have an open, learning culture may collude with deception and the individual should not be deemed wholly responsible in such cases. The likelihood of recurrence and risk should be the deciding factor in such cases, not the act in isolation.

6. **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?**

   We strongly agree with early resolution whenever it is fair and safe to do so. Resolution should depend on the risk of repetition, so remediation is key. We do not think that the outcome for the patient should be a determining factor. It should be the behaviour of the registrant, not the outcome, that is the focus in a system that is dealing in risk rather than dealing in punishment. In recent years, there has been an attempt to link patient outcomes with the severity of the sanction, and in our view it has created situations that are arbitrary and distract from learning and safety. For example, we represented members who had all made the same mistake over a few shifts, by not administering a medication, and the panel spent time considering which mistakes had hastened the patient's death and which had made no difference. This endeavour was unhelpful and we have been pleased to note that the NMC has moved away from that approach.

7. **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?**

   Currently decisions about voluntary removal are not published on the website, but they are reflected on the registrant's entry on the register. Those who are voluntarily removed often have health issues and/or are retiring and do not intend to nurse again. Given that publication of the outcome can be googled and is more likely to end up in the local paper, we would ask that if it is deemed necessary for this change to be made in the interests of transparency, details are kept as brief as possible. We know that health information will not be published, but we would also ask that where there are health concerns and publicity could damage that individual's health further, the NMC is able to make a reasonable adjustment around publication that is able to take that issue into account.

8. **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?**

   We very strongly agree that the correct regulatory outcome is a professional culture that values equality and diversity. We agree that openness and learning in the interests of public safety must be the priority. We commend the proposed changes to the role of employers as a way to encourage employers to examine their own referral processes and improve their awareness of any discriminatory patterns in their referrals. We commend the proposed focus on context upon avoiding a blame culture and enabling openness and learning to improve patient safety.

9. **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?**

   We agree that the positive and supportive focus upon ensuring that registrants are fit to practise safely and professionally is the right regulatory outcome and is a great improvement on what has been the perceived historic focus upon removing ‘bad’ nurses.

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

    We agree that the 2 heads of patient safety and supporting registrants to achieve effective practice are a good choice of overriding regulatory ambitions. Proportionality and fairness are also important principles to consider, and we think that the ensuing sections are likely to achieve them more frequently, but they could be considered for inclusion in the overriding regulatory outcomes.

11. **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 preparing this response we have considered this question with nurses at different levels of seniority, including groups of nurses who would be the decision makers about making referrals at their organisations. There has been very strong support for this proposal, and in well managed organisations, a sense that this is how they would manage a concern already.

    There is a recognition that employers are variable in their ability to deal with capability management well and our members have requested clearer guidance for employers if this proposal is to be successful. For example, one member commented:

"The NMC must, however, publish very clear guidance for senior nurses to refer to. Nurse Managers cannot be expected to make these decisions for them only to be criticized by the regulator in hindsight. At present referral may be made on a 'just in case' or 'if the NMC do nothing then that's up to them' basis. This gives some protection to senior nurse managers in the absence of very solid and clear guidance."

Another member, who acts as a steward notes:

"My experiences as a RCN Steward have identified both good and bad practice in dealing with capability issues and the lack of training for investigations into practice in my current organisation leads me to have concerns which would need to be resolved."

A senior nursing group in Scotland added this:

*"It is essentially good management to deal with things that do not warrant a hearing at a local level, **but** we need reassurance that Employers will be supported, informed and confident both to challenge a professional and to adopt the appropriate rehabilitative response."*

Significantly, we had responses from senior nurses within the independent sector that Safeguarding in Local Authorities, CCGs and CQC puts pressure on home managers to report any issue to the NMC irrespective of their own internal procedures, otherwise the Managers registration is called in question, even when that Home Manager advises they have consulted with the NMC. There was a sense that nurses working for these sorts of employers did not think that this was appropriate, but few cases reach the chief nurse because most cases are referred by the local HR adviser and manager direct.

In Northern Ireland it was noted that safeguarding exercises often led to the social worker in charge advising that a referral should be made.

However, some independent sector employers felt able to deal with issues locally. This senior nurse considered that a nurse should only be referred after there had been an outcome of dismissal following a properly conducted employment process, and she added:

"The employer has a duty to decide on sanctions which could include further training and reduced duties- but again good employment procedures would ensure this happens."

Senior managers commented on how much work is involved in resolving a capability matter well.

There was commentary that the NMC's Employer Link Service will have a role in providing such guidance and support and should be strengthened. Currently, some senior nurses said that the service was very helpful, but tends to encourage referral. This was one comment taken from a note of a call:

> *She advised that she regularly speaks to the NMC employer advisers for advice partly on the basis of pressure from regulators – however, while they provide advice on next steps and paperwork required etc. which may delay the referral itself, they have never advised her not to refer.*

Other members noted that the process of the employer resolving the issue would be less stressful for the registrant, and allow for more timely and effective outcomes. There would be more opportunity for employers to take on board the lessons about systemic issues right at the outset, so that safety improvements could be put in place more quickly.

There was some concern that the process of informing other employers that there had been an issue about a practitioner would be lost if that practitioner had not been referred to the NMC, and some mention of the old practice of blacklists in the NHS. It is our view that it will need to be clear that the regulatory route will still be open if the registrant still presents a risk.

Members agreed that complaints from members of the public should be sent to employers to investigate. This might have several benefits including the prevention of some instances of the pursuit of malicious complaints that currently entangle registrants in drawn out processes, even if they are usually then resolved without sanction. Learning from complaints from the public is better experienced by the organisation which can then make the necessary changes to prevent similar problems in the future. One member suggested a sensible proviso:

> *"that the complaint from the member of the public is related to work issues and not events that have happened outside of the work environment unless they are related to clinical practice, i.e. a breach of confidentiality"*

Another member noted that:

> *CQC take this approach when complaints come directly to them. The provider is then required to report back to the regulator/commissioner on the outcome following the investigation.*

On the other side of the equation, there is also a hope among members that greater interaction between the NMC and employers will help control the poor practices of some employers. For example, one member told us about her possibly malicious referral after she had raised concerns about unsafe systems at that employer's premises. She was then cleared at the NMC without sanction and was working at a different employer where she noted an issue that she would have raised, but had become so fearful after her first

experience that she chose not to do so. She believes that the first employer had frequently made referrals, and a closer relationship and greater use of data and scrutiny between the NMC, employers and systems regulators should help identify this and avoid this type of outcome.

12. **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?**

    There was overwhelming support among RCN members for taking context into account, with which we whole-heartedly concur. Many members pointed out that nurses work in increasingly challenging settings. Comments included the following:

    "Given the wealth of knowledge around human factors and the difficult circumstances and challenges that are prevalent in the current climate of financial challenge in health and social care there are too many factors that are not in the control of the registrant and most are doing the very best they can in very difficult circumstances."

Along the same lines, this from another senior nurse:

"Absolutely. We need to get a more Human Factors approach to the management of staff. The professional 'blame-game' in health care impedes improvement and drives poor practice into the shadows. We need to learn from industries such as aviation where personal accountability for error is the conclusion of last resort, with more focus given to the systems in which those professionals were operating. The NMC should have the ability to at least comment on an employer's systems and how they impacted on the actions of the nurse, recommending changes or improvements in those. If there are a lack of safe systems, training and monitoring then the NMC should understand that this leaves registrants vulnerable to making unwitting error or to taking chances with safety in order to 'get the job done'. Human Factors thinking, and in particular emerging theories around Safety 1 and Safety 2 thinking, is vital to developing safe systems of care, and the NMC should not only take account of it but also promote Human Factors approaches. However, Human Factors cannot be used as an 'excuse' for poor practise and bad malicious behaviour, so it is about building a 'Just Culture' where the analysis of systems is the starting point when reviewing or investigating error, but where accountability is a staging post on that journey."

And an insight from an investigator:

*"Yes, **always**. As an NPSA- trained investigator for patient safety incidents, I can vouch that there is always further learning gained by taking the entire context of any incident, complaint or problem into consideration to gain a fuller understanding of what happened. This circumspective approach helps to reduce the risk of false assumptions being made which may have negative consequences for the individual or the organisation."*

Other responders pointed to factors like increased agency use, with staff being initially less familiar with processes and environment, and the evolution of new models of care that ought to be considered during investigations.

There was a strong sense that unless this is properly incorporated, a punitive culture of blame will persist. We have been struck by the fearfulness of registrants about becoming involved in a Fitness to Practise investigation, but if they are reassured that the context of an incident will be properly evaluated and learning will be shared, we would expect them to have a more positive attitude to the fitness to Practise process.

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

We agree that this could be an excellent way of achieving the aim of returning registrants to practise as quickly as possible. In most cases we expect that this will be warmly received by registrants under investigation. We would be pleased if the NMC could assist in ensuring that courses undertaken by such registrants are good quality.

We would want there to be a sensible approach towards registrants who choose not to comply with any proposals for early remediation, so that their reasons are given a fair hearing.

The NMC should not lose sight of the need for nurses to take responsibility themselves as well for improving their practice, but as this commentator from our membership put it, early remediation is no bar:

> *"Nurses should be reflecting on criticism of their practise and taking responsibility to think for themselves not only what they need to do better, but also how they will get themselves to a place where they can do that. So, this is not about spoon-feeding, it is about giving honest feedback and direction and then judging how seriously the nurse has taken that feedback and how much effort they have given to improving."*

14. **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?**

We do agree that cases should be dealt with at a meeting unless a hearing is necessary because facts or disposal are disputed. We recognise that the outcome of meetings will be published, and that, in our view, adequately deals with the issue of transparency and openness.

Our members are of the same outlook. For example, a member commented:

"Yes, hearings take far too long to happen and are enormously stressful. If we take a Human Factors approach then we should already be viewing the majority of errors as equally a failing of the system that nurse was working in as it was a failing of their own actions. Most nurses will 'punish' themselves far more than an employer or regulator can and will want to improve and learn from what happened."

Another senior nurse working in the independent sector commented to us, from our note of the call:

> She also talked about the disruption and stress hearings had on colleagues and home staff, particularly the detrimental impact this then had on patient care – if you put nursing staff witnesses under pressure though legal processes and investigations and then remove a home manager and a few nursing staff/HCAs for a week from the home to attend the NMC, resident's safety and standards would be challenged at the best of times!

We note that a higher proportion of complaints about nurses currently end up at a hearing compared to complaints about doctors. Although the NMC reduced the number of hearings by 26% during 2011-2016 it still holds almost four times as many as the GMC, despite receiving many fewer complaints[1]. We have had experience of nurses that we are representing ending up at a full hearing when the doctors they worked alongside at the time of an incident had their cases resolved at a much earlier stage. We consider that this change would lead to a more consistent approach between regulators.

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

We have been very pleased by the proposals. We would like to see more information given about the nature of referrals in the annual report to allow us to evaluate where more work could be done to achieve fairer outcomes.

16. **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?**

We expect that these changes will lead to a need for more interaction between registrants, their representatives and the NMC to reach agreements that can then be put before panels at meetings. We would like to be involved in developing those processes further so that there are fruitful discussions at the earliest stage that address the issues. We would ask that initial investigations are thorough so that registrants can know the

[1] Figures taken from a General Medical Council report, 'UK health regulator comparative data report 2016' (https://www.gmc-uk.org/static/documents/content/UK_health_regulator_comparative_report_FINAL_220217.pdf)

case against them early, and not be faced with changing allegations following post investigative work. This will encourage registrants to engage fully without the fear that their open reflections might be turned into new charges against them.

We consider that some members of the public will be disappointed if certain cases are not sent to a full hearing because they hope for an opportunity for their concerns and distress to be heard. In our view, FtP hearings are not usually the right forum for that type of resolution of patient concerns and we have seen patients and family members frustrated that the focus is upon the safety of the practitioner rather than a review of what happened. We consider that spending time explaining this to members of the public would be a good service to provide.

A member has offered this suggestion:

> *"Care and liaison with members of the public by staff independent of the investigation or case management process is vital, such as the service offered to witnesses and family members in criminal and coroners' court proceedings."*

We are very pleased to note that the NMC has created a new service for supporting patients and their families, and there were useful recommendations in the 'Lessons Learned' review, and we support the provision of compassionate support for all those involved in NMC proceedings.

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

We do think that an FtP process that values equality, diversity and inclusion results in fairer outcomes. We are aware that currently certain groups are over-represented in referrals and this creates a sense of mistrust about the fairness of the FtP process. If this was tackled, this would enhance trust in FtP outcomes.

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

We do think that the NMC should support employers to incorporate the principles of equality, diversity and inclusion. We support the expectation that all referrals would need to be signed off by a senior manager, as this could raise awareness within an organisation if registrants with particular characteristics were being disproportionately referred. We would like to see NMC data utilised to identify which employers and which types of employers are making more referrals than others, particularly if they appear to be making more referrals of certain types of registrants. We would like to see the NMC share this data with systems regulators who could explore with employers whether improvements to their processes could be made. In this way, registrants could expect more protection against careless or malicious referrals by employers.

NHS employers (as well as the NMC) are already subject to the public sector equality duties of the Equality Act, and hence addressing the implications of their processes in this respect, will help them discharge their legal duties

19. **Will any of these proposals have a particular impact on people who share protected characteristics (including nurses, midwives, patients and the public)? The protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, race, religion or belief, sex, sexual orientation, pregnancy and maternity.**

    Please see the answer to question 18. If followed through, there is potential for these changes, particularly through closer work with employers, to result in better protection for those who have protected characteristics.

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

    We consider that there will be good relations between the NMC and groups like registrants under investigation, witnesses and representative bodies if the NMC does not adopt an overly prosecutorial approach. We all want to see a focus upon serious risks to patient safety and a move away from undue time spent upon myriad less substantial allegations. The recent guidance from the NMC to stop spending time on the causation of patient outcomes is a welcome step in that direction. Flexibility around time frames and a more collaborative and communicative approach to investigations could also provide a fruitful way forward.

    We noted above (question 11) that employers, particularly in the independent sector, have felt themselves under pressure from CCGs, CQC and local authority safeguarding, to the extent of being threatened about their own Home Manager registration, to refer nurses to their regulator against their own processes. We would ask that this experience is shared with the organisations concerned and that the NMC works with those organisations to come to a shared viewpoint about when it is appropriate to refer.

    Finally, we consider that there should be a fairer approach to the treatment of registrants, which would lead the nursing community to have a greater trust in the impartiality of the NMC. At present, witness support is very much focussed upon witnesses for the NMC. All expenses are paid and they have the benefit of the services of the Witness Liaison Team. Registrants are not entitled to have their expenses met, except those in the most severe hardship. Sometimes, particularly if several registrants' cases have been joined in to a single hearing, the registrant may have to fund hotel stays in London and expensive travel across several weeks, on top of missing work and needing to arrange childcare. The expense discourages registrants from appearing at their own hearings. This unequal approach gives the impression that the registrant has already been deemed to be at fault

and should not be supported to attend because it is their fault that the case has to be heard. As the PSA has proposed in right touch regulation, fairness is central to the credibility of regulation and we ask the NMC to review this policy.

About the Royal College of Nursing

With a membership of around 435,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the RCN is the voice of nursing across the UK and the largest professional union of nursing staff in the world.

For more information, please contact Roz Hooper, Head of Legal (Regulatory), Legal Services, Royal College of Nursing (Roz.Hooper@rcn.org.uk, 020 7647 3544).