Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

Volume 2: Analysis of evidence and lessons learned (part 2)
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.\(^{115}\)

\(^{12.126}\) 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.

**Involvement with the Trust**

\(^{12.127}\) 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.\(^{116}\)

**Overall conclusions**

\(^{12.128}\) 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


\(^{116}\) 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.

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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.