NMC submission for the inquiry into the safety of maternity services in England

About us

1 Our vision is safe, effective and kind nursing and midwifery that improves everyone's health and wellbeing. As the professional regulator of more than 700,000 nursing and midwifery professionals, we have an important role to play in making this a reality.

2 Our core role is to regulate. First, we promote high professional standards for nurses and midwives across the UK and nursing associates in England. Second, we maintain the register of professionals eligible to practise. Third, we investigate when nursing or midwifery care goes wrong – something that affects less than one percent of professionals each year.

3 To regulate well, we support our professions and the public. We create resources and guidance that are useful throughout people's careers, helping them to deliver our standards in practice and address new challenges. We also support people involved in our investigations, and we're increasing our visibility so people feel engaged and empowered to shape our work.

4 Regulating and supporting our professions allows us to influence health and social care. We share intelligence from our regulatory activities and work with our partners to support workforce planning and sector-wide decision making. We use our voice to speak up for a healthy and inclusive working environment for our professions.

Summary

5 We welcome the opportunity to submit written evidence to the Committee's inquiry into the safety of maternity services in England. We acknowledge there has been a long history of concerns and failures in care relating to maternity safety, including but not limited to those relating to Morecambe Bay, Shrewsbury and Telford and East Kent.

6 Having the right number of midwives, with the right skills, in the right place is fundamental to delivering a safe, high quality care. As of March 2020, the total number of midwives on our register with an address in England grew to 31,224.[1]

7 We recognise the full magnitude on women and families of failures in care and we are committed to using our insight and influence to help drive improvements in maternity services across the sector. Our 2020-2025 strategy[2] sets out our ambitious programme of collaboration with other regulators, key stakeholders,

[1] https://www.nmc.org.uk/globalassets/sitedocuments/nmc-register/march-2020/nmc-register-march-2020-england.pdf
[2] https://www.nmc.org.uk/globalassets/sitedocuments/strategy/nmc-strategy-2020-2025.pdf

women and families to ensure that changes are made across the system based on lessons learned and shared examples of good practice.

8 We are currently working in a number of key areas to promote safety and best practice:

8.1 **Monitoring the Future Midwife Standards.** We built on learning from past inquiries and reviews using best evidence and extensive engagement with key stakeholders and women and families to co-produce these standards. Our Standards set out the proficiencies midwives need to have to be able to join our register and are described in more detail below.

8.2 **Embedding just culture and safety principles into our fitness to practise processes.** We have made major changes to our approach to fitness to practise which is designed to foster a professional culture that prioritises openness and learning in the interest of safety. We have adopted a person-centred approach so that women and their families remain at the heart of all we do to improve care in maternity services.

8.3 **Collaborative work with the Care Quality Commission (CQC) and the General Medical Council (GMC).** We know from previous inquiries that open communication and multidisciplinary team work are essential in the delivery of safe and effective care. Regulatory collaboration is just as essential in addressing concerns so we are working collaboratively with the CQC and GMC to identify themes in maternity safety and improve the way we share intelligence and embed lessons learned into our processes.

9 While this work is a good start, we know we need to do more. Failures in maternity care have a long lasting and devastating impact on women and families and we must work with women who use maternity services in our commitment to supporting the professionals on our register in delivering better and safer care. Our Strategy[3] for the 2020-2025 period sets our ambition for the pillars of our work including:

9.1 **Regulating:** Promoting and upholding high standards and stepping in to investigate the rare occasions when care goes wrong;

9.2 **Supporting:** Proactively supporting members of the public and the professionals on our register by striking the right balance between investigating poor practice and promoting excellent practice; and

9.3 **Influencing:** Collaborating with our partners is key to addressing common concerns and driving improvement across the sector.

Q1. What has the impact has been of the work which has already taken place aimed at improving maternity safety, and the extent to which the recommendations of past work on maternity safety by Trusts, Government and its arm's-length bodies, and review of previous maternity safety incidents, are being consistently and rigorously implemented across the country

[3] https://www.nmc.org.uk/globalassets/sitedocuments/strategy/nmc-strategy-2020-2025.pdf

10 In 2015, Dr Bill Kirkup's independent investigation into the maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust[4] was published. In 2018, the Professional Standards Authority (PSA) published their 'Lessons Learned' review into our handling of concerns about midwives' fitness to practise at the Furness General Hospital.[5]

11 We take the findings of these reviews extremely seriously, and in response to this and other Reviews[6] we have taken a number of key actions to improve the way we work. These include taking steps to better communicate, support and engage with women and their families and to ensure that recommendations relating to education, training and professional practice are systematically reviewed and incorporated into our regulatory standards.

12 Our Code[7] and standards[8] provide the platform for safe and effective practice, and, by way of fostering good workplace culture, emphasise amongst other things the importance of personal accountability, inter-professional learning, and strong team working.

Changes to the regulation of midwives

13 The separation of midwifery supervision and regulation and the removal of our statutory Midwifery Committee in 2017 means we are now solely responsible for all aspects of midwifery regulation, this means we have more ability to directly influence midwifery care through our regulatory role.

14 To ensure effective and meaningful engagement with midwives and women using maternity services we have a non-statutory Midwifery Panel that provides the NMC with expertise and advice about midwifery and maternity issues across the UK. Our Midwifery Panel has been vital in providing oversight through the consultation and production of our Future Midwife Standards and on our 2020-2025 strategy.[9]

15 We recognise that effective learning in healthcare systems means learning from examples of success and identifying themes underlying failures to ensure an informed response. Poor outcomes in maternity care often include underlying failure to recognise or escalate concerns, inadequate leadership, poor culture and problems with capacity and skill mix. These are central themes to the safety of women and so they are at the heart of our new standards of proficiency for midwives.

New Future Midwife Standards

[4] https://www.gov.uk/government/publications/morecambe-bay-investigation-report
[5] https://www.professionalstandards.org.uk/docs/default-source/publications/nmc-lessons-learned-review-may-2018.pdf?sfvrsn=ff177220_0
[6] www.ombudsman.org.uk/sites/default/files/Midwifery%20supervision%20and%20regulation_%20recommendations%20for%20change.pdf
[7] https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf
[8] https://www.nmc.org.uk/standards/standards-for-midwives/standards-of-proficiency-for-midwives/
[9] https://www.nmc.org.uk/globalassets/sitedocuments/strategy/nmc-strategy-2020-2025.pdf

16 In November 2019, we published our new standards of proficiency for midwives.[10] Our standards set out best practice for midwives in the UK and the knowledge and skills midwives need to join our register.

17 We co-produced the new standards using best evidence and extensive engagement with key stakeholders and women and families who use services.[11] The process was overseen by the Midwifery Panel, and content was based on learning from key reviews, investigations, maternity policies from the four UK countries, best current evidence and the Quality Maternal Newborn Care (QMNC) Framework published in The Lancet Series on Midwifery.[12]

18 Midwives are ideally placed to anticipate and recognise changes that may lead to complications and additional care needs. We expect midwives to provide care based on the best available evidence, keeping up to date with current knowledge and skills to ensure that care is responsive to emerging evidence and practice changes.

19 We recognise that effective learning in healthcare systems means learning from examples of success and identifying themes underlying failures to ensure an informed response. Our standards highlight particular competencies for midwives which are linked to improved outcomes including: continuity of care, interdisciplinary and multiagency working, communication, and anticipating, preventing and responding to complications and additional care needs.

20 The first approved education institutions (AEIs) in England will begin to use their new curriculum for midwifery based on these standards this academic year (2020) and all AEIs educating midwives will be using a standards-based curriculum by 2022.

Monitoring and evaluation of the new standards

21 As part of our quality assurance process, we monitor approved education institutions (AEIs) and their practice learning partners to make sure that they continue to meet our standards. If our standards are not met or we receive a report that indicates significant risk or concerns we may withdraw approval.

22 We have a robust process for identifying information about risks that we receive and work closely with other professional and system regulators to identify risks early by building on initiatives such as the emerging concerns protocol,[13] rather than waiting for a serious risk or event to occur.

23 We remain committed to promoting better and safer care, and in October 2019[14] we gave a commitment to our Council to evaluate our education standards.

[10] https://www.nmc.org.uk/standards/standards-for-midwives/standards-of-proficiency-for-midwives/
[11] https://www.nmc.org.uk/globalassets/sitedocuments/midwifery/future-midwife-consultation/future-midwife-consultation-response-document.pdf
[12] https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(14)60789-3.pdf
[13] https://www.cqc.org.uk/files/emerging-concerns-protocol
[14] https://www.nmc.org.uk/globalassets/sitedocuments/councilpapersanddocuments/council-2019/open-council-papers-27-november-2019.pdf

Revalidation

24 We require all professionals on our register to revalidate every three years to maintain their registration. Revalidation is the process by which they demonstrate that they are continually reflecting, learning and applying the principles of the Code[15] to their practice. Our requirements for revalidation include practice hours, continuing professional development (CPD), reflective activities and collecting feedback, as well as declarations of ongoing health and character and professional indemnity arrangements.[16]

25 We share the data we collect on revalidation every year in our annual reports, and continue to evaluate our approach to revalidation to ensure continuous improvements support best practice and post-registration learning.

Changes to fitness to practise

26 When things do go wrong, it can be easy to assign blame. We are committed to ensuring our processes help to drive insight and understanding of why something happened and to sharing these insights to prevent it happening again.

27 Our fitness to practise principles ensure that we are consistent and transparent in the way we work and are designed to help us deliver our aim of promoting open and learning cultures in the interests of safety.

28 The outcomes of our fitness to practise consultation showed widespread support for moving beyond punishing people. To promote safety and enable cultural change we are:

28.1 Providing better support for the public, people who use services, patients and registered professionals;

28.2 Prioritising effective local action by employers to resolve issues without the need for formal regulatory intervention;

28.3 Enabling remediation to support professionals in taking steps to put things right and improve their practice; and

28.4 Seeking to resolve cases wherever possible without the need for an adversarial hearing process.

Collaborative regulatory work

29 We understand the importance of collaboration with other regulators, key stakeholders and people who use services in addressing safety concerns. We are working closely with the CQC and the GMC to identify the common themes in maternity safety emerging from our data, reviews and inquiries. We have collaboratively identified several areas of priority:

[15] https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf
[16] http://revalidation.nmc.org.uk/welcome-to-revalidation.1.html

29.1 Improving our shared understanding of risk in maternity services by working together to improve how we identify, analyse and collectively respond to risk;

29.2 Improving how we share data in order to analyse and identify common issues that cross professional boundaries; and

29.3 Longer-term improvements in regulatory collaboration to improve our data-sharing capabilities and be more preventative in our regulatory activity.

Q2. **The contribution of clinical negligence and litigation processes to maternity safety, and what changes could be made to clinical negligence and litigation processes to improve the safety of maternity services**

30 We are committed to enabling a culture of openness and learning so that we – working together with employers, our partners and other regulatory bodies – can ask the right questions when mistakes do happen and truly understand the context where mistakes have occurred in order to prevent reoccurrence.

31 While this question does not directly relate to our role as a regulator, we know that if midwives are involved in inquests, local investigations or clinical negligence cases this can create long delays to resolution. Multiple concurrent or consecutive inquiries into the same issues add to the burden on families and midwives. We support enhanced collaboration between investigating bodies to ensure inquiries are successfully concluded as quickly as possible.

Q3. 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"

32 Our standards emphasise the importance of midwives using evidence-based information to enable women, their partners and families to make individualised and informed care choices and decisions. Midwives are required to have the skills to assess, screen and plan care; and must always work to promote woman-centred care, positive outcomes and prevent complications.

33 We know that in the past professionals have expressed fear of speaking up and of our processes. A culture of blame can impact on care by acting as a barrier to speaking up and learning. Our changes to our fitness to practise approach are designed to foster a professional culture that prioritises openness and learning in the interest of safety for people who use services.

NMC information and guidance

52 Research[17] shows there is a high level of trust in midwives and that context of care is important for safety. There are high expectations on midwives for the delivery of

[17] https://www.nmc.org.uk/globalassets/sitedocuments/shaping-the-future/building-trust-and-confidence-research.pdf

care, and significant frustration and disappointment when these expectations go unmet.

53 We recognise the need to build confidence in newly qualified midwives and have published preceptorship principles[18] to integrate the newly registered midwife into the care team, build confidence and build the skills and knowledge required for independent practise.

54 In line with the pillars of our 2020-2025 strategy and in order to support our professionals in enhancing public safety we have published information on topics including raising concerns,[19] enabling professionalism[20] and practising as a midwife in the UK.[21]

55 In the context of maternity safety and collaboration with other regulators, we have published duty of candour[22] guidance with the GMC. This guidance promotes a learning culture by encouraging openness and transparency when things go wrong.

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

56 One of the main reasons for midwives leaving the workforce is the lack of focus on development and career progression.[23] Continuing professional development equips midwives with the skills to meet the needs of women and their families now and in the future. To ensure midwives' continuing professional development after registration, protected time for essential learning and career development opportunities are vital and must be made available.

57 Workforce pressures in midwifery are a major concern. Shortages threaten the quality of care and the learning environment, as well as the wellbeing of staff. Our 2020-2025 strategy sets out our goal to use our insight and influence to support high quality routes to registration, to support overseas trained midwives and to develop closer relationships with the people on our register. This will allow us to be more visible and informed and to provide access to resources and guidance that are useful to midwives throughout their career.

58 We know that the work carried out by the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP), and the Maternity Transformation Programme have contributed to the reducing perinatal and maternal mortality, despite an overall increase in the complexity of care.[24]

[18] https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-principles-for-preceptorship-a5.pdf
[19] www.nmc.org.uk/globalassets/blocks/media-block/raising-concerns-v2.pdf
[20] www.nmc.org.uk/globalassets/sitedocuments/other-publications/enabling-professionalism.pdf
[21] www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/practising-as-a-midwife-in-the-uk.pdf
[22] https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/openness-and-honesty-professional-duty-of-candour.pdf
[23] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
[24] https://www.england.nhs.uk/wp-content/uploads/2020/03/better-births-four-years-on-progress-report.pdf

59 While the stillbirth rate has reduced, and the women's experience survey[25] showed an overall improvement in what women said about their care, the picture is complex. There are several areas requiring further action by the maternity service in England, including addressing inequalities in outcomes and prioritising improvements in maternity services for people with worse care outcomes, including Black, Asian and ethnic minority families, and those from the most deprived areas.

Q5 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.

60 We welcome the role of the HSIB in undertaking maternity investigations to improve safety for people who use services. We think these investigations should be considered alongside other initiatives to encourage learning. The recurrent themes identified from the recent HSIB report[26] are included in our Standards of proficiency for midwives and we expect midwives in England to be familiar with these themes, to learn from them and use the findings to inform decisions.

61 We hold a number of memorandums of understanding (MOUs) with organisations throughout the health and care sector. This ensures that we share and receive data and concerns around professionals and settings from other organisations, ensuring that we work together to improve safety. We are aware that we can always improve collaborative working and our data collection and sharing, and are doing this through our Employer Link Service and Regulatory Intelligence Unit.

62 We have a variety of forums and methods of collaboration with other regulators and key stakeholders. We host the Midwifery Panel[27] and the Strategic Reference Group for the Lead Midwives for Education in the UK.

63 We are continuing an ambitious programme of collaborative work with the GMC and CQC to improve our intelligence sharing capabilities. Maternity services is a priority area to continue to improve collaborative ways of working. This includes shared identification of themes in maternity safety and development of collaborative work to address these themes.

64 We welcome the opportunity to work alongside the HSIB and other key stakeholders to improve the safety of maternity services and improve our data sharing capabilities.

[25] https://www.cqc.org.uk/sites/default/files/20200128_mat19_technicaldocument.pdf
[26] https://www.hsib.org.uk/documents/224/hsib-national-learning-report-summary-themes-maternity-programme.pdf
[27] https://www.nmc.org.uk/about-us/our-role/who-we-regulate/midwifery/meet-the-midwifery-panel/