

Summary - NMC Responding to the Francis Report recommendations forum, 10 July 2013

A range of stakeholders including patient and public representatives, health charities, other regulators, directors of nursing, local supervising authority midwifery officers (LSAMOs) and Department of Health were invited to discuss three recommendations from the Francis Report.

These stakeholders were asked to share their thoughts on these recommendations to help inform the NMC's response.

Statutory duty of candour and related criminal liability on individuals (Recommendations 181 and 183)

1. What do you see as the potential advantages and disadvantages for public protection of introducing a statutory duty of candour?

Advantages

There would be more clarity for nurses and midwives about how to act, making what is written in the code more explicit.

It would apply across professions and disciplines so everyone becomes accountable including the individual, organisation and the whole system.

There would be a universal approach where sanctions can be applied to those who do nothing as well as those who are obstructive.

Patients and families want to know when things have gone wrong, and they want to make sure it does not happen to anyone else.

It would offer a way in for the police to investigate.

It raises awareness of the need for training and development of nurses and midwives.

Boards would be able to offer assurance that candour is expressed. Current 'levers' that we have are not creating the openness that Francis envisages. Perhaps another 'lever' by way of statutory duty of candour will add to this.

Disadvantages

Fear of a criminal sanction could drive issues underground. There is already fear in raising concerns among staff if they are not supported by their organisations. It is also important to learn from 'near misses' and fear may stop people raising these issues.

There are different burdens of proof for criminal and fitness to practise cases. This could lead to different processes reaching different conclusions. It could become a costly and time consuming process.

It might be difficult to define the criminality of an individual and their 'intent'. Would seeing something wrong and not reporting it through fear have the same sanction as deliberately covering it up? There could be a risk of scapegoating to lowest common denominator.

Professionals already know they have a duty of candour in the code. They know they should be reporting issues because it is the right thing to do, not because of fear of a criminal sanction. A statutory duty of candour could be seen as undermining the values of existing codes.

Candour may not be an easy term to understand. Better to talk about openness and honesty instead. The public need to understand what it really means and might have the wrong expectations about what could be considered and what sanction could be applied. Nurses and midwives need to understand what candour is and how to describe it. They also need to understand the consequences of not doing it.

There were concerns about defining scope of duty and levels of harm and also concerns that it would not cover "near misses" which did not result in death or serious harm but should also be disclosed so lessons could be learned.

Organisational structures might not lend themselves to a clear system for being candid and there would need to be a cultural change. There is also a risk it could become a box ticking exercise.

There is concern about the negative effects of bad publicity causing reputation damage, regardless of the outcome of the case.

A duty of candour needs to be balanced with protecting patient confidentiality.

2. What you think would be the likely consequences of introducing criminal sanctions for failures to comply with such a duty?

There was concern that the introduction of criminal sanctions would have the opposite effect and would drive problems underground. It could also become more difficult for professionals to reflect on and learn from errors. Questions were raised about how the levels of harm would be defined and how much evidence someone would need before raising a concern.

Current processes used by regulators, trusts, employers and the police would all need to change. It was felt that the length of time taken to hear cases would increase as regulators have to wait for a criminal investigation to be completed first. Then there is a risk of repetition by carrying out another investigation. There would be an increase in costs related to legal advice and processing cases.

A criminal record will affect the ability of a nurse or midwife to gain employment. This would help to assure the public that those who are not candid and cover up issues will face serious consequences. It could also put people off joining the profession in the first place, if they were worried about the potential risk of facing criminal proceedings.

3. Do you think the introduction of such a regime would have a positive or negative effect on the efforts being made to increase openness and transparency in the healthcare system?

There were concerns that it might deter people from raising concerns because of the potential consequences for their colleagues. There could be less willingness to raise concerns and therefore those issues will not be addressed and put right. It needed to be made more clear to professionals that being honest about an issue is not the same as admitting liability in a legal sense.

There were worries that it could be used to bully staff and that false or unsubstantiated allegations could damage the reputation of individuals and organisations.

There is already a clear duty in codes of conduct to be honest however nurses and midwives need to be reminded of this and the public need a greater understanding of what to expect from a nurse or midwife.

There were questions whether this would address the public need for openness and transparency. Discussing concerns and how they are being dealt with in Trusts public meetings would be more reassuring for the public.

4. If a new statutory duty is not introduced, what steps can the NMC take within its current legislation to encourage nurses and midwives to comply with their existing duties to be candid and to take action against those who breach these duties?

Existing duties to be candid should be included as part of the appraisal process for nurses and midwives. These processes should include feedback from patients and colleagues. The NMC should be doing this as a part of the revalidation process in the future.

Professionals need to see giving and receiving regular feedback as positive and to be encouraged.

The code needs to be strengthened and nurses and midwives need to better understand how to apply it in practice. The NMC needs to work more effectively with royal colleges to raise awareness of the code and professionals' responsibilities. Awareness raising campaigns for professionals and the public were suggested, however it was noted that the NMC has a large register and limited resources.

There needs to be consistency across all regulators on the duties of professionals to be candid.

There needs to be more guidance for investigating managers and more support for mentors.

NMC involvement in systemic concerns (Recommendation 227)

1. What do you see as the potential advantages and disadvantages for public protection of the NMC becoming directly involved in investigating systemic concerns?

Advantages

The public would welcome a joined up approach and would find it easier to make complaints. Potentially issues would be better examined if there was one point of contact and focus for complaints. However, it was felt that better joint working would address this issue more effectively.

The NMC would be able to identify areas of risk before they reach crisis point by gathering more intelligence.

It would become easier to understand how working environments and culture can contribute to issues with fitness to practise.

The NMC already has links to patient / user / stakeholder groups and advocates so they would be able to better investigate the concerns they raise, rather than passing it on to another organisation.

Disadvantages

The majority of those attending felt that it was not the role of the NMC to become directly involved in investigating systemic concerns. It could be very costly and time consuming and distract the NMC from its core role of regulating nurses and midwives. Instead, the NMC should be raising concerns with other regulators when it sees trends developing in an organisation.

It would be difficult for the NMC to investigate as there are other regulators involved e.g. the CQC and Monitor. It is already seen as the role of the CQC to investigate systems so if they are doing their job, why would NMC need to do this? The Francis report highlighted that there were a number of organisations involved yet no one was accountable.

There was a discussion about the dual role of organisations who act both as royal colleges and as unions. NMC would be taking on a dual role regulating individuals and organisations. There was no consensus on whether these dual roles are an issue or not.

Concerns were raised about how this would be funded. If the NMC was investigating the whole system then why should just nurses and midwives be expected to fund it.

2. Do you feel that this would blur the current lines of responsibility between professional (self-funded) regulators and systems regulators and, if so, do you have any concerns about this?

There was consensus that the lines of responsibility would become blurred and that there would be an increased risk of no one doing anything. It would also be more likely to create duplication of work.

There needs to be a greater understanding of the existing role of each regulator. The CQC needs to listen more to the patient voice.

3. If you support this recommendation, how do you think the additional resources should be funded?

The recommendation was generally not supported. If it was to be introduced it was felt that it should be funded by government and not through an increase in nurses and midwives fees.

4. What other practical steps could the NMC take within its current remit to achieve the same outcome of improved public protection where systemic failure lies behind individual fitness to practise issues?

Develop closer relationships with other regulators, health and wellbeing boards, patient groups, health professionals and other bodies. Carrying out joint investigations more frequently and improving how these are carried out and evaluated.

Look to learn from other revalidation models and existing models of supervision (i.e. midwifery supervision).

Joint proceedings and a common tribunal (Recommendation 235)

1. Are you aware of problems in practice arising out of separate regulatory systems for different healthcare professionals and apparent inconsistency in outcomes?

Each profession has its own code of conduct and uses different thresholds for referrals which can be confusing, especially for the public. There is a feeling that nurses are perceived as having lower thresholds for referring colleagues than doctors.

There can be different models or cultures for managing different professions within an organisation.

There can be delays while regulators wait for each other to complete investigations. There are differences in the responsiveness of regulators and how they communicate. It would be better to have more consistency across regulators with shared sanctions and frameworks.

Regulators act as both prosecutor and judge and this can feel confusing and lead to a conflict of interest.

2. What practical steps do you think could be taken by the NMC and other regulators to address these problems?

The NMC should look to better identify areas of common concern and participate more in joint investigations. Joint panels could be used for some investigations.

A common code of practice could be developed.

3. What do you see as the potential advantages and disadvantages for public protection of joint regulatory investigations or hearings?

The advantages would be a more consistent approach across professions with common thresholds for referrals and more common outcomes. The public might find it easier to make a complaint if they could go to more than one regulator.

The disadvantages include increasing the length of time cases would take and the cost. As well as problems created by the need to understand the specifics of each profession. Each regulator has its own specific investigating and judicial functions so how would these work together? There could also be conflicts of interest between professions. In addition, there is a question about who would regulate a joint regulatory investigation.

There would need to be strong evidence for such a change and better joint working would be a more effective approach.

4. Do you think health and social care regulators should be moving towards a single common independent regulator?

Participants were in agreement that there is no evidence to suggest this would be of benefit. It was felt that working together better and discussions around agreement on standards would be a better approach.

There were concerns about how a single regulator would be funded and that it would be too big to be effective.

However there were also suggestions that an integrated regulator might be easier for the public to understand.

5. Do you think other regulators should be moving towards separation of their investigation and adjudication functions like the GMC?

Some participants felt that the functions are already seen as being 'separate' within each organisation so this is not necessary.

Others felt that separating these functions in all regulators would lead to greater parity and consistency.

If the functions are separated then organisations need to ensure panels have a skilled understanding of conditions and sanctions