# AvMA's response to the NMC consultation:
# Ensuring patient safety, enabling professionalism
# June 2018

Action against Medical Accidents (AvMA) is the UK charity for patient safety and justice. Established in 1982, AvMA provides specialist support and advice to around 3,000 people each year who have been affected by lapses in patient safety. We have staff and trustees with extensive knowledge of and experience in patient safety as well as medico-legal matters. AvMA works with government departments, health professionals, the NHS, regulatory bodies, lawyers and other patients' organisations to improve patient safety and the way injured patients and their families are treated following lapses in patient safety.

AvMA offers specialist services to the public, free of charge. AvMA's specialist services are its helpline, pro bono inquest service and advice and information services.

**Executive summary**

- Whilst in theory it is reasonable for less serious concerns to be raised with employers first this does require employers to be set up to undertake the investigations and assessments required to establish whether there are fitness to practise issues or if specific remediation is required. In going forward, the NMC needs to take into account that many organisations will not have the resources or expertise in place.
- There will be situations where there will be barriers to a member of the public raising concerns with an employer or the nature of the allegation is so serious it warrants early NMC involvement. The NMC must remain prepared to investigate on the basis of a direct referral to it in those circumstances.
- There needs to be the opportunity for the maker of a referral to appeal an unreasonable decision not to investigate.
- The NMC should engage in an education campaign about duty of candour – AvMA has raised this with the NMC and is awaiting a response to our invitation to work with the NMC on this.
- The need for <u>independent</u> advice for advice for members of the public has been agreed by stakeholders for some time. Improving the NMC's internal communication with the public is no substitute for that. It would reduce the number of premature or inappropriate referrals to the NMC and would help ensure that serious concerns about registrants are brought to the attention of the NMC
- AvMA can not support consensual disposal unless the NMC builds in safeguards
- Voluntary erasure should not be allowed when there is an outstanding FTP concern about the nurse/midwife. At the very least there should be a permanent notice that there was an outstanding FTP issue to be resolved at the time of erasure
- The NMC should be pro-active in following up potential fitness to practise issues even where these are not directly reported to the NMC

**Q1 We think that fitness to practise should primarily be about managing the risk that a registrant poses to patients or members of the public in the future. Do you agree?**

AvMA recognises the importance of modernising the NMC's fitness to practise procedures. These have become cumbersome and subject to very lengthy delays. Any reforms should be aimed at making the procedures more responsive in identifying serious concerns, quicker in resolving FTP issues and ultimately able to achieve the right outcomes in terms of safeguarding patients and maintaining high professional standards. Having said that, the description that fitness to practise is primarily about 'managing the risk that a registrant poses to patients' is possibly giving out the wrong message in that it implies the NMC is prepared to tolerate an undefined level of risk with respect to individuals on the register.

The NMC has had a difficult and well-publicised history with respect to fitness to practise and there is a need to regain some of that trust on the part of both patients and registrants. There is some concern about the direction of travel in relation to seeing employers as the primary agency for dealing with concerns about registrants without first establishing that employers are or will be equipped to deal with these matters, which in turn risks further undermining the role of the NMC as regulator. There will clearly be some cases where this will be appropriate but the implication is that the default position will be that employers will deal with the majority of concerns in the first instance. If this is done well and cases that warrant referral to the NMC are identified promptly, that does allow for a more timely response. However, if it is not done well, poor practice will go unchallenged and patients will be put at risk, reflecting poorly on the NMC and the profession.

The move to resolve the majority of fitness to practise cases at meetings, will need to be accompanied by a high level of transparency around the decision making process and the outcomes and with the full engagement of those reporting concerns to the NMC. If decisions are perceived as being made behind closed doors without the involvement of the patients who have been most directly affected, and in the absence of a full explanation of the reasons why a particular decision has been made, trust in the NMC will diminish. Equally, if cases are referred back to employers and are dealt with as employment issues, patients will again be largely excluded, and any failure on the part of the employer to take appropriate action, may well in turn reflect poorly on the NMC.

An important check on the system is for those reporting concerns to have access to an appeals system with respect to any decision by the NMC not to investigate a case or to challenge the basis on which a case is to be concluded. One option would be in the form of a review undertaken by the Professional Standards Authority. The existence of an appeals process could potentially have prevented the longstanding problems at Furness General Hospital.

**Q2 We don't think fitness to practise is about punishing people for past events. Do you agree?**

We would agree that it is not about 'punishing' people but it is about clear accountability for the individual as a professional and the profession more widely. It is also about demonstrating what is acceptable and what is not. That may in effect amount to punishment where it is necessary to impose sanctions and there will, and perhaps should be, an element of punishment where the conduct is particularly egregious. There is a risk that if it is perceived that professional transgressions are increasingly 'forgiven', and regulatory action by the NMC becomes the exception, that professional standards overall will fall and the profession will be perceived as largely unaccountable. Patients and the public need to be assured that the NMC will continue to

be responsible for maintaining professional standards through the exercise of its fitness to practise procedures in whatever form that takes and that the move to refer more matters back to the employer will not come to represent an abrogation of responsibility.

With many of the professional regulators including the NMC, the issue of punishment often comes less from any sanction imposed but from the often tortuous operation of the procedures themselves with registrants (and patients) being put through years of uncertainty. That is unacceptable and counterproductive if you are looking to remediate individuals. A slimmed down more responsive system for dealing with fitness to practise issues is therefore to be welcomed but the NMC must ensure it remains effective in maintaining standards.

**Q3 We propose that we will only take action to uphold public confidence when the conduct is so serious, that if we did not take action, the public wouldn't want to use the services of registrants. Do you agree?**

The consultation does cast some doubt as to what the NMC would define as 'serious'. There needs to be more work in terms of arriving at a common understanding between the NMC, registrants and the public of what that threshold should be. This is particularly in the context of the NMC referring more cases back to the employer. If a patient has suffered significant harm but the NMC decides it is not a matter that meets their threshold, the NMC will need to be able to fully justify that position and explain why an alternative course of action would be more appropriate

There will also be a body of registrants who are not fit to practise on the basis that they are not competent to practise safety but for various reasons manage to stay under the radar. It is this group that is perhaps of particular concern and that the NMC needs to do more to identify. Some of these may be subject to a series of minor complaints that do not meet the NMC threshold of serious but reflects an underlying issue with their competence or conduct. The NMC needs to have systems in place to identify these individuals and ensure that either the concerns are addressed or they are removed from the register.

**Q4 Some clinical conduct, such as deliberately covering up when things go wrong, seriously damages public trust in the professions and undermines patient safety. Do you agree?**

Yes. In 2015 the NMC revised the Code of Practice and included the Duty of Candour. It is unclear to what extent the NMC's understanding of the Duty of Candour is fully shared and understood by their registrants and what steps the NMC has taken to ensure that local interpretations across the full range of employment situations are consistent with the NMC's understanding.

**Q5 In those types of cases, the registrant should be removed from the register. Do you agree?**

Yes. If there has been a deliberate attempt to cover up information, then yes. There is also a duty on employers and organisations to create a work and employment environment where 'covering

up' is not only completely unacceptable but is also unnecessary. Registrants should always feel able to be open and honest without fear of inappropriate or disproportionate consequences. There will be many work environments where there is a culture of fear underpinned by bullying, usually due to a lack of good leadership from the top. That has been evident in many of the healthcare scandals.

**Q6 We propose that cases should be resolved at an early stage in the process if a registrant has fully remediated their clinical failings, even where those clinical failings have led to serious patient harm. Do you agree?**

Where there has been serious harm or a very serious failing, the NMC should always be involved at some level, whether it is oversight of a local procedure or directly involved in investigating the matter. The NMC needs to be satisfied that the employer is capable of carrying out a satisfactory investigation. In relation to the example given in the consultation, serious cases of this nature should not just be left to the employing organisation. There are clear issues around conflicts of interest and mitigation between employer and registrant. Any failings on the part of the registrant can only be fairly investigated by a credible external body. The NMC should always either be directly involved or be overseeing these cases.

The appropriateness of resolving cases at an early stage will depend on a number of factors. This includes the quality of the investigation, the quality of the evidence to demonstrate both remediation and insight on the part of the registrant, and confirmation that the registrant does not present a continuing risk. In terms of investigation, patients might reasonably expect that a serious failing would as a minimum lead to an assessment of core and other relevant competencies to ensure the incident was not an indicator of underlying issues in relation to the registrant's competence or conduct.

In the absence of public hearings, patients should be allowed to be active participants in the process including being able to comment on the findings of the investigation and proposed outcome before it is presented to the registrant. If significant harm has been caused but a decision is taken to return a registrant to unrestricted practice, that decision needs to be fully explained to the patients and families involved if they are to retain trust in the profession and the system of regulation. In some instances, it may be worth considering whether mediation would help in that process with both patient and registrant in attendance.

**Q7 We propose that every decision that relates to a restriction being placed on a registrant's practice (including voluntary removal) should be published. Do you agree?**

Yes. As indicated above, increased transparency throughout the process will be essential in maintaining (and regaining) public trust in the effectiveness of the NMC as regulator. If a family has suffered a traumatic death or a patient serious harm as a result of the actions or inactions of a registrant, they need to feel assured that appropriate corrective action has been taken and that the registrant has been through a rigorous assessment process to ensure they do not pose a continuing risk to other patients. If the NMC is perceived as being unresponsive or seemingly dismissive of concerns reported to them, then trust will inevitably be undermined.

**Q8 We propose that fitness to practise should support a professional culture that values equality, diversity and inclusion and prioritises openness and learning in the interests of patient safety. Do you think this is the right regulatory outcome?**

Yes but see comments below.

**Q9 We propose that fitness to practise should ensure that registrants are fit to practise safely and professionally. Do you think this is the right regulatory outcome?**

Yes but subject to how fitness to practise is defined. The public would expect the NMC to ensure that those entering the register meet a set of common core competencies, are caring and professional, and that the NMC ensures that registrants continue to practise in line with relevant standards throughout their careers. The current system of revalidation does not fulfil that task and we would encourage the NMC to look at a system of revalidation that better assures ongoing competencies. This is particularly important for registrants who are working in enhanced roles such as advanced nurse practitioners, specialist nurses, training roles etc. If a more effective system of revalidation was introduced registrants would be better supported in maintaining a high standard of professional practice and any potential problems could be identified and addressed much earlier. It is unfair on the majority of registrants who do practise to a high standard to be undermined by those registrants who are not performing to the required professional standard and are providing a poor standard of care.

**Q10 Please tell us your views on our regulatory outcomes as we've set them out in this consultation.**

- *Regulatory outcome one A professional culture that values equality, diversity and inclusion and prioritises openness and learning in the interests of patient safety.*
- *Regulatory outcome two Registrants who are fit to practise safely and professionally*

Regulatory outcome one is quite difficult to unpick because it encompasses a number of issues and may not be particularly meaningful to patients and the public. For example, 'openness and learning' should not come at the expense of setting an unsafe threshold for triggering action under the fitness to practise procedures.

As indicated above, regulatory outcome two is perhaps the more meaningful to patients but it does very much depend on how fitness to practise is defined and the standard against which that is measured.

**Q11 We think that employers are usually in the best position to resolve concerns immediately, and we should only take regulatory action if the concern has already been raised with and investigated by the employer (where there is one), unless there is an immediate risk to patient safety that we have to deal with. Do you agree?**

Whilst dealing with concerns at the level of the employer and being able to institute early remediation would appear to offer the most expedient solution to addressing issues of competence, in practice, there are considerable barriers to ensuring patient safety. It is therefore unrealistic to make a blanket statement that 'employers are usually in the best position to resolve concerns immediately.'

To ensure that concerns about registrants are dealt with appropriately by employers, it would require considerable resources in terms of the time, supervision and assessments required. This would in turn necessitate having to put in place what would inevitably be a relatively bureaucratic system. Before the NMC proceeds down this road, it needs to be established that a highly pressurised NHS has the will and the capacity to invest in taking on this responsibility. If other regulators are also wanting to be seen as 'dynamic, innovative regulators', they may also decide to change their processes to more 'local solutions' and will also expect 'the employers' to take on more of the professional competency assurance roles. It has to be questioned whether there is evidence to suggest that the majority of employers are at this stage ready willing and able to take on this additional burden and cost. This is not to say that concerns could not be dealt with at local level but you have to put the systems in place first.

Separate from this, the proposals tend to look from the perspective of systems being implemented in large NHS Trust environments. They may be able to bear the costs of setting up a complex, bureaucratic system but this ignores the mainly private sector smaller units and care homes, and Primary care settings, which are unlikely to be able to meet the additional costs or have the necessary resources and expertise at hand to put in place the infrastructure required. The other potential problem with smaller units is that there may be a reluctance to take action for fear of losing staff or being too close to take an objective position.

More generally, we only have to look at the examples of Furness General Hospital, Mid Staffs, and Winterbourne, to know that we cannot rely on all employers to be able to address concerns about registrants at local level. Whilst some organisations will have the leadership skills to take effective action, there will be other organisations where there is a lack of good leadership, an unhealthy or bullying culture, or a lack of appropriate skills and resources.

With any significant concerns about competence or where serious harm has been caused, the NMC needs a hands-on approach in all these cases. The NMC needs to be in a position to track and assess outcomes and to intervene early if they identify that the employer is not taking appropriate action or if the case is clearly one that should be being considered as a FTP matter. If a patient reports a concern to the NMC, even if they are advised to go back to the employing organisation, the NMC should monitor these cases and encourage the patient to report back the outcome. This will allow the NMC to track how cases are being managed and will give the patient some reassurance that there is external oversight. The other concern is that particularly in organisations that are failing, there will be conflicts of interest between registrants and employer, and cultural issues to overcome in terms of a lack of a safety culture leading to an underlying lack of insight or willingness to recognise that there is anything warranting action. This is repeatedly evidenced in the various healthcare scandals that have come to light.

The NMC will need to do a lot more work in conjunction with employers and patients to ensure that if more cases are to be dealt with at local level, there will in fact be effective systems in place to deal with concerns about registrants. Where those systems are lacking, the NMC must take responsibility. The risk otherwise is that unsafe or unprofessional practice will in effect be deemed acceptable by default.

Clear cut off points would need to be established between the assessment and remedial actions allowed at local level and those that should be referred to the NMC. Without that in place, there would inevitably be variations both between organisations and geographically which could in turn bring the profession into disrepute and public confidence would be lost in the 'innovative' processes.

If more issues are dealt with at employer level, there is the question of how the employment record with any information about professional competence/safety matters will get transferred to other

employers when a registrant leaves and particularly in cases where a registrant is in the middle of an employer's assessment process. Often employees leave when disciplinary or remedial matters are raised. Patient safety could be compromised as this could leave competency and conduct issues unresolved. There are also questions around the legal position and the extent to which employers could be held responsible for ensuring professional competency is upheld given that this would normally be deemed the responsibility of the relevant regulator. Again, it is about clarity over the division of roles.

Issues of transparency also arise where cases are dealt with by the employing organisation. If a case is referred back to the employer, it is likely to be become an 'employment' issue, and the patient will effectively be locked out of the process. The patient or family might also be very mistrustful that the organisation is capable or can be trusted to ensure any remedial action is going to be effective, particularly if the organisation has already failed to address their concerns more broadly. This may well reflect badly on the NMC if patients believe that there has been an ineffective response to the actions of a registrant by both the NMC and the employer. It can also have a negative effect on other registrants who witness the failure to address the practice of poorly performing colleagues.

**Q12 Do you agree that we should always take the context in which a patient safety incident occurs into account when deciding what regulatory action is appropriate?**

Yes but not as the overriding consideration. Registrants still have a professional duty to their patients and there is a risk that 'context' can be used to mitigate actions and shield registrants who should be subject to intervention because they are not in fact safe to practise regardless of the context.

**Q13 Do you agree that we should be exploring other ways to enable registrants to remediate at the earliest opportunity?**

Yes. This is subject to our response to Qu.11. Ensuring safe standards of practice starts with ensuring practitioners meet professional standards at the point of registration and that this is reviewed throughout a registrant's professional career. This is in the light of the pace of change within healthcare and medicine, the enhanced roles registrants are increasingly moving into, and the demands placed on them both professionally and personally. AvMA is particularly concerned about registrants who move into specialist clinical roles in the absence of an accredited training programme or standardised assessment process, as well as those in advanced nurse practitioner roles where professional boundaries can become blurred. If these roles are not clearly defined and the boundaries clearly set by the NMC, there is an obvious risk that registrants will not always recognise when they are straying beyond the limitations of their education and training. AvMA has started to see examples of serious harm to patients where professional boundaries have become blurred and individuals have lost sight of where the professional boundaries lie.

We would recommend the need for a more effective system of revalidation, possibly less frequent but more in depth in terms of verifying that registrants are continuing to meet both core competencies as well as those required for safe practice in any enhanced role. The latter would require the NMC to take responsibility for establishing minimum standards of education and training for specialist and enhanced roles and a system of accreditation so that there is a common understanding of where the boundaries of those roles lie.

Early intervention requires early identification. Evidence from a whole series of healthcare related enquiries has demonstrated that organisations and individuals often lack insight or simply do not act despite knowing that there is a problem. The risk of the NMC referring the majority of cases back to employers is that people will no longer report concerns to the NMC. The NMC needs to maintain a very sensitive and responsive screening process so that it does not miss FTP cases where there is an ongoing risk to patients and those cases that might signify a much wider problem within an organisation. If nothing else has been learnt from Furness General Hospital and Mid Staffs, we need to have much more sensitive triggers for initiating intervention. This includes being far more responsive to patients and the public when they report concerns.

If a concern about a registrant is referred back to the employer, there may be a number of inherent conflicts that may prevent the employer taking appropriate action, particularly where context may be a contributing factor which the employer may be unwilling or unable to acknowledge. This could either lead to a situation like Furness General Hospital where the problem is simply ignored altogether or the alternative being that the employer scapegoats the individual as a way of 'resolving' the issue and completely ignoring other failures within the organisation. Neither is going to safeguard patients nor will such an organisation be able to offer a satisfactory setting for remediation without external scrutiny and oversight. This also risks undermining the NMC's stated intention of ensuring equality, diversion and inclusion in how concerns about registrants are dealt with.

As set out in response to Question 11, most employers will need considerable support and external input to enable them to ensure effective remediation of registrants where concerns have been identified. Assuming employers have the resources to undertake this role, if the NMC is going to effectively delegate responsibility for addressing concerns about registrants, they will first need to ensure that there are good systems in place at the employer level, and if there are not, that the NMC deals with these directly.

**Q14 We propose that unless there is a serious dispute about the facts or disposal of a case, or a registrant has requested a hearing, all cases should be dealt with at a meeting. Do you agree?**

We would support this approach in principle but in practice, considerable work needs to be done to ensure this approach upholds the principles the NMC has set itself. This includes ensuring the quality of the investigations that underpin those meetings. The recent Professional Standards Authority report into the NMC's handling of concerns about midwives at the Furness General Infirmary, indicated significant failings in the investigative process. Whilst a hearing could be considered a somewhat cumbersome process, it does at least allow for the evidence to be tested and for there to be a degree of oversight into the process overall. If meetings are in general going to replace hearings, then there have to be safeguards built into the process that can incorporate some of the benefits that derive from hearings.

In terms of meetings there are a number of key considerations.

The first is assurance that sanctions will be determined before the meeting is held with the registrant and that these will not be open to negotiation. Registrants should be presented with the decision and if they wish to dispute that, it should then be referred to a hearing.

Transparency of process. This is not just about publishing the outcome of a FTP meeting. It is setting out the decision making process, the evidence on which it was based, the thinking behind

the outcome, why a particular sanction was imposed or not imposed, what the mitigating factors were that were taken into account, and how remedial action will be undertaken and assured.

Patients and those reporting concerns should be allowed to be fully engaged in the process and that they have an opportunity to respond to the findings of the investigation. It is important that patients are not locked out of the process and their rights as the person who has been most directly affected by the actions of the registrant are recognised.

**Q15 Please tell us what you think about our proposals and if there are any other approaches we could take**

The proposals come with risks to the NMC and the standing of the professions it regulates unless clear safeguards are put in place. The overriding message that appears to come out of the consultation is the move to refer the majority of cases back to the employing organisation and that the NMC will only be concerned with the most serious cases however that is defined. This could lead to the perception that the NMC has largely abrogated responsibility for addressing incompetent, unsafe or unprofessional conduct of its registrants, leaving this to employers who may well not be equipped to deal with concerns effectively, fairly or equitably which may in turn undermine one of the NMC's stated principles around fitness to practise.

Develop revalidation to include competency assessments so that you have an ongoing assessment to ensure registrants remain fit to practise.

In terms of remediation, the NMC should look at the National Clinical Assessment Service and whether there are approaches they could be adopted that would assist in making assessments and determinations around remediation, particularly for organisations that do not have the relevant resources or expertise.

If the NMC is made aware of a potential fitness to practise issue through avenues other than a reported concern e.g. through a media report, the NMC should be pro-actively following up on those reports with a view to determining whether regulatory action or intervention is required. This should not rely on someone having to report a concern.

**Q16 Tell us what you think about our proposals to improve our processes. Are there any other ways we could give more support to members of the public, or improve how we work with other organisations, including other regulators?**

AvMA welcomes the fact that the NMC is looking to improve how it deals with fitness to practise issues but as set out above, there is more work to be done to ensure the changes do not undermine the NMC's role as professional regulator.

It is essential that patients have access to independent specialist advice and support to help them navigate what can appear to be an impenetrable and complex system with multiple avenues and unexpected dead ends, particularly if they are being bounced from one organisation to another. It can take a considerable amount of courage and stamina to pursue a complaint, and the person may already be feeling vulnerable and uncertain about what to do. For most people, this will hopefully be their first and last experience of having to raise a serious concern about a registrant

and so that advice and support is essential to empower them in the process. It will also assist the NMC in their role as professional regulator.

Even assuming employers have the resources to undertake the role suggested, many would need an enormous amount of input in order to ensure they are equipped to deal with registrants who are poorly performing. Even for those organisations that are well led, the NMC should consider developing a best practice template for dealing with concerns about registrants including a framework for how best to achieve remediation and the trigger points for referral to the NMC.

Underpinning all of this is to develop revalidation so that it becomes a more effective system of identifying areas where a registrant is falling short of the required professional standard. This is particularly important for registrants working in enhanced or specialist roles.

**Equality and Diversity questions**

**Q17 Do you agree that having a fitness to practise process that values equality, diversity and inclusion could result in fairer outcomes?**

Yes. This is on the basis that the NMC has already identified evidence that this is resulting in unfair and discriminatory treatment of registrants. However, as indicated above, if more cases are to be referred back to employers, there is a risk that any commitment to equality, diversity and inclusion may well be undermined because the NMC will have little control over the behaviour of employers in their dealings with registrants unless the NMC takes an active part in monitoring and recording how concerns about registrants are dealt with, particularly given this is an issue that the regulators themselves have struggled with.

**Q18 Do you agree that we should support employers to incorporate the principles of equality, diversity and inclusion when considering making referrals?**

Yes, particularly if that is evidenced as a key issue in relation to registrants being unfairly and inappropriately referred to the NMC. However this should not act as a barrier to referral where referral is clearly justified.

**Q19 The protected characteristics are: • age • disability • gender reassignment • marriage and civil partnership • race • religion or belief • sex • sexual orientation • pregnancy and maternity.**

*Will any of these proposals have a particular impact on people who share these protected characteristics (including nurses, midwives, patients and the public)?*

• ***Mainly positive impacts anticipated***

• *Mainly negative impacts anticipated*

• *No impacts anticipated*

• *I don't know*

*Please give a reason for your answer.*

As an organisation representing the interests of patients, our focus is from the patients' perspective. Some patients will be particularly vulnerable when it comes to reporting concerns or may face particular barriers in doing so. For example, people in long term care, people with learning difficulties, people with mental health problems, disadvantaged groups more generally. In all these cases, it is important that people have easy access to independent specialist advice to support them in reporting their concerns. For those in receipt of long term care, particularly those with additional vulnerabilities, reporting concerns to the employing organisation may be perceived as putting them at risk of repercussions and in turn preventing them from speaking out.

The NMC needs to recognise the importance of having systems in place that will ensure no one is prevented from being able to raise legitimate concerns with the NMC and that they can do so without fear of any form of retribution either by the registrant or the registrant's employer.

**Q20 How can we amend our proposals to advance equality of opportunity and foster good relations between groups? Please give a reason for your answer**

The accessibility of the language used in publications and the NMC website including how inclusive this is of patients, their families and the public more generally. Good information in different formats explaining how the NMC operates its FTP procedures and why. Patients should be seen as partners in the process of maintaining professional standards and part of the early warning system that identifies where intervention is required in the interests of patient safety.

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