Written evidence submitted by The Professional Standards Authority for Health and Social Care (MSE0071)

Response to the Health and Social Care Committee's inquiry into the safety of maternity services in England

September 2020

1. Introduction

1.1 The Professional Standards Authority for Health and Social Care promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and registration of people working in health and care. We are an independent body, accountable to the UK Parliament. More information about our work and the approach we take is available at www.professionalstandards.org.uk

1.2 As part of our work we:

- Oversee the ten health and care professional regulators and report annually to Parliament on their performance
- Accredit registers of healthcare practitioners working in occupations not regulated by law through the Accredited Registers programme
- Conduct research and advise the four UK governments on improvements in regulation
- Promote right-touch regulation and publish papers on regulatory policy and practice.

2. Overview

2.1 We are pleased to see the Committee focusing its attention on maternity safety in England, as there appear to be recurrent failings in these services that the healthcare system and its regulatory framework have not succeeded in addressing, in spite of successive public inquiries. We therefore welcome the opportunity to submit evidence to this inquiry.

2.2 Our submission focuses on four areas:

- Evidence collected through our targeted Lessons Learned Review relating to the failings in maternity care at University Hospitals of Morecambe Bay NHS Foundation Trust, and annual performance reviews of the Nursing and Midwifery Council (NMC).[1] [2] We found that the NMC's fitness to practise processes had greatly improved, but that more work was still to be done to improve the way the NMC interacted with patients and families throughout the process, and to make better use of clinical expertise in investigating complaints. It is too early to assess the impact of the NMC's response to our feedback. (*Inquiry heading 1*)

[1] Professional Standards Authority, May 2018. *Lessons Learned Review into the Nursing and Midwifery Council's handling of concerns about midwives' fitness to practise at the Furness General Hospital.* Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/nmc-lessons-learned-review-may-2018.pdf?sfvrsn=ff177220_0

[2] Professional Standards Authority, March 2020. *Annual report of performance, 2018/19, Nursing and Midwifery Council.* Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/performance-review---nmc-2018-19.pdf?sfvrsn=9237720_0

- Our views on the Healthcare Safety Investigation Branch (HSIB) adopting 'safe space' principles for carrying out investigations, which could have unintended consequences for the professional duty of candour and the ability of the professional regulators to properly investigate concerns about professionals. Openness with families and proper investigation of concerns about professionals have repeatedly been identified as problem areas in reviews of maternity care failings. (*Inquiry heading 5*)
- Concerns about proposals for reform of professional regulation that appear unlikely to deliver a more coherent system and the closer working between regulators that is needed to support effective multi-professional working, such as between midwives and doctors. (*additional information*)
- Proposals for reform of fitness to practise that could make future disciplinary action by regulators less effective, transparent and accountable, while also limiting the extent to which lessons could be learned from these cases. One of the recurring themes arising from successive inquiries is that patients and families are not listened to – making fitness to practise proceedings significantly less open and transparent is likely to exacerbate this issue. (*additional information*)

3. Background on professional regulation and maternity services

3.1 The NMC plays an important role in maternity safety. As the professional regulator for nurses and midwives in the UK, and nursing associates in England, it exists to protect the public, uphold professional standards and to maintain public confidence in the professions. It sets standards of education, training, conduct and performance and seeks assurance that education courses are equipping nurses, nursing associates and midwives with the skills and knowledge required. It admits nurses, nursing associates and midwives to its register so that employers and the public can check that someone is authorised to practise. Where problems arise, it will investigate and, if necessary, act by removing them from the register or otherwise restricting their practice.

3.2 The General Medical Council (GMC) regulates obstetricians using a broadly similar model, although obstetrics is a postgraduate specialty of medicine, rather than a graduate profession like midwifery. We have no significant concerns about the performance of the GMC, which has met all our Standards of Good Regulation for the past seven completed performance reviews. These reviews have included targeted scrutiny of a range of functions, particularly when changes have been made to existing processes or new ones introduced. The GMC has not been the subject of any special inquiries by the Authority.

3.3 The NMC has been through periods of underperformance in the past, and since 2008, the Professional Standards Authority has carried out three special reviews at the behest of the Secretary of State for Health (and Social Care), including the aforementioned review of the handling of cases relating to failings at Furness General Hospital. However, our performance reviews evidence many improvements in recent years. Below we highlight to the Committee where we have identified further improvements that are required within fitness to practise, to achieve greater transparency and more effective involvement of all parties in the fitness to practise process. We also provide an update on the NMC's performance in relation to standard-setting and quality assurance of education.

4. Inquiry headings

1. The impact of previous work aimed at improving maternity safety, and the extent to which the recommendations of past work and reviews of maternity safety incidents are being consistently and rigorously implemented across the country

Failings in maternity services of Furness General Hospital, University Hospitals of Morecambe Bay NHS Foundation Trust

4.1 A number of the recommendations in the 2015 Kirkup inquiry report into the maternity services at Morecambe Bay were targeted at professional regulators, specifically the NMC and the GMC. These include:

- Recommendation 27, which called for clarity and reinforcement of the duty of professional staff to report concerns and making a failure to report concerns a lapse of professional standards. Both the NMC and GMC currently publish guidance for registrants which clarifies this duty and emphasises its relevance to fitness to practise.
- Recommendation 32, which advocated the urgent reform of the Local Supervising Authority system for midwives. Following additional concerns raised in reports from the Parliamentary and Health Service Ombudsman[3] and an external review by the King's Fund[4], this system was abolished in 2017 with the active support of the NMC and the Authority. The NMC now liaises directly with the senior officers at the relevant Trust if there are concerns about individual midwives.

4.2 Following the publication of the Kirkup investigation report, the Authority was commissioned by the Department of Health and Social Care to undertake a Lessons Learned Review into the NMC's handling of concerns about midwives at the Furness General Hospital. We published this in May 2018.[5]

4.3 The Review focussed on the processes and activities undertaken by the NMC in investigating and prosecuting cases. We concluded that, prior to 2014, the NMC's handling of fitness to practise cases was frequently inadequate; this accords with the findings of previous special reviews of the NMC carried out by the Authority, and our general understanding of the NMC's performance history in fitness to practise.[6]

4.4 Our 2018 review also acknowledged the many changes and improvements the NMC had made since the incidents reported by Kirkup, which included establishing an Employer Link Service in 2016 to promote regular contact between the regulator and health and care providers, following a recommendation in the Francis Report into failures in care at the Mid Staffordshire NHS Foundation Trust.

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[3] Parliamentary and Health Service Ombudsman, 2013. *Midwifery supervision and regulation: a report by the Health Service Ombudsman of an investigation into a complaint from Mr L about the North West Strategic Health Authority*. Available at: https://www.ombudsman.org.uk/sites/default/files/Midwifery_supervision_and_regulation_Mr_M_report.pdf

[4] The King's Fund, 2015. *Midwifery Regulation in the UK*. Available at: https://www.nmc.org.uk/globalassets/sitedocuments/councilpapersanddocuments/council-2015/kings-fund-review.pdf

[5] Professional Standards Authority, May 2018. *Lessons Learned Review into the Nursing and Midwifery Council's handling of concerns about midwives' fitness to practise at the Furness General Hospital.* Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/nmc-lessons-learned-review-may-2018.pdf?sfvrsn=ff177220_0

[6] The NMC cooperated with an investigation by the Authority in 2008 and with a Strategic Review by the Authority in 2012 (Professional Standards Authority, 2016. *Strategic review of the Nursing and Midwifery Council*. Available at: www.professionalstandards.org.uk/publications/detail/strategic-review-of-the-nursing-and-midwifery-council)

4.5 Nonetheless some failings persisted. We identified that the fitness to practise investigation and decision-making at the early stages lacked sufficient input from clinical experts. This can lead to cases being closed at the early stages, or, where they progress, to the clinical aspects of a particular case not being properly investigated alongside other issues.

4.6 Of greatest concern however was the NMC's approach to the value of evidence from and communication with patients, along with its commitment in practice to transparency, which we found still required improvement.

4.7 It appeared from our review that these shortcomings compounded the difficult experiences of patients, who already felt that they had been kept in the dark and not been listened to by the Trust and its staff. We had concerns that this was a cultural issue for the NMC, and not just one of policy and process, suggesting it may be more challenging to address:

> '*The cases that we saw suggested to us that, culturally, the NMC does not recognise the value that patient and family evidence provides or that patients and families have an interest in cases which, as a regulator, it needs to take seriously. It was not frank and open with them.'*

4.8 This is therefore an issue to which we are paying particular attention in our performance reviews (see below).

Subsequent NMC performance reviews

4.9 The Authority undertakes annual performance reviews of the regulators it oversees, assessing each against our Standards of Good Regulation.[7] [8]

4.10 The NMC has not met our Fitness to Practise Standard relating to the involvement of all parties in the process for the past three consecutive years – which reflects the findings of our Lessons Learned Review.

4.11 However, the NMC has introduced a number of initiatives to improve its engagement with the public:

- The NMC set up a Public Support Service (PSS) in September 2018 to offer support to patients, service users, family members, and members of the public who have raised fitness to practise concerns. A PSS Steering Group has been established, consisting of NMC staff and stakeholders, including members of the public affected by the fitness to practise process. We understand that the group has been focusing on how the NMC can humanise its process and developing a standard framework for a person-centred approach to complaints handling. These initiatives were at an early stage of implementation during the period of our last performance review[9].
- Other measures taken to improve the way in which the NMC communicates with parties to the fitness to practise process include staff training and a review of all its templates for correspondence with the public.
- Together with the GMC, the NMC launched a 24-hour independent support line for the public and those involved in the fitness to practise process.

4.12 Our Review highlighted the need for the NMC to ensure that those analysing and investigating complaints had access to appropriate clinical advice. It has recruited six new

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[7] Professional Standards Authority, 2019. *The Standards of Good Regulation (revised)*. Available at: https://www.professionalstandards.org.uk/publications/detail/standards-of-good-regulation-2019

[8] The Authority's performance review cycle for the NMC runs from April to March and the assessment and report writing stages usually take several months; the most recent published review covers 2018-19 and was published in March 2020.

[9] Professional Standards Authority, April 2020. *Annual review of performance 2018/19: Nursing and Midwifery Council*. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/performance-review---nmc-2018-19.pdf?sfvrsn=9237720_0

clinical advisers who offer clinical input on all referrals from members of the public that involve alleged failings in clinical care. We have also seen that the NMC has updated internal process documentation to support this.

4.13 It is too early to comment on the effectiveness of these measures. However, the Authority will continue to monitor progress in relation to all these initiatives in forthcoming performance reviews.

2. The contribution of clinical negligence and litigation processes to maternity safety and changes that could be made to clinical negligence and litigation processes to improve the safety of maternity services

4.14 We have no evidence to offer on this topic.

3. Advice, guidance and practice on the choices available to pregnant women about natural births, home births and interventions such as C-sections, and the extent to which medical advice and decision-making is affected by a fear of the "blame culture"

4.15 We have no evidence to offer on this topic.

4. How effective the training and support offered to maternity staff is, and what improvements could be made to them to improve the safety of maternity services

4.16 The Authority assesses the NMC and GMC's performance relating to the setting of standards for the relevant professions, and their quality assurance of education programmes. It also follows up where inquiries have identified failings that are relevant to our Standards of Good Regulation in these areas.

Standards for obstetricians and midwives

4.17 Through our performance reviews we assess whether the regulators we oversee maintain up-to-date standards for registrants which are kept under review and prioritise patient and service user centred care and safety.

4.18 The NMC published new standards of proficiency for midwives and standards for pre-registration midwifery education programmes in November 2019 following a full public consultation and extensive communication with relevant stakeholders. We have seen evidence that changes were made during the development of the standards to reflect the views and expertise of the stakeholders consulted.

4.19 The Committee may be interested to note that the new standards of proficiency set out a range of clinical and other skills which are relevant to the concerns identified in a number of recent reviews into maternity care. This includes monitoring and assessing vital signs, responding to possible complications, and working in partnership with women and with other professionals.

4.20 The impact of the introduction of the new standards is not yet apparent at this early stage. The NMC has committed to a programme of evaluation to establish how the standards are being implemented and what improvements may be needed in the future. We understand that the evaluation will be undertaken by an external organisation commissioned by the NMC, and overseen by an advisory group of relevant stakeholders. We will report on the outcomes of that work, and any other available evidence of the effectiveness of the new standards in protecting the public, in future performance reviews.

4.21 The GMC does not publish specific standards of practice for obstetricians, however *Good Medical Practice*[10] sets out the standards all doctors must meet. It also sets standards for and

[10] General Medical Council, *Good medical practice - The duties of a doctor registered with the GMC.* Available at: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-

approves and monitors postgraduate medical training curricula, further detail on this at 4.25-4.26.

Quality assurance of education programmes

4.22 Our Standards of Good Regulation also require the regulators to have in place a proportionate and transparent mechanism for assuring that the educational providers and programmes they oversee are delivering students and trainees that meet the regulator's requirements for registration, and that they take action where assurance activities identify concerns either about training or wider patient safety concerns.

4.23 The NMC has consistently met this Standard in recent performance reviews. We have seen evidence that the NMC takes appropriate action in response to patient safety concerns through its quality assurance activity. A recent example of this was its extraordinary review of midwifery and nursing education at Staffordshire University, which uses the Shrewsbury and Telford NHS Foundation Trust as a placement setting for nursing and midwifery students.[11]

4.24 Through its introduction of new pre-registration standards for midwifery education the NMC is changing the way in which it assures the quality of midwifery education.[12] The implementation date of the standards was extended from September 2021 to September 2022 in light of the Covid-19 pandemic, to allow appropriate time for education providers and their practice learning partners to develop new curricula and seek approval. As noted above, we will report on the effectiveness of these changes in future performance reviews.

4.25 The GMC approves and monitors postgraduate medical training curricula. The current curriculum for obstetrics and gynaecology was developed by the Royal College of Obstetricians and Gynaecologists (RCOG) and approved by the GMC in May 2019.[13] It includes requirements about foetal heart rate monitoring and multi-professional teamworking. The RCOG provides assurance that it was developed in consultation with stakeholders including trainers, other specialties, employers and public and patient groups.

4.26 The GMC has published standards which postgraduate curricula must meet.[14] Its quality assurance of postgraduate training includes regular reporting from organisations and a programme of risk-based visits. Serious concerns about patient safety or training quality may be subject to its enhanced monitoring process. The GMC publishes information about programmes subject to enhanced monitoring – the published information includes six Obstetrics & Gynaecology programmes, and one for neonatal medicine currently subject to enhanced monitoring.[15] It also publishes case studies illustrating good practice.[16]

Following up on inquiry recommendations

4.27 Our revised Standards of Good Regulation, introduced in 2019, incorporate a new requirement that the regulators consider the implications of findings of public inquiries and other relevant reports about healthcare regulatory issues.

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practice

[11] *NMC publishes extraordinary review into Staffordshire University student education programmes*. Available at: https://www.nmc.org.uk/news/news-and-updates/extraordinary-review-staffordshire-university-education-programmes/

[12] Nursing and Midwifery Council, *New standards for the future midwife*. Available at: https://www.nmc.org.uk/about-us/our-role/who-we-regulate/midwifery/education/

[13] Available at: https://www.rcog.org.uk/globalassets/documents/careers-and-training/curriculum/curriculum2019/2020-07-23-core-curriculum-2019---definitive-document.pdf

[14] General Medical Council, *Excellence by design: standards for postgraduate curricula*. Available at: https://www.gmc-uk.org/-/media/documents/excellence-by-design---standards-for-postgraduate-curricula-0517_pdf-70436125.pdf

[15] General Medical Council, *Enhanced monitoring*. Available at: https://www.gmc-uk.org/education/how-we-quality-assure/postgraduate-bodies/enhanced-monitoring

[16] https://www.gmc-uk.org/education/how-we-quality-assure/sharing-good-practice

4.28 It is clear that a number of recent reviews into maternity care have relevance to different aspects of the NMC's work, and we will consider and report on the extent to which it has considered the implications of these and taken appropriate action in response.

5. The role and work of the Healthcare Safety Investigation Branch in improving the safety of maternity services, and the adequacy and appropriateness of the collection and analysis of data on maternity safety

4.29 Though not specific to the maternity investigation programme of the Healthcare Safety Investigation Branch (HSIB), we believe it is pertinent to note here our concerns about the proposals for HSIB to become an independent body and to be able to carry out investigations along 'safe space' principles.[17] These could impact on the professional duty of candour to patients and families, and the ability of the professional regulators to properly investigate concerns about professionals. As reported in the Morecambe Bay inquiry, one area consistently highlighted for improvement when problems arise within maternity services is the communication and level of engagement offered to the public when they are involved in fitness to practise processes.

4.30 We believe that patient safety depends upon a learning culture, where near misses and errors are openly discussed and learnt from. However, an open culture where information is shared between professionals must not be closed to patients and the public. The proposals for secret 'safe space' investigations appear counter to evidence which suggests that factors such as organisational culture and support for openness may influence whether professionals speak up when something has gone wrong. Indeed, the Kirkup report into Morecambe Bay found deep-rooted problems of organisational culture and failures to spot and learn from untoward incidents with similar features to those that had occurred previously.

4.31 We are also concerned that this may create further problems for regulators in accessing the information they need from trusts to fully investigate and act on concerns where there may be a risk to public protection; and for patients and their families seeking information they expect. We consider that the principles of transparency and accountability, and the core aim of public protection, should be central to any future reform of investigations.

5. Additional information: concerns about reforms to professional regulation

Consistency, cooperation and coherence

5.1 The Authority has long argued that the regulatory landscape is crowded, confusing, and lacking in coherence.[18] There is a major difficulty in scrutinising and holding to account the healthcare system when it fails, because the system and the individuals working within it are regulated by different bodies; in addition, there are ten regulators covering the different health and care professions.

5.2 Midwives and obstetricians working together in the same team are held to different standards, and trained separately. If failings are brought to the attention of their professional regulator, they will be dealt with through different processes. They undoubtedly have

[17] For further information about our thinking on this matter, please see: Professional Standards Authority, June 2018, *Evidence to the Joint Committee on the Draft Health Service Safety Investigations Bill*. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/consultation-response/others-consultations/2018/professional-standards-authority-evidence-on-draft-health-service-safety-investigations-bill.pdf?sfvrsn=a0397220_4

[18] See Professional Standards Authority 2015, *Rethinking regulation.* Available at: https://www.professionalstandards.org.uk/publications/detail/rethinking-regulation and Professional Standards Authority 2016, *Regulation rethought*. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/regulation-rethought.pdf?sfvrsn=c537120_20

different professional identities, which are reinforced by their having different regulators. While a strong professional identity can be an asset, it sometimes be a hindrance to working well with other professions in a multi-professional team whose identities may be markedly different. We touch on this issue in our paper on the regulators' role in professional identity.[19]

5.3 The recurring issues of poor communication and ineffective handovers between midwives and obstetricians only reinforce arguments for ever closer working and greater consistency between professional regulators.

5.4 We had hopes that the Government's current plans for reform, while less ambitious than we would have liked, might at least deliver some consistency across the ten regulators we oversee.[20] However, the original drive for consistency now appears significantly diminished, with plans to allow individual regulators to set many of their own processes with no independent oversight, and lack of clarity over the likely sequencing of reforms to regulators via statutory instruments with the risk of perpetuating a piecemeal approach.

Fitness to practise

5.5 Fitness to practise has a key role to play in holding registrants to account when things have gone wrong, for the purposes of protecting the public from unsafe practitioners, as well as maintaining public confidence, and declaring and upholding professional standards.

5.6 The Government is planning to reform fitness to practise, by allowing cases to be settled behind closed doors, by agreement between the registrant and the regulator – in a process known as accepted outcomes.

5.7 We support the introduction of more proportionate means of disposing of cases where the registrant is willing to agree with the outcome of an investigation and the proposed sanction. However, we believe that there is a risk that such an approach, if not properly prescribed in legislation, could allow regulators to agree outcomes with no public declaration of the full details of the case, or of the reasoning to support a particular outcome.

5.8 This means that where the standard of care provided by doctors or midwives has fallen below what is acceptable and led to mothers and babies dying or suffering life-changing injuries, the details of the case may not come to light.

5.9 We noted in our review of the NMC's handling of the Morecambe Bay cases that lack of communication had led to further distress for the families. The following quote from our report illustrates the concerns that can arise when there is a perceived lack of transparency:

> '*From [the perspective of Mrs D] the NMC had been 'very, very quiet ... almost like shrouded in secrecy. They are a regulator ... so there should not be any shroud of secrecy there...people should know what they are doing and how they do it I think and it isn't like that at all.'* [21]

5.10 The proposals could therefore undermine the regulators' ability to maintain public confidence in regulatory processes and outcomes. This would present a fundamental

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[19] Professional Standards Authority 2018, *The regulator's role in professional identity: validator not creator.* Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/professional-identity-and-the-role-of-the-regulator-overview.pdf?sfvrsn=dc8c7220_4

[20] *The Authority welcomes reform of professional regulation but calls for greater accountability to match increased flexibility*, July 2019. Available at: https://www.professionalstandards.org.uk/news-and-blog/latest-news/detail/2019/07/09/the-authority-welcomes-reform-of-professional-regulation-but-calls-for-greater-accountability-to-match-increased-flexibility

[21] Professional Standards Authority, May 2018. *Lessons Learned Review into the Nursing and Midwifery Council's handling of concerns about midwives' fitness to practise at the Furness General Hospital.* p 27, para 3.90. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/nmc-lessons-learned-review-may-2018.pdf?sfvrsn=ff177220_0

problem for this crucial patient safety function, which is dependent on patients being willing to come forward with complaints, comply with investigations, and act as witnesses.

5.11 They would also hamper the function's role in declaring the standards below which conduct and competence should not fall, and limit the scope for learning from such cases, which is so vitally important to avoid further harm.

5.12 The Government proposals as currently drafted, would also create a public protection gap. The Authority has a unique power to appeal an outcome to the High Court if it appears to us that a decision is insufficient to protect the public. Accepted outcomes, on the other hand, would be subject neither to such challenges, nor to the systematic scrutiny of decisions that forms an integral part of our process.

5.13 We reviewed the fitness to practise decisions relating to the failings Morecambe Bay through this process. While we found no reason to appeal these particular decisions, our powers nonetheless provide assurance to the public, Parliament, and Ministers that all cases are being dealt with properly in the public interest.

5.14 By way of example, the Authority was instrumental in ensuring that Janice Harry, who was Director of Nursing at Mid Staffordshire Foundation Trust during the period covered by the Francis Inquiry, was struck off, after the NMC panel had originally imposed a five-year caution order.[22]

5.15 The Government policies relating to accepted outcomes and our appeal powers are all still in development, however time is short: the policy positions set to apply to all the regulators, along with draft legislation is set to be consulted on later this year.

6. Further information

6.1 Please get in touch if you would like to discuss any aspect of this response in further detail. You can contact us at:

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[22] The striking off was agreed by consent order under our s.29 powers: https://www.professionalstandards.org.uk/docs/default-source/section-29/consent-orders/nmc/consent-order-nmc-and-janice-harry-28-jan-14.pdf?sfvrsn=56af7e20_2