MFP0001

Written evidence from the Nursing and Midwifery Council

Dear Dr Wollaston

I wanted to update you on our plans to implement and build on the recommendations in the Professional Standard's Authority's (PSA's) *Lessons Learned Review* into our handling of the Morecambe Bay fitness to practise cases, and the findings of the Gosport Independent Panel report. I also wanted to take this opportunity to let you know that we've appointed an Interim Chief Executive and Registrar.

PSA's Lessons Learned Review – our programme of work

We fully accept the recommendations in the Lessons Learned Review. It's clear that we failed the families and we did not listen to them, or show those who raised concerns the respect they deserved. We're very sorry for the distress we caused. Due to our failures to act and the resulting delays in our investigations and hearings, some midwives continued to practise who may not have been safe to do so and mothers and babies may have been at risk of harm during this period. We're committed to learning the lessons of the past and ensuring that no other families have to go through the same experience.

On Wednesday, our Council agreed a programme of work to address the recommendations. We're adopting a new person-centred approach to fitness to practise, ensuring that patients and families are treated with compassion and respect, and that their concerns are properly addressed and listened to. We've set up a new Public Support Service, and a network of 50 employee Public Support Champions who are already starting to bring about change. We're also taking immediate steps to improve the way we communicate with patients, families and the public, and how we handle complaints. You can read about the steps we're taking in our 'Lessons Learned Review: Putting patients and the public at the heart of what we do' programme of work.

Gosport Independent Panel Report

In June, the Gosport Independent Panel published its report into how the health service failed people in Hampshire from 1988 to the early 2000s. Families of those who died have fought for more than 20 years to understand what went wrong. We want to pay tribute to all the families involved – they have shown enormous tenacity and courage in the face of a system that was failing. A great many people were let down and we're very sorry for the part we played in this. The report relates to events that happened some time ago, but there are important lessons we'll learn from it, in particular, the way we treat families who raise concerns with us. We're considering the report carefully and what actions we may need to take.

Introducing Sue Killen, Interim Chief Executive and Registrar

Sue Killen has been appointed as our Interim Chief Executive and Registrar and we look forward to her joining us on Monday. Sue was previously Chief Executive of St John Ambulance for ten years, and she's held a number of senior roles in the civil service.

We'll keep you updated on our work over the coming months and would welcome the opportunity to discuss it with you further.

Yours sincerely,

Matthew

Matthew McClelland
Director, Fitness to Practise

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