Our culture of curiosity

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As an independent regulator we need to understand what happened when we receive a concern about someone's fitness to practise. Understanding what happened and why helps us decide if there is any action we need to take to protect the public, or if a referral can be closed. We will listen to and fairly consider the accounts of relevant people involved where this is appropriate, reasonable and proportionate to understand what happened; for example, this may include a person receiving care or a family member, the professional, a Director of Nursing or employer. This guidance seeks to encourage a culture of curiosity and to clarify when we can seek information and when we cannot.

What is a culture of curiosity?

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Having a culture of curiosity means we consider who has information that can assist us. We won't accept a single source of information at face value where it is appropriate, reasonable and proportionate for us to make other enquiries.

We'll listen carefully to what people tell us about their experience and will take their account seriously. Sometimes we will be told very different accounts of what happened from the person receiving care, the professional being investigated or the professional's employer. Where necessary we will have the confidence to ask sensitive questions or respectfully challenge what we're being told.

We avoid making assumptions and take steps to ensure that bias (whether conscious or unconscious) doesn't impact our decision making. We will consider all the evidence without preconceived ideas of whose account is most likely to be accurate. We may need to scrutinise the conclusions others have reached. Where necessary we'll consider if there are other reasonable and proportionate investigative steps we're able to take to clarify what happened.

We seek advice from our clinical advice team where this is necessary to understand the concerns raised and any response to those concerns. Understanding if similar concerns have been raised in relation to the same organisation can help us weigh up the concerns and the wider context. For example the risks identified may be caused by systemic issues or as a result of group norms or culture and our guidance on context explains why it's important to understand this.

By following this approach we can be satisfied we have fairly assessed the concerns that have been raised.

Who it's important we hear from

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As set out in our guidance on engaging with your case and insight and strengthened practice where we're dealing with a referral which may require regulatory action by us it's really important that we hear from the professional involved. This is so we can understand the professional's perspective, including any wider context issues, to fairly assess if they pose a risk to people in the future.

We know that listening to the experience of people receiving care and their wider families can be essential to make sure we protect the public. It is important they are heard and their perspectives are understood, and also because their accounts can be crucial in understanding what happened and provide insights about the culture within a particular organisation. It's therefore important that where it's relevant to our investigation we make all reasonable efforts to contact people receiving care or their families.

People receiving care and their families are less likely to have access to all of the documentation that may be relevant and therefore it's really important we listen to what they have to say and consider if there's any documentation or information we're able to request which may help us assess the information we've received. For example, people receiving care and their families won't usually have access to staff rotas which may support their version of what happened. Equally, they may not have access to information which explains the care provided and why this was appropriate. We should clearly explain the conclusions we have reached as a result of assessing the various sources of evidence so those involved can understand our decision.

Organisations and professionals must comply with the duty of candour which includes being open and honest with people receiving care and their families and embracing a culture of learning from mistakes. Where organisations aren't listening to the experience of people receiving care and their families, they are missing the opportunity to learn from this. This may be something we need to investigate further or refer to other organisations, such as systems regulators including the Care Quality Commission, Care Inspectorate Scotland, Care Inspectorate Wales and Regulation and Quality Improvement Authority in Northern Ireland or another regulator. If we find the experiences of people receiving care and their families are being dismissed or ignored, this may reflect a poor culture within an organisation.

Most organisations and employers make sure concerns are appropriately dealt with and assist our investigations. There may be occasions where an organisation seeks to assure us that there isn't a serious issue for us to consider. These assurances may not always be reliable. This could be for a number of reasons; for example, they have investigated but, as they have a different remit to us, this doesn't cover everything we would need to consider. Whilst less frequently the case, there are occasions where organisations are aware of concerns and want to avoid outside scrutiny. This means we cannot always be satisfied there is nothing for us to investigate solely on the assurance of an organisation. Where another organisation or body has carried out an investigation, our guidance on Findings of other organisations and bodies explains how we should approach the evidence and any findings of the other investigation. However, where we have made enquiries and are satisfied that there isn't a fitness to practise issue we need to investigate, we cannot make further enquiries in order to respond to complaints or wider concerns raised by parties that don't relate to any individual's fitness to practise as that isn't our role. Where appropriate, we may refer concerns to other organisations, such as the systems regulator for the relevant country[1] or another regulator.

Our legal framework

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When we're considering a referral relating to a professional's fitness to practise we have specific legal powers to carry out appropriate enquiries and investigations. These include the power to require information from someone other than the professional concerned where that information appears relevant for the purpose of our fitness to practise proceedings. Where a person fails to supply that information they are committing a criminal offence[2]. We cannot require disclosure of information which is prohibited by other legislation including the General Data Protection Regulation.

We're obliged to exercise these powers fairly and proportionately. We must therefore restrict our enquiries to what is appropriate and relevant to the assessment of whether the professional's fitness to practise is impaired.

Screening concerns

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Closing straightforward referrals

Some concerns raised with us will be straightforward. It will be clear that they do not require regulatory action to protect the public and further enquiries will be neither necessary nor proportionate. Where this is the case, it is in everyone's best interests that we close these referrals as soon as possible. For example, where concerns are raised which are not sufficiently serious to suggest a concern about a professional's fitness to practise, we should not make further enquiries. A culture of curiosity does not mean looking to see if there is any evidence of other alleged wrongdoing by a professional regardless of what has been raised in the referral. This would be unfair, unreasonable and disproportionate.

We must be clear we understand the concerns before deciding not to investigate

However, when we're considering referrals which may concern us, we want to be satisfied we have an accurate and complete understanding of the concerns raised before we make a decision that we do not need to investigate further. This includes making sure we have a full understanding of the perspectives of the person raising the concern with us. Where we're considering closing a referral we will consider if we've been sufficiently curious and whether there are any further enquiries we should make. This may include seeking clinical advice where this might assist the decision maker to understand the nature of the concerns raised.

Example 1

The daughter of a resident in a care home refers a concern to us about the care their mother received from a number of professionals at the Home. They say they are concerned that the Home is not being open with them about what happened when their mother's health seriously deteriorated, requiring an ambulance to be called and her being admitted for a lengthy stay in hospital. They explain they are a former nurse and that they have looked at their mother's care records and noted these include observations and checks which were not carried out. They explain that they kept their own records of any checks which were carried out on their mother when they were visiting.

We make enquiries with the relevant Home and they provide the care records for the referrer's mother and tell us they have no concerns about any of the professionals involved.

The referrer tells us that she is aware that another family were concerned about the care provided and accuracy of the care records kept and have recently referred their concerns to us. We locate the other referral and raise both concerns with the Home and ask for the care records for the residents for both referrals to be provided along with any material relating to the complaints that were raised. We also ask for staff rotas which reveal that the people making entries into the Home's care records do not match the staff rotas and there are occasions where there are not sufficient staff. We request the records the referrer said they kept about their mother's care and see that their records match the staff rota, but not the records kept by staff at the Home.

We make further enquiries with the Home to identify the staff who have recorded observations when they were not on shift and those who were responsible for investigating the complaints and managing the Home.

Were we to assume that the assurances the Home have given and the documentation the Home provided are more likely to be accurate than the concerns the family of the person receiving care have raised without making any further enquiries, we risk failing to identify a pattern of similar referrals in relation to the Home and wider concerns about the way it is operating. As we investigate the case, we may decide that there are other professionals who need to be investigated. We may also need to refer concerns about safe staffing or the way the Home is operating to the systems regulator.

Example 2

An employer refers a professional to us in relation to a concern where a person receiving care unexpectedly died after a routine operation. The employer explains they have made the referral because the professional made some significant errors in the administration of medication to the patient but that they did not have wider concerns about the professional's practice and the death could not have been anticipated or prevented. They explain that the family raised a number of concerns throughout the time the person was in their care.

We're aware that the person receiving care had family who were involved in their care and had visited them at the hospital and that they had raised concerns with the employer about whether sufficient monitoring and checks were carried out after the operation given their medical history. We should ask for contact details for the family and arrange to speak with them to make sure we fully understand their account of what happened and what they

think may have gone wrong before making a decision on whether further investigation is necessary.

We would also ask to see any organisational investigation or learning and would ask our clinical advisers to look at the patient's records to clarify if the treatment and care were appropriate and if there was any cause for concern. We may also ask our clinical adviser for their view on any investigation carried out by the Trust.

Example 3

A professional makes a referral about their line manager who has management responsibilities for a team of professionals who work on the same ward in a hospital. The allegations are that they bully and discriminate against members of staff, show favouritism to white members of staff and target staff who are black, Asian or from other ethnic minorities as they make excessive demands of them and scrutinise their performance more closely.

The Trust tell us they have investigated the concerns and decided the allegations of racism were not proved and that the professional has shown insight into the areas of concern raised. We ask to see the report, its terms of reference and consider the evidence within the report ourselves. When considering the report we see that the Trust acknowledges that they did not interview any staff who are black, Asian or from other ethnic minorities. We also see that the report identified that the professional made comments that could be considered offensive on the grounds of culture or ethnicity and that the professional fostered a culture where some staff felt excluded, particularly those from black, Asian and minority backgrounds. We also see that the reflective statement the professional provided does not reflect on the allegations of discrimination, and only covers the stress and challenges they had faced as a manager.

We decide to open an investigation based on the content of the report. Had we not looked more closely at what the Trust identified we may have decided there were no concerns for us to investigate.

Example 4

We receive a referral from a professional we're currently investigating. We're investigating concerns about the professional's clinical practice as a result of a referral from their employer. The professional has referred a senior colleague who works for their employer as they say they have been bullied, harassed and discriminated against by them on the basis of their skin colour. They do not provide any further details.

We take allegations of discrimination, bullying and harassment very seriously. However, we don't have any detail on what happened and therefore we will need to make further enquiries before deciding if an investigation is necessary. We'll want to get the referrer's account of the incidents they have raised to understand who was involved, or may have witnessed the incidents, where and when they took place, what happened and why. We'll also want to speak to the employer to see if they were aware of these concerns, whether they have investigated these and if they are able to supply any information which may assist us in assessing these.

We speak to the employer who says that no concerns have ever been raised about the senior colleague by the referrer or anyone else and they have spoken to the senior colleague and looked at records and can find no evidence to support the concerns raised. They believe this referral has been made in retaliation to the referral they made about the professional. In these circumstances it will be really important what further information the referrer provides us. If we speak to them and they say they can't provide any detail on particular incidents but they feel they were discriminated against and that is why the referral was made, and there isn't evidence to suggest the referral was discriminatory in itself, for example as another colleague who was white was also referred for the same behaviour, we're unlikely to investigate further. However, if we speak to them and they provide us with information about specific incidents, we'll consider if there are concerns we need to investigate or if there are any enquiries we can make which may assist us in making that decision.

Example 5

We receive a referral from a family about a professional who was involved in the care of their mother on a general ward in hospital just before their condition deteriorated and they ended up being transferred to the intensive care unit. The family allege that the professional failed to carry out appropriate checks and sufficient monitoring of their mother which meant that the deterioration in her condition was only noticed once it had reached a critical stage. We speak to the family and they explain their concerns that their mother would not have ended up in the intensive care unit had more frequent monitoring been carried out.

We request the medical records from the Trust which includes the printouts from the machines used to carry out the monitoring checks on the referrer's mother. These checks were carried out an hourly intervals. We ask our clinical advisors to review these records and they confirm that the regularity of the checks was in accordance with National Institute of Clinical Excellence ('NICE') guidance based on the person's medical history and age.

We close the referral as there is no evidence to support the concerns that have been raised about the

professional. We explain to the family that the monitoring checks carried out on their mother were automatically recorded on the system and that the frequency of the checks was in accordance with the guidance that was in place and therefore there is no evidence to support the concerns they have raised about the standard of care the professional provided.

Deciding to close a referral where we can't get further information

We should close the referral where the following set of circumstances apply:

- it isn't clear what the concerns are, and therefore if there could be a fitness to practise concern, and
- we have made numerous attempts to contact the person who raised them by various means without success, and
- there are no other potential sources of information.

Concerns investigated by employers

Where a concern has been appropriately managed by an employer or where the employer is still dealing with the concerns, it's unlikely we will need to open our own investigation unless we need to take immediate action to protect the public. There will be some concerns which can only be appropriately managed by our wider regulatory powers.

Where an allegation is serious enough to suggest there may be a risk to the public but the employer has investigated, we will need to consider the concerns and the employer's investigation and may need to ask further questions before we can decide if a concern has been appropriately managed; this may be where they have upheld all of the concerns and have taken action, or where some or all of the concerns have not been upheld.

Where the employer is still dealing with the concerns, we'll carefully consider the ongoing risk and whether it is necessary to apply for interim restrictions on the professional's practice.

Extent of enquiries and managing risk

We must take care to get the balance right. We can make appropriate, reasonable, proportionate enquiries based on concerns raised with us and any information in our possession. We should not go beyond that. We will consider what is appropriate, reasonable and proportionate based on the nature and seriousness of the concerns raised; the more serious the concerns are, the more likely it is that more extensive enquiries will be appropriate, reasonable and proportionate. We will also keep in mind that fitness to practise is about managing the risk a professional poses to people, not punishing them for past events.

Steps we might take when we decide to close a referral

Where we decide not to investigate, we may still need to take steps to alert others of the situation. We'll consider[3] if there is a need to refer to others, for example:

- another regulator where other health care professionals are involved,
- a systems regulator where we feel there a wider organisational issue,
- the police,
- safeguarding services such as local authority social services teams.

Investigating concerns

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Getting a holistic perspective

Where we decide to investigate a concern, we'll need to make appropriate enquiries so we're in the best position to understand what happened and why. We want to have a holistic picture. This will mean looking at available sources of evidence, asking questions, following up on answers and reflecting on the information we've received. Having "a culture of curiosity" means that when we consider the concerns raised with us, we:

- weigh up what the information is telling us,
- assess whether there are further enquiries we need to make,
- consider who may be able to assist us in providing information about what happened,

- make reasonable attempts to contact them to ask about the concerns raised,
- listen carefully and ask appropriate questions, which may include asking sensitive questions or challenging some of the answers provided when this is necessary and proportionate,
- Consider the information and any views or perspectives about what we've obtained and what they tell us about what happened and what we need to do to keep people safe,
- are open, alert to and follow up on information suggesting other concerns or risks that we haven't previously identified,
- use our context commitments to help us identify what other enquiries or actions we might need to take.

The examples set out in the screening section may also be helpful once we've decided to investigate a referral.

People we may need to speak to

When concerns are raised about a professional, we may need to speak to a number of people. This is particularly important in cases where there is a dispute of fact between the parties; for example, where someone else involved in the case provides a different version of events to that provided by the professional. Where we have contradictory information from different sources, we do not make assumptions about the likely accuracy of what we've been told based *solely* on who has provided the information. We seek to assess what the information tells us by appropriately considering all sources of information. The people we may need to speak to could include:

- their employer,
- any person who was receiving care who may be involved,
- any family members of the person receiving care,
- colleagues who were working alongside the professional at the time,
- any person who may have witnessed or have knowledge of the matter(s) that have been alleged
- other organisations who may have investigated the concerns raised, such as the police or social services.

We will also consider if it will be appropriate for us to get clinical advice from one of our internal clinical advisers so we're satisfied we understand the concerns raised and any response to those concerns. They may also be able to suggest additional enquiries that we need to make.

Support for people

We recognise that people may need support so they are able to provide the information we need. We will consider if we need to offer support and may ask people what support they need or how we can best support them.

If we have made enquiries with a member of the public or referrer and have not received an appropriate response, we'll want to consider if we need to try another approach; for example, we may want to try to speak to the person concerned rather than send them an email, we may want to ask if there is support they might need in order to engage with us.

We may also consider if we might be able to find the information we need from another source.

Extent of enquiries

We will assess what enquiries are appropriate, reasonable and proportionate. This will vary depending on the circumstances but appropriate considerations include:

- the seriousness of the allegations,
- the likely relevance of the evidence the witness can provide,
- the likely weight of the evidence and whether there are other sources of evidence,
- if there are other more serious allegations where we have obtained sufficient evidence.

1 In England the Care Quality Commission, In Scotland, Care Inspectorate (Scotland). In Wales, Care Inspectorate Wales. In Northern Ireland, Regulation and Quality Improvement Authority (NI).

2 Rule 2A (4) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 and Article 25 and 26 of the nursing and Midwifery Order 2001 sets out the power to require information and Article 44(4) of the Order makes the failure to provide information, without reasonable excuse, a criminal offence.

3 Screening colleagues should consider referring to our safeguarding team, Regulatory Intelligence Unit or a

Regulation adviser in our Employer Link Service.