Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

Volume 2: Analysis of evidence and lessons learned (part 2)
Chapter 12
Professional regulation

Key themes

- The General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) have been largely reactive to individual complaints against identifiable individuals which may suggest unfitness to practise on the part of unidentified doctors and nurses.

- Stafford demonstrated a lack of referrals by professionals to their regulators when they have concerns.

- The Trust failed to have a proper policy for referring clinicians to professional regulators.

- Regulators should themselves refer or flag cases of concern with professional regulators, either by complying more properly with their current memoranda of understanding or by clarifying the terms of these.

- The NMC and the GMC need to develop a close working relationship with the Care Quality Commission (CQC).

- Patients are often not aware of the existence and procedure for complaining to the NMC and the GMC.

- The NMC has failed properly to define its role or that of its representatives in the NHS.

- Doctors have been reluctant to accept standard processes and to engage with team and management roles.

Introduction

12.1 This chapter considers the involvement of the professional regulators with jurisdiction over the registration of healthcare professionals in the affairs of the Trust. Insofar as the same organisations have training responsibilities, these are addressed in Chapter 18: Medical training.

12.2 In truth, little came to the attention of the professional regulators to indicate that there was more fitness to practise issues at Stafford than elsewhere. Given what is now known about the standard of service being delivered there, this may seem surprising, but the regulatory operational model of the regulators depends on complaints – and if there are no complaints no investigation is likely to follow.
General Medical Council

Statutory framework

12.3 The GMC is a statutory body that was established in 1858. Its main statutory objective is “to protect, promote and maintain the health and safety of the public.”

12.4 It does this by ensuring proper standards in the practice of medicine. The GMC’s role is to protect patients. Whilst it is funded through registration fees paid by registrants, its role is not to represent doctors.

12.5 Under the statutory provisions of the Medical Act 1983 the GMC has four main functions:

- Fostering good medical practice which reflects what the general public and the profession expect of doctors;
- Promoting high standards of medical education and training for medical schools and postgraduate training and for doctors’ continuing professional development;
- Keeping up-to-date registers of qualified doctors;
- Dealing firmly and fairly with doctors whose fitness to practise is in doubt.

12.6 Doctors are provisionally registered with the GMC upon completion of their undergraduate medical school training and fully registered after successfully completing the first year of the foundation programme.

12.7 The GMC has statutory functions relating to the education and training of doctors, which are considered elsewhere.

Good medical practice

12.8 The GMC exercises its function of maintaining standards through guidance on professional conduct, performance and medical ethics. This is published in the form of *Good Medical Practice*, which is reviewed periodically. The relevant editions for the period under review by the Inquiry are 2001 and 2006. The GMC also publishes ethical guidance on specific topics such as consent, confidentiality, and end of life care.

12.9 The totality of this guidance forms the basis on which the GMC regulates the registration of doctors and it is made clear that a serious or persistent failure to follow it will put the responsible practitioner’s registration at risk. As with all guidance, it is recognised that

---

1. GMC0001000004 Medical Act 1983 (as amended), section 1A
3. Dickson/GMC WS (Provisional) – GMC00000000013, para 45
4. ND/50 WS00000049971–996; ND/50 WS0000004997–50047
5. Dickson/GMC WS (Provisional) – GMC00000000013, para 48
practitioners must exercise their judgement in relation to the circumstances confronting them, but doctors are expected to be able to justify the decisions they make.

12.10 The appalling stories of care uncovered by the Healthcare Commission (HCC) investigation and the first inquiry are highly unlikely to have happened without multiple lapses from the standards set out in the GMC’s guidance.

12.11 The principal duties of a doctor as laid down by Good Medical Practice are:6

- Make the care of your patient your first concern;
- Protect and promote the health of patients and the public;
- Provide a good standard of practice and care:
  - Keep your professional knowledge and skills up to date;
  - Recognise and work within the limits of your competence;
  - Work with colleagues in the ways that best serve patients’ interests;
- Treat patients as individuals and respect their dignity:
  - Treat patients politely and considerately;
  - Respect patients’ right to confidentiality;
- Work in partnership with patients:
  - Listen to patients and respond to their concerns and preferences;
  - Give patients the information they want or need in a way they can understand;
  - Respect patients’ right to reach decisions with you about their treatment and care;
  - Support patients in caring for themselves to improve and maintain their health;
- Be honest and open and act with integrity:
  - Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk;
  - Never discriminate unfairly against patients or colleagues;
  - Never abuse your patients’ trust in you or the public’s trust in the profession.

Obligation to report concerns about patient safety

12.12 It is made clear that it is the duty of every doctor to be open about mistakes they have made leading to harm to patients and to report concerns about colleagues or otherwise relating to patient safety.

---

6 www.gmc-uk.org/guidance/good_medical_practice/duties_of_a_doctor.asp
12.13 This duty is not confined to concerns about colleagues but extends to unsafe systems, equipment and so on:

If you have good reason to think that patient safety is or may be seriously compromised by inadequate premises, equipment, or other resources, policies or systems, you should put the matter right if that is possible. In all other cases you should draw the matter to the attention of your employing or contracting body. If they do not take adequate action, you should take independent advice on how to take the matter further. You must record your concerns and the steps you have taken to try to resolve them.7

12.14 When something has gone wrong with the treatment of a patient, the doctor’s duty of honesty and integrity requires being open with the patient and others:

If a patient under your care has suffered harm or distress, you must act immediately to put matters right, if that is possible. You should offer an apology and explain fully and promptly to the patient what has happened, and the likely short-term and long-term effects.

Patients who complain about the care or treatment they have received have a right to expect a prompt, open, constructive and honest response including an explanation and, if appropriate, an apology. You must not allow a patient’s complaint to affect adversely the care or treatment you provide or arrange.8

12.15 Mr Niall Dickson, Chief Executive and Registrar at the GMC from January 2010, accepted that the GMC should consider whether this guidance should apply equally to near misses:

I think that’s a very good point. We are currently reviewing Good Medical Practice. In my view, doctors should be open and honest with patients, full stop, and that doesn’t necessarily require the condition that harm has been done.9

12.16 When there are concerns about colleagues, these must be reported:

You must protect patients from risk of harm posed by another colleague’s conduct, performance or health. The safety of patients must come first at all times. If you have concerns that a colleague may not be fit to practise, you must take appropriate steps without delay, so that the concerns are investigated and patients protected where necessary. This means you must give an honest explanation of your concerns to an

---

7 ND/SO WS0000050007 Good Medical Practice (2006), para 6
8 ND/SO WS0000050016 Good Medical Practice (2006), paras 30, 31
9 Dickson T105.121; a consultation on the review of Good Medical Practice closed in February 2012 – www.gmc-uk.org/guidance/10051.asp
appropriate person from your employing or contracting body, and follow their procedures.  

12.17 In the absence of “appropriate local systems”, or where local systems appear not to have resolved the problem, the doctor should report the matter to a regulator.  

12.18 The doctor is also obliged to cooperate fully with any formal inquiry into the treatment of a patient and any inquest or other formal inquiry into a patient’s death.  

12.19 Mr Dickson explained why the GMC considers that the duty of doctors is to report concerns to their employer first, rather than to a regulator:

*I think it is our view that if you see something wrong in the first instance, then you should bring it to the attention locally as a first step, rather than immediately contact the GMC. But I don’t want to suggest that we’re in any way reluctant to accept people coming to us or seeking advice or making contact with us, as many thousands do. But in the first instance, when somebody sees a patient safety concern, apart from the fact the speed with which it would be dealt with, the best place to raise it is locally.*  

12.20 Dr Peter Daggett, a General Physician at the Trust during the relevant period, suggested to the Inquiry that reporting concerns about an individual was an exceptional event, not just at Stafford but throughout the country. Mr Dickson accepted this was the case to some extent, but commented that it is less exceptional than it used to be.  

12.21 Mr Dickson accepted that it was necessary for the GMC, among other organisations, to change the professional culture to promote such reporting:

*The events at the Trust suggest that the culture of the organisation was severely compromised and, judging by some of the comments made to the inquiry, this had a negative impact on the way that individuals within that organisation behaved. It is very difficult to measure the impact of cultural change and we are one of a number of organisations who should be helping to drive this change.*  

*It is quite clear, and it is the thing that concerns me, that at Mid Staffs there must have been significant numbers of doctors who metaphorically walked on the other side of the ward. They were not following our advice.*  

---  

10 ND/50 WS0000050021 Good Medical Practice (2006), para 43  
11 ND/50 WS0000050021 Good Medical Practice (2006), para 44  
12 ND/50 WS0000050027 Good Medical Practice (2006), para 68, 69  
13 Dickson T105.111  
14 Daggett T46.146  
15 Dickson T105.114-116  
16 Dickson WS0000048839, para 132
Now, of course, as somebody remarked since the Ten Commandments, people have not always followed guidance and rules. But I think there is a duty on us, as the regulator, to redouble our efforts to try and embed this in the profession, and I know Ian Kennedy remarked, in his evidence to you, that he thought that Good Medical Practice had not been the cultural catalyst that was hoped. I would disagree with that.

I think, and it’s impossible to identify its role, but what’s happened over the last 15 years in medicine I think has been quite significant. I think doctors are much more open than they were, they’re less paternalistic than they were and they’re much more likely to report each other and to recognise it, but I entirely accept there’s quite a long way to go.17

12.22 However, he did not think the GMC was necessarily the correct place to report a concern about a system as opposed to an individual:

Dr Daggett I think elsewhere in that statement, was making the point that the GMC wasn’t the right place to go because this was a whole system that was wrong, rather than an individual, and I think that’s a fair point he makes, that the difficulty of saying, “How do I go to the GMC? I’m not complaining about Dr X or Dr Y. I’m saying this whole place is not functioning properly”, and I can understand the difficulty with that, though I think there are places he can and should be able to go as a result of that.18

Maintaining and improving performance

12.23 The guidance requires doctors to work with their colleagues “to maintain and improve the quality of your work and promote patient safety”.

12.24 The actions that are required to bring this about include:

- Maintaining a record of information and evidence, drawn from the doctor’s medical practice;
- Reflecting regularly on his or her standards of medical practice;
- Participation in regular and systematic audit and systems of quality assurance and quality improvement;
- Constructive response to the outcome of audit, appraisals and performance reviews, and undertaking further training where necessary;
- Cooperation with confidential inquiries, and adverse event recognition and reporting, to help reduce risk to patients.19

---

17 Dickson T105.116-117
18 Dickson T105.114
19 ND/50 W50000050011 Good Medical Practice (2006), para 14
Doctors as managers

12.25 The GMC has separate guidance for doctors who are managers. This makes it clear that the principles of *Good Medical Practice* continue to apply to medically qualified managers, even where their post could be taken by a person who is not medically qualified or registered.\(^{20}\) It is recognised that the circumstances of medically qualified managers vary widely but the overall requirements are:

You should do your best to make sure that:

- Systems are in place to enable high quality medical services to be provided;
- Care is provided and supervised only by staff who have the appropriate skills (including communication skills), experience, training and qualifications;
- Significant risks to patients, staff and the health of the wider community are identified, assessed and addressed to minimise risk, and that they are reported in line with local and national procedures;
- The people you manage (both doctors and other professionals) are aware of and follow the guidance issued by relevant professional and regulatory bodies, and that they are able to fulfil their professional duties so that standards of practice and care are maintained and improved;
- Systems are in place to identify the educational and training needs of students and staff, including locums, so that the best use is made of the time and resources available for keeping knowledge and skills up to date;
- All decisions, working practices and the working environment are lawful, with particular regard to the law on employment, equal opportunities and health and safety;
- Information and policies on clinical effectiveness and clinical governance are publicised and implemented effectively.\(^{21}\)

Fitness to practise procedure

Statutory framework

12.26 The GMC has a statutory duty to investigate information calling into question the fitness to practise of a registered medical practitioner. Fitness to practise may be found lacking due to concerns over the health, competence, capability or conduct of a practitioner. The exercise is forward looking; it must be determined whether, having regard to the facts proved, the practitioner is now fit to practise.

---


12.27 Where it is found that a practitioner lacks fitness to practise, a range of sanctions is available:

- Warning;
- Undertakings;
- Conditions imposed on registration;
- Suspension;
- Removal from the register.22

Procedure

12.28 On receipt of such information there is a “triage” process to determine whether it raises a question about a doctor’s fitness to practise. If it could never do so, the case is closed. If the information calls into question the doctor’s fitness, it is referred for a full investigation, called “stream 1”. If it does not in itself raise such a question but would do so as part of a wider pattern of behaviour, the GMC will make inquiries of the doctor’s employers to establish if they have wider concerns (a “stream 2” investigation).23

12.29 On completion of this stage of the investigation, the case is referred to two case examiners, one medical and one non-medical, who decide by reference to the regulations whether the allegation should be referred for adjudication. They so refer where it is decided that there is a reasonable prospect of establishing that the doctor’s fitness to practise is impaired to a degree justifying action on his or her registration. The options open to the case examiners are to conclude the case with no further action, issue a warning, agree undertakings with doctors to restrict their practise, or refer the case for adjudication to a Fitness to Practise Panel (now the Medical Services Tribunal).24

12.30 Interim powers are available to make an order suspending or imposing conditions on the doctor’s registration pending the outcome of the process.25 There can be a number of reasons why proceedings take a long time to come to a conclusion, but Mr Dickson told the Inquiry that the GMC will not hesitate to use these powers, where deemed necessary, to protect patient safety.26

12.31 The Medical Services Tribunal conducts a full and formal hearing akin to a trial, usually in public and conducted on an adversarial basis.27 It is unnecessary to consider here the full detail of the procedure, but if it is determined that the practitioner’s fitness to practise is impaired the range of sanctions mentioned above is available. The tribunal has to have regard to the sanctions guidance issued by the GMC.

22 Dickson WS0000048844, para 146
23 Dickson WS0000048842–43, para 143
24 Dickson WS0000048844, para 146
25 Dickson WS0000048845, para 151
26 Dickson WS0000048848, para 160
27 Dickson WS0000048845–47, paras 152–157
Identification of registered practitioners against whom to proceed

12.32 As indicated earlier, the GMC approach to regulating doctors is to act on a complaint or information received. Generally, it does not proactively seek out material that might lead to an investigation unless and until it receives information identifying a registered practitioner whose fitness to practise may be called into question.

12.33 Mr Dickson told the Inquiry that if information was received that did not identify one or more individuals, but revealed circumstances where a fitness to practise issue might have arisen, a formal investigation would not – indeed could not – be commenced.28 However, the GMC would approach the relevant medical director, postgraduate dean or the CQC to find out more:

So I think we’re not saying, “Oh, that’s nothing to do with us”. I think we have that wider responsibility in our work, but obviously the machine that is fitness to practise is dealing with an individual practitioner.29

12.34 Challenged on whether that meant that people potentially responsible for systemic failings might avoid fitness to practise proceedings unless someone else has identified them, Mr Dickson demurred:

There certainly could be circumstances where there was systemic failure within an organisation, and without a complainant coming forward, we were able to identify that a doctor was responsible for that system and had caused or was suspected of causing patient safety issues. We could indeed pursue that. So, yes, we could in that sense. But we would be pursuing an individual, it could be the result not of direct patient care that they were giving, but oversight that they had failed to provide, which allowed systemic failure to take place.30

12.35 However the GMC approach to this issue is clearly in a state of evolution as illustrated by another of Mr Dickson’s answers:

THE CHAIRMAN: Well, if I can put it in a sort of criminal analogy, if you’re told about a murder, do you go out and try to find out who committed the murder or do you wait for someone else to do that part of the inquiry and present you with the name of the individual who is alleged to have committed it?

29 Dickson T105.82–84
30 Dickson T105.84–85
A. I think we’re moving towards the latter, and I think – and, again, I don’t want to try and imply that employment liaison advisers or the GMC is out to go and hound responsible officers and all the rest of it. But absolutely, if there is systemic failure within an organisation, and we identify – or somebody else identifies to us – individuals who have had responsibility for that, which calls into question their fitness to practise, then we will pursue that.31

12.36 Following the first inquiry, the GMC asked for consideration to be given to the Inquiry identifying to it the names of practitioners referred to in the report. This facility was declined due to the fact that the witnesses had given evidence on the basis of an undertaking of confidentiality. Mr Dickson was asked whether that was the limit of inquiry made into that sort of case. He explained that the GMC might take a number of steps, subject to resources. For example, they might follow up a media report by making inquiries into the names of doctors who might have been involved and their responsibilities.32 He accepted this might be done more now than in the past:

I hope it is. I mean, certainly it’s something that I would encourage in my current role. I don’t have enough experience to know whether the GMC – how often the GMC has done it. In the recent past I would think it’s become more common. If you went back longer, it definitely is different because the GMC was really not concerned about performance issues, even clinical performance issues, in the way that it is now. It used to be concerned mainly with conduct issues.33

12.37 There is no internal system for triggering a proactive investigation, but there was, Mr Dickson said, an increasing resource enabling information that might trigger an investigation. He cited the employment liaison advisers and regional advisers being put in place to engage with all employers, allowing the GMC the opportunity of “getting up close and personal”. He thought that would enable the GMC to do more proactive investigation.34

12.38 The GMC has also invested in its information systems and collects more information from individual doctors. It is therefore in a better position to identify trends that may cause concern.35

Fitness to practise cases from the Trust

12.39 The GMC has received information or complaints about 32 doctors working at the Trust during the period under review by the Inquiry. These were received from a wide variety of sources,
including patients, relatives, scrutiny of media coverage, the 2009 Royal College of Surgeons (RCS) review\textsuperscript{36} and the report of the first inquiry.\textsuperscript{37}

12.40 Of this total, 14 doctors had come to the attention of the GMC before the HCC report as a result of 17 complaints. Ten complaints were from patients, three from the Trust, three from colleagues and one from the Strategic Health Authority (SHA).

12.41 Of the 17 complaints, three were closed at the initial assessment stage, five were followed up with the Trust, who confirmed there were no further concerns, eight were investigated and one was the subject of continuing investigation.

12.42 Of the eight complaints investigated, in three cases the outcome was the issuing of advice, in two cases warnings were given, in one case conditions were imposed on the doctor’s registration and in two complaints, both in respect of the same doctor, an offer of voluntary erasure from the medical register was accepted.

12.43 Cases against 19 of the 32 doctors were continuing at the time of the GMC evidence, and four of these doctors were subject to interim restrictions on their registration.\textsuperscript{38}

12.44 Mr Dickson did not consider that a pattern of concern about the Trust could have been discerned from the cases that arose before the HCC report for a number of reasons:

- At the time the GMC did not look at its cases in a systematic way to try to identify trends;
- Its systems were not capable of conducting that sort of analysis, although this is something now being developed;
- More recently, the GMC has carried out a systematic analysis, but the Trust was not shown to be an outlier. One reason for this may be that the complaints involved a range of specialties, and the number of complaints at Trust level was always likely to be too small for conclusions to be drawn readily.\textsuperscript{39}

12.45 Following publication of the HCC report in March 2009, Ms Jackie Smith, the GMC’s Head of Investigation at the time, met Dr Heather Wood, the HCC investigator, because the report led the GMC to question whether there were underlying fitness to practise issues. Ms Smith also met Dr Manjit Obhrai, the Trust’s then Medical Director. On both occasions she was told that problems with the fitness to practise of individual doctors had not been identified.\textsuperscript{40} Looking at the range of concerns raised in that report, that has to be considered a surprising response.

\textsuperscript{36} JB/14 WSO0000043966
\textsuperscript{37} Dickson WSO0000048851–52, paras 169–171
\textsuperscript{38} Dickson WSO0000048852–55, paras 173–182
\textsuperscript{39} Dickson WSO0000048854, para 181; Dickson T105.145
\textsuperscript{40} Dickson WSO0000048856, para 188
12.46 Mr Dickson was concerned to hear that, according to Julie Hendry, Director of Quality and Patient Experience at the Trust, the Trust did not have a policy for referral of individuals to the GMC. He said such a policy was important to enable staff to raise and escalate concerns about colleagues, and for them to know that they were free to contact the GMC or the CQC if they felt their concerns were not being addressed adequately.

Interrelationship between the General Medical Council and employers’ disciplinary procedures

12.47 Mr Antony Sumara, the Trust’s Chief Executive from July 2009 to August 2012, expressed concern at the effect of GMC proceedings on the Trust’s ability to dismiss an unsatisfactory employee:

In my experience the regulatory framework for doctors and nurses is extremely protectionist ... [If] a doctor is causing harm to patients I would be unable to dismiss him without referring him to the GMC which again is a lengthy process.

12.48 Mr Dickson rejected this:

As far as we are aware, there is no reason why an employer cannot take disciplinary action against a doctor because that doctor is subject to a GMC investigation. The important point is that the employer observes employment law and the relevant NHS guidance and procedures. If there were a risk to patient safety caused by a doctor, we would expect that employer to take action immediately.

An employer’s disciplinary proceedings and our own fitness to practise investigations can be run in parallel. Although a doctor’s employment cannot be terminated solely because of an interim suspension, this does not prevent the Trust from taking disciplinary action based on its own investigation.

As a general observation, where performance management systems are not strong, organisations may not be able to take action against an employee because they have not made or kept adequate records and thus do not have enough evidence to act.

I think my message, I guess, to employers is, I am trying to speed up, we are trying to speed up our systems, but you should really take whatever action you believe is necessary under employment law to deal with the case as you see it and try and avoid the use of the GMC as being an excuse why it can’t be done.
12.49 He did not accept that the prospect of a doctor being suspended for a long time acted as a disincentive to employers from reporting doctors to the GMC:

If I were running a trust, I am responsible for an organisation of 3 or GBP 400 million, but my prime objective is to provide safe patient care, then I don’t think that should be a consideration. But I accept that that makes it more important than ever that we as an organisation deal with these matters as quickly as we can, but in a way that is consistent with being fair. And undergoing things like performance assessments, as you probably know, can be time-consuming and difficult.\footnote{Dickson T105.149}

Revalidation

12.50 On 19 October 2012 the GMC announced that it would be introducing a system of revalidation, which would provide for a five-yearly periodic review by the GMC, based on the process of an annual appraisal of each doctor’s fitness to practise, compliance with professional standards and current knowledge.\footnote{www.gmc-uk.org/news/14004.asp} Doctors will need to collect information about their practice, including feedback from patients, other doctors, nurses and other colleagues. The objective of the scheme is to drive up the standard of individual practice, quality of care and to provide assurance to service users and employers.\footnote{Dickson WS0000048860, para 204} The GMC expects most doctors to have received revalidation by March 2016.

12.51 The key components of the scheme will be:

- A network of Responsible Officers (ROs), usually a senior medical manager of the doctor’s employer, with whom each doctor will be connected. ROs will be licensed medical practitioners with statutory duties and subject to a quality assurance programme. The ROs will be responsible for ensuring that doctors are properly managed and supported in maintaining and raising their standards, and for ensuring the existence of fair and effective local systems to identify doctors who fall short of the expected standards. They will be required to report to the GMC on the fitness to practise of doctors causing concern, and to make recommendations for action. They themselves will be accountable to the GMC for their performance in this role;\footnote{Dickson WS0000048861–65, paras 207–223}

- A portfolio of evidence of compliance with standards, personal and professional development and so on, which each registered practitioner will be required to maintain.\footnote{Ready for Revalidation: The Good Medical Practice Framework for appraisal and revalidation, (March 2011) GMC, p 1}
12.52 Mr Dickson was optimistic that the revalidation system would make another Stafford experience less likely to happen:

The GMC sets out the values and principles which doctors must follow in their everyday practice. But the GMC is not an employer of doctors and is not in a position to monitor adherence to those principles on a day to day basis in practice across the UK. This requires a more effective local system of clinical governance within healthcare institutions. However, the GMC does have an important contribution to make. A more proactive GMC focused on encouraging good practice, coupled with robust local systems for identifying and acting upon poor practice, should contribute to improving the overall quality of patient care. At the same time it should help to ensure that poor practice can be identified and acted upon more swiftly and before problems become serious …

I would also add that revalidation is based on local systems of appraisal and clinical governance and can act as a driver for developing and strengthening those systems. It will be based on a continuing evaluation of a doctor’s fitness to practise rather than a point in time assessment. All appraisals will be based on the principles of Good Medical Practice and we believe embedding our standards into the appraisal will remind doctors of the core values and principles that underpin the practice of medicine in the UK. The appraisal should also provide an opportunity for them to reflect on what that might mean for them in their day to day practice.\(^50\)

12.53 ROs are already in place and, according to Mr Dickson, are in a much stronger position to drive positive change in employers’ systems of clinical governance because of their newly acquired responsibility:

My impression, and it is only an impression, since the responsible officers arrived in January this year, that already people are starting to, the clue is in the title of the name, that people are starting to take this seriously and they take their relationship as doctors with the GMC pretty seriously.

So I’m not suggesting this is a perfect system which can stop this happening. I think it will be a more focused system, because it is about the management of doctors, that we’re concerned about, and I think the requirements under revalidation, doctors themselves because they will be saying, “We’re not getting the support we need. I haven’t got clinical audit and if I don’t have the clinical audit, I won’t be able to get through my appraisal. So please supply this information, hospital, otherwise we’re going to be in trouble.”

---

\(^{50}\) Dickson WS0000048870-71, paras 246-247
So I think there are a number of pressures within the system which should make it more effective. My hope is that we can make it more effective over time. In other words, it’s an instrument which we will all get better at using over time, but it is something we will be actively using in a way that APS [Approved Practice Settings], frankly, is not a system that we’re actively using in that way.51

General Medical Council relationships with other organisations

Healthcare Commission and Care Quality Commission

12.54 There is a Memorandum of Understanding between the GMC and a number of other organisations, including the HCC, now the CQC. At the relevant time, it provided that:

The Healthcare Commission and the GMC will share information about trends, concerns, data, approaches and initiatives, which are relevant to the shared aim of helping healthcare providers and registered medical practitioners to provide high quality patient care.52

12.55 Mr Dickson, who had not been in office at the GMC at the relevant time, had initially been under the impression that the GMC had not been aware of the investigation until very shortly before the publication of the report.53 It was later accepted that this was not strictly accurate. The GMC was made aware of the terms of reference on 9 July 2008.54 There were also conversation about two specific doctors in July and August.

12.56 The GMC received no information about the investigation from the Trust or the Postgraduate Dean (whose involvement is considered in Chapter 18: Medical training).55

12.57 Asked why he thought this information had not been shared, Mr Dickson suggested:

This is not to excuse either party in this, I do think that systems regulators have tended to see professional regulators only ... at the edge of what ... their main focus is. And I don’t think that’s just the GMC. And what ... I’m attempting to do, certainly in our relationship with the CQC, is say I don’t expect the CQC to be thinking about the GMC morning, noon and night, but I do think they’ve got to see us as a more integral part of the whole quality matrix. That we’re not something that’s strange and is done with doctors, we’re a patient safety organisation ... and our concerns are about patient safety, and that means we have to work together, and that means that if you’re the system regulator – I’m sure there are other things we could do better as well, [as the] systems regulator you have to

51 Dickson T105.31–32
52 ND/64 W500000050300, para 19
53 Dickson T105.76
54 Wood WS(4) W500000074566, para 18
55 Dickson T105.76
think GMC. You have to think patient safety in relation to all our functions, both our educational ones and our fitness to practise ones as well.\textsuperscript{56}

12.58 It is now clear that there was a level at which information was being shared by the HCC about its investigation, but there was a degree of confusion between, and within, the various organisations concerned about its significance and what required to be escalated to higher levels.

12.59 What this answer demonstrates is the apparent difficulty experienced by organisations, who, in principle, are willing to cooperate with each other in determining what is of relevance to one another. In the particular case of the GMC and the CQC, matters may have been improved by the more specific terms of the Memorandum of Understanding signed between them on 11 May 2010.\textsuperscript{57} This provides for referral to the GMC of:

- Any concerns and relevant information about a doctor which may call into question his or her fitness to practise;
- Any concerns and relevant information about a healthcare organisation which may call into question its suitability as a GMC Approved Practice Setting (APS);
- Any concerns and relevant information about a healthcare organisation which may call into question its suitability as a learning environment for medical students or doctors in training;
- Any concerns and relevant information about a healthcare organisation which may call into question the robustness of its systems of appraisal and clinical governance.\textsuperscript{58}

12.60 In return, the GMC will refer to the CQC any concerns and relevant information about a health or adult social care organisation in which doctors practise or are trained, which may call into question its registration with the CQC.\textsuperscript{59}

12.61 Asked why it had taken so long to establish this working relationship with the CQC, Mr Dickson pointed to the negative effects of constant reorganisation:

\begin{quote}
I do not believe the relationship between system and professional regulators has been helped by the constant reorganisations to which the former have been subjected.\textsuperscript{60}
\end{quote}

\begin{footnotes}
\item 56 Dickson T105.80–81
\item 57 CQC000500000041 Memorandum of Understanding between the Care Quality Commission and the General Medical Council (11 May 2010)
\item 58 CQC000500000043 Memorandum of Understanding between the Care Quality Commission and the General Medical Council (11 May 2010), para 12
\item 59 CQC000500000043 Memorandum of Understanding between the Care Quality Commission and the General Medical Council (11 May 2010), para 13
\item 60 Dickson WS0000048875, para 265
\end{footnotes}
I think the problem in this area has been that system regulators have come and gone. I think we have had three or, you could argue, four in the last ten years. I do think that these relationships depend on having, first of all, good relationships at the top of the organisation and clear goals about how you share information and rather than just rather waffly memorandums of understanding, and that’s what we’re seeking to get with CQC. The short answer to the question is I don’t know whether it’s better or worse than under the Healthcare Commission. I think we now have in place a good contact system. I think we will get significantly better when we get regional people on the ground, and we’re going to have not only these employment liaison advisers who would certainly be contacting about fitness to practise issues, but we’re also having regional people ourselves who will link in with the CQC regional people, and I would expect transfers of information to be better than they have been in the past because of that.61

**Nursing and Midwifery Council**

12.62 The GMC has a Memorandum of Understanding with the NMC that also provides for a sharing of information. Pursuant to this, the GMC did refer a number of nurses to the NMC following a hearing in 2010. In the case of the Trust, the GMC met with the NMC and this led to a series of meetings with patient groups, and cases being opened against four doctors.62

**Royal Colleges**

12.63 The GMC has a necessary relationship with the medical Royal Colleges in relation to its education training responsibilities, which is considered in Chapter 18: Medical training.

12.64 The 2007 the Royal College of Surgeons (RCS) peer review team report63 has been described in Chapter 2: The Trust.64 The report found cause for concern at the lack of cooperation between certain surgeons, lack of leadership and a generally dysfunctional department. This was not shared with the GMC.65

12.65 A further review was conducted in 200966 and raised significant concerns with the cases of four of the surgeons. These included:

- Poor judgement and decision-making;
- Lack of current knowledge and suboptimal post-operative care;

---

61 Dickson T105.68
62 Dickson WS0000048876, para 269
63 JB/9 WS0000043904
64 JB/6 WS0000043864
65 Dickson T105.141
66 JB/15 WS0000043990
Decisions taken by the colorectal multidisciplinary team had been overturned by individual surgeons and non-specialist surgeons operating on colorectal patients in an emergency situation, who had then failed to liaise with or hand the patients back to the colorectal team, as would be the accepted best practice;

There was reference within the report to the Trust providing care that was “grossly negligent”.

12.66 The surgical division was described as “dangerous” and 43 recommendations were made to the Trust. The review stated that the alternative to immediate urgent action was the closure of the department. Some of the issues identified had persisted since the earlier review. Mr Black, then President of the RCS, accepted that evidence of dysfunction in a department represented a significant risk to patients. He described the 2009 report as being one of the most outspoken reports ever produced by the College.

12.67 In spite of these findings, Mr Black gave evidence that, in line with usual practice, the College did not report it to the GMC. His explanation was as follows:

_The Case Review Report refers to so many badly managed cases that it would be difficult to single out any particular surgeon. It was for the Trust to take a view based on the findings of the review and refer individuals to the GMC if it so wished._

12.68 With the benefit of hindsight Mr Black accepted that a referral to the GMC ought to have been recommended.

12.69 In each case the report findings could have been read as raising concerns about the fitness to practise of identifiable individuals. However, Mr Dickson pointed to the Trust as having had the responsibility to disclose these reports, rather than the RCS. He was in no doubt as to what effect such disclosure would have had:

_ Q. Can we take it that you accept on behalf of the GMC that you did not spot this as a failing organisation?
_

_A. No, we did not.
_

_ Q. You’ve now read, I suspect, the Royal College of Surgeons’ reports …
_

_A. I have._

---

67 Black T106.175
68 Black T106.193
69 Black W500000043785, para 67
70 Black W500000043785, para 67
71 Black W500000043786, para 68
Q ... both for 2007 and then the rather more powerful report in 2009. Having read those, do you think that the GMC processes were in fact engaged when they should have been?

A. No, I think they should have been engaged earlier and I think we should have been told about the Royal College of Surgeons’ report before we were.

Q. By whom?

A. I think the prime responsibility is the Trust, as the client who is receiving the report ... I would have hoped that within the report itself, and maybe this is a criticism of us as much of the College, but I would have hoped that they would have reflected on the regulatory implications of the words which they were putting down, such as “dangerous” and “the most dysfunctional team”. I think, from memory, those were expressions that were used. Those should have rung alarm bells at the Trust and at the College, or those who were compiling the report about the need to alert the GMC to what was happening here.

And I would hope, again, thinking [about] this in the positive way, I think we now have a closer relationship with the Trust and I think that we will have closer relationships with trusts as a whole. So I would expect if similar reports emerged in future, that they would alert us immediately.72

12.70 These reports contained information unequivocally suggesting that doctors were in breach of the requirements of Good Medical Practice and that patient safety was at risk. They also exposed issues of clinical governance suggestive that the guidance of the GMC to managers was not being observed. In these circumstances, any doctor coming into possession of this report was likely to be under a duty to report the matter if the concerns raised were not being resolved. By 2009 it was clear that the concerns identified in 2007 had persisted. Indeed, the situation had deteriorated. While there was much else for the Trust to do in response to these reports, disclosure to the GMC was certainly one step that should have been taken.

12.71 Mr Black was clearly right to concede that the report should have recommended referral to the GMC. Given the obligations of Good Medical Practice, it might be thought that the College should itself have shared the report with the GMC.

12.72 Mr Black welcomed the impending “duty of cooperation” regulations, which would foster more openness and, in his opinion, strengthen the College’s influence on the standards of practice. He considered that an imposition of a duty to share reports was desirable.73

72 Dickson T105.141
73 Black T106.207-208
Conclusions with regard to the General Medical Council

12.73 *Good Medical Practice* is a sound basis from which to judge the fitness to practise of doctors. It gives highest priority to the safety of patients and the maintenance of public confidence in the profession, and sets out clearly, albeit at a relatively high level, the standards to be observed. It contains sufficient flexibility to cater for individual circumstances, and preserves the independence of clinical judgement.

12.74 This is not the place to reflect generally on the procedures of the GMC in fitness to practise cases, but one particular concern that has arisen from the Stafford experience has been the absence of any systematic, proactive investigation triggered by information not identifying individual doctors. While Mr Dickson did his best to persuade the Inquiry that such concerns were looked at, there is clearly an element of chance about this in the absence of a clear policy. Historically, the GMC has only investigated specific complaints about identified individuals, and its statutory framework is drafted from that premise, although it does not prevent a more proactive approach to monitoring fitness to practise or to investigating concerns even where individual doctors have not as yet been identified. It is, however, important to remember that the GMC is the regulator of individual registered practitioners and not the system as a whole. Therefore, it is able, if it sees fit to do so, to investigate systemic failures and then take proceedings against individuals it identifies as being professionally responsible.

12.75 Without a clear policy, neither the public nor trusts will be aware of the circumstances in which a generic complaint or report, not in itself identifying individual registered practitioners, can be made to the GMC.

12.76 If the GMC is to be effective in looking into generic complaints and information, it will probably need either greater resources or better cooperation with the CQC and other organisations such as the Royal Colleges to ensure that it is provided with the appropriate information. Even if that is achieved, the GMC needs to be alert to information about system failures of the sort that may indicate fitness to practise concerns, relating not only to front-line clinicians but also clinically qualified managers and leaders. For that purpose the GMC must ensure that the information it does receive or obtain is analysed by persons qualified to discern these possibilities. The GMC is emphatically not a systems regulator, but it cannot ignore the implications for individual registered practitioners. The GMC has told the Inquiry that it is developing a more proactive role through measures such as monitoring news media and other sources of information, and then taking action without waiting for a complaint. This development is to be welcomed, and, as it recognises, pursued and strengthened in conjunction with its regulatory partners.

12.77 The GMC has suffered in the past from poor cooperation from other organisations. The Inquiry has seen evidence of a failure to disclose information raising serious concerns in the form of
the two RCS reports. It should have occurred to both the Trust leadership and the Royal College that the GMC should have sight of them. Steps must be taken to systematise the exchange of information between the royal colleges and the GMC, and guidance issued for use by employers of doctors to the same effect.

12.78 The advantages of peer review is considered in *Chapter 21: Values and standards*, but the GMC should have regard to the possibility of commissioning reviews where concerns are raised in a generic way, in order to be advised whether there are individual concerns. Such reviews could be jointly commissioned with the CQC in appropriate cases.

**Nursing and Midwifery Council**

**Statutory framework**

12.79 The NMC regulates nurses and midwives in England, Wales, Scotland, Northern Ireland, the Channel Islands and the Isle of Man. It was established in 2001 to replace the United Kingdom Central Council for Nursing, Midwifery and Health Visitors (UKCC). Its aim is to safeguard the health and well-being of persons using or needing the services of its registrants. It does this by:

- Registering all nurses and midwives and ensuring that they are properly qualified and competent to work in the UK;
- Setting standards of education, training, conduct and performance for nurses and midwives;
- Ensuring that nurses and midwives maintain those standards;
- Ensuring that midwives are safe to practise by setting rules for their practice and supervision;
- Maintaining fair processes for investigation of allegations made against registered nurses and midwives.74

12.80 The training functions of the NMC are considered in *Chapter 23: Nursing*.

12.81 The NMC’s jurisdiction extends only to individual registered nurses and midwives and not to healthcare support workers. The lack of regulation of such workers is also considered in *Chapter 23: Nursing*.

12.82 The NMC must act on allegations that a nurse or midwife’s fitness to practise is impaired by misconduct, lack of competence, a conviction or caution for a criminal offence, health, or the finding of another health or social care regulator.75

---

74 Weir-Hughes WS0000047480, para 6
75 Weir-Hughes WS0000047493, para 59
12.83 The assessment of fitness to practise comprises three practice committees, the Investigating Committee, the Conduct and Competence Committee and the Health Committee.

**Code of conduct**

12.84 Similarly to the GMC, in order to fulfil its function of establishing standards for education, training, conduct and performance for nurses and midwives and its responsibility for enforcing those standards, the NMC publishes *The Code: Standards of conduct, performance and ethics for nurses and midwives*, which sets out standards that are enforced through its fitness to practise function.\(^{76}\) Compliance with *The Code* is mandatory, and it is enforced against individuals. It is reviewed and revised on a three-yearly basis. In his statement Professor Dickon Weir-Hughes, then Chief Executive of the NMC, described *The Code* as the key tool in safeguarding the health and well-being of the public. It forms the benchmark against which to measure a registrant’s conduct or competence.\(^{77}\)

12.85 *The Code* is shorter than *Good Medical Practice* but contains many of the same features, adapted for the nursing profession. Amongst the provisions of the version published in 2008 are the following:

> The people in your care must be able to trust you with their health and well-being.

To justify that trust, you must:

- Make the care of people your first concern, treating them as individuals and respecting their dignity;
- Work with others to protect and promote the health and well-being of those in your care, their families and carers, and the wider community;
- Provide a high standard of practice and care at all times;
- Be open and honest, act with integrity and uphold the reputation of your profession.\(^{78}\)

... 

Treat people as individuals.

1 You must treat people as individuals and respect their dignity.

2 You must not discriminate in any way against those in your care.

3 You must treat people kindly and considerately.

\(^{76}\) DH/2 W500000047612

\(^{77}\) Weir-Hughes W50000047482, para 15

\(^{78}\) DH/2 W500000047614
4 You must act as an advocate for those in your care, helping them to access relevant health and social care, information and support.79

...  

22 You must work with colleagues to monitor the quality of your work and maintain the safety of those in your care.  

...  

32 You must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk.  

33 You must inform someone in authority if you experience problems that prevent you working within this code or other nationally agreed standards.  

34 You must report your concerns in writing if problems in the environment of care are putting people at risk.  

35 You must deliver care based on the best available evidence or best practice.  

...  

38 You must have the knowledge and skills for safe and effective practice when working without direct supervision.  

39 You must recognise and work within the limits of your competence.  

40 You must keep your knowledge and skills up to date throughout your working life.  

41 You must take part in appropriate learning and practice activities that maintain and develop your competence and performance.  

Keep clear and accurate records.  

42 You must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give, and how effective these have been.  

43 You must complete records as soon as possible after an event has occurred.  

44 You must not tamper with original records in any way.  

...  

Deal with problems  

52 You must give a constructive and honest response to anyone who complains about the care they have received.
53 You must not allow someone’s complaint to prejudice the care you provide for them.

54 You must act immediately to put matters right if someone in your care has suffered harm for any reason.

55 You must explain fully and promptly to the person affected what has happened and the likely effects.

56 You must cooperate with internal and external investigations.80

12.86 As with the GMC, the NMC produces guidance on a number of topics. Nurses are expected to comply with The Code and have regard to the guidance. Failure to do so can be visited with disciplinary sanction.

12.87 A cursory consideration of the findings of the HCC investigation and the first inquiry suggests that there have been multiple failures on the part of nurses to comply with The Code.

12.88 It was suggested to Professor Dickon Weir-Hughes that the previous version of The Code had not placed such emphasis on the care of the patient being the priority. Professor Weir-Hughes had not been involved with the NMC at that time, but, as a long-standing registered nurse himself, he rejected this:

I probably can best speak about this as a registrant myself and certainly even before the NMC, when we ... were the UKCC and had a code then, I was always perfectly clear about the responsibilities. So I struggled to understand how someone could not understand what it is that they were supposed to be doing and the priority they were supposed to be placing upon patient care, for example, regardless of the ... style or writing or the words in this particular version. Because, actually, all of us ... have lived through a number of different iterations of the code, and because it’s something that’s widely consulted on, and has to be widely consulted on, we do – they will, because of that, inevitably vary slightly. But actually the central themes have always been the same ... So I understand the point you’re making completely, ... but I struggle to understand how somebody could have misunderstood their responsibilities, having even read this previous version.81

12.89 Professor Weir-Hughes thought that the current Code was adequate to deal with the work of nurses acting as leaders or managers, although the NMC is working on new guidance on the issue.82
**Fitness to practise process**

12.90 The NMC’s screening team considers all referrals from someone who is not a registered nurse or midwife to determine whether it refers to a registered person, in fact constitutes a fitness to practise matter, or whether sufficient information is provided. If basic requirements are met, the case is referred to the Investigating Committee. This Committee has to decide if there is a case to answer; if there is, the matter is referred to the Conduct and Competence or Health Committees for determination.

12.91 Cases can be determined at relatively informal meetings where simple and where there is no public interest in a public hearing, but most take place at public hearings in a formal adversarial process. If the case is proved, the sanctions available are a caution, imposition of conditions of practice, suspension, or an order for striking off the register.83

12.92 There are interim powers of suspension, which can be imposed at any stage of the process.84

**Past criticism of the Nursing and Midwifery Council**

12.93 On 11 June 2008, the Council for Healthcare Regulatory Excellence (CHRE) submitted a *Special Report to the Minister of State for Health Services on the Nursing and Midwifery Council*, addressing “the central question of whether the NMC is fulfilling its statutory functions”.85 The CHRE concluded that, at the time, the NMC “fail[ed] to fulfil [its statutory functions] to the standard of performance that the public has a right to expect of a regulator”, and that:

> There are serious weaknesses in the NMC’s governance and culture, in the conduct of its Council, in its ability to protect the interests of the public through the operation of fitness to practise processes and in its ability to retain the confidence of key stakeholders.

12.94 Six areas “of significant weakness” in the management of the NMC fitness to practise process were identified, including the absence of an IT-based case management system, the poor quality of correspondence, which was sometimes insensitive, misleading and discouraging of complaints, and delays throughout the process. The NMC made a number of commitments to improving its work.86

12.95 The progress of the NMC was reviewed as part of the CHRE annual performance reviews in 2008/09 and 2009/10. These highlighted that serious concerns remained about the NMC’s performance, particularly in relation to customer care, timeliness and the recording of decisions.87 In a specially commissioned *NMC Progress Review*, published in January 2011,

---

83 The process is outlined at Weir-Hughes WS0000047495–98, paras 71–92
84 Weir-Hughes WS0000047498, paras 93–95
85 JB/1 WS0000050724
86 JB/1 WS0000050727-29
87 JB/2 WS0000050763, para 1.4
the CHRE concluded that the NMC had made a number of significant improvements since the Special Report in 2008 in both its fitness to practise procedures and general governance arrangements. However, there was still concern “about the seriousness of the amount and nature of the improvements that the NMC has to make”.88 In particular, the CHRE concluded that:

Third party feedback we have received, feedback from the NMC’s own committee members and the external audit the NMC commissioned on the quality of its committees clearly show that the administration of the fitness to practise process is poor.

12.96 Examples of poor administration identified included the non-availability of guidance documentation, poor committee allocation, breaches of confidentiality, inaccurate notifications to registrants and poor witness liaison.89

12.97 The CHRE published a *Strategic Review of the NMC* on 3 July 2012, after the Inquiry hearings had come to an end.90 The report concluded:

The NMC has continued to carry out its public protection duties, although not as well as it should but, as its stakeholders make clear, it is not inspiring confidence in the professions or in professional regulation.

As we said in our interim report [published in April 2012], at the heart of the NMC’s failure to succeed lies confusion over its regulatory purpose, lack of clear, consistent strategic direction, unbalanced working relationships and inadequate business systems.

... The main problem rests with the NMC’s performance in fitness to practise. CHRE consistently highlighted problems with its performance of this regulatory function but only recently has the organisation shown any real determination to address its shortfalls. It has underinvested in fitness to practise compared to other regulators, it needs to have a clearer strategy for turnaround, better focus on planning and a more streamlined approach to delivery.

12.98 The CHRE did identify that by the time the review had concluded, “there were some encouraging signs that foundations for change were beginning to be put in place”.91

---

88 JB/2 WS0000050790
89 JB/2 WS0000050788
Professor Dickon Weir-Hughes, then Chief Executive of the NMC, giving evidence before this latest report had been published, was asked why it had taken so long to address the perceived deficiencies in the organisation. He said:

... I simply don’t know why it wasn’t ... I can speak more confidently I think about what I found when I arrived which will have been some of those things which were carry-overs from the time you’re referring to. I think a lack of basic management process, a lack of performance management of staff, a lack of training, a lack of proper procedures for dealing with serious incidents or serious cases. I think perhaps a lack of enthusiasm to challenge our cumbersome legislation, which is difficult and makes one rather unpopular but nevertheless it’s important to do. So perhaps ... just an acceptance of what was there, rather than any thought of actually challenging it and making it better.\textsuperscript{92}

**Generic complaints**

Like the GMC, the NMC has not historically investigated cases unless it has received information about a specific identified or identifiable registrant. It has acted on information received, rather than proactively seeking out causes for concern. No doubt for this reason, it has had an information system that does not permit a great deal of analysis.

The NMC informed the Inquiry that searches of its records had only identified three cases concerning the quality of care of nursing at the Trust in the period under review. It was not made aware of any systemic failing. It was only possible to discover these three cases by a search referring to the names of the Trust’s directors of nursing: the system did not allow a search by reference to place of employment or employing trust.\textsuperscript{93} The Trust’s own records suggested there had only been one referral between 1 April 2005 and 17 June 2009.\textsuperscript{94}

Professor Weir-Hughes told the Inquiry that the NMC now has a new management structure, new members of staff, a new screening team and an IT case management system, which will allow for the more effective processing of cases. While this may expedite the processing of referred cases, a much-needed facility if the above reports are to be accepted, the NMC is also making improvements to its data management allowing for greater analysis of fitness to practise statistics. It now builds up information from multiple sources enabling it to have a broader picture than before. This should assist it in becoming a more proactive regulator.\textsuperscript{95}

\textsuperscript{92} Weir-Hughes T106.111–112
\textsuperscript{93} Weir-Hughes WS0000047503, paras 112, 114
\textsuperscript{94} Weir-Hughes WS0000047505, para 120
\textsuperscript{95} Weir-Hughes T106.109–111
12.103 Following the Stafford experience Professor Weir-Hughes told the Inquiry that the NMC was becoming increasingly proactive:

*I think I’ve been very keen, since I came into post in 2009, to make the NMC into a much more proactive organisation. And that, if I’m honest, has not necessarily been welcomed in every corner, but we’re clearly not there to be popular ... I have been very keen that we move in a direction of proactivity, because really, although fitness to practise is a very, very important part of our work, it is really a bit like closing a stable door after the horse has bolted, and our desire, of course, would be to see far fewer fitness to practise cases, because they’re - you know, not - because people aren’t doing things that require them to be referred, not because they’re not being referred.*

*So I think the whole team that we have now is very enthusiastic about being proactive, which is good.*

12.104 This answer was given in the context of the issuing of guidance for nurse managers, obviously a positive and proactive step in itself, but not in relation to the investigation of concerns. However, the NMC has taken a number of steps designed to allow it to be more interventionist:

- The approach to fitness to practise cases has changed. More use is made of the power possessed by the Registrar to refer cases to fitness to practise procedures without a referral from a third party;  
- A report by Dame Elizabeth Fradd was commissioned and delivered in September 2010 to address the regulatory gap between NMC activity and the systems regulators’ activity. This recommended that the NMC develop a critical standards intervention system to assist in identifying possible systemic failures. This will require the recruitment of experienced staff, a framework of indicators, and a system for collating and analysing information. The NMC is actively working towards implementation. There is, however, a limit to the progress that can be made in this direction, because the statutory powers of the NMC do not permit it to investigate organisations as opposed to individuals. The report also recommended requiring nursing directors to report annually on compliance with NMC standards in their organisations.  

**Referrals in relation to nurses at the Trust**

12.105 As has been seen, very few referrals of nurses at the Trust were made. One example of the apparent reluctance of the then Trust management to grasp the nettle with regard to alleged misconduct reported by a whistleblower, has been considered in *Chapter 2: The Trust.*

---

96 Weir-Hughes T106.64–65  
97 Weir-Hughes WSO0000047522, paras 183–184  
98 Weir-Hughes WSO0000047519–21, paras 174–182
12.106 Asked why he thought there had been so few referrals, Professor Weir-Hughes speculated that there may have been a culture of isolation that overrode the professional responsibility to report concerns.99 Recognising this issue in 2009, the NMC undertook a project to review guidance and support offered to registrants, involving public meetings and the involvement of organisations such as Public Concern at Work. The guidance, Raising and Escalating Concerns, was finalised and published in November 2010 and circulated to all registrants.100 Professor Weir-Hughes considered that the guidance had been shown to be effective because of the number of whistleblowers who now report concerns to the NMC.101 With regard to the inevitable fears whistleblowers will have about recrimination, the NMC frequently works with the Royal College of Nursing (RCN) to ensure that informants receive support in addressing any such problems.102

Interrelationship between the Nursing and Midwifery Council process and employers’ disciplinary process

12.107 Professor Weir-Hughes said it was important for nurse directors to refer cases to the NMC when internal disciplinary procedures were being taken for matters involving a breach of the Code. Otherwise, there would be nothing to stops nurses moving off to another employer and continuing to practise, even if there was a need to protect the public. He understood that it could sometimes be difficult for nurse managers to know when the boundary had been crossed between a matter that could be dealt with locally and one that required NMC intervention. He counselled erring on the side of referral.103

12.108 Professor Weir-Hughes told the Inquiry that a rolling programme of meetings with nurse directors and others is being held to explain the role of the NMC and how they should be working together.

The profile of the Nursing and Midwifery Council

12.109 Professor Weir-Hughes accepted that public awareness of the NMC was not as good as it might have been, although there had recently been a more prominent NMC media presence and an increase in referrals both from employers and members of the public.104

12.110 He thought that an obligation on healthcare providers to provide complainants with information about the NMC would be helpful.105

99 Weir-Hughes W50000047505, para 121
100 Weir-Hughes T106.48; Weir-Hughes W50000047517-18, paras 164–168; DH/25 W50000048110
101 Weir-Hughes T106.49
102 Weir-Hughes T106.56
103 Weir Hughes T106.77-78
104 Weir-Hughes T160.79–80; Weir-Hughes W50000047505, para 121
105 Weir-Hughes T106.80–81
Relationship with the Healthcare Commission and the Care Quality Commission

12.111 The NMC had a Memorandum of Understanding with the HCC providing that significant concerns should be shared mutually, including those arising out of the HCC’s investigations and reviews. However, the NMC were not informed formally of the HCC’s investigation into the Trust until about two weeks before publication of the report. Professor Weir-Hughes, who was not in post at the time, could not rule out the possibility that knowledge of the investigation existed at some level in the organisation, but stated that it did not feed into any assurance process if the information was there. To him, this illustrated the importance of developing strong professional relationships with the CQC.

12.112 In September 2010 the NMC and the CQC signed a Memorandum of Understanding which defined the circumstances in which the CQC would refer a matter to the NMC and vice versa. Professor Weir-Hughes told the Inquiry that, although the two organisations have a reasonable working relationship, there are still problems over the timely transfer of information. He considered this was contributed to by the CQC not having the benefit of a director of nursing (or other dedicated NMC conduit), as he felt there was something of a lack of understanding about the importance of sharing information with the NMC.

12.113 Once again, this emphasises the importance of all regulatory organisations having, not only high level memoranda of understanding, but a mutual system for allowing each other to know of the actions of the others, and to understand their importance and significance for their own responsibilities.

Conclusions on the Nursing and Midwifery Council

12.114 The NMC’s fitness to practise role is based on a Code which, like the GMC’s Good Medical Practice, has the merit of clarity and simplicity. Criticisms have been suggested of the 2002 version of the NMC’s Code for not making clear the priority that has to be given to patients. That criticism is unfounded. Not only is the requirement plain on a reading of the whole of The Code, it was also the product of a time when it was probably presumed that no nurse would ever think anything else was the priority. Unhappily, experiences such as that of Mid Staffordshire show that this presumption can no longer be made. The later version of the code remedies this to the extent that is required.

12.115 The NMC’s involvement with the Trust and the fitness to practise of its nursing staff was very limited prior to the HCC report. Given what may have been widespread non-compliance with the nursing Code on the part of at least some nurses during the period under review, it is clear that cases which should have been referred to the NMC were not. The systemic failures

---

106 NMC00020000117 Memorandum of Understanding between the Healthcare Commission and the using and Midwifery Council (January 2008) (historic), paras 13–15
107 Weir-Hughes T106.25–27; Weir-Hughes WS0000047502, para 105
108 Weir-Hughes T106.85–86
in themselves suggest that an investigation into the part played by nurse managers and leaders should have been considered. However, the NMC could not be expected to take such a step unless it received information enabling it to do so. It was not set up as a proactive investigative regulator but one whose principal task was to act on information offered to it, by way of complaint or referral.

12.116 However, if the NMC is to act as an effective regulator of nurse managers and leaders acting in those roles, as well as more front-line nurses, it needs to be equipped to look at systemic concerns as well as individual ones. It does not have to take the place of the systems regulators but it needs to work closely with them and to share their information and analyses on the working of systems in organisations in which nurses are active. It should not have to wait until a disaster has occurred to intervene with its fitness to practise procedures. If concerns are developed, for example at the CQC, either through its Quality Risk Profile system, or the observations of local inspectors communicated to the NMC, it should be able to make a judgement as to whether issues have been raised about nursing fitness to practise and compliance with the nursing Code. Therefore, full access to CQC information in particular is vital. It is not, however, sufficient. The NMC needs to have its own internal capacity to assess systems and launch its own proactive investigations where it becomes aware of concerns which may give rise to nursing fitness to practise issues, even if it is first off unaware of the identity of a registered nurse to whom this applies. It may decide to seek the cooperation of the CQC, but as an independent regulator it must be empowered to act on its own if it considers it necessary and in the public interest. This will require resources, both in terms of appropriately expert staff, data systems and finance. Given the power of the registrar to refer cases without a formal third-party complaint, it would not appear that a change of regulation is necessary. Indeed, as at the time of Professor Dickon Weir-Hughes’ evidence, 181 fitness to practise cases had been opened since 2009 without a referral to the NMC by an external agency.109

12.117 It is of concern that the administration of the NMC, which has not been examined by this Inquiry, is still found by other reviews to be wanting. It is imperative in the public interest that this is remedied urgently. Without doing so there is a danger that the regulatory gap between the NMC and the CQC will widen rather than narrow.

12.118 The Inquiry was told that the NMC intends to introduce a system of revalidation similar to that being deployed by the GMC. This is highly desirable as a means of reinforcing the status and competence of registered nurses, as well as providing additional protection to the public. However, revalidation is very complex, and it is essential that the NMC has the resources and the administrative and leadership skills to ensure that this does not detract from its existing core function of regulating fitness to practise of registered nurses.

109 Weir-Hughes T106.26–27
12.119 The profile of the NMC needs to be raised with the public, who are the prime and most valuable source of information about the conduct of nurses. All patients should be informed by those providing treatment or care of the existence and role of the NMC together with its contact details. The NMC itself needs to undertake more by way of public promotion of its functions.

12.120 As with the GMC, the length and complexity of NMC procedures may deter nurse employers from referring as many cases as they should. While the NMC does not accept that its regulations require it, there is some evidence of a perception in the wider healthcare world that internal disciplinary action must await the outcome of any NMC proceedings so as not to prejudice them.\textsuperscript{110} Given that the prime objective of both types of procedure is to protect patients and the public, it is essential that, so far as practicable, one does not obstruct the progress of the other. In most cases it should be possible, through cooperation, to allow both to proceed in parallel. As Professor Weir-Hughes pointed out, it may be important for the public to be protected by an interim suspension order even if the employer has suspended a registrant under her or his contract of employment, but that otherwise the employer can take its own proceedings before or instead of a referral to the NMC.\textsuperscript{111} There is nothing in the NMC’s regulations which prevents parallel proceedings, although it appears that it is the NMC’s policy generally to await the outcome of the employer’s procedures before taking its own action. This may require a review of employment disciplinary procedures to make it clear that the employer is entitled to proceed even if there are pending NMC proceedings.

12.121 It is clear that the role of Director of Nursing is an important and often lonely one in relation to ensuring compliance with the nursing Code, not only in her/his own work, but among the staff of the organisation. The availability of support for those in this role is very important, but it is not clear how the support previously provided by nursing directors at SHAs is to be replaced. The GMC are seeking to rely on the new concept of employment liaison officers to offer some such support. The NMC could consider some similar solution, but if this is impractical, a support network of senior nurse leaders will have to be engaged in filling this gap.

**Health and Care Professions Council**

**Statutory framework**

12.122 The Health and Care Professions Council (HCPC) was established (as the Health Professions Council) by the Health and Social Work Professions Order 2001, made under section 60 of the Health Act 1999. The HCPC came into force on 12 February 2002. It is an independent statutory regulator with responsibility for the regulation of the following professions: art therapists, biomedical scientists, chiropodists and podiatrists, clinical scientists, dieticians,

\textsuperscript{110} Sumara WS(1) W500000005929, para 78

\textsuperscript{111} Weir-Hughes T106.74-5
occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists and orthotists, radiographers, speech and language therapists, practitioner psychologists and hearing aid dispensers.112

12.123 The aims of the HCPC are:

- Maintaining and publishing a public register of properly qualified members of the professions;
- Approving and upholding high standards of education and training, and continuing good practice;
- Investigating complaints and taking appropriate action;
- Working in partnership with the public, and a range of other groups including professional bodies;
- Promoting awareness and understanding of the aims of the council.113

12.124 The principal functions of the HCPC are to establish standards of education, training, conduct and performance for members of the relevant professions and to ensure the maintenance of those standards. The main objective in exercising these functions is to safeguard the health and well-being of persons using or needing the services of registrants. The HCPC’s statutory powers are complaints-led insofar as it is responsible for regulating individual registrants rather than services. It has no general powers of inspection or oversight. In that regard its functions are similar to those of the GMC and the NMC. The HCPC has a statutory duty to cooperate with the employers of registrants as well as with the regulators of other healthcare professionals.114

Code of conduct

12.125 The HCPC has set standards of ethics and performance applicable to all its regulated professions. The standards themselves are expressed very simply:

1 You must act in the best interests of service users.
2 You must respect the confidentiality of service users.
3 You must keep high standards of personal conduct.
4 You must provide (to us and any other relevant regulators) any important information about your conduct and competence.
5 You must keep your professional knowledge and skills up to date.
6 You must act within the limits of your knowledge, skills and experience and, if necessary, refer the matter to another practitioner.
7 You must communicate properly and effectively with service users and other practitioners.
8 You must effectively supervise tasks that you have asked other people to carry out.
9 You must get informed consent to give treatment (except in an emergency).
10 You must keep accurate records.
11 You must deal fairly and safely with the risks of infection.
12 You must limit your work or stop practising if your performance or judgement is affected by your health.
13 You must behave with honesty and integrity and make sure that your behaviour does not damage the public’s confidence in you or your profession.
14 You must make sure that any advertising you do is accurate.\textsuperscript{115}

\textbf{12.126} Clearly these standards are somewhat less sophisticated than those produced by the GMC and the NMC but have to be common to a varied collection of professions.

\textbf{Involvement with the Trust}

\textbf{12.127} The HCPC informed the Inquiry that it had no direct knowledge or information with regard to events at the Trust. It had received no complaints about its registrants there. Therefore, no further evidence was sought.\textsuperscript{116}

\textbf{Overall conclusions}

\textbf{12.128} It has been seen that the GMC and the NMC have both faced similar challenges in regulating the role of healthcare professionals in cases of systems failures. Where there is an effective local system of clinical governance it might be expected that individual cases of suspected impairment of fitness to practise would be referred to the GMC or the NMC without hesitation. So far as the absence of referrals from professionals in the hospital is concerned, this may well have been due to the unhealthy culture described in the first inquiry report. The lack of complaints from the public may well have been due to the lack of profile each organisation has. It is common to see the media mistaking the British Medical Association for the GMC and it is likely that the public suffer from a similar confusion. While both the GMC and the NMC have highly informative internet sites, both need to ensure that patients and other service...

\textsuperscript{115} \textit{Standards of Conduct, Performance and Ethics} (1 July 2008), Health and Care Professions Council, p 3, \url{www.hpc-uk.org/assets/documents/10002367FINALcopyofSCPEjuly2008.pdf}
\textsuperscript{116} Health and Care Professions Council WS (Provisional) – HPC00000000004
users are made aware at the point of service provision of their existence, of their role and their contact details.

12.129 Both the public and professionals may be deterred from referring cases by the apparent complexity of the process and the time taken to resolve cases. Julie Bailey, of Cure the NHS, complained to the Inquiry about her experience pursuing a complaint with the NMC:

Well ... as a complainant, it’s just a long drawn out process and I’ve had to constantly ring them to keep me up to date with what’s going on. I contacted them last week and they’ve told me now that – although I haven’t received this in writing, that on 22nd December [2010] there will be a sort of the first stage of the investigation where they decide if they are going to pursue the complaint. So, here we are now, it must be eight months that I first put in the request, and ... the decision is not going to be taken until 22 December if my complaint is going to be taken further.

What I am led to believe for people who have gone through the process, have got experience is the majority of cases aren’t pursued because the nurse has now got quite a period without any further blemishes on her record. 117

12.130 Without coming to any conclusion on this particular complaint, both organisations need constantly to have in mind the need to explain to complainants what is happening, why it is happening and what is being done about the complaint. While the regulatory process requires the regulator to represent the public interest not the complainant, the latter must be fully supported and, so far as possible, treated as a partner.

12.131 Where referral is absent, as was the case at the Trust, then other means are necessary to ensure that the public is protected. Both organisations need to develop their capacity to examine and investigate concerns even where no named individual has been identified to them. In a case like Stafford there may be many professionals whose role requires examination. At the moment, the impression is that neither the GMC nor the NMC has the capacity or skills to undertake this sort of work. In addition to its own capacity to undertake proactive investigations, and perhaps to minimise the need to do so, both organisations must develop closer working relationships with the CQC – in many cases there should be joint working to minimise the time taken to resolve issues and maximise the protection afforded to the public.

12.132 How this is achieved is an operational matter but one which requires continual public scrutiny. Therefore, the three organisations should be required to produce a joint periodic report on their cooperation and joint achievements.

117 Bailey T10:98–99
12.133 The story of Stafford shows that the conduct of individual doctors and nurses can be relevant to the analysis of the failure of an organisation to perform its duty to its patients. Even in cases involving a single patient there will often, sadly, be lapses in standards by members of both professions. Currently such cases, where they come to light, are dealt with by the relevant professional regulator as if in a silo, applying a differently worded code of conduct, a different approach to sanctions, and by reason of the matters being dealt with in different systems, the possibility of inconsistent outcomes. The previous Government created the Office of the Health Professions Adjudicator, with a view in part towards aligning the procedures, approaches and sanctions of the various healthcare professional regulators. That body has been abolished and its role in this regard transferred to the CHRE, which in December 2012 became the Professional Standards Authority for Health and Social Care (PSA). The PSA, together with the regulators under its supervision, should seek to devise procedures for dealing consistently and in the public interest with cases arising out of the same event or series of events, but involving professionals regulated by more than one body. While it would require new regulations, consideration should be given to the possibility of moving towards a common independent tribunal to determine fitness to practise issues and sanctions across the healthcare professional field. All regulators should exchange details of those members found to be substandard and look at where they are working in order to achieve cross correlation. The abolition of the OHPA, which was to be such a tribunal, need not inhibit the PSA from considering the economic and public interest gains that might be made from such a step.

12.134 Historically, the GMC has only investigated specific complaints about identified individuals, and its statutory framework is drafted from that premise, although it does not prevent a more proactive approach to monitoring fitness to practise.

12.135 Without a clear policy, neither the public nor trusts will be aware of the circumstances in which a generic complaint or report ought to be made to the GMC.

12.136 If the GMC is to be effective in looking into generic complaints and information it will probably need either greater resources, or better cooperation with the CQC and other organisations such as the royal colleges to ensure that it is provided with the appropriate information. Even if that is achieved, the GMC needs to be alert to information about system failures of the sort which may indicate fitness to practise concerns, relating not only to front-line clinicians but also clinically qualified managers and leaders. For that purpose the GMC must ensure that the information it does receive or obtain is analysed by persons qualified to discern these possibilities. The GMC is emphatically not a systems regulator, but it cannot ignore the implications for individual registered practitioners.

12.137 Steps must be taken to systematise the exchange of information between the Royal Colleges and the GMC, and guidance issued for use by employers of doctors to the same effect.
12.138 The advantages of peer review is considered in Chapter 21: Values and standards, but the GMC should have regard to the possibility of commissioning reviews where concerns are raised in a generic way, in order to be advised whether there are individual concerns. Such reviews could be jointly commissioned with the CQC in appropriate cases.

12.139 If the NMC is to act as an effective regulator of nurse managers and leaders acting in those roles, as well as more front-line nurses, it needs to be equipped to look at systemic concerns as well as individual ones. It does not have to take the place of the systems regulators but it must be enabled to work closely with them and to share their information and analyses on the working of systems in organisations in which nurses are active. It should not have to wait until a disaster has occurred to intervene with its fitness to practise procedures. If concerns are developed for example at the CQC, either through its Quality Risk Profile system, or the observations of local inspectors, the NMC should be able to make a judgement as to whether issues have been raised about nursing fitness to practise and compliance with the nursing Code. Therefore, full access to CQC information in particular is vital. That is not, however, sufficient. The NMC needs to have its own internal capacity to assess systems and launch its own proactive investigations where it becomes aware of concerns which may give rise to nursing fitness to practise issues. It may decide to seek the cooperation of the CQC, but as an independent regulator it must be empowered to act on its own if it considers it necessary, in the public interest. This will require resources, both in terms of appropriately expert staff, data systems and finance.

12.140 Given the power of the registrar to refer cases without a formal third-party complaint, it would not appear that a change of regulation is necessary, but this should be reviewed.

12.141 It is of concern that the administration of the NMC, which has not been examined by this Inquiry, is still found by other reviews to be wanting. It is imperative in the public interest that this is remedied urgently. Without doing so there is a danger that the regulatory gap between the NMC and the CQC will widen rather than narrow.

12.142 The Inquiry was told that the NMC intends to introduce a system of revalidation similar to that being deployed by the GMC. This is highly desirable as a means of reinforcing the status and competence of registered nurses, as well as providing additional protection to the public. However, revalidation is very complex, and it is essential that the NMC has the resources and the administrative and leadership skills to ensure that this does not detract from its existing core function of regulating fitness to practise of registered nurses.

12.143 The profile of the NMC needs to be raised with the public, who are the prime and most valuable source of information about the conduct of nurses. All patients should be informed by those providing treatment or care of the existence and role of the NMC together with its
contact details. The NMC itself needs to undertake more by way of public promotion of its functions.

12.144 As with the GMC, the length and complexity of NMC procedures may deter nurse employers from referring as many cases as they should. While the NMC may not believe it to be the case, there is a perception in the wider healthcare world that NMC procedures hinder progress with internal disciplinary action, on the basis that such action must await the outcome of any NMC proceedings so as not to prejudice them. Given that the prime objective of both types of procedure is to protect patients and the public, it is essential that, so far as practicable, one does not obstruct the progress of the other. In most cases it should be possible, through cooperation, to allow both to proceed in parallel. This may require a review of employment disciplinary procedures to make it clear that the employer is entitled to proceed even if there are pending NMC proceedings.

12.145 It is clear that the role of Director of Nursing is an important and often lonely one in relation to ensuring compliance with the nursing Code, not only in her/his own work, but among the staff of the organisation. The availability of support for those in this role is very important, but it is not clear how that previously provided by nursing directors of SHAs is to be replaced. The GMC are seeking to rely on the new concept of employment liaison officers to offer some such support. The NMC could consider some similar solution, but if this is impractical a support network of senior nurse leaders will have to be engaged in filling this gap.

Summary of recommendations

Recommendation 222
The General Medical Council should have a clear policy about the circumstances in which a generic complaint or report ought to be made to it, enabling a more proactive approach to monitoring fitness to practise.

Recommendation 223
If the General Medical Council is to be effective in looking into generic complaints and information it will probably need either greater resources, or better cooperation with the Care Quality Commission and other organisations such as the Royal Colleges to ensure that it is provided with the appropriate information.

Recommendation 224
Steps must be taken to systematise the exchange of information between the Royal Colleges and the General Medical Council, and to issue guidance for use by employers of doctors to the same effect.
**Recommendation 225**

The General Medical Council should have regard to the possibility of commissioning peer reviews pursuant to section 35 of the Medical Act 1983 where concerns are raised in a generic way, in order to be advised whether there are individual concerns. Such reviews could be jointly commissioned with the Care Quality Commission in appropriate cases.

**Recommendation 226**

To act as an effective regulator of nurse managers and leaders, as well as more front-line nurses, the Nursing and Midwifery Council needs to be equipped to look at systemic concerns as well as individual ones. It must be enabled to work closely with the systems regulators and to share their information and analyses on the working of systems in organisations in which nurses are active. It should not have to wait until a disaster has occurred to intervene with its fitness to practise procedures. Full access to the Care Quality Commission information in particular is vital.

**Recommendation 227**

The Nursing and Midwifery Council needs to have its own internal capacity to assess systems and launch its own proactive investigations where it becomes aware of concerns which may give rise to nursing fitness to practise issues. It may decide to seek the cooperation of the Care Quality Commission, but as an independent regulator it must be empowered to act on its own if it considers it necessary in the public interest. This will require resources in terms of appropriately expert staff, data systems and finance. Given the power of the registrar to refer cases without a formal third party complaint, it would not appear that a change of regulation is necessary, but this should be reviewed.

**Recommendation 228**

It is of concern that the administration of the Nursing and Midwifery Council, which has not been examined by this Inquiry, is still found by other reviews to be wanting. It is imperative in the public interest that this is remedied urgently. Without doing so, there is a danger that the regulatory gap between the Nursing and Midwifery Council and the Care Quality Commission will widen rather than narrow.

**Recommendation 229**

It is highly desirable that the Nursing and Midwifery Council introduces a system of revalidation similar to that of the General Medical Council, as a means of reinforcing the status and competence of registered nurses, as well as providing additional protection to the public. It is essential that the Nursing and Midwifery Council has the resources and the administrative and leadership skills to ensure that this does not detract from its existing core function of regulating fitness to practise of registered nurses.
Recommendation 230

The profile of the Nursing and Midwifery Council needs to be raised with the public, who are the prime and most valuable source of information about the conduct of nurses. All patients should be informed, by those providing treatment or care, of the existence and role of the Nursing and Midwifery Council, together with contact details. The Nursing and Midwifery Council itself needs to undertake more by way of public promotion of its functions.

Recommendation 231

It is essential that, so far as practicable, Nursing and Midwifery Council procedures do not obstruct the progress of internal disciplinary action in providers. In most cases it should be possible, through cooperation, to allow both to proceed in parallel. This may require a review of employment disciplinary procedures, to make it clear that the employer is entitled to proceed even if there are pending Nursing and Midwifery Council proceedings.

Recommendation 232

The Nursing and Midwifery Council could consider a concept of employment liaison officers, similar to that of the General Medical Council, to provide support to directors of nursing. If this is impractical, a support network of senior nurse leaders will have to be engaged in filling this gap.

Recommendation 233

While both the General Medical Council and the Nursing and Midwifery Council have highly informative internet sites, both need to ensure that patients and other service users are made aware at the point of service provision of their existence, their role and their contact details.

Recommendation 234

Both the General Medical Council and Nursing and Midwifery Council must develop closer working relationships with the Care Quality Commission – in many cases there should be joint working to minimise the time taken to resolve issues and maximise the protection afforded to the public.
Recommendation 235

The Professional Standards Authority for Health and Social Care (PSA) (formerly the Council for Healthcare Regulatory Excellence), together with the regulators under its supervision, should seek to devise procedures for dealing consistently and in the public interest with cases arising out of the same event or series of events but involving professionals regulated by more than one body. While it would require new regulations, consideration should be given to the possibility of moving towards a common independent tribunal to determine fitness to practise issues and sanctions across the healthcare professional field.