Written evidence from the Nursing and Midwifery Council

NMC progress on delivering the lessons learned from the PSA's review into our handling of the Morecambe Bay cases

Summary

We would like to update Health and Social Care Committee members on the progress we're making to address the lessons learned in the Professional Standards Authority's (PSA) review into our handling of the Morecambe Bay fitness to practise cases. We've focused on the following areas:

- the actions we've already taken and our new programme of work
- our new approach to engaging with patients, service users and families
- how we're embedding our values and improving our behaviours
- the new approach to fitness to practise which we began piloting on 1 September
- our work with midwives
- how we're supporting change across the healthcare sector

We would also like to invite Committee members to visit our offices to meet our Registration and Revalidation and Fitness to Practise teams, as we'd welcome the opportunity to show you the work we're doing.

Background

- In May, the Professional Standards Authority's (PSA) published its review into our handling of the Morecambe Bay fitness to practise cases.

- As we said to the Committee in July, we know that our approach to the Morecambe Bay cases – in particular the way we communicated with the families – was unacceptable. We're extremely sorry to the families affected by our failings. We did not listen to them or act on credible evidence. Multiple opportunities to take action were missed, we didn't investigate concerns and when we did, we took too long. Our communication with them was not acceptable.

- 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 hope that we've reassured the families, and the Committee, that we take the findings of this review very seriously. Acting on the lessons learned is our priority, and we're committed to making sure families are at the heart of what we do.

- Since 2014 we've made significant changes to improve the way we work and, as the PSA report recognises, we're now a very different organisation. Our most recent performance review from the PSA, published in June 2018, was our best ever. We achieved 23 out of 24 standards of good regulation, up from 15 out of 24 in 2013/14.

Governance and the role of our Council

- Council is our governing body, which sets our strategic direction and holds the Executive to account. Council comprises 12 members, with equal numbers of lay and registrant members. Philip Graf joined the NMC as our Chair on 1 May 2018.

- Council is committed to openness and transparency and holds its meetings in public at least six times a year. Anyone is welcome to observe a Council meeting. At our meetings there's an opportunity for comments from observers in attendance. We also publish our papers online in advance, and our minutes following the meeting, which are accessible on our website.

- We've recognised as a result of Lessons Learned that we need to do more to ensure that our Council members get greater exposure to the voices of patients, service users and families. We're committed to ensuring this happens so we're exploring ways to make sure that their voice is heard at meetings in future.

- In June, Council discussed how to gain greater assurance in the work of fitness to practise.

- We've outlined below the actions that we're taking to address the PSA's recommendations and we'll continue to keep the PSA updated on our progress.

Putting patients and the public at the heart of what we do: How we're acting on the lessons learned

- On 6 June 2018, our Council fully considered and discussed the Lessons Learned Review, during which we apologised unreservedly to the families. Council asked our Executive to prepare a wide ranging programme of work to address the recommendations and this was agreed at its meeting on 25 July 2018.

- Our 'Lessons Learned Review: Putting patients and the public at the heart of what we do' programme is published on our website and outlined in detail below. We shared it with the Committee and our stakeholders on 27 July 2018.

- Since then, we've been making changes to the way we do things, focusing initially on improving how we communicate and engage with patients, service users and families, and being more open and transparent in our work.

- As you're aware, we wrote to all the families affected following the publication of the review and said sorry for the way in which we treated them. Since then we've worked closely with a number of families, speaking to them about their experiences and getting their input into how we can make sure the voices of patients and the public can be reflected in all of our work.

A new approach to supporting patients, service users and families

- We've set up a Public Support Service that will lead our work to embed a person-centred approach in the organisation. We've appointed a Head of the Public Support Service and have now completed recruitment of the core Public Support team.

- We've already started improving our direct support to patients, families and members of the public, and we've so far provided advice and guidance to colleagues to support 27 cases.

- We're setting up a steering group, including patient groups and experts, to guide the set up and delivery of the service, which is due to hold its first meeting in October.

- We'll provide better information and more support for patients and families. We've already created a new area on our website which provides support to patients, families and other members of the public who are thinking about raising a concern or a complaint. We'll launch the full service in October 2018.

- We've committed to introducing a rolling programme of training and development for our employees. Colleagues have commenced training in mental health awareness, learning from deaths, person-centred approaches, with further sessions on conversations with vulnerable people and safeguarding scheduled for later this year.

- We'll treat each person who makes a referral to us as an individual by assessing their needs. We've started to introduce this since August 2018, together with an introductory telephone call from a case officer at the point we receive a referral.

- We're designing a pilot programme offering meetings at the beginning and end of the investigation with members of the public who have made a referral. We expect the pilot to begin in October 2018 and to last for 12 months. We'll review the outcomes of the pilot before deciding whether to implement in full.

Improving the way we communicate with people every day and being open, approachable and helpful

- We're only as good as our last letter, phone call, contact and face-to-face meeting. We've started to review all our correspondence and letters to make sure they're clear,

empathetic and offer the right level of support. We're also rolling out our new 'tone of voice', which will help shape all our communication across the organisation.

- A strong theme emerging from the Lessons Learned Review was that we failed to be open with the families when things went wrong. We're now introducing new approach to handling enquiries, information requests and complaints. We want to support people to gain access to the information they need before they have to put it in a formal request or raise a complaint. We intend to have an independent third party review our complaint handling.

- We regularly survey those who have contact with us, and the results are reported to our Council. We know we can do more, and one of our actions is to look at how we capture and report on customer satisfaction across the whole organisation to make sure themes and issues are identified, shared with our Executive and Council, and acted upon.

- In addition, we will be hosting a number of events throughout the autumn with service user groups, patients and their families to hear from them about their experiences and get their views on how we can continue to improve the way we work.

Creating change

- Since the publication of the report we've been talking to our employees about the lessons and what changes we need to make together, so that we demonstrate greater empathy and understanding for those we're working with and supporting.

- Our all-employee conference in November 2018 will focus on our values and behaviours and what it means to work for the NMC.

- We are also currently reviewing our People Strategy in light of the lessons learned review so that we can identify the areas that need greater attention.

A new strategic direction for Fitness to Practise

- Since 2014 we've significantly improved our fitness to practise function. We now resolve more than 80% of cases in 15 months from start to finish. We have a Witness Liaison team to support witnesses during investigations and hearings. Our Employer Link Service and Regulatory Intelligence Unit mean that we are working much more closely with employers and other regulators to share information and to make sure that risks are identified and addressed quickly.

- We're planning to go much further, and in July 2018 our Council gave us the go ahead to move forward with a new approach to fitness to practise, Ensuring patient safety, enabling professionalism.

- On 31 August 2018, we launched new guidance to support our employees and independent panel members to resolve cases in line with our new approach. This month we start piloting operation improvements that will make a real difference to patients, service users, and families and to nurses and midwives.

- To help shape our new approach, we held a consultation on our proposals and heard from over a thousand patients and family members, nurses and midwives, employers, other regulators, and stakeholders. The vast majority were in support of our proposals.

- We think that effective and proportionate fitness to practise means putting patient safety first, and that an open, transparent and learning culture will best achieve this. We're taking a 'just culture' approach, which will encourage nurses and midwives to speak up at the earliest opportunity when things go wrong, and see the fitness to practise process as an opportunity to learn and reflect.

- We think it's important that we work even more closely with employers so that as many issues as possible can be resolved quickly and effectively at a local level. We'll give more consideration to the context in which incidents occur, in recognition of the complex issues and unique pressures nurses and midwives face every day in the NHS.

Engaging with midwives

- The demands on modern midwives are constantly changing, with the need to deal with more wide ranging challenges than ever before. The profile of pregnant women is changing, their birthing choices have never been more diverse. This, and other challenges are placing greater demands on what a midwife needs to know and be prepared for. We recognise that we need to do more to make sure we are hearing voices on the ground.

- To make sure that the midwives of the future are ready for the challenges ahead, we're reviewing and working to future-proof the standards of proficiency for registered midwives. The new standards will outline what's required of student midwives before they can join the register and begin practising as qualified midwives. Mary Renfrew, Professor of Mother and Infant Health at the University of Dundee and an internationally respected academic in the field of midwifery, is leading this work.

- We're proactively seeking the views of midwives, women, their families, educators, students and advocacy groups, on what the new standards should include. We've so far engaged with over 500 people across the UK through workshops, focus groups with clinical midwifes and educators, webinars, email updates, and 'Twitter chats'. We're also engaging with midwives, women and families to keep them updated through the media, blogs, updates to our website, social media and videos.

Supporting change across the healthcare sector

- We're committed to being part of a learning and open culture across the healthcare sector. We want to take more holistic view of patient safety across the system.

- We're fully supportive of the aims behind the creation of the Health Service Safety Investigations Body and are committed to working in partnership with it.

- Within the limitations of our current legislation, we've put in place an ambitious programme of change for how we carry out our fitness to practise and registration functions. However, we believe that our current legislation is prescriptive, outdated and a barrier to becoming the dynamic leading regulator which is the cornerstone of our strategy.

- Although we've made significant progress to the way we work through Section 60 orders, which have enabled us to change our processes, they're piecemeal and not able to offer the level of reform needed to affect real change. We want to be able to bring real value in terms of our contribution to the workforce, to patient safety and public support, whilst being a more efficient regulator. This includes getting nurses and midwives onto our register without making them jump through unnecessary hoops, facilitating pioneering new models of education, and by giving a voice to patients and the public through wider sharing of information in fitness to practise. Regulation can and should do more, but we need wholesale legislative change to achieve this.

- We're proactively working towards building a compassionate, modern regulatory system, supporting nurses and midwives to deliver the best possible care to people in the UK across the healthcare system.