HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: The NMC's handling of concerns about midwives' fitness to practise at the Furness General Hospital, HC 1350

Tuesday 17 July 2018

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Watch the meeting

Members present: Dr Sarah Wollaston (Chair); Mr Ben Bradshaw; Diana Johnson; Andrew Selous; Derek Thomas; Martin Vickers; Dr Paul Williams.

Questions 1 - 85

Witnesses

I: Jackie Smith, Chief Executive and Registrar, Nursing and Midwifery Council; Philip Graf, Chair, Nursing and Midwifery Council; and Matthew McClelland, Director of Fitness to Practise, Nursing and Midwifery Council.

Examination of witnesses

Witnesses: Jackie Smith, Philip Graf and Matthew McClelland.

Q1 **Chair:** Good afternoon and thank you for coming to this afternoon's hearing with the Nursing and Midwifery Council. I would like to start with a brief opening statement, if I may, to give some context to this.

At Furness General Hospital between 2004 and 2012 there were at least 20 major failures of care, which tragically were associated with the deaths of three mothers and 16 babies. A different outcome would have been expected in 13 of these cases if there had been different care. There was a failure of systems that are meant to protect patients, and today we are discussing one specific element of that system, which is the Nursing and Midwifery Council, the body that regulates nurses and midwives.

I would like to open this session by expressing this Committee's heartfelt sympathies to the families of all those involved and our immense gratitude to them for their courage in coming forward.

With that, I would like to start, please, by asking those of you here before us today to introduce yourselves for those who are following from outside and what your role is. Matthew, would you like to start?

Matthew McClelland: My name is Matthew McClelland. I am director of fitness to practise for the Nursing and Midwifery Council.

Philip Graf: I am Philip Graf. I am chair of the Nursing and Midwifery Council.

Jackie Smith: I am Jackie Smith. I am the chief executive and registrar of the Nursing and Midwifery Council.

Q2 **Chair:** Thank you. I understand, Mr Graf, that you would like to start with an opening statement; is that right?

Philip Graf: Yes, if I may, Chair, thank you. I want to say, like you, that I am extremely sorry for our part in the families' suffering over this. We did not listen, and when we did listen we did not act quickly enough. Those gaps in what we did and did not do have caused a risk to families. We have situations where our listening was simply inadequate. Also, the gaps meant that there were midwives practising who maybe should not have been practising and, therefore, mothers and babies were put at risk because of those delays and gaps. We accept completely our responsibility for that and apologise for it.

We have, however, I believe, made significant progress, and the PSA report recognised that. We have made progress in our relationships in dealing with the families, in what we have set up to do that, and in our work with trusts and employers to spot problems earlier.

We have done something. There is clearly much more for us to do and I hope we have the opportunity of explaining to you today some of the things we are planning and are doing currently.

Chair: Thank you. Because you are softly spoken, Mr Graf, it would help some of the members if you could speak up.

Philip Graf: I apologise.

Q3 **Chair:** To be absolutely clear about this, because it has been a very important issue, do you accept the PSA's view that your failure to act on police reports meant that registrants continued to practise who may have not been fit to do so and that that put lives at risk?

Philip Graf: Yes.

Q4 **Chair:** Thank you. Could we for a moment focus on a really important aspect of this? If a similar situation were to arise now, do you think the outcome would be different, and can you be very specific in why and how it would be different?

Philip Graf: May I ask Matthew to answer that?

Matthew McClelland: Thank you. As you said at the beginning, Chair, one feature of Morecambe Bay was a system that failed on multiple levels. We have been working very hard to address our part in that and to make sure that the errors that we made could not happen again.

Part of what we have been doing, as Mr Graf alluded to a minute ago, is about working much more closely with employers. In 2016 we set up our employer link service, which works very closely with directors of nursing around the country so that we are really engaged with them, we can spot risks early and we can work with them to resolve those issues at a local level before they escalate into something more serious.

As to how we handle the cases ourselves, as the PSA reports or identifies, we are a very significantly changed organisation now compared even with what we were in 2014, and certainly completely different from what we were in 2009, when these cases first came to us. Back in those days, there had been very significant underinvestment in fitness to practise; it was a smaller team without the resources that it needed to do its job effectively. Now, it is a much larger team, we have a very significant budget attached to it, and we have 440 really committed members of staff, who have much better systems and processes available to them to deal effectively with cases.

We absolutely accept that we must do more to listen to concerns raised with us by family members and patients. That is absolutely where there remains work for us to do. That is exactly what we have been putting in train over the last weeks and months.

So, the short answer to your question is, yes, I think we are in a completely different position than we were those years ago.

Q5 **Chair:** We are going to explore some of those aspects in more detail in a moment, in particular about families, but if you had the police come to you with reports of concern, what specifically would you now be doing with those reports and how would you respond?

Matthew McClelland: Certainly back in 2012, when those reports came to us, there was a complete lack of clarity within the organisation about what we should be doing and whether we should be doing anything at all. Now, we are very clear that if we receive concerns from any source, including from the police or any other agency that is investigating, it is our responsibility to look at those carefully and to see whether we can take action straightaway or whether it may be better for the other organisation to take action first. We have a completely different procedure for doing that now than we did then.

Q6 **Chair:** If you are in doubt about patient safety, would you take action to suspend someone immediately?

Matthew McClelland: Absolutely. That is a key part of what we do.

Jackie Smith: May I add to that? I think the point that you are making is at the heart of this. The fact is that we took too long and we allowed other people to do whatever it was they felt they needed to do while we sat back and waited. The effect of that was that it took us years to deal with these cases, and that presented a risk. What is clear in the PSA report is that we would not now do that. We have a process in place that says we challenge other agencies if they say, "We want you to wait."

Q7 **Chair:** You take action in that situation.

Jackie Smith: Yes.

Q8 **Mr Bradshaw:** Could you give us some historical context, because when I was a Health Minister between 2007 and 2009 we determined that the NMC was a dysfunctional organisation. I remember there was a complete clear-out of the leadership and we instigated a major reform programme to try to address exactly the kinds of problems that you were saying continued after that. What happened? Did the momentum stop? Was it just slow?

Jackie Smith: If I can attempt to answer this, you are quite right that in 2008, when you were the Minister, you asked the CHRE, which was the organisation before the PSA, to undertake a special review of the NMC because at that time there were problems within the council, hence your reference to a clear-out, but there were issues with fitness to practise. Cases were taking too long. That was in 2008.

I joined the organisation in 2010 as the director of fitness to practise. At that time, case officers were holding 200 or 300 cases each and cases

were taking about five years to get through, because, as Matthew said, there simply was not the investment.

At the end of 2011, I became the acting chief exec, and Anne Milton, who was the Minister at that time, ordered a strategic review of the NMC, which meant that the PSA did another review leading to 15 recommendations in 2012. That was the focus of the organisation in 2012. They concluded then that we had not appreciated what our core function was, which was protecting the public. But of course, it was the entire organisation in 2012 that was failing, not just fitness to practise. There was not the investment and we had no money. What we had to do in 2012 was increase the registration fee from £76 to £120, and at that point the Department stepped in and gave us a £20 million grant to hold the fee at £100, but they attached conditions to that grant, one of which was that we had to get through our fitness to practise cases quickly.

Frankly, it took the organisation two years to recover from the strategic review. Then, in 2014, which is years after these events, we began to figure out what we needed to do, which is no comfort at all to these families, but the context is important.

Q9 **Mr Bradshaw:** Are you satisfied, though, that it was a cultural problem, or is it a problem with the way we do regulation and self-regulation in this country with some of our medical professions, in that they see their job more as defending their own rather than defending the safety and rights of patients?

Jackie Smith: The problem with the NMC historically was that it did not understand what it needed to do in fitness to practise sufficiently clearly and it did not invest. When it needed to invest, it did not have the money to do so. Now, it is taking us on average about 15 months to get through our cases from start to finish. When I joined, it was taking five years and sometimes longer. We have a decent track record now, but there is still more that we need to do. We certainly haven't got it right and we need to really listen to families who come into contact with us.

Q10 **Diana Johnson:** I would like to ask you some questions about the way that you treat bereaved families, but I want to start by referring back to Bishop James Jones, who referred in the Hillsborough inquiry to the way that the families had been treated by talking about "the patronising disposition of unaccountable power," which I think is a really powerful statement. I know, Mr Graf, you have just said that you are very sorry about what happened, you apologise for the role that the NMC played and that you are making progress on work with the families. Mr McClelland, you also just said that work was going on but there was more to do.

However, the PSA concluded: "The NMC has yet to demonstrate tangibly that it has properly addressed the need to deal appropriately with patients and families who complain." Having regard to that comment, what do you think about the position now?

Philip Graf: We accept that comment as being true, and a fundamental part of the work that we are doing is seeking to deal with that justified criticism. Since the report was issued, we have written to families. I have met two of the families; I have talked to a third family; and we are continuing to seek to talk to the families and to seek their help and comments about what we can do better. That is what we want to do. As I said, we accept fully what was said there, and we know that, not just as a one-off but on a regular basis, we have to do this and engage with families in a better way.

Matthew McClelland: Could I give some practical examples of how we are doing that as well? We have started the process of setting up what we call our public support service, which is designed to be at the heart of fitness to practise, to make sure we take a person-centred approach to what we do, that we really listen right from the outset to what families are telling us went wrong and act effectively on their concerns.

We have appointed a brilliant person to lead that service. She is in the process of setting up her team now. She has already identified 50 colleagues within the directorate who are going to act as champions. They are getting training next month, and we are changing our processes so that, right at the outset, when we get a concern referred to us by a patient or a family member, the first thing we do is pick up the phone to them, really understand what their concerns are, and that becomes the starting point for what we look at, but also how we communicate and engage with them through the process.

We are at the beginning of the road, but we have a very clear action plan set out now for how we are going to deal with families, and so on, better.

Stepping back a little into perhaps a slightly more strategic space, as Philip said, there is a real need to engage on an ongoing basis with patients and their families to understand what it is that people want from the NMC in the future. What I have described is how we deal with fitness to practise cases, but there is also the strategic question about what it means for patients and families to be at the centre of regulation. That is a programme of work that we will be kicking off later in the year so that we get into that habit of really engaging and understanding what people want from regulation and are able to change and improve it in the future.

Q11 **Diana Johnson:** Can you tell me how you feel this new way of working will be properly embedded throughout this new culture? How are you going to embed that in this organisation, which clearly has failed so badly in the past? What practical steps will you be undertaking?

Jackie Smith: Can I come back? You make a really important point here that goes to the heart of this. We essentially operate a legal process and it is very adversarial. People get missed in that, and we missed the people who mattered here.

If we are going to make a difference going forward, we have to put that to one side, recognising of course that it is important, and listen to people. That is going to take time. It is a big shift in the way in which we do things because we are working with a legal framework. It is about embedding a different approach, it is about listening to the person on the end of the phone, taking account of what they are saying and using that in a constructive way so that they feel they have been heard. All the regulators suffer from this legal process, which I think gets in the way. We have some real lessons to learn here and we need to use it positively.

Q12 **Diana Johnson:** Is there a plan, and are you publishing the plan?

Jackie Smith: Yes.

Q13 **Diana Johnson:** Does it have timescales on it?

Jackie Smith: Yes.

Philip Graf: There is a document on our website that is going to our council meeting next week and that will be discussed by them. We have also sent copies of that to the families involved in this case. We are anxious to get feedback from it before the council finally makes a decision on it. But it has exactly what you say on it: it has a plan with timescales attached, and that is what we are seeking to deliver.

Q14 **Andrew Selous:** The PSA report also said: "The NMC appears not to have engaged properly with the families affected by the events either to seek information or to address the concerns that were raised." You would accept that comment.

Philip Graf: Completely.

Q15 **Andrew Selous:** In relation to Mr Titcombe in particular, whose decision was it to monitor his Twitter and treat him as someone who was almost hostile and needed to be managed?

Jackie Smith: There was not a corporate decision to monitor individuals.

Q16 **Andrew Selous:** How did it happen? It did happen.

Jackie Smith: Yes, there is absolutely no doubt, and, from his perspective, it must seem as if an organisation is monitoring an individual for a particular purpose. I am deeply sorry about that and can understand how he feels about it, but there was not a corporate decision to monitor him. Every organisation has a regime in place to understand what is going on and what is being said about it.

Q17 **Andrew Selous:** Were there many other individuals that you viewed as a nuisance such that you were monitoring their Twitter and Facebook, because you saw them as a problem rather than people trying to—

Jackie Smith: No.

Q18 **Andrew Selous:** It was just him or just a small number of people, was

it?

Jackie Smith: No. As I say, there was not a decision to monitor him.

Q19 **Andrew Selous:** I am asking whether he was the only person you monitored on social media in that way.

Jackie Smith: Our media team looks at all sorts of people and what they are saying, because it is relevant to how we take forward the work that we are doing.

Q20 **Andrew Selous:** The point is that that is a culture of viewing a family member as a problem to be managed rather than someone from whom you are going to learn because they have had an adverse experience. Would you accept that?

Jackie Smith: Yes, absolutely; I do accept that. I can certainly see from his perspective that that is how it felt and how it was seen.

Q21 **Andrew Selous:** Were you aware, Mr Graf, that this media monitoring was going on in this way?

Philip Graf: No, because I became chair on 1 May, so this—

Q22 **Andrew Selous:** On 1 May which year?

Philip Graf: It was this year, so I was absolutely not aware.

Q23 **Andrew Selous:** You were not present at the time, okay. What is the culture—and I use that word deliberately—now of the NMC towards families? Can you spell that out for us?

Jackie Smith: One of the first things that we did very shortly after the review was published was talk to staff about what it said about us and how we dealt with individuals who came into contact with us, because, quite clearly, the review shows that we did not listen, we did not spot them and we did not take notice of them. We have been doing a programme of work with staff about recognising the value that patients and family members bring—and hearing it. I would say that we have a lot of very committed staff who are extremely determined to do a very good job.

Clearly, here, in these cases we failed. There is absolutely no doubt about that, and that made a tragic situation worse for these families, but we have a lot of very committed staff who want to learn the lessons, who are passionate about learning the lessons, because they do not want to see this written about an organisation that they work for.

Philip Graf: Can I mention one small but I think quite important part of this? We have invited two of the families down to speak to colleagues and staff in the organisation, and they are going to do that. I think it is quite important that people hear it absolutely directly from two of the families themselves. That is what we are trying to do, going back to an earlier point, to help embed this into the organisation.

Q24 **Andrew Selous:** How are you going to keep on making sure that families are not viewed as a problem and that they are listened to respectfully and properly in future, given what has happened? How are you really going to monitor that and make sure it is properly embedded, to use Ms Johnson's term, which is a very good one?

Philip Graf: That is a significant part of what the council, under my leadership, has to do. We have to look quite actively at the behaviours going on in the organisation and the ways that we are dealing with things, understand what is happening and see what specific measures there might be that we can put in place to see that and, therefore, monitor it on those terms, and continue to talk and lead the organisation. One area, for example, is to look at the values that we espouse in the organisation. Are those the right values? Are we delivering those as opposed to just talking about them?

Q25 **Andrew Selous:** I am sorry to interrupt, but do you ask families for feedback on their experience of engaging with you?

Matthew McClelland: We do. We ask families for feedback.

Q26 **Andrew Selous:** What is the result of that most recent feedback?

Matthew McClelland: It is mixed. Some people give us excellent feedback. I have had some really brilliant examples of feedback.

Q27 **Andrew Selous:** Can you break that down a bit? Is it more favourable than unfavourable? What is the analysis of it?

Matthew McClelland: It is more favourable than unfavourable.

Q28 **Andrew Selous:** What is the unfavourable proportion of families?

Matthew McClelland: I do not have the precise numbers to hand.

Q29 **Andrew Selous:** What is it roughly—a ballpark figure?

Matthew McClelland: It is about 25%.

Q30 **Andrew Selous:** So about 25% of families are still dissatisfied.

Matthew McClelland: Yes, but I will need to confirm that.

Q31 **Andrew Selous:** Do you regularly survey families?

Matthew McClelland: We regularly survey all parties to cases at different points through the process and we take what they are telling us, look at that and see whether there are things that we can learn from that. That gets fed back into the way we train staff, into the way we develop our processes.

Q32 **Andrew Selous:** Mr Graf, is that survey information made available to you as chair on your council?

Philip Graf: It will be.

Q33 **Andrew Selous:** It will be. It is not yet, but it will be.

Philip Graf: Yes.

Q34 **Andrew Selous:** At every board meeting you will see that, will you?

Philip Graf: There will be a mechanism. We are looking very closely—and it is in the proposal for the next meeting—at the whole procedure of how we handle complaints. The council will want to know and will want to see, quite properly, a proper monitoring process for that and how it is handled.

Q35 **Dr Williams:** I would like to ask some other questions around the culture of the NMC, first around transparency. The PSA has questioned the NMC's commitment in practice to transparency. What steps do you intend to take to ensure that policies and statements about transparency are translated into actual improvements in practice?

Matthew McClelland: I am very happy to answer. Absolutely, we accept what the PSA says around transparency and I think there are two elements to what it was saying. One was that we did not deal effectively with requests for information from one of the family members. We absolutely accept that. We have apologised and we are very sorry about that.

Q36 **Dr Williams:** Was that partly because there were some disparaging things said about that individual?

Matthew McClelland: Absolutely not, no. In fact, when we made the subject access request disclosure, we included within that some emails that contained disparaging remarks, but there was no intention to hide things from that person.

Q37 **Dr Williams:** The PSA review said that there were two documents that were disrespectful of Mr Titcombe, whom we are talking about, that were not disclosed.

Matthew McClelland: Yes, that is right. We accept that there were two emails that were not disclosed. That was a mistake; we have apologised for that and we have disclosed them. There was a small number of other emails that were disclosed at the time. There was no intention to hide things, but we just did not get everything right with that subject access request.

Q38 **Dr Williams:** What is wrong with the culture of your organisation that there are people within the organisation making disparaging, disrespectful remarks about people who have suffered great tragedy? You have a responsibility to make sure that they are being cared for by competent, qualified professionals.

Jackie Smith: Yes. It is a terrible situation; it should not have happened. We would not want staff members making those comments. It is horrible for Mr Titcombe.

Q39 **Dr Williams:** You are the leader of the organisation. Did that happen at the time when you were the leader or was it before you were the leader?

Jackie Smith: I do not know the dates of the emails, I am afraid, but I am almost certain, yes, that it would have been me as chief exec. It should not happen. I sincerely hope it will never happen again. Those individuals have been spoken to. It is appalling for Mr Titcombe and I deeply regret it.

Q40 **Mr Bradshaw:** They were only "spoken to." What else has happened to them?

Matthew McClelland: There were a small number of emails. We spoke to all those people to reinforce the fact that that behaviour was completely unacceptable. Some of those people are no longer with the organisation.

Q41 **Dr Williams:** How are you going to change the culture of an organisation that does this to the very people whom you are there to protect?

Jackie Smith: Changing culture is obviously going to take time. Philip might want to say something about this. We have an opportunity with this. We are taking this "lessons learned" review incredibly seriously; we have to. There are some very hard lessons that we need to learn about our staff respecting people who come into contact with us, treating them with respect and listening to them. These are the fundamental points in this review that the NMC must learn going forward.

Q42 **Dr Williams:** As the chair of the organisation, how will you ensure that that is happening?

Philip Graf: May I say two things? First, in the immediate and short term, the paper that is coming back to the board next week is an important paper. It has actions and deadlines in it. That is part of changing how we behave—how we act.

The more fundamental aspect of how we move our culture forward is about leadership in the organisation. It is about leadership going forward, and, therefore, we will need to get a permanent chief executive in place before we can really move some of that forward.

There is already in place at a level in the organisation quite a bit of leadership seeking to change it—in Matthew's team, with people under Matthew's leadership, and in other parts of the organisation. But it is about us. It is about the organisation and leadership, and the council having oversight of it, and about me and the council being determined that we can set a frame and set a way that we expect people in the organisation to behave.

Q43 **Dr Williams:** If the chief executive had not resigned ahead of the report, would you have dismissed them as a result of the report?

Philip Graf: You have to put a little bit of context around this. Under Jackie's leadership—and the PSA recognises it, by the way—significant improvements were made in this area. There were other areas where we saw improvement: the whole question of revalidation; the question around education; the reputation of the organisation after a very rocky period between 2008 and 2012; and a situation where the PSA moved from having 12 areas of concern to one area of concern.

I would have considered this very carefully and gone to my colleagues in council, but I would not have seen merit at this point in dismissing the chief executive.

Q44 **Dr Williams:** Can I ask something else about the culture of the organisation? I saw in the *Nursing Times* last month some comments from Dr Helen Shallow, a consultant midwife, who joined your organisation a year ago as a midwifery education and policy adviser. She resigned largely because she felt there were some things wrong with the culture of the NMC. She said that there were colleagues—and this is within the last year— making derogatory comments about midwives, which were then later dismissed as banter. Does this represent the culture of the NMC?

Jackie Smith: I would say it does not. Obviously, Helen has had a very unpleasant experience working for us, and I know that we would very much like to hear from her to see what more we can learn from her experience. I think that is important. Obviously she feels very strongly about this, and we have to understand how we arrived in this position, because, again, it is not what we would want at all.

Q45 **Dr Williams:** Would you agree with her that the relationship between the NMC and midwifery registrants is deteriorating?

Jackie Smith: I would agree that there are some significant challenges at the moment between the regulator and midwives. They are complex, and we definitely need to find a better way of listening to midwives and understanding their concerns.

Q46 **Dr Williams:** Are there any other comments that you would like to make? It is very worrying that there are problems with the culture of the organisation, which are being acknowledged, and that somebody has had to leave the organisation who did not feel that she was being taken seriously from within the organisation, and yet she had a position of trying to influence policy. It sounds to me as though there are still significant problems with the NMC. Would you agree?

Philip Graf: There are still things we need to do; we absolutely recognise that. There are short-term things that we can deal with and longer-term issues that we also need to deal with. As Jackie has said very specifically, midwifery work is a complex and difficult area. Those relationships are complex and difficult.

Q47 **Dr Williams:** Why is working with midwives more complex than working

with nurses?

Jackie Smith: I am not sure that there are necessarily more complexities. We are trying to put ourselves in a position where we can understand what midwives need in terms of their skills and proficiencies in the future. That is a major piece of work, and we need to do it on the back of Morecambe Bay and other areas where things have gone wrong. Our relationship as a regulator with midwives needs to improve. We recognise that, and we need to work harder.

Q48 **Dr Williams:** As a regulator, what steps are you taking to support nurses and midwives?

Jackie Smith: Revalidation, which Philip has mentioned, is a very big step in the right direction. This is about nurses and midwives reflecting on their practice, making sure they show us that they are keeping themselves up to date. That has been hugely successful. That has brought us closer to understanding their professional context. The work that we have done on the future nurse standards, again, is about understanding their practice and protecting the public. We have done a massive amount of engagement with nurses and midwives across the UK. There is always more that we can do and always more we can learn, and we are not complacent about that. We just need to show that we are doing it.

Q49 **Dr Williams:** Mr Graf, Jackie Smith said that the organisation wanted to learn from its critics. Will you be listening to Dr Helen Shallow, and how do you plan to engage with her in order to listen to friendly criticism?

Philip Graf: As it happens—and I promise you this was a coincidence—I spoke to her just before the hearing and said I would like to come and talk to her. That is the level at which I want to go and do that—to listen to her and understand her concerns.

Q50 **Dr Williams:** Thank you. Can I ask one more question around transparency? There were some examples given in the PSA report about your handling of the subject access request by James Titcombe and there was an initial decision not to publish some legal advice as well. Could you comment on that, please?

Jackie Smith: Yes. We obtained some legal opinion in respect of one of the midwives and we decided in 2016, I think it was, not to publish that legal opinion. The reason for that at the time was that the cases were still ongoing. I think the decision then was wrong. We should have published it. With the benefit of hindsight, that is what we should have done.

Q51 **Dr Williams:** Not publishing it adds up to a feeling that the NMC had something to hide.

Jackie Smith: Yes, I understand that.

Q52 **Dr Williams:** Have you been as open and as transparent as possible regarding what happened to the chronology that was prepared by James

Titcombe at the time of his son's death?

Matthew McClelland: I have looked quite carefully at this since the PSA report was published, because obviously it is an area of great concern to Mr Titcombe and to us. As the report points out, it is clear that at some point we had the chronology in our possession because it is referred to in the case files for another case. But by 2015, by the time it came to be referred to in two other cases, it does not appear to have been in our possession at that point.

Q53 **Dr Williams:** Was it shredded? Did you lose it? Was it left on a train?

Matthew McClelland: Unfortunately, because our record keeping, as the report says, was poor, we do not know what happened to it. Recollections are different within the organisation. Given that we cannot identify what happened to it, we absolutely accept the PSA's conclusion that it is more likely than not that we did not have it at that point. Subsequently, assurances were given that we had considered it carefully. Those assurances were not backed up by the record. What happened, as I see it, in those cases was that we too readily internally accepted verbal assurances that were given. There was not sufficient checking that was applied to those assurances before they were given externally. That was a mistake and it should not have happened.

Q54 **Dr Williams:** The question to you, Mr Graf, is, if I were a parent who submitted evidence to the NMC, what assurances could you give me that the organisation would not lose my information in the same way that it lost Mr Titcombe's information?

Philip Graf: The assurance I can give you is that I know there have been significant improvements in the methods and standards of record keeping. We will be pursuing that more. Again, that is planned to make sure not only that we improve it but that, as a council, we get assurances on a regular basis that that is in fact happening.

Dr Williams: Thank you.

Q55 **Chair:** Following on from that point, would you be open and honest about the fact that it had been lost if that happened in the future?

Philip Graf: Oh, yes. Yes.

Q56 **Chair:** Thank you. It is an important point.

Philip Graf: Absolutely. I am sorry, Chair. It is just that it is so fundamental to me to say that.

Chair: We accept that is an important point.

Q57 **Derek Thomas:** Please correct me if I have the circumstances or the situation wrong, but it seems to me that the chief exec resigns, the report is launched or published two days later, and then effectively there is complete silence and no media spokesperson is put forward. In this difficult situation, families look forward to a report being published and

then questions being answered, because obviously they live with enormous trauma and stress in the lead-up to it. In theory, the report being published should be a form of relief, although not that significant. Is that a fair assessment of what took place when the report was launched?

Philip Graf: We did not put someone up in the media on the day of the launch. We did write to families and spoke to families afterwards; we offered to talk to them individually about what happened and to encourage their questions to us about that. In that sense, we did engage with the families and wanted to engage with them, but we did not put somebody up that day.

Q58 **Derek Thomas:** You started, Mr Graf, with your statement, which was an apology, but I want to understand a bit about whether it is a significant enough apology. What I mean by this is that lives were lost. Our information suggests that 13 outcomes could have been different if things had been handled differently, but in your statement your organisation accepted responsibility that you put lives at risk, whereas I think what we are hearing is that lives were lost; they were not just put at risk. Is the statement from you and your organisation that, while you were not responsible for the actual care itself, you put it at risk for the families, do you think?

Philip Graf: Jackie and Matthew may wish to add to this. It is fairly clear that we did not cause the deaths of those babies. Without wishing to sound defensive about it, there were other factors involved, in terms of the trust, before it came to us. Our delay in dealing with the cases probably led to midwives practising who should not have been practising and, therefore, we do not know. Therefore, there was, for sure, an increased risk that death happened, but we were not responsible for the deaths of those babies.

Q59 **Derek Thomas:** Before Jackie comes in, if the response had been more rapid and action taken more quickly, is it possible and is there evidence that suggests that the outcomes might have been different? Are you suggesting that, Jackie?

Jackie Smith: I think the PSA covers this in its review. It says it simply cannot say. The facts are that we took too long and that that created a risk. In an ideal situation, you would have an event happening like this and the trust investigating it immediately, dealing with the event there and then, because they are best placed to do it, and only after that investigation, if there remains a serious patient safety risk, would it come to us.

Of course, that was not what happened here. The trust did not do an investigation that could be relied upon. Then many other agencies came in, such as the CQC, the police, the coroner and Bill Kirkup, and of course we sat back and waited because we felt it was the right thing to do. That

was wrong and it created a risk, but in an ideal situation the trust would be in there straightaway looking at this.

Q60 **Derek Thomas:** Did you want to say anything? We have heard a lot today about the changes to your organisation, how things would be different today, but am I right in saying that the organisation is effectively leaderless now, given your resignation? Can you advise the Committee when you plan to leave and what preparations are going forward to find a replacement?

Jackie Smith: I leave in two weeks' time, and Philip can talk about the future arrangements.

Philip Graf: There are two things. One is that we are in the final stages of negotiating with someone to be the interim chief executive, and I am, without being absolutely certain about it, very confident that we will have someone in place for the day Jackie leaves. We have also put in place a recruitment process for a permanent chief executive. The reality is that that is likely to take probably until the end of the year or the early months of next year. We are looking for an interim chief executive for between now and, probably, the first two months of next year.

Q61 **Derek Thomas:** Finally, would you consider, Mr Graf, again—although I am happy to hear from any of you—that you have engaged with the detailed findings of the PSA report sufficiently in the way that you have dealt with the families themselves; in your dealings with the families involved?

Philip Graf: I am sorry, I—

Q62 **Derek Thomas:** What I am getting at is this. We have detailed findings in the PSA reports. In terms of your ongoing relationship with the families and your dealings with them, are your actions consistent with what the report is asking for?

Philip Graf: I believe so, yes. We are seeking to engage with those families very specifically. We are seeking to set in train—and have set in train already—processes and ways of acting to allow us to have a much better relationship with the families and also be more transparent in the way that we operate. I am very clear that the plans that we have, which will be discussed next week, are a good starting point for that. They are not the end, but they are a good starting point.

Matthew McClelland: To add to that, we know that some of the family members, quite understandably, have questions about the past that need to be answered, as well as things that we need to focus on for the future. So, part of the work that Philip has been doing and that I and others have been doing in engaging with families is to understand what those questions are to try to answer those on a personal basis, so that we can seek to answer all the questions that they have.

Then, as we have been saying, the report very clearly says that there are two areas on which the organisation needs to make progress. They are supporting families much better through the process and improving our transparency. We have absolutely set out for the council next week our plans in those two regards, but we have also been through, as you would expect, the whole report, all the lessons, to see whether there are more things that we can learn and do, so that we really get absolutely the most learning we possibly can out of the report.

Philip Graf: Again, if I may say, we recognise that rebuilding trust with the families is not something you do by simply writing them a nice letter.

Q63 **Diana Johnson:** I want to ask a question about interim chief executives. It seems to me, from what is being said today, that this organisation needs someone at the helm who can make sure that things happen. I always worry when interim people come in. Why have you not been able to move to getting a permanent chief executive? Is it the timescale?

Philip Graf: Yes.

Q64 **Diana Johnson:** I was looking to see when the resignation was offered—two days before the report came out. That was—

Jackie Smith: I resigned on 11 May.

Q65 **Diana Johnson:** It is purely the timescale that is the problem, is it?

Philip Graf: Yes. To find a suitable chief executive for any organisation takes time. You are looking to use recruitment consultants to find people for longlisting and shortlisting; there is a process to go through, for a good reason. Part of what we have to allow for is that good chief executives are employed—they have notice periods—and people do not often release them automatically. My assumption is that it will take us time to find a person or those people, and it may take us time to get them released from their current occupation. In the meantime, we need leadership. It is important that we find—and I absolutely understand the point you are making—someone who can hold, if you like, the organisation and at the same time move forward on these issues that we have identified.

Q66 **Diana Johnson:** When do you think you will have a permanent chief executive?

Philip Graf: I strongly believe we will have someone in place next week.

Diana Johnson: No, a permanent chief executive.

Philip Graf: I misunderstood; I am sorry. I believe it is proper to plan on the basis that it will be 1 January at the earliest.

Q67 **Mr Bradshaw:** Mr Graf, given what you said earlier about everything that Jackie Smith had done to improve the organisation, why did you let her go?

Philip Graf: Jackie came and resigned, and she gave me—

Q68 **Mr Bradshaw:** Should you have accepted her resignation, given what you have just said to my colleague about the problems of having an interim and recruiting a new chief executive, and what you said earlier about everything she has done to improve the organisation?

Philip Graf: I accepted the points that Jackie had made—that she had been feeling it was time and that she wanted to move on, and that this report and its publication provided a point at which the organisation could look forward differently. I accepted that as a reason.

Q69 **Mr Bradshaw:** Jackie Smith, how long have you been chief executive of the organisation?

Jackie Smith: It will be six and a half years when I leave in two weeks' time.

Q70 **Mr Bradshaw:** How long were your predecessors' tenures, generally? They were pretty short, were they not?

Jackie Smith: Yes—two years.

Q71 **Mr Bradshaw:** How many of them were that short? Several?

Jackie Smith: Several, yes.

Q72 **Mr Bradshaw:** Given the seriousness of this, why wasn't a decision taken to retain some stability, given everything that you say Jackie had achieved to improve the situation? Was she not the right person to finish off that work rather than for you to accept her resignation?

Jackie Smith: If I might explain from my perspective—

Q73 **Mr Bradshaw:** Why did you decide to resign?

Jackie Smith: I had always said that I would do five years at the NMC. I had not intended to be the chief exec; I came as the director of fitness to practise. I said it would take five years to turn it round. At the end of five years, we were meeting 23 of the 24 standards.

When the report came out, I said that it was time for the NMC and others to move on, and, therefore, it was the right time for me to move on. I did not feel it was necessary for me to resign on the basis of the contents of the report, but I did feel it was right for the NMC and others to move on.

Chair: Thank you.

Q74 **Andrew Selous:** Can I ask you, Mr Graf, about the composition of your council? I have had a look through it just now and it is a bit of a roll-call of the great and the good. They are clearly people who have experience. You do not seem to have any representatives of patients' organisations or family members who have been through a similar experience. Do you think that might add some comfort to people out there? Have you considered diversifying the type of people who are on your council?

Philip Graf: We are actively considering how we can get a better patient voice—to use a phrase—around council. There are different ways of doing that.

Q75 **Andrew Selous:** I do not think there is any patient voice at all. I have had a quick look through all your council members, but I do not think there is any patient voice at all there, is there?

Philip Graf: Not currently, no; there is not.

Q76 **Andrew Selous:** Do you intend to change that?

Philip Graf: I want to look at what is the best way of getting the patient voice. One way is to have a patient advocate who is not within council but comes to council meetings. There are different options.

Q77 **Andrew Selous:** But the council is the senior decision-making body of the organisation, which appoints the chief exec and holds everyone to account, does it not?

Philip Graf: Absolutely. The point you make is a good one.

Q78 **Andrew Selous:** How many midwives are there of the 690,000—

Jackie Smith: There are 43,000.

Q79 **Andrew Selous:** So they are quite small in number. Are they the poor relation of the organisation in how they are looked after? You said there were problems earlier.

Jackie Smith: No, I would not say that at all. I think organisations such as the Royal College of Midwives over time have questioned whether midwives should be part of the NMC, because I think it is fair to say they feel outnumbered, given there are 43,000 of them and 640,000 nurses, but our approach to nursing and midwifery in terms of regulation is exactly the same.

Q80 **Andrew Selous:** You think—and this is a question to Mr Graf as well—that midwives are best served by carrying on being regulated by the NMC in its current format, do you?

Philip Graf: Yes.

Q81 **Andrew Selous:** That is in spite of the difficulties that we have heard, to which Dr Williams referred earlier.

Philip Graf: As I understand it, I think those difficulties—and Jackie will answer this better than me—are being addressed. We recognise that they happen. I do not think they are fundamental in the sense of creating a need for a different or another regulator.

Q82 **Dr Williams:** Mr Graf, are you familiar with the Law Commission's report from 2014 that recommended that each profession should have separate or distinct regulation?

Philip Graf: I am aware that there was a Law Commission report, yes.

Q83 **Dr Williams:** If the Law Commission recommended that there should be distinct registration for midwives, why do you think that there should not be?

Philip Graf: I think that there is sufficient commonality, from my understanding of it, that it makes sense, from a point of view of expertise and scale, to put the two together. I recognise that there are arguments on the other side, but on balance that is what I think.

Q84 **Dr Williams:** That is fair enough. There are things in common but there are also very distinct things. How do you, as an organisation, protect the distinct professionalism of midwives as distinct from nurses?

Jackie Smith: We do that by understanding their practice and the context in which they are working. Professor Mary Renfrew, who is a midwife, is currently leading our work on reviewing the standards for midwifery. She is doing an excellent piece of work going around the UK listening to midwives so that we can make sure that the future midwife has the right skills. That is how you do it. Structures do not necessarily solve problems. We need to show that we are listening and engaging in the same way that we do with families, and we need to do it better.

Q85 **Chair:** Thank you. Can I close by asking, Jackie, what your advice would be to your successor? This is important. You keep laughing, Mr Graf, and it is unfortunate; this is very important. What would be your advice to your successor about how we should be tackling the culture within the NMC, but also encouraging an open culture within the professions so that people feel they can come forward honestly to discuss where there are problems within their own organisation?

Jackie Smith: Thank you for giving me the opportunity to say that. Can I just say that this is about 66 cases where we failed? We failed to listen, we failed to engage, and we failed to take notice. The PSA has very recently concluded that we are meeting 23 out of the 24 standards, so I would suggest to the Committee that this is not an organisation that is failing. It is an organisation that has improved, but we still have a long way to go.

The work on which we have just consulted in respect of fitness to practise is about allowing nurses, midwives and doctors to come forward when things go wrong, so it is the just culture. We have to move away from punishing people publicly when, actually, they have made a genuine mistake that they want to learn from and they want to carry on practising. All regulators must be in that space if healthcare professionals are ever going to stay in a profession in which we all need them to stay.

Chair: Thank you very much. Thank you for coming this afternoon.

Philip Graf: Thank you very much indeed, Chair.