Meeting of the Council

To be held from 09:30am on 6 June 2018
at 23 Portland Place, London, W1B 1PZ

Agenda

Philip Graf
Chair

Fionnuala Gill
Secretary

1	**Welcome and Chair's opening remarks**	NMC/18/39	**09:30**
2	**Apologies for absence**	NMC/18/40	
3	**Declarations of interest**	NMC/18/41	
4	**Minutes of the previous meeting** Chair	NMC/18/42	
5	**Summary of actions** Secretary	NMC/18/43	

Matters for decision

6	**PSA Lessons Learned Review** Chief Executive and Registrar	NMC/18/44	09:40
	Questions from observers Chair of the Council		
	Coffee		**11:00–11:15**

Corporate reporting

7	**Chief Executive's report** Chief Executive and Registrar	NMC/18/45	11:15

8	**Performance and Risk Report** Interim Director of Resources	NMC/18/46	11:25
9	**Audit Committee Report** Chair of the Audit Committee	NMC/18/47	12:00

Matters for information

Matters for information will normally be taken without discussion. Members should notify the Chair or the Secretary to the Council in advance of the meeting should they wish for any item to be opened for discussion.

10	**Chair's action taken since the last meeting** **None to report** Chair of the Council	NMC/18/48	
11	**Questions from observers** Chair of the Council	NMC/18/49 **(Oral)**	12:10

Lunch (12:20–13:00)

Item 4
NMC/18/42
6 June 2018

Meeting of the Council
Held on 28 March 2018 at 23 Portland Place, London, W1B 1PZ

Minutes

Present

Members:

Dame Janet Finch	Chair
Sir Hugh Bayley	Member
Karen Cox	Member
Maura Devlin	Member
Maureen Morgan	Member
Robert Parry	Member
Marta Phillips	Member
Derek Pretty	Member
Stephen Thornton	Member
Ruth Walker	Member
Anne Wright	Member

NMC Officers:

Jackie Smith	Chief Executive and Registrar
Emma Broadbent	Director of Registration and Revalidation
Sarah Daniels	Director of People and Organisational Development
Matthew McClelland	Director of Fitness to Practise
Gary Walker	Interim Director of Resources
Geraldine Walters	Director of Education, Standards and Policy
Clare Padley	General Counsel
Anne Trotter	Assistant Director, Education and Standards*****
Emma Westcott	Assistant Director, Strategy and Insight*****
Alison Neyle	Strategic Adviser
Fionnuala Gill	Secretary to the Council
Pernilla White	Governance and Committee Manager

**** Present until NMC/18/32***

Minutes

NMC/18/19 Welcome and Chair's opening remarks

1. The Chair welcomed all attendees to the meeting, including stakeholders and public observers.

2. The Chair noted that this was Maureen Morgan's last public meeting as her second term of office on the Council ended on 30 April 2018. On behalf of the Council, the Chair thanked Maureen for her dedication and commitment to the Council over the past five years and to the nursing profession over many more.

3. As it was also the Chair's last meeting having also completed her term of office, on behalf of the Council, Anne Wright and Maura Devlin, Vice-Chairs thanked the Chair for her invaluable contribution to the work of the NMC during her term in office. This included setting the five year strategy for 2015–2020; historic decisions, such as, reform of midwifery regulation and the agreement to regulate nursing associates; substantive changes to the relationship with registrants such as introduction of the new Code and revalidation; and the Education programme including review of pre-registration nursing and midwifery standards. The Chair had also built an effective Council and had contributed considerably more than the two day a week commitment expected.

NMC/18/20 Apologies for absence

1. There were apologies from Lorna Tinsley.

NMC/18/21 Declarations of interest

1. The following declarations of interest were made.

   a) NMC/18/25: Standards of proficiency for registered nurses and standards for education and training and NMC/18/26: Education quality assurance framework – Dame Janet Finch, Maureen Morgan, Karen Cox, Rob Parry and Ruth Walker declared an interest given their involvement in education. This was not considered material as the individuals were not affected any more than other individuals.
   b) NMC/18/27: Nursing Associates – All registrant members and Geraldine Walters declared an interest. This was not considered material as the individuals were not affected any more than other registrants.
   c) NMC/18/30: Midwifery update –Ruth Walker as an employer of midwives declared an interest. This was not considered prejudicial as the individual was not affected any more than other registrants.
   d) NMC/18/33: Ensuring patient safety, enabling professionalism: a

new strategic direction for fitness to practise. All registrant members and Geraldine Walters declared an interest. This was not considered material as the individuals were not affected any more than other registrants.

e) NMC/18/34: Draft Corporate plan and budget 2018–2021. All registrant members and Geraldine Walters declared an interest in the annual review of the registration fee. This was not considered material as the individuals were not affected any more than other individuals. All staff declared an interest in the review of staff pay. This was not material as staff would not be involved in any decisions.

NMC/18/22 Minutes of the previous meeting

1. The minutes of the meeting on 31 January 2018 were agreed as an accurate record.

NMC/18/23 Summary of actions

1. The Council noted progress on actions from the previous meetings.

NMC/18/24 Chief Executive's report

1. The Council considered a report from the Chief Executive and Registrar on key external developments, strategic engagement, and media activity since the previous Council meeting. The following points were noted in discussion:

a) The Chief Executive had given evidence to the Williams' review, ordered by the Secretary of State.
b) Meet the NMC events have been re-launched: the first event held on 22 March had been a success.
c) The Chief Executive had met with the Director of Nursing, senior colleagues and front-line staff in Northern Ireland in January 2018.
d) The Council was pleased that the UK Directors of Fitness to Practise (FtP) meeting hosted by the NMC involved the Northern Ireland Social Care Council and the Scottish Social Services Council. They would also attend the next meeting, along with the Welsh CSS, to be hosted by the GMC in Manchester. The Director of FtP had a programme of regular visits to Scotland, Wales and Northern Ireland and made every effort to discuss joint working opportunities with other regulators.

NMC/18/25 Education

7a. Standards of proficiency for registered nurses and standards for education and training

1. The Director of Education, Standards and Policy introduced the new standards of proficiency for registered nurses and new standards for

education and training. A number of changes had been made to the drafts as a result of the consultation feedback and further analysis. Areas which had generated the greatest amount of comment and feedback were:

a) The applicability of the standards of proficiency for registered nurses to the four fields of practice; public health; and prescribing readiness for new registrants.
b) Standards for Learning and Assessment in Practice as part of the standards for education and training.

2. In discussion the following points were noted:

a) The depth and breadth of the consultation and subsequent analysis had been impressive. A large number of standards had been revised as a result of the consultation outcomes: this was a positive outcome and a clear indication that views of professionals and public had been listened to and given thorough consideration to ensure the most appropriate standards.
b) An evidence document would be published on the NMC's website setting out the outcomes of the consultation and further work. A detailed decision pack had been prepared on each standard which provided a clear audit trail of how each of the final provisions had been reached.
c) As Council was potentially agreeing new education standards elements of which would have implications for midwives, the standards would be open to revision, as necessary, should issues emerge in developing the pre-registration standards for midwives.

Four fields of practice

d) The ambitious approach set out in the new standards to prepare nurses to provide skilled care for people who may have complex mental, physical and behavioural needs, working more flexibly across different care settings whilst maintaining the ability to enter the register in one or more of the four fields had been maintained. The standards now clarified those nursing procedures and skills where there would be a need to demonstrate greater knowledge within their chosen field. The Council welcomed this solution which secured an appropriate balance between the need for a generic skill base and more specialist knowledge.
e) There was a need to be mindful that some education providers may only be offering programmes in one field. In such cases, quality assurance of the programme would need to ensure that an appropriate range of practice placements were in place.
f) The focus of the standards on person centred care was extremely welcome; this was a positive outcome for both patients and their families/carers.
g) The NMC would support development of a national standardised

assessment document, although it could not own such guidance. There were already documents available for London and Northern Ireland and work would be taken forward jointly with the four countries and key partners to develop a consistent approach.

Simulation

h) In accordance with the outcomes based approach adopted, the new standards did not set a cap on hours of simulated learning. This had been an area of controversy. There were increasingly advanced and innovative approaches to simulated training which provided good opportunities to practice specific skills; at the same time learning experience with real people/patients was critical.
i) The quality assurance model would require approved education institutions (AEIs) to demonstrate that an appropriate balance was in place. This would need to be carefully monitored.

Standards for learning and assessment in practice

j) The new sections on practice learning and principles of student supervision were welcome, including the scope for inter-professional supervision and learning in multi-disciplinary teams.
k) The new standards refined the description of supernumerary status to recognise that supervision could decrease as learning advanced. The key consideration was patient safety. Critically, *'students were not in the numbers, but they were in the team'*: this was a powerful message.
l) The new quality assurance model would ensure increased emphasis would be placed on the quality of practice placements. This would include ensuring greater scope for flexibility for various practice settings. Good conversations would need to be had between AEIs and employers about practice placements. The Council would wish to seek assurance that that was happening in practice.
m) Given the significant changes to the standards, considerable support would be provided for implementation. Universities were already engaged and further work would be done with practise settings. It was important that this included the care sector and independent providers as well as NHS employers.
n) The emphasis on student empowerment was welcome; students were keen to have more control over their learning. It would be good to understand what the NMC would do to support this. The quality assurance model would need to ensure this was embedded. Student surveys, other forms of student feedback, together with the upcoming changes to higher education should support this.
o) Once the new programmes were introduced, it would take at least a year to begin to see the effects and benefits of the new standards. FtP data and revalidation figures would be used for a future stocktake review. Once a nurse entered the register, revalidation together with the individual's responsibility to ensure they remain

competent within their field were the basis for ensuring ongoing fitness to practise.

Decisions - The Council agreed to:

3.

i. **approve the new standards of proficiency for registered nurses, as the standards of proficiency for entry to the nursing part of the register (as required by Article 5 (2) of the Nursing and Midwifery Order 2001 ('the Order')) with effect from 28 January 2019;**
ii. **approve the new standards framework for nursing and midwifery education as part of the standards for education and training that are necessary to achieve the relevant standards of proficiency for entry to all parts of the register and for additional qualifications as required by Article 15 (1) of the Order with effect from 28 January 2019;**
iii. **approve the new standards for student supervision and assessment as part of the standards for education and training that are necessary to achieve the relevant standards of proficiency for entry to all parts of the register and for additional qualifications as required by Article 15 (1) of the Order with effect from 28 January 2019;**
iv. **approve the new standards for pre-registration nursing programmes as part of the standards for education and training that are necessary to achieve the new standards of proficiency for entry to the nursing part of the register as required by Article 15 (1) of the Order with effect from 28 January 2019; and**
v. **approve the proposed transitional arrangements related to the above standards.**

4. The Council expressed its considerable thanks to the Director of Education, Standards and Policy, Geraldine Walters, the Assistant Director, Education and Standards, Anne Trotter, Professor Dame Jill Macleod Clark and the Education team at the NMC for all the work to date on the standards and associated consultations.

Action:	**Consider i. how and when to undertake a stocktake review of the effects and benefits of the new Standards; ii how to monitor and provide assurance on a) appropriate use of simulation and b) practice placement quality through QA reports**
For:	**Director of Education, Standards and Policy**
By:	**TBA**

7b. Standards for prescribing and medicines management

5. The Director of Education, Standards and Policy introduced the new standards for prescribing and medicines management. In discussion, the following points were noted:

a) It was intended to proceed with the proposal to adopt *the RPS competency framework for all prescribers*. The NMC would work with the RPS, RCN and others in developing cross-professional guidance in key areas of prescribing practice.
b) The consultation proposals had been generally well received, although there were some areas of contention. Some refinements had been made to the initial proposals to reinforce the commitment to patient safety and ensure that entry requirements for prescribing programmes were outcome focused and based upon the achievement of the necessary experience and skill for prescribing practice.
c) It was important to acknowledge that time served does not necessarily equip someone to become a prescriber, but potentially experience does. As assessment would need to be undertaken by employers to assess the suitability of individuals to train as prescribers. Employers also need to support staff to be ready to prescribe.
d) The reference to academic ability referred to a person's ability to study at a level competent to complete the course.
e) Although there had been mixed views about the proposals to withdraw the *Standards for Medicines Management*, the rationale for doing so remained sound. The NMC would continue to work with the RPS and others on development of cross-professional guidance on safe and effective medicines management.

6. **Decisions - The Council:**

i. approved adoption of the Royal Pharmaceutical Society's (RPS) A Competency Framework for all Prescribers as our standards of proficiency for the purpose of receiving a recordable qualification in nurse and midwife prescribing with effect from 28 January 2019;
ii. approved the draft standards for prescribing programmes as part of the standards for education and training that are necessary for the purpose of receiving a recordable qualification in nurse and midwife prescribing in accordance with Article 19 (6) of the Nursing and Midwifery Order 2001 ('the Order'), with effect from 28 January 2019;
iii. agreed the transitional arrangements related to the above standards;
iv. agreed to the withdrawal of the Standards of Medicines Management; and
v. agreed that the NMC should support initiatives in the development of cross- professional guidance by the RPS and others.

Action:	**Provide an update for Council on development of cross-professional guidance on prescribing practice and medicines management**

For:	**Director of Education, Standards and Policy**
By:	**25 July 2018**

NMC/18/26 Education quality assurance framework

1. The Director of Education, Standards and Policy introduced the paper on the proposed new education quality assurance (QA) framework for implementation from September 2019.

2. The new framework adopted a risk based approach and would be more streamlined in removing the need for separate institutional and programme institutional approval. All approval requests for the new programmes would involve a visit to ensure an appropriate baseline. Approvals would be indefinite, subject to the right to suspend or withdraw approval should the need arise. This new approach should lead to a reduction in the overall number of QA visits and would enable a focus of resources on situations where the risks were greatest.

3. In discussion, the following points were noted:

a) The new risk based approach and scope for increased autonomy for AEIs was welcome.
b) It was important to monitor risks in practice placements and work with other regulators in this regard.
c) The risk based approach should improve in sensitivity over time with increased intelligence gathering. Data from the Care Quality Commission and other system regulators was already gathered by the Employer Link Service (ELS).
d) It would be useful to be clearer about what constituted minor and major modifications to programmes, given that these invoked different responses.
e) In relation to enhanced scrutiny, the expectation of self-assessments and data returns every six months would be subject to further work to ensure that this was well structured, proportionate and not too onerous and to consider whether there was scope for flex.
f) When issues were identified, there would be a staged response as now which would include engaging with the AEI and assessing the issues and action taken or planned. Students can be removed from placements and action plans can be put in place.
g) The model should set out clearly the process for withdrawing approval and the circumstances in which this might apply, for example, if an AEI had its degree-awarding powers withdrawn.
h) All providers would be subject to the same QA requirements whether private for-profit; not for profit; or partly publicly funded.
i) The costs and potential benefits of developing a student survey had not yet been included as this would require further work and would not be needed until the first students had experienced the new programmes.
j) Overall costs were driven by demand for approval requests. Given

that the future nurse programmes provided the foundation of entry on the register, it was important that there was sufficient resource to provide robust QA for programme approvals. Financial efficiencies should be achieved through an ability to better manage costs.

k) The existing outsourcing partner was in place until August 2019 with a new tender process starting shortly for QA provision from September 2019.

4. **Decisions - The Council:**

i. approved the new education quality assurance framework; and

ii. agreed that further work be undertaken to scope out the approach, possible collaborations, benefits, risks and costs to developing an NMC student survey.

Action:	**Update the Council on the final QA framework, including i. the differences between major and minor modifications; ii. further work on enhanced scrutiny arrangements; and iii. the criteria and process for withdrawing approvals**
For:	**Director of Education, Standards and Policy**
By:	**25 July 2018**

NMC/18/27 Consulting on the regulation of nursing associates

1. The Director of Education, Standards and Policy introduced the paper seeking approval to consult on the regulation of nursing associates (NAs).

2. In discussion, the following points were noted:

a) It was recognised that, given workforce pressures, there were still anxieties about the risk of NAs being used as 'substitute' nurses and/or 'scope creep'. However legitimate, these concerns were deployment matters and not the responsibility of the NMC. It was incumbent on all registrants to practice within their competence.

b) The clarity in setting out the key areas of differences between proficiencies for nurses and NAs was welcome.

c) There was a need to pay attention to any reference to ‘assess’ in the consultation document - this would be reviewed.

d) Consistency of language around degree levels was needed, including use of the term 'graduate nurse'; someone with a foundation degree was also a 'graduate'.

e) Pilot sites had been able to offer any level 5 qualification but most had opted for foundation degrees: the consultation therefore asked whether the NMC should specify a foundation degree. It was recognised that there would be implications for the NMC processes if the qualification were not a foundation degree, and potential issues with subsequent top-up programmes.

f) A similar approach would be adopted for the consultation as was

taken for the future nurse consultation. Ways to ensure four country input would be assessed on an ongoing basis; engagement would be undertaken with public/patients and hard to reach groups.

g) The views of patients and public were important; it was also an opportunity to allay any fears and concerns. In particular, language in the consultation document should be reviewed to make it straightforward and accessible to patients and public.

h) The consultation included questions around appropriateness of supernumerary status, given that the route adopted by the pilots was primarily a work-based one. The key was to ensure that there was time for 'protected learning' and patient safety should be the primary consideration.

i) It was important to recognise that the NMC was designing a qualification: there may be many varied routes to such a qualification and the NMC needed to ensure that it did not constrain this.

3. **Decision: Subject to the comments made, the Council agreed to approve the consultation on the regulation of nursing associates.**

Action:	**Ensure public/patients are consulted using straightforward language and make other changes to the consultation document as discussed**
For:	**Director of Education, Standards and Policy**
By:	**06 June 2018**

NMC/18/28 Council Scheme of Delegation

1. The Chair of the Remuneration Committee introduced the paper on the amendment to the Committee's terms of reference in the Council Scheme of Delegation reflecting revised processes for approval of non-contractual payments.

2. The Chair of the Council thanked the Chair of the Remuneration Committee for his service as both member and Chair and having steered the Committee so ably.

3. **Decision: The Council agreed the revised terms of reference for the Remuneration Committee in the Scheme of Delegation at Annexe 1.**

NMC/18/29 Panel member reappointments, transfers and removal

1. The Director of Fitness to Practise introduced the paper which outlined the re-appointment of two panel members of the Fitness to Practise Committee; transfer of two panel members to the Investigating Committee and the removal of a panel member.

2 **Decision - The Council agreed to:**

i. approve the reappointment of panel members 1 and 2 listed at Annexe 1 to a second term on the Fitness to Practise

Committee of four years from 28 March 2018 to 27 March 2022.

ii. approve transfer of panel members 3 and 4 to the Investigating Committee as listed in Annexe 1 effective from 28 March 2018.

iii. **the removal of panel member 5 as listed in Annexe 1 with effect from 28 March 2018.**

NMC/18/30 Midwifery update

1. The Director of Education, Standards and Policy introduced the update on midwifery, including the work of the Midwifery Panel.

2. The Midwifery Panel's membership had been extended to include Lord Willis of Knaresborough, a member of the House of Lords, and Leigh Kendall, a maternity campaigner and communications expert. Their knowledge and input on the Panel was welcome.

3. The extensive engagement events in relation to the future midwife project had now concluded. The input from the engagement events would be analysed by the in-house team and would inform the drafting of future standards of proficiency.

4. It was noted that the Council had formally asked the Midwifery Panel to oversee progress of the work around the future midwife standards, and to advise the Council on whether its requirements were being met.

5. In discussion, the following points were noted:

a) The Council's ownership of the principles which should underpin the new Standards as set out in the paper was important and a welcome step.
b) Given the different timeframe for the future midwife standards, there was flexibility to make adjustments to the education standards as a result of the consultation on the future midwife standards.
c) Consideration should be given to whether the work around the future midwife standards should be added to the risk register. This would be discussed as part of the annual corporate risk register discussion.
d) A systematic review of evidence from Fitness to Practise cases of areas where educational standards could be strengthened to improve public safety and prevent harm would be undertaken.

Action:	**Consider if the work around the future midwife standards should be added to the corporate risk register**
For:	**Director of Education, Standards and Policy**
By:	**06 June 2018**

NMC/18/31 Performance and Risk report

1. The interim Director of Resources introduced the paper and noted the following key updates:

a) Progress against corporate KPIs for UK initial registration applications (KPI 1) and EU/Overseas registrations applications (KPI 2) remained stable and exceeding target.
b) Call answering rates remained above 90% and the volume of calls had decreased by 21%.
c) Conclusion of FtP cases within 15 months of being opened had reached the target of 80% for the first time.
d) Customer satisfaction remained stable with an average of 76% reporting that they are very satisfied/satisfied with the service received.
e) Staff turnover had reduced slightly since December 2017 by 0.7% to 22.4%.
f) The next performance report would include an overview of serious events and complaints.
g) Deep dives into individual risks would continue throughout the year.

2. In discussion, the following points were noted:

a) The content and format of the performance and risk report had been subject to considerable discussion with the Executive over time and the current report was good. It was important to appreciate that this report formed only one element of the Council's oversight and monitoring, for example, deep dives into specific risks were carried out in the confidential session.
b) The report indicated that more information on those dissatisfied with the NMC's customer service would be brought to the next meeting; this should focus on the high level of those who were highly dissatisfied.
c) The addition of information on staff leaving within the first six months' of service was welcome. It was important to understand the reasons for this as it was not good for either the individual or the NMC and represented wasted effort and investment.
d) On the Corporate risk summary there was one red rated risk indicating there was a lot going on within the organisation which presented challenges for the Executive team.

Action:	**Focus further information on customer service on those highly dissatisfied**
For:	**Director of Registration and Revalidation**
By:	**6 June 2018**

NMC/18/32 Financial monitoring report

1. The Council considered the report on financial performance to 28

February 2018.

2. The year end picture now being forecast was better than anticipated in January: there was now an expected under spend of £1.9 million. In addition, the shortfall in expected income at £0.7 million was lower than the £1.0 million previously forecast. This resulted in a slightly higher level of Available Free Reserves at £22.6 million at the year end.

3. Some of the under spend was due to slippage on programmes. It was not expected to carry this forward to 2018–2019, as additional provision of £0.5m had been included in the proposed 2018–2019 project budget.

4. It was important to ensure resources were tightly managed and value for money secured; it was equally important to ensure that the right money was spent in the right places at the right time.

Comments from Observers

1. The Chair invited questions from observers. The following comments were made:

a) An observer from UNITE congratulated the NMC on the new standards but expressed concern that there would be no requirement for a SCPHN in a particular field to be assessed by a SCPHN in that field (eg school nurse trainee by school nurse): practice educators were anxious about this. The Director of Education, Standards and Policy confirmed that whilst this was not specified, it was not intended to change fundamentally what happened at present but simply to open up opportunities in the margins.
b) An observer from the RCN welcomed the newly approved education standards and noted the fundamental significance and importance of the new standards. She asked about plans for a long term evaluation of the impact of the new standards. The Director of Education, Standards and Policy said that there were no immediate plans for a longitudinal study.
c) An observer from an education institution asked about the possible impact of the new education standards on overseas nurses' ability to join the register. The overseas review of processes was timely in this regard and would take this into account.
d) An observer from the Scottish government asked if learning from the recent High Court judgement (PSA v NMC and X) would be taken into account in work on the new strategic direction for fitness to practise. It was confirmed that this would happen.

NMC/18/33 Ensuring patient safety, enabling professionalism: a new strategic direction for fitness to practise

1. The Director of Fitness to Practise introduced proposals for a public

consultation on a new strategic direction for fitness to practise.

2. The proposals sought to take a new approach to fitness to practise, in line with the NMC's 2015–2020 strategic objectives, within existing legislative constraints. Although good progress and improvements had been made in recent years, the current process was lengthy, adversarial and had a significant impact on all parties who engage with it. The new approach focused on assessment of risks posed by registrants to public protection and on openness and learning by encouraging early engagement and action by registrants. The need to support members of the public better was recognised: this would be the role of the Public Support Service.

3. In future, fitness to practise would work more closely with employers to encourage early local resolution of issues; this should benefit the public who wanted issues to be dealt with quickly. A more systematic approach would be taken to considering context to ensure that action was only taken when issues were clearly the result of an individual's failings. The aim would be to hold fewer hearings by agreeing as much as possible in advance, only using hearings for those matters that remained in dispute. In the interests of natural justice, registrants would still have a right to request a full hearing should they wish. Transparency would be served by continuing to publish all decisions, as now, and expanding this to include voluntary removals.

4. Legal advice had been sought in relation to the case referenced (PSA v NMC and X); learning from this case and others had been taken into account in developing the new strategic direction.

5. In discussion, the following points were noted:

a) The style of the proposed consultation was very good and the ten policy principles were clearly set out. In relation to principle six, there may be value in spelling out more clearly the different types of fitness to practise situations that may arise eg competence, conduct etc.
b) The NMC's role was to protect the public; not to punish registrants. This was not well understood: more could be done to help the public and others understand this and stress the NMC's role as strongly as possible.
c) Many registrants also felt that fitness to practise was 'punishment' and it was important to allay these concerns. The aim of encouraging nurses and midwives to speak up openly and honestly when things when wrong was important and welcome.
d) The public may feel that 'justice' was being taken away from them if there was no 'punishment' and no access to a public hearing. This should be addressed explicitly in the consultation.
e) Concerns about secrecy/transparency issue had already been aired by patient advocacy groups and others: these should be clearly

addressed in the consultation document. The publication of outcomes was part of fulfilling the transparency objective. There were plans to publish more summary fitness to practise data, including types of allegations; cases disposals; trends, thematic reviews etc, so that fitness to practise activity was open to public scrutiny.

f) The role of the NMC is to keep a register and regulate who gets on and who can stay on the register. The fitness to practise process was about who could stay on the register and who could continue to practice. The process was not the equivalent of a criminal court case but more like that of an employment tribunal deciding if a person could continue to work safely.

g) The expectations of employers and the levers that would be used if an employer failed to take action could be set out more clearly. There were different types of employers and in some cases, no employer if an individual was self-employed. Given the high dependency on employers taking action, greater clarity about the different approaches that would be needed would be helpful. It would also be important not to raise public expectations about what employers could do and how quickly.

h) The language used in the consultation needed to be straightforward and understandable eg avoiding use of words such as 'remediate'.

i) There would be public consultation through the website. External expert assistance had been secured to ensure that the views of all stakeholders were heard, including patients and the public; registrants, employers and other stakeholders. This would include focus groups and action to involve hard to reach groups.

j) The establishment of the Public Support Service was welcome. Regular reports on progress, including in due course updates on trends and learning should be provided.

k) More clarity around the benefits, including around holding fewer hearings, would also be helpful. One of the benefits of encouraging earlier engagement and remediation by registrants envisaged would be to drive up the quality of nursing and midwifery care.

l) The new direction should in the longer term provide more opportunity for increasing NMC effort and resource on driving up standards which should in turn help improve the quality of care for patients and service users. This was the next step on the journey.

6. **Decision: Subject to the comments made, the Council approved the draft consultation document.**

Action:	**Reflect the Council's views in the final consultation proposals**
For:	**Director of Fitness to Practise**
By:	**06 June 2018**
Action:	**Report further to Council on the Public Support Service**
For:	**Director of Fitness to Practise**
By:	**26 September 2018**

NMC/18/34 Draft Corporate Plan and budget 2018–2021

1. The Interim Director of Resources introduced the draft Corporate draft Corporate plan and budget for 2018–2021. In discussion, the following points were noted:

a) Given IT/technology issues and the need for a major investment programme, this should be specifically referenced as a priority within the corporate plan 2018–2019.
b) The corporate plan could be clearer about how use of intelligence would be addressed.
c) The key performance indicators could be more ambitious, given that performance generally exceeded targets and had done so for some time. A review of KPIs and targets should take place after six months to consider if more challenging targets should be set.
d) There would be a need to review the overall budgetary position once the spending requirements relating to IT and future accommodation were available to consider how these should be funded.
e) In view of the healthy cashflow position, the Council, as trustees should give serious consideration to investment options for cash in current accounts.

2. **Decision - The Council agreed to approve:**

i. the Corporate Plan 2018–2019, subject to adding IT as a priority and clearer reference to use of intelligence;
ii. the KPIs and targets for 2018–2019, subject to a review in six months time;
iii. that Available Free Reserves (AFR) should remain within the range £10–25 million;
iv. that the annual registration fee for all registrants should remain at its current level of £120; and
v. the proposed budget for 2018–2019, as set out in Table 1.

Action:	**Amend the Corporate Plan 2018–2019 to include a priority around IT and clearer reference to use of intelligence**
For:	**Interim Director of Resources**
By:	**6 June 2018**
Action:	**Review the scope for more stretching key performance indicators after six months**
For:	**Interim Director of Resources/all Directors**
By:	**28 November 2018**
Action:	**Bring investment options to Council**
For:	**Interim Director of Resources**
By:	**6 June 2018**

NMC/18/35 Audit Committee Report

1. The Chair of the Audit Committee introduced the report. Key points highlighted included:

a) New internal auditors (RSM) had been appointed and arrangements were in place for a smooth transition.
b) The Audit Committee would continue to monitor the technology issues on the risk register.
c) The Committee would also review progress on readiness for compliance with the General Data Protection Regulation (GDPR).

NMC/18/36 Council Appointments

1. The Council noted the report on Council appointments and Committee membership for 2018–2019.

NMC/18/37 Chair's action taken since the last meeting

1. The Council noted the report.

NMC/18/38 Questions from observers

1. The Chair invited questions and comments.

2. An NMC registrant asked whether the impact on the mental health of registrants going through fitness to practise would feature in developing the new strategy. For example, registrants leaving the register could be asked about whether this was linked to mental health issues. The Council recognised that this was a very important issue. Early discussions were underway with the GMC about its work in relation to Doctors. The NMC would encourage respondents to raise this in the consultation process.

The next meeting of the Council in public will be held on Wednesday 6 June 2018 at the NMC, 23 Portland Place.

Confirmed by the Council as a correct record and signed by the Chair:

SIGNATURE: .....

DATE: .....

Item 5
NMC/18/43
6 June 2018

Council

Summary of actions

Action:	For information.
Issue:	Summarises progress on completing actions from previous Council meetings.
Core regulatory function:	Supporting functions.
Strategic priority:	Strategic priority 4: An effective organisation.
Decision required:	None.
Annexes:	None.
Further information:	If you require clarification about any point in the paper or would like further information please contact the author below.

Secretary: Fionnuala Gill
Phone: 020 7681 5842
Fionnuala.gill@nmc-uk.org

Summary of outstanding actions arising from the Council meeting on 28 March 2018

Minute	Action	Action owner	Report back to: Date:	Progress to date
NMC/18/25	**Education** **7a. Standards of proficiency for registered nurses and standards for education and training** Consider i. how and when to undertake a stocktake review of the effects and benefits of the new Standards; ii. how to monitor and provide assurance on a) appropriate use of simulation and b) practice placement quality through QA reports.	Director of Education and Standards	6 June 2018	i. As part of the programme of change for education we are considering how to approach the task of evaluating our new standards. The level to which we will undertake this is dependent on the resources available. Options will be presented to the Council in due course. ii. This is being built into our new QA framework in three main ways: through including appropriate criteria for prospective programme approvals and reporting against this; through thematic review; and through annual reporting. Explicit criteria and lines of enquiry will be developed to ensure that responses are outcome focussed and capable of being comprehensively analysed and reported.
NMC/18/25	**7b. Standards for prescribing and medicines management** Provide an update for Council on i. further collaborative work on prescribing practice;	Director of Education and Standards	25 July 2018	This is on the agenda for the 25 July 2018 meeting of the Council.

Minute	Action	Action owner	Report back to: Date:	Progress to date
	ii. development of cross-professional guidance on medicines management.			
NMC/18/26	**Education quality assurance framework** Update the Council on the final QA framework, including i. the differences between major and minor modifications; ii. further work on enhanced scrutiny arrangements; and iii. the criteria and process for withdrawing approvals.	Director of Education and Standards	25 July 2018	Criteria are being developed and finalised. These will be available in the new publically facing QA framework document and the new QA handbook, by summer 2018.
NMC/18/27	**Consulting on the regulation of nursing associates** Ensure public/patients are consulted using straightforward language and make other changes to the consultation document as discussed.	Director of Education and Standards	6 June 2018	There is an easy read, shorter version of the consultation on our website and patients/members of the public are already responding to this. We are commissioning our own focus groups with service users and working with the Richmond Group of charities to identify third party opportunities for patient and service user engagement in the consultation.
NMC/18/30	**Midwifery update**	Director of Education	6 June 2018	This was discussed at the Education

Minute	Action	Action owner	Report back to: Date:	Progress to date
	Consider if the work around the future midwife standards should be added to the corporate risk register.	and Standards		Programme Board (EPB) in May 2018. It was concluded that, whilst the scope of stakeholder views is complex to navigate, we do not believe these translate to a corporate risk at this stage. The EPB will continue to discuss and monitor education programme risks, including future midwife, and we will escalate if necessary.
NMC/18/31 **NMC/18/15**	**Performance and Risk report** Focus further information on customer service on those highly dissatisfied.	Director of Registration and Revalidation	25 July 2018	Information will be provided for the July 2018 Council.
NMC/18/33	**Ensuring patient safety, enabling professionalism: a new strategic direction for fitness to practise** Reflect the Council's views in the final consultation proposals.	Director of Fitness to Practise	6 June 2018	Council's views were reflected in the final consultation proposals.
NMC/18/33	**Ensuring patient safety, enabling professionalism: a new strategic direction for fitness to practise** Report further to Council on the	Director of Fitness to Practise	26 September 2018	Not yet due.

Minute	Action	Action owner	Report back to: Date:	Progress to date
	Public Support Service.			
NMC/18/34	**Draft Corporate Plan and budget 2018–2021** Amend the Corporate Plan 2018-2019 to include a priority around IT and clearer reference to use of intelligence.	Interim Director of Resources	6 June 2018	The plan was amended as requested and published on the NMC website in April 2018.
NMC/18/34	**Draft Corporate Plan and budget 2018–2021** Review the scope for more stretching key performance indicators after six months.	Interim Director of Resources/all Directors	28 November 2018	Not yet due.
NMC/18/34	**Draft Corporate Plan and budget 2018–2021** Bring investment options to Council.	Interim Director of Resources	6 June 2018	Investment proposals have been drafted, and are due to be considered by the Executive Board on 29 May. Options will be brought to the Council meeting on 25 July 2018.

Summary of outstanding actions arising from the Council meeting on 31 January 2018

Minute	Action	Action owner	Report back to: Date:	Progress to date
NMC/18/10	**Review of Council allowances 2017** Develop proposals for a 'remuneration philosophy' for consideration by the Council	Secretary/Remuneration Committee	28 November 2018	Not yet due.
NMC/18/15	**Performance and Risk report** Report back in more detail on cases classified as concluded but still subject to a substantive order review	Director of Fitness to Practise	6 June 2018	Information is included in the Performance and Risk report on the agenda.

Summary of outstanding actions arising from the Council meeting on 29 November 2017

Minute	Action	Action owner	Report back to: Date:	Progress to date
NMC/17/100	**Education Quality Assurance Annual Report 2016–2017** Include trend data and information around public protection in future annual reports	Director of Education, Standards and Policy	28 November 2018	Not yet due.
NMC/17/101	**People Strategy** Provide more information on the key outcomes being sought; the priorities for action and the key indicators/measurements which will be used to measure progress against the key outcomes	Director of People and Organisational Development	31 January 2018 Deferred to 25 July 2018	Not yet due.
NMC/17/103	**Annual equality, diversity and inclusion report 2016–2017 and strategic action plan** Provide more analysis of data in future reports and planed action to address findings	Director of Registration and Revalidations	26 September 2018	Not yet due.

Summary of outstanding actions arising from the Council meeting on 27 September 2017

Minute	Action	Action owner	Report back to: Date:	Progress to date
NMC/17/86	**Employer Link Service report one year on** Take account of the Council's comments in future reports.	Director of Fitness to Practise	26 September 2018	Not yet due.

Item 6
NMC/18/44
6 June 2018

Council

PSA Lessons Learned Review

Action: For decision.

Issue: To consider the Professional Standards Authority's (PSA's) Lessons Learned Review of our handling of concerns about midwives' fitness to practise at Furness General Hospital and actions we will take to address the recommendations.

Core regulatory function: All regulatory functions.

Strategic priority: All strategic priorities.

Decision required: The Council is invited to:

- discuss the Lessons Learned Review (annexe 1);
- discuss and agree the priority areas for change (paragraph 10 below);
- discuss and agree the strategic actions (paragraph 11 below).

Annexes: The following annexe is attached to this paper:

- Annexe 1: PSA Lessons Learned Review.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

Chief Executive: Jackie Smith
Phone: 020 7681 5428
jackie.smith@nmc-uk.org

Context:

1 The Professional Standards Authority for Health and Social Care (PSA) has undertaken a Lessons Learned Review of our handling of concerns about midwives' fitness to practise at Furness General Hospital. The report was published on 16 May 2018 (**annexe 1**). It identifies eight lessons for us and other regulators.

2 We are sorry that we got things wrong and for the traumatic impact this has had on the families concerned. We accept all the recommendations and have identified the following priority areas where we need to make a significant change in the way we work:

2.1 Treating everyone who comes into contact with us with respect and supporting them better when they engage with our processes.

2.2 Improving our approach to transparency and making sure we are open with people when things go wrong.

2.3 Embedding a culture of openness and learning throughout the organisation.

Four country factors:

3 The lessons apply to all our work across all four countries.

Discussion:

4 The PSA began the Lessons Learned Review in July 2017. It looked at the way in which we handled concerns about midwives' fitness to practise at Furness General Hospital. The concerns arose between 2004 and 2014. Tragically, during the period there were several avoidable deaths of babies and mothers.

5 As part of the review, the PSA examined our files and spoke to some of the families affected by the events; stakeholders with knowledge of the events; one of the midwives who was subject to a fitness to practise case; and members of NMC staff. We are very grateful to the PSA for its work to identify learning and to all those who participated in the review. We are particularly grateful to the family members who contributed and we are determined to learn from what they have said.

6 We fully accept that our approach to the Morecambe Bay cases was unacceptable. Our management of the cases and the way we treated the patients and families affected did not live up to our values as an organisation. Our mistakes have had a significant, traumatic impact on patients and families and we are very sorry for that.

7 We fully accept the lessons identified in the review. We know that we need to do more to listen to and engage empathetically with people who are come into contact with us. It is especially important that we support patients and families better and make sure that we

properly understand and take full account of concerns they raise with us about nurses and midwives.

8 It is also essential that we demonstrate that we are willing to be open when things go wrong and are learning from our mistakes. We must ensure that complaints are always seen as opportunities to learn and that we do not respond to them defensively.

9 After we received the report, we took some immediate steps to start changing things:

9.1 We wrote to the families to apologise and to offer to meet with them if they would like to do so.

9.2 We provided Mr A with a copy of the two disrespectful emails referred to in the PSA's report. We have apologised to him for not disclosing these to him sooner, and for the content of the emails.

9.3 We have released a legal opinion from senior counsel to the families affected and to those who made freedom of information requests for it.

9.4 The Chair and the Chief Executive have discussed the review and the lessons learned with our staff.

9.5 We have invited the PSA's Chief Executive to meet our executive team to provide input on next steps.

9.6 The executive team has discussed the culture and values of the organisation in light of the review and agreed priority areas and actions.

10 The priority areas where we wish to make a significant change in the way we work are:

10.1 Treating everyone who comes into contact with us with respect and supporting them better when they engage with our processes.

10.2 Improving our approach to transparency and making sure we are open with people when things go wrong.

10.3 Embedding a culture of openness and learning throughout the organisation.

11 The key strategic actions we are taking forward in order to effect these changes are:

11.1 We have set up our new Public Support Service (PSS). This will be critically important to how we support patients and their families better, helping us to hear their voice and take

their views fully into account. We hope the families affected by the events at Furness General Hospital, as well as patients and members of the public more generally, will give us their views and help shape the Service to ensure it meets their needs. We will report progress to the Council in September 2018.

11.2 We want to hear from the families affected by the poor care at Furness General Hospital and elsewhere, so that learning from their experience improves how midwives are educated and trained in future. We will offer to meet them in their home town, or other preferred location, to make it as easy as possible for them to talk to us directly. We will report back on this as part of our regular reports on progress in developing the Future Midwife standards.

11.3 We are consulting on a new strategic direction for fitness to practise and have extended the deadline for responses so that those who wish to contribute in the light of the review findings can do so. We are keen to hear from the families, as well as patients and the wider public, so that we can incorporate the lessons learned into our new approach and get this right. We will report back to the Council on the consultation outcomes in July 2018 but will continue to listen to views and feedback as we begin to introduce the new approach.

11.4 We want to be open and transparent when people complain to us and be honest with them when we get things wrong. When we do make mistakes, we want to make sure that we not only put things right but learn from them so we do not make the same mistakes again. We will review and update our complaint policies and ensure all our staff understand this. We will report back to the Council in July 2018.

11.5 When people ask us for information we hold about them or about what we are doing, we will be as open and transparent as we can be. We will update our policies and guidance for staff to make sure this happens. We will report back to the Council in July 2018.

11.6 The values we expect of everyone who works for, or with, the NMC are transparency, fairness and valuing people. We will be engaging with our staff to make sure that these values are integral to everything we do and that everyone is involved in how we develop and improve in these areas. We will report back to the Council as part of our regular reporting on the People Strategy.

12 **Recommendation: The Council is invited to:**

12.1 **discuss the Lessons Learned Review (annexe 1);**

12.2 **discuss and agree the priority areas for change (paragraph 10 above);**

12.3 **discuss and agree the strategic actions (paragraph 11 above).**

Public protection implications: 13 The issues identified in the report clearly posed a risk to public protection. At this point, our assessment is that there are no immediate public protection concerns. We recognise that we must work hard to ensure that we maintain public confidence in us as a regulator.

Resource implications: 14 No immediate resource implications.

Equality and diversity implications: 15 None.

Stakeholder engagement: 16 We are committed to engaging effectively with patients and members of the public as we take forward the strategic actions. In particular, we are undertaking engagement in developing the Future Midwife standards, setting up the Public Support Service, and as part of the consultation on our proposed new strategic direction for fitness to practise.

Risk implications: 17 The issues identified in the report are relevant to corporate risk 2: the risk that we may fail to take appropriate action to address a regulatory concern. It is clear that such failures did occur in our handling of concerns about midwives at Furness General Hospital. Our assessment is that it is right that the risk remains amber at present, given the improvements to our process that we have made since 2014.

Legal implications: 18 None.

Lessons Learned Review

The Nursing and Midwifery Council's handling of concerns about midwives' fitness to practise at the Furness General Hospital

May 2018

professional standards authority

About the Professional Standards Authority

The Professional Standards Authority for Health and Social Care[1] promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament.

We oversee the work of nine statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.

We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards.

To encourage improvement, we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation.[2] We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care. We also undertake some international commissions to extend our understanding of regulation and to promote safety in the mobility of the health and care workforce.

We are committed to being independent, impartial, fair, accessible and consistent. More information about our work and the approach we take is available at www.professionalstandards.org.uk

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1 The Professional Standards Authority for Health and Social Care was previously known as the Council for Healthcare Regulatory Excellence.

2 The Professional Standards Authority. 2015. *Right-touch regulation – revised*. Available at: www.professionalstandards.org.uk/policy-and-research/right-touch-regulation [Accessed: 14/05/2018].

From the Chief Executive

professional standards authority

The Rt Hon Jeremy Hunt MP
Secretary of State
Department of Health and Social Care
39 Victoria Street
London
SW1H 0EU

27 April 2018

Dear Secretary of State,

I am pleased to submit the Authority's *Lessons Learned Review* of the Nursing and Midwifery Council's handling of allegations against midwives working at Furness General Hospital. The review has been prepared in accordance with the Terms of Reference set out and approved in the Department of Health's letter of 16 March 2017.

This is to some extent an historical review. The tragic deaths of babies and in some cases mothers took place between 2004 and 2016. The passage of time however does not lessen the seriousness of the events as they unfolded nor the importance of learning from them. The NMC has made clear to us that it has done and intends to continue to do so.

We are grateful to the families who spoke to us and shared their experiences however painful it was. They generously allowed us to reflect their knowledge in this review. Many other witnesses provided us with valuable information including the Cumbria Police. We thank them.

These matters have already been subject to an investigation chaired by Dr Bill Kirkup CBE We have relied substantially on his report and we are grateful for his personal assistance to us.

This Review recognises the many changes and improvements the NMC has made but I highlight here two areas where further consideration is needed; the NMC's approach to the value of evidence from and communication with patients and the NMC's commitment in practice to transparency.

We are grateful to the NMC Chief Executive, the former and present Directors of Fitness to Practise and the many other members of NMC staff who assisted us.

Yours sincerely

Harry Cayton CBE
Chief Executive

Contents

1. Introduction

1.1 In February 2017, the Secretary of State for Health asked the Professional Standards Authority (the Authority) to undertake a 'lessons learned' review of the Nursing and Midwifery Council's (NMC) handling of concerns about midwives at the University Hospitals of Morecambe Bay NHS Foundation Trust (the Trust).[3] The NMC supported that decision and welcomed the review.

1.2 The concerns arose between 2004 and 2014 and were the subject of an independent Investigation conducted by Dr Bill Kirkup CBE[4] which found serious concerns about the clinical competence and integrity of the midwifery unit at Furness General Hospital (FGH). During that period there were several avoidable deaths of mothers and babies. The NMC received its first complaint about midwives at the hospital in 2009. It did not complete its work until July 2017.

1.3 Our terms of reference approved by the Secretary of State were:

'1. To review the handling by the NMC of the complaints against midwives in the University Hospitals of Morecambe Bay NHS Foundation Trust arising out of events in 2008 and later and, in particular:

a) The NMC's approach to managing the complaints;
b) The administration of the cases; and
c) The relationship management with witnesses, registrants and other key stakeholders

2. To identify lessons for the NMC (and other regulators) about its handling of these cases and its approach to relationships with witnesses and other stakeholders.

3. In the light of the NMC's present procedures to make further recommendations if necessary for changes to its processes and approach.

The review will not look at the substance of the NMC's decisions or its panels' decisions on the facts of individual cases and whether to proceed with them. It will look particularly at matters of patient protection, the NMC's communications with families, including the NMC's handling of recent subject access and freedom of information requests.'

1.4 As our terms of reference make clear, this is a 'lessons learned' review which means that our review does not:

[3] Letter from the Deputy Director – Professional Regulation, Department of Health to Harry Cayton CBE dated 17 February 2017.
[4] Dr Bill Kirkup CBE. (March 2015) *The Report of the Morecambe Bay Investigation*. Available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf [Accessed: 22/02/2018].

- Investigate further the events at FGH or make findings about them
- Make any findings about midwives, individuals or organisations, other than the NMC, involved in the incidents and subsequent investigations at the Trust
- Examine or make judgements on the decisions made by committees and panels of the NMC.

1.5 We have therefore concentrated on the processes and activities undertaken by the NMC in investigating and prosecuting the cases it identified and its approach to those with whom it worked. We have also looked at the way in which it handled a Subject Access Request (SAR) made by one of the parents who complained to the NMC about the midwives. We also make some general comments about the legal framework surrounding the fitness to practise process and its suitability for addressing the problems that existed at the Trust.

1.6 We discuss our process for carrying out the review at paragraphs 1.8-1.18 below. We thank colleagues at the NMC for their assistance to us. We are also grateful to the other individuals who gave up their time to speak to us.

1.7 For our understanding of the background to these events we have relied on the Report of the Morecambe Bay Investigation by Dr Bill Kirkup CBE published in March 2015 (the Kirkup report), together with reports by the Parliamentary and Health Service Ombudsman (the Ombudsman).[5] We have also taken account of Coroners' inquests into the deaths of three mothers and babies.

How we carried out this review

1.8 The review and its terms of reference were agreed in March 2017. At that point, we held an initial meeting with the NMC to discuss practicalities and had a preliminary discussion with Dr Kirkup.

1.9 We thought it important to take account of the experience of families who had been involved in the NMC's fitness to practise investigations and asked the NMC to identify those families. It made initial contact with those families, who were invited to contact us if they wished to do so. We took out advertisements in the local press and contacted a firm of solicitors who had represented several of the families. We recognise that many years have passed since the events that gave rise to the NMC's investigations and understand that some of the families involved did not wish or feel able to discuss the cases with us further.

1.10 We publicised our review on our website, and provided contact details for anyone who might wish to contribute to it.

1.12 We began our work in July 2017 having waited for the final fitness to practise case dealing with the concerns at the FGH to be concluded.

1.13 The NMC opened cases against 30 named individuals. Some of the individuals had more than one case opened against them. The NMC gave us access to 66

[5] Listed at footnotes 15-19 below.

electronic case files which related to registrants employed by the Trust between 2006 and 2017. Two of these cases (and individuals) we did not consider to be relevant for the purposes of this review. Of the 64 remaining cases, a number were duplicates. We examined 51 cases in total. The NMC also provided us with access to an electronic file of documents which related to the Morecambe Bay cases but which were not case specific. It also gave us access to some paper files for the earliest period of investigation as not all documentation was available electronically.

1.14 In relation to its response to the SAR, the NMC gave us access to electronic copies of the original and redacted versions of the documents that it had provided. We discuss our process with respect to this aspect of our work at paragraphs 4.111-4.117.

1.15 We spoke to a number of individuals who had contacted us or who we thought could help. These included members of those families who wished to speak to us, Dr Kirkup, representatives of the NHS Trust, the Royal College of Midwives (RCM), the General Medical Council (GMC), the Care Quality Commission (CQC), Cumbria Police, one of the midwives affected by the investigations, a former member of the NMC's staff and one of the Kirkup investigation's expert advisors.

1.16 We invited the NMC to look at a sample of six files that we had reviewed so that it could itself identify any issues and tell us how the cases would be dealt with now under its revised and improved procedures that did not exist before 2014. The NMC provided a detailed and helpful response.

1.17 Following our review of the case files and interviews, we asked the NMC a number of questions for response in writing. We also interviewed members of the NMC's present staff.

1.18 We obtained legal advice where we considered it necessary.

Concerns about the evidence

1.19 The NMC has assured us that we have seen all the papers available with respect to the Morecambe Bay cases. However, it should be noted that:

- The standard of record-keeping at the NMC, particularly before 2014, was very poor and we cannot be sure that all documentation was in fact saved to the case files
- We found documentation in our review of the SAR material that was relevant to the NMC's handling of the complaints and which was not included in the relevant case files. This raises the possibility that there is other material that we have not seen and that the NMC is not aware of
- The NMC's poor record-keeping has also meant that it has been difficult for us to consistently ascertain whether documents existed, who saw them, whether they were discussed and, generally, what decisions were taken, by whom and the reasons for those decisions

- A number of file notes of decisions and telephone conversations were either not made or not saved
- Poor record-keeping was exacerbated by the staff turnover at the NMC in the years when it was looking at the cases, so that it was often not possible to clarify what happened or why decisions were taken, because the relevant staff had left
- The length of time that has elapsed since some actions were taken is too great for memories to be relied upon.

1.20 Despite this, we think that we have seen enough to support the conclusions we have reached in this report and the lessons we consider the NMC and others could learn.

The structure of this report

1.21 We have adopted the following structure for this report

- In Section 2, we provide factual background about the history of concerns about FGH, the structure of midwifery regulation, the role of the NMC and its fitness to practise process
- In Section 3, we provide a narrative about the key cases that we looked at and a discussion of the families' concerns
- In Section 4, we set out our analysis of the NMC's approach to the cases and the families
- In Section 5, we look at the changes in the NMC and the key lessons that have been learned or are to be learned from these cases.

1.22 Inevitably this report discusses the actions of individuals and their effect on others. Since this review is intended to focus on lessons to be learned, we have taken the view that it would be inappropriate to name people who were directly involved in the events either as members of the families, midwives or staff at the NMC. We therefore use the following conventions:

- Parents are referred to as Mr and Mrs A etc
- Midwives are referred to as Midwife 1 etc
- Staff and former staff at the NMC are not individually identified, except for senior executive and non-executive members, who are referred to by their job titles.

1.23 As some families do not wish the identity of their baby to be revealed – even where it may already be known – we have avoided referring to gender. We have also not given the babies a pseudonym but instead refer to them with reference to their relationship with their parents. We acknowledge, given the material already in the public domain, that it may be possible for some to be identified, but ask that the families be afforded privacy so that the impacts of these sad events are not compounded by our efforts to learn from them.

1.24 The impact upon the families who lost babies and mothers has of course been immense. The families we spoke to hoped that lessons would be learnt by all those involved in maternity services so that other babies and their families are

protected. Our review therefore examines the way in which the NMC responded to the complaints it received about poor care by midwives and considers how far improvements which it has already made address the concerns that we identify.

2. The factual background

2.1 In this section, we look at the background to the concerns, as established by the Kirkup report, and describe the regulatory system governing midwives, together with the NMC's structure and system for dealing with complaints.

The concerns at FGH

2.2 The expert analysis quoted in the Kirkup report identified at least 20 instances of significant or major failures of care associated with three maternal deaths, ten stillbirths and six neonatal deaths at the FGH between 2004 and 2012. Of these, it suggested that a different result might have been expected in 13 cases had there been different care.[6]

2.3 The Kirkup report stated that the midwifery unit at FGH suffered from poor clinical knowledge, poor working relationships between different groups of staff, together with grossly deficient responses to adverse incidents. The midwives had developed a defensive culture that tended to support each other rather than identifying and acting on lessons from such incidents. The report said that the reactions of staff in the maternity unit were shaped by a denial that there was a problem. It found 'clear evidence of distortion of truth in responses to investigation' and of improper preparation of staff who were witnesses at an inquest. In addition, it found that there was a 'conflict of roles of one individual who inappropriately combined the functions of senior midwife, maternity risk manager, supervisor of midwives and staff representative'.[7] We note that concerns about the alleged distortion of the truth had been investigated by Cumbria Police, but no prosecutions followed.

2.4 In addition, the Kirkup report said that clinical governance systems generally in the Trust were inadequate and placed too great a reliance on inadequate internal investigations.[8] It also found that, by the time the report was published, the Trust had made significant strides to address the concerns.

Other investigations

2.5 Many of these concerns were identified by an inquest in 2011[9] into the death of a baby at the FGH where the coroner identified areas of poor care and took the view that, in giving evidence, the midwives concerned were likely to have colluded. A further inquest in February 2018 heard of poor care involved in the death of a baby as late as 2016.[10]

[6] Paragraph 1.7 of the Kirkup report.
[7] Page 8 of the Kirkup report, point 10.
[8] Page 8 of the Kirkup report, point 12
[9] Inquest touching the death of Mr and Mrs A's baby – 1-6 June 2011.
[10] Inquest touching the death of Mrs C's baby – 6 February 2018.

2.6 In July 2011, the NMC and CQC jointly undertook a review of the Trust to assess whether all the requirements regarding the arrangements then governing the statutory supervision of midwives were in place and were effective in supporting safe midwifery practice and in identifying and responding to poor and unsafe practice.[11] The review found that there was a focus by the Supervisors of Midwives at FGH (but not at the other maternity units within the Trust) on supporting midwives and their practice ahead of the purpose of statutory supervision – which is to protect mothers and babies. Recommendations were made to address these concerns. The review was followed up in June 2012 and a report published in July 2012.[12] The published report found that action to implement eight of the 15 recommendations had been completed and there was progress on a further six.

2.7 Cumbria Police had been approached by one of the families late in 2010 as a result of concerns about the actions of the Trust and the midwives. In July 2011, Cumbria Police opened a formal investigation into the Trust which looked at clinical concerns to see whether these met the threshold for criminal prosecution, together with the allegations of collusion by the midwives. The investigation into collusion was completed in April 2013 without charges being brought. The remainder of the investigation was completed in December 2013 also without charges being brought, though the case was not finally closed until the Kirkup report was published.[13]

2.8 Between December 2013 and February 2014, the Ombudsman published five reports of investigations into events at FGH. The first, in December 2013 made findings of poor clinical practice and about the quality of the local investigation.[14] The second (also in December 2013) found similar concerns about the quality of the local investigations carried out by the Trust and by the supervisors of midwives in that these investigations had failed to identify major concerns or account to parents.[15] The third (also December 2013) considered the role of the

[11] Nursing and Midwifery Council (October 2011). *Review of University Hospitals of Morecambe Bay NHS Foundation Trust*. Available at: www.nmc.org.uk/globalassets/sitedocuments/midwiferyextraordinaryreviewreports/nmc_review-of-university-hospitals-of-morecambe-bay-nhs-foundation-trust.pdf [Accessed: 24/04/2018].
[12] Nursing and Midwifery Council (July 2012). *Review of University Hospitals of Morecambe Bay Foundation Trust.* Available at: www.nmc.org.uk/globalassets/sitedocuments/midwiferyextraordinaryreviewreports/final-morecambe-bay-extra-ordinary-report-20120907.pdf [Accessed: 22/02/2018].
[13] Interview with Cumbria Police.
[14] Parliamentary and Health Service Ombudsman. *Midwifery supervision and regulation: A report by the Health Service Ombudsman of an investigation into a complaint from Mr M about the North West Strategic Health Authority*. Available at: www.ombudsman.org.uk/sites/default/files/Midwifery_supervision_and_regulation_Mr_M_report.pdf [Accessed: 22/02/2018].
[15] Parliamentary and Health Service Ombudsman. *Midwifery supervision and regulation: A report by the Health Service Ombudsman of an investigation into a complaint from Ms Q and Mr R about the North West Strategic Health Authority*. Available at: www.ombudsman.org.uk/sites/default/files/Midwifery_supervision_and_regulation_Ms_Q_and_Mr_R_report_0.pdf [Accessed: 22/02/2018].

Strategic Health Authority in investigating the concerns.[16] The fourth (published in February 2014) found similar concerns and also considered that the Trust had not fulfilled its obligations to the parents under the Data Protection Act[17]. In the fifth report (published in December 2013), the Ombudsman recommended significant changes to the system for supervising midwives.[18]

2.9 The NMC received its first complaint against a midwife at FGH in relation to these concerns in February 2009. The last case that it considered was heard by its Conduct and Competence Committee (CCC) in June 2017.

The Local Supervisory system for regulating midwives

2.10 The system for regulating midwives and responding to adverse events in place at the time is relevant background to this review. Until 2017, Local Supervisory Authorities (LSAs) (until 2012 the Strategic Health Authorities and, after that, NHS England) were responsible for the local regulation and supervision of midwives. The LSA Midwifery Officer (LSAMO) was responsible for appointing Supervisors of Midwives. The purpose of the supervisors was to protect women and babies by actively promoting safe standards of midwifery practice. They investigated adverse incidents, could make recommendations for improvements and could require midwives to undergo periods of supervised practice.[19] The system was intended to provide support and guidance to every midwife practising in the UK and to promote excellence in midwifery care. The NMC set the rules and standards for the functions of the LSAs.

2.11 The Ombudsman's reports found a series of flaws in the system for midwifery supervision at the FGH: reports were not sufficiently detailed, they were delayed, matters were not escalated to the LSAMO, there was little external scrutiny and there was a blurring of roles.

2.12 The system was abolished in 2017 following the Ombudsman's reports 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.

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[16] Parliamentary and Health Service Ombudsman. *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 www.ombudsman.org.uk/publications/midwifery-supervision-and-regulation-report-health-service-ombudsman-1 [Accessed 22/02/2018].

[17] Parliamentary and Health Service Ombudsman. *Investigation reports concerning the University Hospitals of Morecambe Bay NHS Foundation Trust*. Available at: www.ombudsman.org.uk/sites/default/files/Investigations_concerning_Morecambe_Bay-_report-140915.pdf [Accessed: 22/02/2018].

[18] Parliamentary and Health Service Ombudsman. *Midwifery supervision and regulation: recommendations for change*. Available at: www.ombudsman.org.uk/sites/default/files/Midwifery%20supervision%20and%20regulation_%20recommendations%20for%20change.pdf [Accessed: 22/02/2018]

[19] Nursing and Midwifery Council (2008). *Support for Parents: How the supervision and supervisors of midwives can help you*. Available at: www.guysandstthomas.nhs.uk/resources/our-services/maternity/n-and-m-council-support-for-parents.pdf. We understand this leaflet is out of date and is being removed.

The NMC's role

2.13 The NMC is responsible for the regulation of nurses and midwives in the UK. It exists to protect the public 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 and midwives with the skills and knowledge required. It admits nurses and midwives to its register so that employers and the public can check that someone is authorised to practise and where problems arise, it will investigate and, if necessary, act by removing them from the register or otherwise restricting their practice.

2.14 The NMC holds the largest register of any UK healthcare regulator, some 690,000 nurses and midwives and currently has an annual income in excess of £86 million. It employs over 400 staff.[20]

2.15 The NMC has had a difficult performance history. It cooperated with an investigation by the Authority in 2008 and with a Strategic Review by the Authority in 2012.[21] Problems in relation to its handling of fitness to practise cases were highlighted in those reviews and in each of our performance reports from 2009 to 2016. The Authority's performance reviews however also chart a steady improvement in performance across all the Standards of Good Regulation from 2014 onwards.

2.16 The Chief Executive of the NMC[22] has been very frank in saying to us that, until 2014 when changes following the Authority's 2012 Strategic Review had largely been implemented, the NMC was not in a state to address the concerns that arose in respect of the FGH.[23]

The NMC's fitness to practise procedures

2.17 The NMC's structure and processes for dealing with fitness to practise matters changed and improved considerably since the first complaint was received in 2009.

2.18 Complaints and concerns about fitness to practise are handled by the NMC's Fitness to Practise Directorate. Since 2011, the procedure has been that complaints are initially reviewed by the NMC's Screening Team which considers whether there appear to be concerns that should be investigated. The team

[20] Nursing and Midwifery Council, *Annual Report and Accounts 2016–2017 and Strategic Plan 2017–2018*. Available at: www.nmc.org.uk/globalassets/sitedocuments/annual_reports_and_accounts/annual-report-and-accounts-2016-2017.pdf [Accessed: 22/02/2018].
[21] 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 [Accessed: 24/04/2018]
[22] She became Acting Chief Executive in December 2011 and appointed to the role of Chief Executive in October 2012.
[23] Interview with the review team 9 January 2018.

conducts an initial risk assessment to consider whether the NMC should seek an interim order. An interim order restricts a registrant's practice pending a final decision if there is evidence that the registrant may be a risk to themselves or other people or there are other public interest reasons to do so. Such an order might suspend the registrant's registration or impose conditions with which the registrant must comply while practising.

2.19 The Screening Team can close a complaint or refer it for further investigation.

2.20 Until 2012, the majority of investigations were undertaken by external solicitors appointed by the NMC. Following a pilot in 2012, the majority of cases are now investigated by its in-house legal team. More complex cases are sent out externally. The investigation generally involves interviewing witnesses, contacting the employer for information, assessing the registrant's answers to the allegations (where these are available) and, where appropriate, seeking expert evidence. A report is then prepared summarising the allegations investigated and the results of the investigation. Until recently, that report recommended whether there was a case to answer against the registrant (that is, that there is evidence that the registrant did the actions complained about and, therefore, their fitness to practise may be impaired). We understand that a formal recommendation is no longer made.

2.21 Until 2016, the investigation report was considered by the Investigating Committee which decided whether or not there was a case to answer. Since 2016, this decision is taken by two Case Examiners, one of whom is a registrant and one of whom is not. The person or body making the complaint and any other interested parties are told the outcome.

2.22 During the period covered by this review, all cases where a case to answer had been found were heard by panels of the Conduct and Competence Committee[24] consisting of three people comprising at least one registrant and one lay person. Cases may be considered at hearings or meetings. The cases covered by this review were all heard at hearings, which are not unlike trials. The NMC is represented by a lawyer who presents the case and calls evidence and witnesses. The registrant may be represented and can challenge the witnesses and call their own. The person who has made the complaint, for example the patient or their relative, may be called to give evidence at the hearing as a witness. They are not represented because they are not a party to the case.

2.23 The panel decides first whether the facts alleged are proved. If they are, it considers whether those facts amount to misconduct or lack of competence. If it decides that there was misconduct or lack of competence, the panel considers whether the registrant's fitness to practise is impaired – in other words, are there concerns about the registrant's fitness to practise at the date of the hearing (as

[24] Since July 2017, by the Fitness to Practise Committee.

opposed to the time when the events occurred). If it is, the panel decides what, if any, sanction should be imposed. The sanctions available to the panel are:

- A caution, which goes on the registrant's record for up to five years but does not restrict the registrant's practice
- Conditions of practice which might require a registrant not to undertake certain work, work under supervision and/or take further training for a set period of time
- Suspension for up to 12 months, during which the registrant must not work as a nurse or midwife
- A Striking-Off order, which means that the registrant is no longer on the register and may not practise as a nurse or midwife.

2.24 Where a panel has imposed conditions or a suspension, that sanction is usually reviewed towards the end of the period to see whether the concerns which led to the sanction have been addressed. The review panel can decide that the registrant is no longer impaired, extend the sanction or impose new sanctions.

2.25 In considering whether the registrant is impaired, the panel must consider any remediation that has been undertaken by the registrant (for example, training), together with any insight that the registrant shows (for example, an understanding of why the error occurred and why it should not happen again) and, based on this, assess whether there is a risk of repetition. It is thus possible, particularly where there has been a clinical error, that the registrant may have undertaken training and demonstrated insight so that there is little or no risk of repetition and the panel might find that the registrant's fitness to practise is not impaired and so no sanction is required.

2.26 The panel must also consider whether a finding of impairment is required to uphold professional standards (so a signal is sent to the profession that the conduct was not acceptable) or to maintain public confidence in the profession (so that the public can see that particularly serious conduct is taken seriously by the regulator).

2.27 The fitness to practise process does not exist to hold a full inquiry into all aspects of a case. It is directed at an individual's fitness to practise at the time of the hearing. This does involve findings of fact but these may not address the full situation, particularly if a number of different individuals are involved. Charges before a panel may not reflect all the concerns that are raised: they will only cover the matters where the regulator considers that there is a case to answer. The NMC recognises, as do we, that the purpose of the fitness to practise process and hearings may not always be fully appreciated or accepted by those making complaints or acting as witnesses, who may understandably have broader concerns.

3. The cases we considered and the families' concerns

3.1 In this section we describe the facts of the main cases considered by the NMC. These provide the evidence on which we base our findings. We also set out the concerns of the families we spoke to. We do not discuss every complaint. Our role is to review the lessons to be learned from the NMC's handling of the cases as a whole, not to consider each in detail.

3.2 The complaints considered by the NMC came from a number of sources:

- The families directly affected
- Cumbria Police
- The Trust
- The NMC itself following discussions with the Kirkup review team.

3.3 As we have reported in Section 1, the NMC opened 64 complaints against 30 named individuals. Five families complained directly to the NMC about the care they had received. However, the complaints received from the Trust and those opened by the NMC involved looking at a considerably larger number of adverse incidents.

3.4 We have set out at Annex A, a chronology of the main events that occurred while the NMC were considering complaints about the midwives at FGH.

3.5 The NMC received its first complaint in February 2009. It began an investigation into that complaint, but this was delayed between June 2010 and January 2014 due to a decision by the NMC to await the findings of an inquest and completion of a police inquiry. Between 2010 and 2014 further information became available and more complaints were received. A number of these were also closed either following an investigation or in error. In early 2014, the NMC conducted a review of all the complaints that it had received since 2009 and opened or re-opened a number of investigations. Further complaints were received after that both from families and the Trust. Following the Kirkup report, it met Dr Kirkup and sought and received information from that team and considered further complaints against individual midwives. The last of the 64 complaints was heard by the Conduct and Competence Committee in June 2017.

The investigation into the care provided to Mrs A and her child

3.6 Mrs A's waters broke two days before the birth of their baby in October 2008. Mr and Mrs A attended FGH that evening. Midwife 1 was on duty, examined Mrs A and sent her home. Mr and Mrs A returned the next day and were seen by Midwife 2. Again, Mrs A was sent home. Mr and Mrs A said that they had told the midwives that they, and their older child, had been feeling ill with viral symptoms

and they were concerned that this might place the baby at risk of infection. They said that no action was taken to follow up these concerns. The midwives did not agree that they were told of the symptoms.

3.7 When contractions began early in the morning of the following day, Mr and Mrs A returned to the maternity unit and their baby was born quickly. Midwives 3, 4 and 5 and 6 were involved in the care either at the birth or in the subsequent period while Mrs A and her baby were at the FGH. There is a conflict of evidence as to the baby's state at birth. Mrs A collapsed shortly after the birth; it was established that she had an infection and antibiotics were administered to her, but not to the baby. The baby's temperature was found to be low, which can be an indicator of infection, and the parents told the local investigation that they observed other symptoms that concerned them. On the morning of the following day, Mrs A found her baby collapsed. The baby was transferred to the special care baby unit at FGH and subsequently to specialist units in other hospitals and died at nine days old of septicaemia. During this time, the observation records were lost.

The local investigation

3.8 In the period between the birth and immediately after their baby's death, Mr and Mrs A prepared a chronology of the events from their perspective. They supplied this to the Trust shortly afterwards, together with a series of questions about the quality of care provided and the outcome for their baby.

3.9 Midwife 7, the maternity risk manager and a supervisor of midwives, began an internal investigation shortly after the incident but, on receipt of Mr and Mrs A's concerns, the Trust instructed an independent midwife to investigate. That independent investigation concluded that there had been a failure to monitor the baby, and a failure to recognise the signs of infection and therefore to treat it at an earlier stage. This investigation made recommendations for the Trust but was not intended to, and did not, identify concerns about the practice of individual midwives.[25]

3.10 Midwife 7 resumed her investigation and undertook a root cause analysis of the events which was completed in January 2009. She subsequently carried out an investigation for the Local Supervisory Authority (completed in May 2009). Midwife 7 did not identify significant concerns about the midwifery care provided to Mrs A. In the absence of the care records, the analysis relied on the recollections of the midwives and tended to blame the paediatricians at the hospital. It did not engage with the initial independent report. Midwife 7's report was shared with Mr A, together with copies of statements made by the midwives to the investigation.

3.11 Mr A believed that there were discrepancies between the various midwives' statements and his own and his wife's recollections. He was concerned that there

[25] *External Investigation into Serious Untoward Incident at Furness General Hospital: (Mr and Mrs A's baby) 2008.*

was an attempt to cover up the events. A review of Midwife 7's root cause analysis was commissioned by the Trust from Midwife 8, who was independent of the Trust.[26] That report did not identify problems with Midwife 7's report. However, it is notable that the NMC's Midwifery Team, which was separate from its Fitness to Practise team, had concerns about the root cause analysis which were not noted in Midwife 8's report.[27] A meeting involving the Trust, the NMC and Mr and Mrs A to discuss the root cause analysis was held in November 2009 and there appears to have been agreement that it was flawed.[28]

The 'NMC shit' email

3.12 In 2009, Mr A was informed by the Trust of a data breach involving his personal information. In response to enquiries he made in late 2010, it appeared that, in the context of the NMC investigation, Midwife 3 had caused an email to her from Midwife 4 to be sent to an incorrect email address. The email was headed 'NMC shit' and included a document which contained information about Mr A's complaint. It was suggested that it contained Midwife 4's statement for the investigation by the NMC, though we note that this was denied by Midwife 4 who told us that the document did not contain any of her response. Mr A was concerned that this was an attempt by the midwives to ensure that the accounts sent to the NMC were consistent.

3.13 The Trust had held an investigation about the data breach. Midwife 4 said that she had sought to provide Midwife 3 with a template to help her write her own statement, rather than to collude over their recollections. Material from the Trust on the NMC's files suggests that a representative of the CQC looked at the documents, though it is not clear in what context, and noted that there was no evidence of similar wording or phrases between the two statements.[29]

Mr A's complaints

3.14 Mr A made his first complaint to the NMC in February 2009 following the independent midwife's investigation[30] for the Trust. It concerned the care provided to his wife and child.

3.15 It took the Trust four months to provide the NMC with the identities of the midwives involved. The Trust was also slow to provide their statements to the NMC. In July 2009, the NMC raised complaints against midwives 3, 4, 5 and 6.

3.16 In July 2009, Mr A raised his concerns about the investigation by Midwife 7 and the discrepancies in the midwives' statements, providing a detailed analysis of his concerns. He sent this to the NMC.

[26] Independent Report Local Supervising Authority Midwifery Office Report for North West Strategic Health Authority, June 2010.
[27] File note of discussion between the NMC's Midwifery Advisor and Midwife 8 dated 1 July 2010.
[28] Report of meeting prepared by the NMC's Midwifery Advisor dated 1 December 2010.
[29] Email dated 15 November 2011 to Mr A.
[30] See footnote 24.

3.17 The NMC sent details of the allegations that it was considering to Midwives 3, 4, 5 and 6 in July 2009. These were very general and did not distinguish between the different midwives and their roles – for example, on the evidence available, it appeared that Midwife 3 had been involved in the aftercare, but not the birth of the baby, but the allegations covered failures at the birth. The midwives' responses to the allegations were received in August 2009 and the complaint was considered by the Investigating Committee in September 2009. It was referred to external lawyers for investigation. The investigation was limited to the failure to identify that the baby had an infection and to the midwives' poor record-keeping.

3.18 Statements were taken by the external lawyers from Mr and Mrs A in late 2009. The statements were signed in May 2010. The chronology they had prepared was referred to in the statement signed by Mr A as 'Exhibit 2'.

3.19 The investigation was completed in May 2010 and the report recommended that there was no case to answer against the midwives. This appears to have been based strongly upon the statements of the midwives, the local investigations and the Trust's own statements. The discrepancies raised by Mr A were not addressed.

3.20 The report was not considered by the Investigating Committee because the inquest into the death of Mr and Mrs A's baby was announced and the NMC decided to wait to see whether there were findings at the inquest which were relevant to the complaints.

3.21 In the meantime, Mr A had contacted the NMC's Midwifery team about his concerns about Midwife 7's 2009 investigation. The NMC's midwifery adviser shared these concerns. She met Mr and Mrs A and the Local Supervisory Authority Midwifery Officer and flaws were identified in the investigation by Midwife 7. The adviser told the Fitness to Practise team that it was important that the Investigating Committee should be made aware of the doubts about the robustness of Midwife 7's investigation when it considered the complaint.

3.22 In January 2011, Mr A informed the NMC about the 'NMC shit' email and made it clear that he was concerned that there might have been collusion over the statements given to the NMC by Midwives 3 and 4. He was informed that he would need to make a new formal complaint for this to be considered. Mr A was upset at being required to fill in more forms when he had already provided the information. Eventually, in March 2011, new complaints were opened by the NMC. It is clear that the NMC intended that the investigation should consider all aspects of Mr A's complaints.

3.23 In April 2011, the NMC appears to have decided[31] that the original complaints should be considered by the Investigating Committee. A note was prepared which was intended to reflect the concerns of the NMC midwifery adviser.

3.24 The inquest into the death of Mr and Mrs A's baby took place in June 2011. The coroner was strongly critical of the care provided and suggested that the midwives had 'colluded' over their evidence.[32] The NMC postponed the Investigating Committee's consideration of the complaints to study the coroner's findings.

3.25 In July 2011, a group of the NMC's Fitness to Practise team members discussed Mr A's complaints and the inquest. They considered that the cases suggested concerns which were not suitable for individual fitness to practise cases but showed major cultural problems at FGH. They proposed that a recommendation should be made to the Investigations Committee that the cases should be closed, the Trust should be referred to the CQC and the midwifery unit put into special measures.[33] This was intended to be discussed with the then Director of Fitness to Practise. We saw no record of the outcome of this discussion but it appears that the NMC took the view that the decision should await further information about the police investigation that had by then been instigated.

3.26 The investigations concerning the treatment of Mr and Mrs A's baby and collusion, were put on hold while the police investigation was continuing. The NMC continued to investigate two aspects of the 'NMC shit' email: the data breach and the offensiveness of the title.

3.27 In June 2012, Mr A sent the NMC a number of documents and emails that he had obtained from the Trust which, he considered, supported his concerns about possible collusion between the midwives and within the Trust over the evidence given at the inquest.[34] Complaints were opened against a number of midwives in June 2012. However, nine of these were closed, apparently on the basis that new ones would be opened (or made part of existing complaints) and then expedited.[35] These then appear to have been forgotten until they were re-opened in April 2014 following the general review of the Morecambe Bay cases. By that time, at least one of the midwives was no longer on the register. Those that were taken forward in 2012 were referred to new external lawyers for investigation. The lawyers were asked to re-investigate the matters that had been looked at by the previous lawyers. The lawyers recommended further investigation of the original allegations and asked whether a complaint should be raised about Midwife 7 and her investigatory reports. The NMC did not raise such a complaint. In any case, none of the investigations were commenced until 2014 when the police investigation ended.

[31] Email chain dated 8 April 2011 but there was no record of the reason.
[32] Inquest touching the death of Mr and Mrs A's baby – 1-6 June 201.1
[33] File note of meeting of members of the Fitness to Practise team dated 21 July 2011.
[34] Letter from Mr A to the NMC 11 June 2012.
[35] Letter of 22 June 2012 to Mr A.

3.28 In January 2013, the Investigating Committee decided that there was no case to answer against the midwives in respect of the 'NMC shit' email, at least as regards the data breach and the offensiveness of the title because the breach was an isolated incident and had been dealt with by the Trust and the offensive title was not serious enough to amount to misconduct. The external lawyers' report suggests that further investigation of the collusion concerns might take place following conclusion of the police investigation. While Midwives 3 and 4 were subject to investigation in respect of wider allegations of collusion, we saw no evidence that the facts in relation to this email were investigated further.

3.29 In September 2013, the Kirkup investigation was set up. In December 2013, Cumbria police informed the NMC that it was no longer pursuing allegations against individuals. Between December 2013 and February 2014, the Ombudsman published its reports.[36]

3.30 In January 2014, the NMC held a major internal review[37] of all the information that it had about all the FGH cases and referred the issues raised by Mr A in respect of the care of his wife and baby to external lawyers for further investigations. In the course of these investigations, further complaints were raised about:

- Midwives 1 and 2 about their alleged failure to act on information about Mrs A's illness
- Midwife 7 about her supervisory investigations
- 14 Midwives in respect of 'dishonesty and collusion' over evidence given at the inquest.

3.31 The external lawyers provided their report in July 2014. The Investigating Committee considered that report in November 2014 and decided that:

- There was a case to answer in respect of the clinical care provided by Midwives 1 and 2 in the days before the birth
- There were cases to answer in respect of Midwives 3, 4 and 6 in respect of the care provided during and/or after the birth
- There was no case for any midwife to answer in respect of the collusion allegations.

3.32 Cases where it was determined that there was a case to answer were referred to a panel of the CCC. The concerns about Midwife 7 were left for further investigation.

3.33 The NMC's in-house legal team then began to prepare the cases for hearings before the CCC. The NMC's intention was that all the cases would be heard together. However, because of the complexity of the cases and defence arguments that the publicity surrounding the cases could lead to unfairness, the

[36] See footnotes 15-19 above.
[37] Documents dated 10 January 2014 on the NMC files.

CCC held a case management meeting in July 2015, which was adjourned until October 2015. At that meeting, the panel decided that:

- The cases in respect of Midwives 1 and 2 would be heard separately from those in respect of Midwives 3, 4 and 6
- The publicity did not mean that there could not be a fair hearing.

Midwives 1 and 2

3.34 The cases of Midwives 1 and 2 were heard in March and April 2016. Mr and Mrs A were called as witnesses. A second statement was taken from them in early 2016. Their statements from 2010 were not put before the panel. Nor was the chronology that Mr A had prepared in 2008, which was referred to as 'Exhibit 2' in his 2010 witness statement. We could find no trace of this chronology prior to the hearing in any of the files that we examined even though there were a number of copies of the 2010 statement referring to it. We do not know whether it was ever received from the external solicitors who took that statement.

3.35 At the hearing,

- Midwife 1 denied that Mr and Mrs A had mentioned that she was feeling ill and that she had not had that conversation with them
- Midwife 2 said that Mrs A had simply told her that she had a headache and this was recorded in the notes and that this did not trigger any obligation to take further action
- In submissions, the defence suggested that Mr and Mrs A had not mentioned that they had told the midwives of the illness until the inquest in 2011

3.36 Mr A sent the chronology to the NMC in the course of the hearing. This provided supporting evidence that, in 2008, he and his wife recalled telling the midwives of the infection. The NMC did not consider that, overall, this would materially add to its case and did not put the chronology before the panel.

3.37 The panel found that Mr and Mrs A were honest witnesses and had mentioned Mrs A's illness to people at the hospital but could not be satisfied that those people had been Midwives 1 and/or 2. It relied on the records made by the midwives as decisive. It decided that there was no case to answer for Midwife 1 because it could not be satisfied that she was the person that Mr and Mrs A had talked to about the illness. The facts were not proved for Midwife 2.

3.38 Mr A told us and the NMC that he and Mrs A found the process of giving evidence extremely stressful and upsetting. He was also distressed about being required by the panel Chair to refer to their child not by name but as 'Baby A'. This he refused to do.

3.39 These cases were completed seven and a half years after the events took place, six years after the possible concerns could have been identified from Mr A's witness statement and two years after they were in fact raised.

3.40 Following the hearing, the Authority looked at this case under its powers under Section 29 of the National Health Service Reform and Health Care Professions Act 2002 (as amended). This enables us to refer cases to the High Court if we consider that the decision was insufficient to protect the public. We were concerned about:

- The failure to provide the panel with the contemporary chronology prepared by Mr & Mrs A
- The panel's approach to the naming of Mr and Mrs A's child
- The cross-examination of Mr and Mrs A.

3.41 The NMC agreed that the panel could have been more sensitive. It did not agree that its decision not to provide the chronology to the panel was wrong. The NMC considered that although the chronology may have supported the evidence on one aspect of the case, overall, it would not support and/or might have undermined its case in other respects. Taking all the circumstances of the case into account and bearing in mind the relevant case law, the Authority decided that the decision was deficient, but was not insufficient to protect the public.

Midwives 3, 4 and 6

3.42 Midwife 6 was out of the country in May 2016 when the hearing was to take place. Her case was heard separately on her return. The cases in respect of Midwives 3 and 4 were begun then and adjourned until June 2016 when, because of scheduling difficulties, the two cases were heard separately. Both were found to have committed misconduct and their fitness to practise was impaired. In September 2016 Midwife 3 was suspended from the register for nine months because, although the clinical concerns had been remediated, there were public interest grounds for finding impairment. In October 2016 Midwife 4 was struck off.

3.43 Midwife 3's fitness to practise was reviewed in May 2017 and was found no longer to be impaired.

3.44 When the case of Midwife 6 was heard, in January 2017, the NMC offered no evidence to the CCC with the result that no case to answer was found. The panel accepted that the expert evidence and other circumstances of the cases made it clear that it was appropriate for the NMC to offer no evidence in these circumstances and that there was no case for Midwife 6 to answer.

3.45 These cases were completed almost eight years after the events took place and more than seven years after the complaints were made.

Midwife 8

3.46 Mr A considered that the NMC ought to have considered whether Midwife 8's report into the adequacy of Midwife 7's analysis raised concerns about Midwife 8's fitness to practise. The NMC told him[38] that it had asked the Kirkup team whether it had identified any specific concerns about Midwife 8's report, that none had been suggested and that it had decided not to open any fitness to practise complaint against her. It told him that it had reviewed this decision in August 2016. The NMC reviewed the matter again in July 2017 and decided that its original decision was correct. We saw that the NMC had asked the Kirkup team for information about individual midwives whose practice might be of concern and the team did not refer to Midwife 8. It appears that this may have been explicitly discussed in a meeting with the team. We saw no evidence that the Kirkup team had any concerns about Midwife 8.

3.47 The team considering whether or not to raise the complaint at the NMC did not look at the original report by Midwife 8[39] even though the report was in the NMC's possession and had been since 2010. It relied on the fact that no concerns had been received from the Kirkup team.

3.48 The review in July 2017[40] again did not look at Midwife 8's original report even though it had been included in the material sent to Mr A as part of his Subject Access Request in late 2016.

Mr A's other concerns

3.49 Mr A raised concerns with the NMC about its handling of the cases through the whole period, particularly about the prolonged length of time, the lack of information that he was given about progress and what he perceived to be the NMC's failure to take action to satisfy itself that the midwives were fit to practise while it was looking into the complaints. There were frequent discussions with the Chief Executive and senior staff by email, over the telephone and in person. The previous Chair and the current Chief Executive met with Mr A and apologised for the time taken to progress the cases. Mr A also raised concerns with the Secretary of State for Health.

3.50 After the hearings, Mr A continued to be concerned about what he perceived to be the NMC's failings in these cases and the approach the NMC had taken to the Authority's criticisms of the cases of Midwives 1 and 2. He made a Subject Access Request (SAR) under the Data Protection Act 1998 in respect of the information held by the NMC relating to him and his child. He was dissatisfied with the NMC's handling of that request.

[38] Letter of 8 September 2016 from the then Director of Fitness to Practise to Mr A.
[39] This is made clear in the initial advice dated 22 May 2015 and in subsequent advice, including that dated 17 July 2017.
[40] Advice dated 17 July 2017.

3.51 Mr A told us[41] that, when he first complained to the NMC, he was not familiar with the NMC or professional regulation so he did not think of it in terms of making complaints about specific individuals. He thought he was simply alerting them to a serious incident and he expected the NMC to take it seriously and investigate. He said he was concerned about the care provided, the disappearance of medical records and possible dishonesty. As time progressed he became increasingly concerned about the NMC's handling of the cases against the midwives involved in his baby's care.

3.52 He told us that, for him, the biggest issue 'wasn't that people made mistakes because you know people do make mistakes and even if there is a tragic outcome it doesn't automatically mean that people need to be referred to the professional regulator'. However, it seemed to him that a set of things had gone wrong, statements had been made by the midwives that he and his wife 'knew were incorrect' and records went missing. He was concerned people were being dishonest, that they were not learning from his baby's death and the same thing could therefore happen to other people.

3.53 Mr A told us that he 'thought it nonsensical' for the NMC to have sent an identical set of allegations to every midwife and expect midwives on the night shift, for example, to comment on allegations in relation to things that had happened on the day shift.

3.54 He told us that he and his wife had hoped the NMC would take their baby's death seriously but it 'felt hopeless and that they were just following a process for the sake of following it. It felt like nobody really cared about what they were doing. Nobody understood that there might be mothers and babies at risk and it was like an administrative process that nobody really cared about'. He felt that the NMC's 'lack of speed or sense of urgency' contributed to that sensation.

3.55 Mr A told us he had wanted to know what was being done and how they were making sure that mothers and babies were safe. He repeatedly made this argument not because he was being 'vindictive' but because he 'was genuinely concerned that some of the things that had happened … might happen again'.

3.56 Mr A said he found the whole process including when hearings took place 'far worse than I could have imagined'. He had not realised that he and his wife would be subjected to cross examination in a manner which he felt attempted to discredit them. They had no one representing them and no-one supporting them to refute statements made against them. He said, 'it just feels like a very unfair process that people can actually base a case and their arguments on trying to discredit a bereaved family and there is nobody there who is supporting the family or arguing or saying hang on a minute that's not true … It was a horrible, horrible process and no wonder, no wonder, people don't want to go through it'.

[41] Interview with the team, September 2017, from which the following paragraphgraphs are taken.

3.57 He told us he was particularly upset by the assertion at the hearing by the defence barrister that the first time he and his wife had first mentioned telling the midwives that she had felt unwell was at the inquest, when in fact they had made a record of that in the chronology they prepared whilst their baby was still in hospital. He could not understand either why the NMC had insisted the chronology was not needed in evidence. The consequential media coverage was also very hard for the family to bear causing his wife to feel unwell.

3.58 Mr A thought the NMC process might be improved, 'if the midwife might acknowledge you and express some words of sympathy… in a humane system the first thing the barrister would say is we are very grateful to Mr [A] for coming. We know it's hard for him and we would like to express on behalf of those involved how sorry they were. That's what humans do.'

3.59 Whilst he had found some people within the NMC were kind, he told us he thought there was no proper emotional support and no representation for the family. He had discovered some of the earlier verdicts by reading it in the media although later the then Director of Fitness to Practise sent him email updates.

3.60 He was upset by what he saw as the attitudes displayed towards him, especially the monitoring by the NMC of his online communications. He thought the NMC was unduly concerned about its reputation instead of responding to him as a bereaved person who had been forced by circumstances into having to complain and in the face of inadequate investigations, having to pursue them over many years. It had taken a heavy toll on him and his family. He failed to understand why the NMC would not share the report that it had commissioned from a senior barrister (see paragraph 3.77) openly as he had been led to expect or why they had so heavily redacted information in response to his Subject Access Request.

3.61 Mr A has a background in the safety industry. His experience is evident in the way that he approached the identification and analysis of problems and his complaint to the NMC.

The investigation into the care provided to Mrs B and her baby

3.62 In July 2008 Mr B's wife died in childbirth from amniotic embolism, which is a rare condition with a 50:50 survival rate. Their baby was brain damaged during the birth and died shortly after. The local investigation found there had been no failures of care. Mr B's recollection differed significantly about the events that took place during labour. The inquest held in July 2009 into both deaths made no criticism of the care provided by the midwives. It noted that there was a discrepancy between the recollections of Mr B and of the midwives but the coroner appears to have preferred the evidence of the midwives.

3.63 These findings were contradicted by the Ombudsman's investigation carried out following a complaint by Mr B. The Ombudsman concluded,[42] with the benefit of clinical advice, that Mrs B's condition, if properly treated, need not have been fatal, and that there were major failures in care provided to the baby, whose heart was not monitored during the delivery. The failures were not identified in the Root Cause Analysis undertaken by Midwife 7. The Ombudsman also criticised the failure of the supervisors of midwives to question the adequacy of a root cause analysis carried out by the Trust, which did not identify the concerns about the care provided to Mr B's child and suggested that a supervisory investigation was unnecessary.

3.64 The NMC received information from Cumbria Police about the death of Mrs B and her child in November 2012. That information included a statement from Mr B, which gave a different account of the birth from that given to the coroner by the midwives who provided the care. Mr B also complained of disrespectful behaviour by the midwives at the inquest including 'high fiving' each other after the verdict.

3.65 The NMC opened a case in November 2012 against Midwife 9, who had been in charge at the birth, and referred the case to external lawyers for investigation. That investigation concentrated only on the failure of Midwife 9 to call for help when Mrs B was taken ill in labour; it did not look at the care provided to her baby. Mr B was not contacted for any statement to be taken, nor was clinical advice sought. Relying on the findings of the inquest, the statements of Mr B to the police and the local investigation, the report recommended that there was no case to answer. It considered that, given the other statements, there was little to be gained from speaking again to Mr B. The Investigating Committee agreed with the recommendations in July 2013.

3.66 Mr B became aware of the NMC investigation through the Trust and asked to be involved in it. Despite being told by the NMC's case officer that he would be interviewed, he was never approached. He made a complaint himself to the NMC in August 2013 with specific allegations about the failure to monitor his son's heart rate, the care records going missing and the midwives' behaviour at the inquest. In October 2013 the NMC refused to re-open the complaint on the basis that the conduct of Midwife 9 had already been investigated.

3.67 However, in January 2014 and following publication of the Ombudsman's report, Mr B made further complaints to the NMC and the case against Midwife 9 was re-opened, together with cases against six Supervisors of Midwives including Midwife 7. The allegation against the supervisors was that they should have identified the flaws in the root cause analysis and challenged it so that a supervisory investigation could have been undertaken; however, the NMC's

[42] Parliamentary and Health Service Ombudsman. *Midwifery supervision and regulation: A report by the Health Service Ombudsman of an investigation into a complaint from Mr M about the North West Strategic Health Authority*. Available at: www.ombudsman.org.uk/sites/default/files/Midwifery_supervision_and_regulation_Mr_M_report.pdf [Accessed: 22/02/2018].

external lawyers were not instructed to consider this allegation but only to investigate whether the decision not to undertake a supervisory investigation was the right one.

3.68 Internal legal advice prepared in January 2014[43] considered whether the clinical concerns about Midwife 9 could be taken forward given that the Investigating Committee had decided there was no case to answer in July 2013. The advice was that, since Midwife 9 had been informed that the events at the delivery were being investigated and that the complaints had been dismissed, the NMC was prevented by its legislation from re-opening the investigation. This was notwithstanding that the initial investigation failed to look at the clinical failures identified by the Ombudsman. The advice suggested that the NMC could only reconsider the original complaint if an allegation arose about a different incident where the original complaint was relevant.

3.69 The decision to close the case concerning Midwife 9 was taken at Screening stage on 11 August 2014. An instruction was given not to inform Mr B of this until the cases against the supervisors had concluded.[44] When Mr B was told in November 2014 about the outcome of his complaint against Midwife 9, the reason given for the delay was that 'new allegations or new evidence may have been identified that would have required us to further consider [Midwife 9's] fitness to practise'.[45]

3.70 The other cases were closed with no case to answer. This was because the Investigating Committee considered that there was no evidence that the root cause analysis was inadequate; and there was insufficient evidence about what had and had not been discussed at the meetings.

3.71 In respect of Midwife 7, the external lawyers' initial recommendation was one of no case to answer. However, due to concerns about her practice identified by the Kirkup investigation team, this recommendation was not put to the Investigations Committee and further investigation was carried out (paragraphs 3.102-3.108 below).

3.72 No investigation was carried out into Mr B's complaint about the behaviour of the midwives at the inquest.

The investigation in to the care provided to Mrs C and her baby

3.73 In March 2016, Mrs C's baby died having suffered brain damage during birth. Midwife 4 was the labour co-ordinator at the time. Midwife 10 was also involved in the birth. The NMC became aware of the matter in the context of the proceedings against Midwife 4 surrounding her involvement in the birth of Mr and

[43] Advice dated 30 January 2014.
[44] Email dated 22 September 2014.
[45] Letter to Mr B dated 13 November 2014.

Mrs A's baby. In June 2016 the Trust referred both midwives to the NMC. The Trust had, itself, suspended Midwife 4.

3.74 Midwife 4 had been under investigation by the NMC for almost seven years in relation to the death of Mr and Mrs A's baby. No restrictions had been placed on her practice during that period. On receipt of the Trust's report, in June 2016, the NMC obtained an interim suspension order preventing Midwife 4 from practising.

3.75 In October 2016, Midwife 4 was struck off the register as a result of failures in her care for Mr and Mrs A's baby. Accordingly, the complaint against her in respect of Mrs C and her baby could not be investigated further.

3.76 Mrs C did not make a direct complaint to the NMC because she was aware that the NMC was investigating the case, but the NMC did contact her during its investigation. The NMC did not notify Mrs C when Midwife 4 was struck off the register and Mrs C learnt of this through media reports. Mrs C complained to the NMC about its handling of this case and, in particular, why the NMC acted so quickly to restrict the practice of Midwife 4 following Mrs C's baby's death yet had failed to do so following Mr and Mrs A's baby's death.

3.77 The NMC asked a senior barrister to review whether the NMC ought to have sought an interim order restricting the practice of Midwife 4 at an earlier stage. The NMC told Mr A that 'at no stage during the numerous review and investigations which took place was the threshold for applying for and imposing an interim order passed.'[46] It also told him that the 'purpose of this review is to identify lessons for the future'. It has not, however, published the barrister's report, which it regards as subject to legal professional privilege. The Information Commissioner upheld this decision in August 2017.[47] We discuss this further at paragraphs 4.99-4.103 below.

3.78 The Case Examiners reviewed the case against Midwife 10 in March 2017 and decided that, in the light of the remediation and insight shown by Midwife 10, there was no case to answer against her.

The investigation into the care provided to Mrs D and her baby

3.79 Mrs D gave birth to a baby in 2004. The baby showed no signs of life at birth, but was revived. The baby died 27 hours later. Mrs D had suffered from high blood pressure throughout her pregnancy and it was known that the baby was large. Midwife 11 was in charge at the birth. The coroner's inquest in 2013 found that the care given by Midwife 11 was poor, including failures to properly risk assess the birth, to monitor the foetal heart rate properly and to adopt appropriate positions for the birth. There were also concerns that Midwife 7's supervisory report was inadequate and that Midwife 7 may have misled Mrs D about the care given. Mrs D did not discover that she might have cause to complain to the NMC

[46] Email from NMC to Mr A of 8 September 2016.
[47] Information Commissioner's Office case reference FS50677575, 7 August 2017.

until contacted by the police, several years later. An inquest into her baby's death was then held[48] and the Kirkup investigation was starting. She became aware that Midwife 11 had been involved in another birth four years later, where the baby was stillborn. She then discovered, through the media, that the Trust had suspended Midwife 11. In January 2014, following the inquest and at the suggestion of her solicitor, she complained to the NMC about Midwife 11.

3.80 The NMC had already opened a complaint against Midwife 11 following a referral by the Trust in November 2013. This arose out of further untoward events in 2013 investigated by the Trust and involved failures to manage high risk births appropriately, to identify low foetal heart rates, to gain consent or to escalate emergencies and poor record-keeping. The Trust suspended Midwife 11 from practice. The NMC obtained an interim suspension order in January 2014. Midwife 11 informed the NMC that she had decided to retire from practice. She was subsequently struck off by a panel of the Conduct and Competence Committee.

3.81 The NMC decided not to include Mrs D's case in its case against Midwife 7 because it considered that it was likely that Midwife 7 would be able to show that the quality of her reports had improved since 2004 and the evidence available did not demonstrate dishonesty.

3.82 Mrs D explained[49] that when she and her husband first lost their baby, they accepted the Trust's explanation that it was 'just one of those things, babies die'. She said that they had simply asked whether there was any procedure that could be changed to stop it happening to another family. At the time they were told there was not but it is clear to her now that there was.

3.83 Following her complaint to the NMC, a solicitor for the NMC interviewed her. Mrs D told us it was 'quite harrowing when you have gone through something, do you know what I mean, nine and a half years earlier and you have grieved as a family and you have grieved as a mother for something that has happened…'

3.84 Mrs D told us 'It was a very, very traumatic time. But we, we had kind of dealt with it and tried to move forward but it kind of opened up old wounds, and then to find out that they had lied to us and, you know, that the basic things that should have happened, that the NMC should have picked up on, that – I just found incredible …and I couldn't understand why – the NMC are there to protect the public but also to protect their registrants and I get that' but she found it hard to understand why the NMC did not check that the registrants were fit to practise.

3.85 When the midwife eventually apologised in her letter to the NMC it had meant more than anything. 'All I wanted was for her not to practise and deliver another baby … I don't want her not to have a life and be miserable for the rest of her life because she didn't go to work that day and think, oh I think I'll kill this woman's

[48] Inquest touching the death [Mrs D's baby] September 2013.
[49] All quotations taken from an interview between Mrs D and the review team October 2017.

baby by not doing my job properly. I don't think for one minute that any of it was an intentional thing but she had been a dripping tap for – she must have been a dripping tap before she delivered [my baby]…I always said she lives with that every day you know…in the very beginning I thought no midwife goes into work to deliver a baby and it dies. That must be a hell of a shock for somebody….'.

3.86 Mrs D found herself propelled into media coverage and 'everybody knew my business'. She understood that there were a lot of charges but felt the NMC had not kept her in the loop. 'I mean, [the midwife] had admitted all the charges in a letter and basically told them she wasn't going to a hearing … six months before and they never even shared that with us. So I still went down to London and still relived that day in a room full of people which was – it's harrowing to relive and relive again and again and again. It's like knocking a scab off a cut and never letting it heal'. Mrs D also highlighted the profound impact on her other children, including media intrusiveness and the length of time the investigations took, which spanned their childhood. It caused them to re-grieve and 'feel robbed'.

3.87 Mrs D found the NMC 'very matter of fact' to deal with. She had had to initiate contact with them to find out information. No-one had really been allocated to support her. She had been given a named contact but did not always manage to get that person when she called. Letters were 'guarded' but 'pleasant enough'. She could not recall receiving any expression of sympathy for her loss. The panel however had been 'lovely …really nice'. The midwife was not present and was not represented so Mrs D did not get asked many questions. After the hearing however it was 'just kind of like well once you had given your evidence it was just like that – away, go, that's it, gone'.

3.88 Mrs D chose not to go to London to hear the decision but was given only about five or so minutes notice before it was 'all over the press', which was very hurtful: 'I think they thought about themselves and their own reputation. They didn't keep us in the loop whatsoever and the process was so long and drawn out'.

3.89 Mrs D said that the NMC had not contacted her about Midwife 7. Following the death of her baby, Mrs D had met with Midwife 7 during a 'listen to mother' session at the Trust with her bereavement counsellor. She thought that the midwife had 'lied to her' about the need to monitor the baby's heartbeat. The NMC, when investigating the complaint, did not ask Mrs D or the bereavement counsellor for a statement about what she thought was dishonesty. She had understood there could not be a hearing when a midwife retired. She did not even know there had been a hearing until after it was held when she discovered it in her local press.

3.90 Mrs D felt that not only the midwife but also 'a catalogue of organisations including the NMC' had let them down that night. From her perspective 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'.

3.91 Mrs D would like the NMC to be far more responsive when complaints are made and keep families in the loop constantly, even if they do not have anything to tell them and just say 'it might not feel like we are doing anything but we just thought we would touch base with you. So it doesn't feel like you are just a statistic, because that's exactly how I felt'.

The investigation into the care provided to Mrs E and her baby

3.92 Mrs E and her baby died in the ambulance on the way to FGH in 2008. The pregnancy was complicated since Mrs E was diabetic and suffered from high blood pressure. It appears that she attended an antenatal appointment where she ought to have been seen by an obstetrician but was not. Records of her blood pressure were not taken. She collapsed at home a week later and died.[50] Midwife 7 undertook a root cause analysis of the death.

3.93 This case was referred to the NMC by the Kirkup Inquiry team as part of its concerns about Midwife 7.[51] Expert evidence obtained by the NMC suggested that there were material flaws in her root cause analysis and was included in the cases against Midwife 7.[52] Mr E was not informed of the investigation. The NMC made attempts to trace his whereabouts[53] but, when information was received, no letter was sent informing him that a hearing was to take place.

The investigation into the care provided to Mrs F and her baby

3.94 Mrs F had had a difficult previous birth. For this baby, she was induced but there were significant problems and it appears that she was not adequately cared for in the process. The baby was large and the delivery attempts caused her considerable pain. Her baby was stillborn. It is clear from the inquest report that the care Mrs F received was inadequate through the use of inappropriate techniques for the birth, failure to monitor the foetal heart rate and to escalate concerns properly[54]. Midwife 11 was the midwife in charge at the birth.

3.95 Mrs F complained to the NMC in December 2013 and her case was investigated by external lawyers.

3.96 The cases of Mrs D and Mrs F were included in the consideration of the other matters raised by the Trust by the NMC. The matters were referred to the CCC and Midwife 11 was struck off in May 2015.

The investigation into the care provided to Ms G and her baby

3.97 In 2008, Ms G's baby was born brain damaged. She was under the care of Midwife 11. Following settlement of a claim against the Trust, Ms G complained

[50] Police report April 2012.
[51] Letter from the Kirkup team to the NMC dated 24 April 2015.
[52] Expert report for the NMC dated 12 May 2017.
[53] Email from tracing agents to NMC – 31 May 2017.
[54] Inquest touching the death of [Mrs F's baby], July 2009.

to the NMC in April 2015. The NMC opened an investigation but closed it following the decision to strike off Midwife 11 in respect of the other cases.

3.98 While the NMC did inform Ms G that there were ongoing cases against Midwife 11, and of the outcome of those cases, we could find no record of the NMC telling her that, if Midwife 11 were to be struck off, then it could not investigate her complaint further.

Concerns about Midwife 7

3.99 The Kirkup report identified a major concern in these cases about the quality of the local investigation reports. Many of these were undertaken by Midwife 7 who was the Maternity Risk Manager at FGH and one of the Supervisors of Midwives. Her investigations involved a number of cases and we set out below the concerns about her investigatory practice as they arose. These were:

- Her investigations were inadequate and failed to identify failings, which meant that that learning was not identified and applied and poor practice continued
- She contributed to a culture of lack of openness and honesty about failings in care, and a perception of cover up and collusion amongst the midwives
- She was alleged to have misled families

3.100 The concerns raised with the NMC were:

- By Mr A, throughout 2009, about the quality of the LSA report written by Midwife 7, and media reports he shared with the NMC about the maternity unit at FGH
- By the NMC Midwifery Team in 2010 about that report
- The complaint made by Mr A in June 2012 alleging that Midwife's 7's report for the LSA was dishonest and that she had guided the midwives' responses to the local investigation, the NMC investigation and the inquest, including preparing a set of model answers
- About her report on the death of Mrs B and her baby, which was included in the material provided to the NMC by Cumbria Police in 2012
- By Mrs D in October 2013 who said that Midwife 7 told her in 2005 that there had been no failings of care in relation to the birth of her baby, when Midwife 7 knew this was not the case
- The Ombudsman's report relating to Mr B's complaint published in December 2013 which was critical of the conflicts in Midwife 7's role
- Mr B's complaint in January 2014
- The Kirkup investigation and report.

3.101 Midwife 7 retired from practice in March 2012 but remained on the NMC's register.

3.102 In June 2012 the NMC opened a complaint against Midwife 7 along with other midwives, following Mr A's complaint about collusion over the inquest into the death of Mr and Mrs A's son but, as described at paragraph 3.27, immediately closed it. This appears to have been an administrative error, but it was not corrected. The NMC does not seem have responded to a recommendation the following month from its external lawyers that one should be opened.

3.103 Following its review of the cases in early 2014, the NMC decided that there should after all be an investigation into Midwife 7. It opened a complaint which covered the allegations of collusion in respect of the inquest and the concerns about the investigation reports prepared by Midwife 7 relating to Mr and Mrs A's baby. In April 2014 a further complaint was opened in respect of Mr B's concerns. In October 2014, following discussions with the Kirkup team about the wider governance concerns at FGH and the receipt of further material, one was opened about her other investigative reports. Ultimately these three cases were treated jointly by the NMC.

3.104 As we have set out above, the Investigating Committee found that there was no case to answer in respect of the concerns about 'collusion', while the NMC's external lawyers did not investigate the concerns about Midwife 7's supervisory report in Mr B's case and initially recommended that there was no case to answer. It was not until June 2015, when the Kirkup report was published and further information received from the Kirkup Investigation team, that a full investigation into the standard of the supervisory reports was begun. Nine supervisory reports were considered by an expert. The investigation took time because of difficulties obtaining information from the Trust, and because there was considerable discussion with the expert who was instructed to advise.

3.105 The complaints were considered by the Case Examiners in December 2016. They decided that there was a case to answer in respect of seven of the reports and referred Midwife 7 to the CCC.

3.106 In April 2017, the case was reviewed, as is normal practice, by a lawyer at the NMC. That lawyer noted a number of evidential problems with the expert's review of some matters and that there was evidence that would support charges of dishonesty, though these might need further investigation. Thought was also being given to whether it might be possible to resolve the case by way of a consensual panel determination (CPD). Under this arrangement, the registrant admits the charges and agrees a sanction. The proposal is considered by the CCC which can approve the agreement or not. If the agreement is approved, a full fact-finding hearing is not required.

3.107 The NMC decided that its aim should be 'focused case management for the best outcome to be reached by June 2017 given the age and history of the case'.[55] We understand this to mean that the priority was to have the case completed. The final charges related to the inadequacy of the root cause analyses and

[55] Internal email dated 6 April 2017.

supervisory reports carried out by Midwife 7 in respect of four families: Mrs A and child, Mrs B and child, Mrs F and her child, and Mrs E and her unborn child. They did not include charges about collusion (because there was no sufficient evidence of other collusion, or realistic prospect of obtaining sufficient evidence of collusion to give rise to a case to answer) or dishonesty to the parents.

3.108 The hearing was scheduled for June 2017. Following discussions with Midwife 7's representative, a CPD was reached with Midwife 7. Under this, she admitted the majority of the charges and agreed that she ought to be struck off. Under the NMC's arrangements, the referrers of the complaint (that is, the family or other people who referred the case to the NMC) are offered the opportunity to comment on the agreement. The agreement was not reached until the Friday of the week before the hearing was due. The referrers were contacted on the Friday afternoon and had until the Monday lunchtime to make comments. Mr A and Mr B raised concerns (a) at the short notice and (b) they were not told what the charges were so could not properly comment. Their comments were put before the Committee considering the CPD agreement. The CPD was accepted by the Committee on the Tuesday afternoon and Midwife 7 was struck off.

3.109 This case was completed eight years after Mr A first raised concerns about the adequacy of Midwife 7's investigations and five years after Midwife 7 had retired.

Other information available to the NMC

3.110 Our examination of the files showed three other pieces of information about the Midwifery Unit at FGH in the NMC's possession.

3.111 The first was an internal email dated 30 September 2011, which referred to information that the CQC had received from a 'whistle-blower' which alleged that midwives at the FGH were incompetent, destroying records in order to disguise incompetence and preparing dishonest reports. The email indicated that the CQC was taking this forward. The CQC was unable to tell us what, if any, action it took following this referral[56]. The NMC could show us no evidence that it had made any attempts to follow this up with the CQC.

3.112 The second was a report of 22 cases investigated by Cumbria Police where there had been significant untoward events at the FGH. This was provided to the NMC by Cumbria Police in April 2012.[57] The report identified the families and the midwives involved in the care. Seven of these cases had arisen after 2009. The midwives included a number who were the subject of complaints already opened by the NMC. We could find no evidence of the NMC taking any action on this information when it arrived. Indeed, it appears to have chased Cumbria Police for the information in December 2013[58] and received the information again.

[56] Interview with the review team, September 2017.
[57] Email from Cumbria Police to the NMC dated 17 April 2012.
[58] Email from NMC to Cumbria Police dated 9 December 2013.

3.113 The NMC looked at this information as part of its review of the cases in early 2014 and, in some cases, considered that more information would be needed from the police. The NMC told us that the scope of the review was to consider the police documentation and the Ombudsman's reports, and to review and identify the position with all open and closed cases. It was not intended to produce an investigation plan for future conduct of the cases, and did not purport to do so. Consideration as to what further information should be sought would be set out in any subsequent investigation plan. We could not identify any consideration being given by the NMC as to whether new complaints needed to be opened or investigated.

3.114 The NMC told us that it had had considerable correspondence with the Trust about the fitness to practise of its midwives working there and provided us with a schedule of the correspondence. That correspondence did not appear to us to seek information directly about most of the cases raised by the police or about all of the midwives concerned.

3.115 In July 2012, Mr A sent the NMC the results of a Freedom of Information Act disclosure from the Trust[59] about the claims raised against it in respect of the midwifery unit at FGH. That information showed that 19 claims had been notified in respect of events from 1 January 2009 and that there had been a sharp rise in claims in respect of untoward incidents after 1 January 2007.

[59] Letter to Mr A from the Trust dated 18 July 2012.

4. The NMC's approach to the cases and the families

4.1 In this section we discuss the issues that we have identified in the handling of these cases by the NMC and from which lessons can be learned. We look at:

- Record-keeping
- Identifying the key concerns and investigating the complaints
- The management of the cases
- Looking at concerns beyond the individual cases
- The length of time taken
- Communication with the families
- Transparency
- Problems with the legal framework of fitness to practise in the context of these concerns.

Record-keeping

4.2 As we described at paragraph 1.19, the NMC's record-keeping was poor before 2014. While documents sent to the NMC before that time appear usually to have been saved to the system, together with letters and emails sent by the NMC to witnesses, registrants, the Trust and others, we found that other matters – particularly internal discussions and instructions – were not consistently recorded or saved. So it is difficult to understand how or why case management decisions were taken. It also appears that matters considered in other parts of the organisation were not always saved in relevant fitness to practise files. We considered that we did not see full records of:

- Internal conversations where instructions may have been given or decisions taken about the handling of complaints
- Discussions between NMC staff and its external lawyers
- Discussions between NMC staff and complainants, witnesses, registrants or their representatives – frequently there are emails from these individuals referring to conversations but no NMC record of them[60]
- Some instructions sent to external lawyers, particularly case presenters, and discussions with them about the charges to be put and the presentation of the cases
- Telephone conversations and meetings, particularly with senior members of the NMC's executive.

4.3 This poor record-keeping created a risk of a lack of continuity in approach and/or of ongoing understanding of a case, particularly when (as we saw here) cases were handled by several individuals in succession. Subsequently, it made it difficult for us or the NMC to establish what happened in the past.

[60] For example, among many, email of 15 October 2009 from Mr A.

4.4 We have reported in our annual performance reviews on the NMC's inadequate record-keeping and steps taken by the NMC, with some success, to improve it. In these cases, we noted significant improvements in record-keeping in the years after 2015.

4.5 However, records of internal discussions and decisions about case management, and discussions with the NMC's lawyers and those representing the registrants were still missing from the files of the cases of Midwives 1 and 2 in the spring of 2016. There were no records of any discussions around the chronology that had been attached to Mr A's 2010 witness statement. We saw emails where he raised the matter and mentioned telephone conversations with the lawyer involved, the then Director of Fitness to Practise and the Chief Executive. However, the emails recording this do not appear on the case file. We found them as part of the documentation disclosed following Mr A's Subject Access Request. Similarly, we did not see clear records of the internal discussions around the decision to offer no evidence against Midwife 6: there is legal advice setting out the reasons for offering no evidence that were given to the panel, but no record of any approval or sign-off for that advice, though we do not question the appropriateness of that advice. In respect of Mrs C, we noted that there were references in emails to telephone conversations without records of the content of those.

4.6 We noted that the discussions in respect of Midwife 7, in 2017, were significantly fuller and the reasons for decisions were clearer and easy to follow. However, in their responses to our questions, the NMC provided us with reasons for decisions taken which had not been apparent to us from the files.

Identifying the key concerns and investigating the complaints

4.7 We identified occasions where the NMC did not identify issues or act on information that could have been followed up. This is serious because:

- The investigation does then not address all the possible concerns
- It may mean that matters are missed when considering whether an interim order is needed
- Registrants may not be fully aware of the case against them
- Risks to patient safety may not be addressed.

4.8 We found the following problems:

- A lack of clinical knowledge in both its Fitness to Practise teams and its external lawyers
- Over-reliance on local investigatory reports
- Failing to engage with the points raised by the families
- Failing to engage with the information provided by Cumbria Police.

Clinical knowledge

4.9 In our audit report in 2009, we recommended that the NMC put in place a mechanism for staff to have access to expert advice on acceptable nursing and midwifery standards. Early clinical input should ensure that the regulator investigates the right issues, and can assess the seriousness of the clinical concerns and so identify and manage any risks to patients posed by individual registrants.

4.10 The NMC obtained expert clinical advice in the majority of cases which were taken to the CCC, but not until after the initial investigation had been completed. The allegations were therefore formulated without the benefit of early clinical advice, and the expert was asked to comment on allegations which had been formulated by lawyers rather than to identify the practice concerns which required investigation. Clinical advice should have been obtained at an earlier stage so that the correct concerns about registrants' practice were identified and investigated.

4.11 This knowledge is also likely to be helpful when dealing with employers and those commenting on individual cases. The Trust's Head of Midwifery told us: 'I was dealing with screening people, or investigating managers, or fitness to practise investigators who have no midwifery background or knowledge. And I think that's the real gap in the NMC as well, that actually some of what we experienced might not have happened if we had actually had the midwifery practitioners doing that screening or the investigation'.[61]

4.12 Early clinical advice ought to have identified that:

- Mr and Mrs A said that they had told 'the midwives' that they were unwell and, therefore, that this should have triggered action from the midwives – this could have been identified when the statement from Mr and Mrs A was taken in 2009 and someone with clinical expertise would be likely to have done so, but the concern was not formally raised until 2014
- There were discrepancies and problems with the supervisory reports prepared by Midwife 7 in respect of Mr and Mrs A's baby and the death of Mrs B and her baby – these were not raised by the NMC until 2014
- There were significant clinical concerns in respect of the deaths of Mr B's wife, which were identified by the Ombudsman, who had clinical advice

4.13 The NMC told us that the bulk of complaints that it receives do not require expert clinical advice. We agree that, unlike the ones we have been considering in this report, many complaints about nurses do not require expert advice. It has also suggested that the points above did not uniquely require clinical advice. That may be so, but clinical expertise would have been more likely to identify them and we note that those without clinical expertise did not do so: neither the NMC

[61] Interview with the review team, October 2017.

nor its external lawyers identified those cases when early clinical input should have been obtained.

4.14 The NMC has told us that it has in the past employed clinical advisers in its Fitness to Practise Directorate. These, however, have left the organisation and the NMC has been unsuccessful in recruiting to the posts. It has made alternative arrangements to ensure that clinical advice remains available by using its clinical case examiners (separately from their statutory decision-making role). It recognises that this is not ideal and plans to recruit for the posts again. Where a need for clinical advice is recognised, the advice is generally sought at the screening stage and so would be available on the file to external firms and to the internal investigation teams, but it can be requested at any time.

Reliance on local supervisory reports

4.15 Great reliance was placed on the local supervisory reports prepared under the old statutory arrangements, particularly in the early years of the investigations. These were made by statutory bodies with statutory powers and duties. Local reports and investigations generally are an important part of clinical governance and a source of learning from adverse incidents. When done appropriately, they can be of significant assistance to the NMC, as was the case in respect of Midwife 11, where the Trust's 2013 investigation into her provided the basis for the NMC obtaining an interim order suspending her from practice and for her subsequent striking off.

4.16 However, it would appear that, at least until 2013, the NMC was not able to rely on frank reports from the Trust. Dr Kirkup told us that the NMC, and the other regulatory and oversight bodies, had problems identifying the concerns at FGH because all they had to rely on was the very limited and, as we have seen, often inaccurate information given by the Trust. However, he also told us that there was a sense of disbelief within his Investigation Team that no individual or organisation had identified what was going on at FGH as it was readily apparent from clinical records and the local investigation reports. He thought that the NMC needs to have 'some ability [to uncover things] every now and again when the Trust is trying to pull the wool over your eyes.'[62]

4.17 We recognise that, in the bulk of cases whether involving midwives or other clinicians, local investigation reports will provide powerful evidence about the facts of untoward events. However, the NMC had evidence and concerns about the quality of the reports in 2010 from Mr A and these concerns were shared by the Midwifery Team to the extent that they reviewed the system at FGH with the CQC in 2011. These concerns do not appear to have been shared with external lawyers investigating the case of Mrs B and her child. Moreover, while the external lawyers investigating the case of Mr and Mrs A took statements from them and referred to those statements in evidence, there is no evidence that they engaged with the concerns raised by Mr A about the quality of the local reports,

[62] Interview with the review team June 2017.

the alleged inconsistencies involved or how far those might have affected the reliability of those reports. Reliance was also placed on local reports by the external lawyers looking at Midwife 4's care of Mrs C.

The evidence from the families

4.18 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. Examples include:

- Mr B was not interviewed by the external lawyers who, in effect, dismissed his concerns. This was a significant omission because the Investigating Committee decided that there was no case to answer on the basis of the investigation report and the NMC then decided that it could not re-open the case when the Ombudsman's decision[63], supporting Mr B's concerns was published
- Mr A's evidence identifying discrepancies between the various statements made by the midwives never seems to have been addressed properly because no one seems to have examined those statements to see whether discrepancies existed and, if so, how serious they were
- The NMC did not address the substance of a complaint by Mr A when considering whether or not to open a complaint but to rely instead on the absence of concerns from the Kirkup team
- The NMC did not contact families identified to the NMC by Cumbria Police in April 2012 for their recollections
- The allegation that Midwife 7 might have been dishonest to some of the families was not properly addressed until it was too late to explore the case properly.

4.19 There also appears to have been a lack of familiarity with the detail of the evidence that the families provided. This is illustrated particularly by the episode of Mr A's chronology, the absence of which appears not to have been noticed. Nor was the content of his witness statement of May 2010. We discuss this in more detail at paragraphs 4.27-4.36.

4.20 Generally, the approach taken by the NMC's investigations appears to have been based on seeking information from the Trust about cases and seeking expert advice on that. While this is important evidence, the experience and evidence of the families is also important in identifying any discrepancies or concerns that might have arisen. The approach by the NMC meant that concerns raised by the

[63] Parliamentary and Health Service Ombudsman. *Midwifery supervision and regulation: A report by the Health Service Ombudsman of an investigation into a complaint from Mr M about the North West Strategic Health Authority*. Available at: www.ombudsman.org.uk/sites/default/files/Midwifery_supervision_and_regulation_Mr_M_report.pdf [Accessed: 14/05/2018].

families, some of which were supported by subsequent investigations, were not addressed.

4.21 We were also concerned that the complainants in these cases were not given the opportunity to see the responses to the allegations from the registrants. In the two cases where this was relevant (Mr A and Mr B), there were major differences of recollection between the families and the midwives. Giving the families the opportunities to see the responses of the registrants would have enabled them to identify any further discrepancies of recollection as to facts. The NMC has told us that, in the cases that went before the CCC, it did not have responses which could be shared with the families. This is correct. However, in others, notably the early ones by Mr A, the midwives did provide responses to the NMC and it is not clear to us why these could not have been shared.

Information from Cumbria Police

4.22 The Fitness to Practise team also missed the significance of other information that was provided. In 2012 Cumbria Police provided the NMC with a list of cases where there were concerns about the care of patients.[64] The NMC appears to have taken no action on the list for almost two years when, as the police told us,[65] the point of providing the information was to enable the NMC to consider whether urgent action ought to be taken. A number of midwives' names appear on the list who were already the subject of complaints and some of the events were relatively recent. These included Midwife 9, who was involved in the care of Mrs B and whose practice was never fully investigated, and Midwife 11, who was suspended by the Trust in 2013 following two adverse incidents and an examination of her practice by the Trust.

4.23 When those cases were considered as part of the review of all the cases, the view seems have been taken that the NMC should await further information from Cumbria Police. We saw no record of the police being asked for this information. However, in our view, the information already sent by the police was sufficient for the NMC to have sought the records of the cases directly from the Trust. It could also have sought contact details for the families. We saw no evidence that it considered doing so.

Management of the cases by the NMC

4.24 From our examination of the files, we found that, particularly before 2014 there was only limited understanding of what the cases were about and the issues they raised. There also appears to have been poor communication between the NMC and its external lawyers. We noted that case managers changed frequently and, possibly hindered by poor record-keeping, did not always understand the history or substance of the cases. The NMC's case management system was inadequate and we were told that it did not have the capacity to enable links

[64] Email from Cumbria Police to the NMC 12 April 2012.
[65] Interview with the review team, August 2017.

between cases to be noted. There appears to have been poor communication of the concerns of the Midwifery team to the Fitness to Practise team. Our interviews with those members of the team who were case officers confirmed that they were not particularly expected to have an understanding of the details of the case or take a view as to the issues. They also spoke of heavy caseloads at the time. These points must go some way to explain why there seems to have been little engagement among NMC staff about the various points raised by Mr A or understanding about their implications.

4.25 This meant that opportunities to pursue potentially serious concerns were missed so that these were either not investigated or the investigation was significantly delayed.

4.26 We look below in detail at two examples where we considered that the NMC failed to keep a clear history of the cases in mind or identify links between cases and identify some more general examples of poor case management.

The chronology prepared by Mr & Mrs A

4.27 The handling of the chronology prepared by Mr and Mrs A in November 2008 is a matter of considerable concern. This chronology was referred to as 'Exhibit 2' in the witness statement signed by Mr A in May 2010. As we have said at paragraph 3.34 we could find no trace of the chronology on the NMC's files prior to March 2016 when Mr A sent the NMC a copy of it. We found copies of the witness statement on several files at the NMC prior to that date, but the exhibit was attached to none of them. We saw no evidence that anyone at the NMC had noticed its absence, or tried to find it or even felt that it might contain information that was relevant to any of the cases. This suggests a lack of interest in the evidence that complainants can provide.

4.28 The 2010 witness statement, in which Mr A also mentioned that he and his wife had 'told the midwives' of their illness, was not included in the papers in the case of Midwives 1 and 2, where it was directly relevant. This may have been because a second statement specifically covering the events involving Midwives 1 and 2 had been taken in early 2016.

4.29 At the hearing, defence counsel suggested that Mr and Mrs A had not mentioned that they had told the midwives of their illness until the coroner's inquest in 2011. Mr A was surprised that the chronology referred to in his May 2010 witness statement was not before the panel because this would have rebutted this point. He sent a copy to the NMC during the hearing.

4.30 The chronology in our view provided relevant evidence because Mr A mentions that he and his wife told 'the midwives' of the infection on the face of his 2010 witness statement and the chronology provides support for that. This chronology is also mentioned in the independent report commissioned by the Trust in 2008, a copy of which was in the NMC's possession.

4.31 Mr A was concerned that the allegations by the midwives' defence had not been challenged by the NMC, and he raised the question with the then Director of Fitness to Practise. He indicated in an email written immediately after a conversation with her that he had understood her to say that the first time that the NMC had seen this chronology had been when he produced it during the hearing. She told us[66] she recalls saying this and believed it to be the case at the time that she said it. There is no record of anyone at the NMC seeking or providing an explanation of what had happened to the chronology. Mr A's direct question to the NMC[67] about this was never answered.

4.32 The Authority asked the NMC about the chronology when it reviewed the cases of Midwives 1 and 2 following the panel's decision. The NMC wrote to us:[68]

'We gave active consideration to the inclusion of this in the bundle of documents. We decided not to include it because;

- There was nothing to indicate when it was made
- It did not support the evidence of Mr [A] in our case against [Midwife 2] The chronology referred to the "the midwife" on 25 October 2008 being told that Mrs [A] was unwell. It made no mention of a second midwife being present and also being informed
- The chronology did not identify the midwives whom Mr and Mrs [A] had spoken to on either 25 or 26 October 2008'.

4.33 In a letter to the Secretary of State for Health,[69] the NMC wrote 'we considered the inclusion of Mr [A's] near contemporaneous statement. We decided not to present this to the panel as our view was that it did not provide new evidence, given that it did not name the individual midwife and it was not clear when it was made.' We note that the chronology is clearly dated 8 November 2008. We understood the NMC's statements to mean that the NMC had the chronology at the time that it was preparing the bundles for the panel.

4.34 The NMC was unable to provide us with a definite answer as to what happened to the chronology. No one was able to say definitively when it first had possession of the chronology. The NMC has told us[70] that it agrees that there is a significant likelihood that the chronology was lost at an early stage and that the first time that it came to its notice was when Mr A presented it at the hearing. The NMC told us that the 'active consideration' given to including it in the bundle had certainly taken place when it was provided by Mr A, and, therefore, after the bundle had been in the panel's possession. It was unable to say whether such consideration had been given before that. We found no documentary evidence to suggest that consideration had taken place earlier or that anyone had noticed the

[66] Email to the Authority, 27 October 2017.
[67] Email from Mr A of 11 March 2016.
[68] Letter from NMC dated 20 May 2016.
[69] Letter from the Chief Executive of the NMC dated 27 June 2016.
[70] Letter to the Authority of 29 March 2018.

absence of the chronology before Mr A provided it. This is despite it being referred to on the face of the witness statement of May 2010.

4.35 The NMC further told us that it had decided not to provide the chronology to the panel because it considered that the document might overall have undermined the case. Our terms of reference do not permit us to comment on this view. It indicated that its point about the date of the document was that it was created after the events rather than contemporaneously. We noted that the document was completed less than three weeks after the events took place.

4.36 We consider that this episode suggests, at the very least, poor record-keeping by the NMC and, if we are correct that the absence of the chronology was not noted until Mr A provided it, a lack of familiarity with the documents or a failure to enquire after what might have been an important, near contemporaneous piece of evidence. We comment on how the NMC dealt with this matter in its responses to the Authority and the Secretary of State at paragraph 4.130 below.

Allegations of collusion and dishonesty

4.37 We looked closely at the allegations concerning possible collusion or dishonesty by the midwives. We noted that the Kirkup report found 'clear evidence of distortion of the truth in responses to investigation' and 'inappropriate distortion in the preparation for an inquest, with circulation of what we could only describe as 'model answers''.[71] These allegations are serious and it is incumbent on a regulator to investigate them, if only because honesty is a key responsibility of all health care professionals. In these cases, moreover, the allegations were that the dishonesty was aimed at covering up poor care. There is, thus, a clear link between the concerns and patient safety. We note that Cumbria Police decided not to prosecute these cases. The police would have had to bear in the mind the criminal standard of proof (beyond reasonable doubt). The NMC panels use the civil standard of proof (more likely than not) and it is, in theory, possible, that a panel might have found an allegation proved to the civil standard which would not have reached the criminal standard.

4.38 We make no allegations against any individual and we do not suggest that any individual ought to have been found to have been dishonest or colluded under the civil standard of proof. Our focus is on how the NMC investigated the allegations. We also recognise that there are often difficulties in proving dishonesty and collusion and these were present here.

4.39 There were three strands of concerns:

- Individual midwives were alleged to have been dishonest in the accounts they gave to local investigations and in their responses to NMC inquiries
- Some midwives were alleged to have colluded to present distorted evidence to the coroner's inquest into the death of Mr and Mrs A's baby

[71] Kirkup report, page 8, point 10.

- Midwife 7 was alleged to have been dishonest to individual parents when discussing the causes of the babies' deaths and in her supervisory reports.

Allegations of dishonesty by the midwives

4.40 We could not see evidence that the NMC had properly engaged with all the evidence available to it about dishonesty among the midwives in respect of local investigations until 2014. There appears to have been no analysis of the alleged discrepancies in their statements or the disparity between those statements and the recollections of Mr and Mrs A and Mr B. No attempt was made to follow up the allegations of the whistle-blower to the CQC.

4.41 The concerns about collusion raised in respect of the 'NMC shit' email were never addressed in that we saw no evidence that the NMC had actually sought a copy of the email and the attachment. This appears to be because the external lawyers only investigated concerns about the offensiveness of the title and the data breach because they considered that the collusion issues should wait until the police investigation had been completed. The complaints were closed after the first two issues had been dismissed by the Investigating Committee and the remaining concerns were not identified in the review of the cases in 2014. Again, we make it clear that we have no evidence to suggest that collusion would, in fact, have been found.

Alleged collusion over the inquest

4.42 The NMC's external lawyers looked in detail at the evidence supplied by Cumbria Police in respect of the allegations of collusion at the inquest. The Investigating Committee concluded, on what appears to have been a thorough investigation, that there was no case to answer against any of the individual midwives identified by Cumbria Police. That investigation, however, was limited to the information obtained by the police. We did not see other evidence that was available (for example, statements made for the 2008/09 investigations into the deaths of Mr and Mrs A's baby) being checked also for discrepancies which might have supported the allegations. We recognise, however, that all of the evidence was available to Cumbria Police.

Alleged dishonesty to the families

4.43 The first time the question of dishonesty to the families was properly addressed was in 2017 when the NMC's lawyer reviewed the case against Midwife 7. She noted possible instances of dishonesty by Midwife 7 towards Mr A and Mrs D and proposed further investigation in order to bring charges. The lawyer's view was that, if dishonesty could be established, this would put Midwife 7's inadequate investigations in a different light, namely that it could be inferred that she was covering up poor practice in all of the investigation reports which were found to be inadequate.

4.44 These concerns were not pursued by the NMC. The NMC told us that there would have been difficulties proving what had been said in conversations that might have taken place some years before and that there could have been abuse of process arguments which may have been successful and would have delayed the hearing significantly. It decided that it was not proportionate or appropriate to pursue the point because it considered that it had sufficient evidence to support a striking-off from the register for Midwife 7.

4.45 Concerns about dishonesty and collusion were highlighted by the Kirkup report. They were matters which the NMC ought to have investigated because, if correct, they would seriously affect the registrant's fitness to practise. It had material as early as 2010 which does not appear to have been investigated adequately and which was not identified as part of its review of the cases in 2014 or following discussions with the Kirkup team. We have no basis on which to suggest that the allegations would have been found proved, but it is regrettable that the NMC's investigatory failings meant that these questions were never formally explored.

Other case management problems

4.46 We also noted that the concerns about the quality of supervisory reports do not seem to have been effectively communicated to the Fitness to Practise team and, therefore, did not inform their or their external lawyers' assessment of the evidence available.

Looking at concerns beyond individual cases

4.47 In these cases, we observed that the NMC tended to concentrate on the substance of the cases and whether they, as individual cases, could be proved but did not consider whether information from one case might impact on others or that there might be wider public protection concerns.

4.48 We have already noted that the NMC did not engage soon enough with the allegations of dishonesty that were raised in many of the cases, that its Midwifery Team's concerns were not effectively considered by its Fitness to Practise Team and that the list of cases provided by Cumbria Police in 2012 was not examined until 2014. In addition, we were surprised that the concerns about the supervisory reports did not trigger questions about the quality of the care provided by the midwives at FGH both generally and in the individual cases where the supervisory report may have been deficient. In those cases which had not been referred by the families or the Trust and where Midwife 7's supervisory reports were criticised; no consideration was given as to whether the fitness to practise of any of the midwives involved in the direct care should be examined.

4.49 The NMC has argued that it did not have evidence which would reach the high threshold needed in order to obtain interim orders against any of the midwives. Our terms of reference preclude us from commenting on this. However, we would observe that it did not appear to have taken steps to see whether further

evidence existed in the light of the information that it had received from Cumbria Police and from Mr A and Mr B.

4.50 We also noted the legal advice about whether the clinical concerns about Midwife 9 in Mr B's complaint could be re-opened. The Ombudsman, of course, had identified those concerns. The advice was that, even though Midwife 9's actions at the time had not been properly investigated, it was not possible for the NMC to re-open the case. The advice does not appear to have considered the public protection concerns that might still exist about Midwife 9 or have noted that her name appears in connection with a number of the cases which concerned Cumbria Police. No consideration appears to have been given as to whether it might have been appropriate to look further at her practice.

4.51 The concerns about FGH involved questions of attitude and culture which were outside the NMC's remit but which were within the remit of both the Trust and of the CQC. We noted that on 21 July 2011 a group of NMC staff did indeed identify wide failings within FGH and that addressing them was substantially beyond the scope of the fitness to practise process. The group appears to have been proposing radical solutions, including the closure of the unit, referral of the problems to the CQC or placing the unit in special measures. The issues were left for discussion with more senior colleagues. There is no record of such a discussion.

The length of time taken

4.52 The length of time taken to deal with the cases is an obvious concern. It took more than eight years between the first complaint being received by the NMC and the final fitness to practise hearing. Untoward incidents involving registrants complained about were occurring until 2016. The NMC itself agrees that the delays were a failing and has apologised for them.[72]

4.53 The RCM told us that the situation as a whole was, understandably, very stressful for all midwives (and other health professionals) at FGH. It told us that 'the process being so lengthy that was a huge issue for our registrants, who at the time were trying to continue to work under extreme stress, they went a number of years without any communication from the NMC and we understand that that was in relation to the pause in the investigation when the police investigation began. But that did cause a lot of stress for our members, because obviously there was no communication for a long time. It was quite stressful at the outset in terms of the registrants that were initially referred all had exactly the same allegations to answer whether they were involved in a specific episode of care or not. So, on a lot of those, responses were not applicable because they had generic allegations sent out to them. So, that was quite stressful for them'.

4.54 As part of this review, one midwife who had been subject to NMC fitness to practise proceedings shared with us her experience, including that of appearing

[72] Letter from NMC to the Authority of 5 October 2017.

at a hearing of the CCC. It was clear that this registrant remains devastated by the outcomes for the families in these cases, and has been through an exceptionally difficult time. Her main concern was the amount of time it took the NMC to conclude the proceedings.[73]

4.55 In these cases, the delay had the following effects:

- Registrants who were subsequently suspended or struck off the register continued to practise
- Registrants retired or otherwise lapsed from the register which meant that their conduct could not be investigated by the NMC and they could not be required to provide evidence
- It caused memories to be questioned, particularly in the case of Midwives 1 and 2
- It added pressure for the NMC to complete cases rapidly in the latter stages, which may have impacted on the quality of its investigation and decision-making
- It affected the reputation of the NMC as an effective regulator.

4.56 There were three main reasons for the slow progress:

- The NMC's failure to identify the key issues in the early years
- Delays caused by the NMC putting its investigations on hold while the inquest and the police investigation took place and
- The timescales involved in the fitness to practise process.

Failure to identify the issues

4.57 The fact that the NMC and its external lawyers did not identify key issues from information in its possession from Mr A, Mr B and Cumbria Police when they were received meant that:

- The question of whether Midwives 1 and 2 should have taken more action about Mrs A's illness was not identified until 2014, over four years after it should have been apparent
- The clinical concerns raised by Mr B were not addressed at all
- Possible concerns about Midwife 9 were not fully investigated
- The concerns about Midwife 7's supervisory reviews were not addressed until 2014
- The concerns about Midwives 3, 4, 5 and 6 needed to be reinvestigated in 2014 to address the flaws in the previous work.

4.58 We recognise that the NMC's work was hampered by the fact that the Trust was slow to answer its requests for information and, at times, indicated a confidence in its registrants' fitness to practise that was subsequently shown to be

[73] Interview with the Review Team, September 2017.

misplaced. It may well also be that there would have been some delay because of the police investigation. However, if the NMC was not properly aware of the issues it ought to have been investigating then it was not in a position to press the Trust on its concerns or to engage properly with the police about what it could investigate. We cannot estimate how long a proper investigation would in fact have taken but identifying the issues properly would undoubtedly have meant that the NMC might have been able to take earlier action on some cases and to have picked up cases more quickly once the police investigation had been completed.

External investigations

4.59 The work on the initial complaints by Mr A was held up for three and a half years because the NMC decided to put its decisions on hold for two investigations:

- Between June 2010 and June 2011 because of the inquest into death of Mr and Mrs A's baby and
- Between July 2011 and December 2013 because of the police investigation.

4.60 Between June 2010 and June 2011, no work was done on Mr and Mrs A's complaints. During the police investigation work was done on aspects of the 'NMC shit' email and on Mr B's complaints.

4.61 There are a number of reasons why regulators postpone fitness to practise investigations for external events such as these:

- Their investigations might prejudice police inquiries
- The police and coroners have stronger investigatory powers and this can provide improved evidence for the regulator's own proceedings
- The outcome of the investigations might affect decisions by the regulator
- If there is a criminal conviction this means that the regulator can rely on the fact of the conviction as proof of the facts, and this can considerably shorten the regulators' own processes.

4.62 However, there are risks associated with such delays and we note that the GMC did not delay its own investigations into the doctors at FGH because of these investigations.[74]

The inquest

4.63 The inquest simply looked at the causes of the death of Mr and Mrs A's baby. The coroner made it clear that he had no objection to other investigations being undertaken while he was preparing for the inquest.[75] We saw no written decision

[74] Interview with the GMC and the Review team, August 2017.
[75] Letter from the Coroner to NMC dated 4 March 2011.

or reasoning behind the NMC's decision to postpone consideration of the cases until the inquest was completed. We do not think that it was necessary for it to do so: it was investigating whether the midwives concerned were fit to practise, not why Mr and Mrs A's baby died.

4.64 We recognise that the coroner's report in this case raised some significant concerns for the NMC. However, these concerns should have been apparent from the material already submitted to the NMC by Mr A. We do not think that the fact of the inquest should have prevented the NMC from looking at the fitness to practise of the individuals complained about, the discrepancies in their statements and the problems with the supervisory reports.

The Cumbria Police investigation

4.65 The formal police investigation opened shortly after the inquest was completed, in July 2011 (though Cumbria Police had been aware of the concerns since late 2010). There were a number of meetings and some email correspondence between the police and the NMC about the investigation. In assessing the NMC's reaction to it, we are hampered by the lack of clear notes of meetings or discussions to provide a clear thread. We saw no formal legal advice discussing whether or not the investigations should be put on hold, though we accept that discussions were held with external lawyers and that their advice was followed.

4.66 From our examination of the papers and discussions with Cumbria Police, it appears that:

- Cumbria Police did not wish to reveal material to the NMC that might find its way to the registrants – the NMC had made it clear that, if it received information relevant to a complaint, then it would disclose that to the registrants concerned
- The NMC understood that the police did not think it was appropriate for them to interview witnesses, other than Mr A, and particularly not the registrants (though the NMC has no power to interview registrants) but that the police had no objection to it investigating the "NMC shit" emails and, when it arose, Mr B's case. The NMC's external lawyers advised that this was as far as it was appropriate to go
- At meetings with Cumbria Police in 2011 and 2012, the NMC indicated that it would find evidence from the police useful in order to assess whether it needed to take action to protect the public
- Cumbria Police provided information to the NMC in April 2012 about more than 20 cases where they considered that there were concerns about the midwives that should be investigated
- In November 2012, Cumbria Police provided information about Mr B's concerns.

4.67 Cumbria Police told us that 'we were really concerned that reports of the same midwives who we had the cases sitting in front of us were still practising at the

hospital' and 'I decided that the safeguarding was going to have to trump the investigation at that point, because I felt I have to give some information on these cases to the NMC'. They were clear to us that their expectation was that the NMC would use the information provided in April 2012 to seek more information from the Trust to enable it to continue its investigations and, if necessary, take action to restrict midwives from practising. The NMC took no action on this and we do not know whether it was even sent to their external lawyers either at the time or when Cumbria Police re-sent the information a year later.

4.68 On receipt of the material in respect of Mr B's complaint, the NMC opened a case against Midwife 9. It did nothing to progress the cases which were already open but continued to wait for the police investigation to conclude. This was contrary to the police's expectation. Cumbria Police told us that it was 'constantly' telling the organisations involved that the police investigation was going to take years and 'no way' did they want to hold up any other body's investigation, particularly as there were safeguarding concerns. The NMC started its work again in January 2014, once the police investigation had been closed.

4.69 From our review of the papers, it is not clear to us that the NMC understood the approach that Cumbria Police were taking. In our view, there was scope for the NMC to investigate the wider fitness to practise of the midwives concerned (for example by seeking information from the Trust or from the families) and the police expected them to do so at the time the information was sent. We saw no evidence that the NMC considered doing so. This was an opportunity missed, given that some of the midwives identified by the police were subsequently involved in adverse events at FGH.

4.70 This delay meant that registrants continued to practise who may not have been safe to do so and that the investigation into Mr A's complaints was delayed by at least 30 months. We note, in particular, that untoward incidents involving two of the registrants noted on Cumbria Police's list took place after the NMC had received the information from the police and that those midwives were subsequently struck off (one for incidents that took place after that list had been received). We recognise that the NMC was in correspondence with the Trust frequently over this period and sought assurances about the Trust's view of the practice of the midwives and, indeed, that the Trust indicated that it had no concerns about the registrants. We cannot say whether an investigation would have provided sufficient evidence to justify the NMC in seeking an interim order restricting those midwives' practice. However, we saw no evidence of the NMC seeking direct evidence from the Trust about the events referred to in the police reports.

The NMC's investigations process

4.71 Fitness to practise cases require a period of investigation, an opportunity for the registrant to respond to the allegations, and (where cases are referred on to a hearing) a legal process in preparing for the hearing. Additional delays can be

caused for a variety of reasons, such as difficulties obtaining evidence or tracing witnesses, or in scheduling hearings at a time when all witnesses can attend. This means that, however effectively the case is managed, the process is unlikely to be quick. In looking at these cases, we considered whether there were delays which were avoidable.

4.72 We found initial delays in the NMC's process in identifying the midwives. The NMC is not necessarily able to identify a registrant from a complaint but needs to contact the employer in order to obtain the relevant Personal Identification Number and confirmation that the registrant was, in fact, involved in the care complained of. The Trust was very slow to respond to these requests and needed considerable chasing by the NMC. We do not criticise the NMC for this delay.

4.73 Following this, the process for investigating allegations takes time. It will frequently depend upon the availability of witnesses and their willingness to co-operate. The NMC sets timescales for investigations. We noted that, in a number of the cases, the external lawyers requested extensions of the usual timescales, for example because of difficulties in obtaining information from the Trust, contacting witnesses and obtaining appointments and signed statements from witnesses and in obtaining approval for experts to be instructed and then following discussions over the detail of those reports.

4.74 We have not been able to review the external lawyers' files, so it is impossible for us to tell whether the time taken to investigate the individual complaints was reasonable or not. We noted that it took six months between Mr A's witness statement being taken by the lawyers and the time Mr A signed it. This appears to be too long. After 2014, we noted significantly improved reports from the external lawyers which provided evidence of continual activity and we doubt that it would have been possible to reduce significantly the length of time that the investigations took at that point.

4.75 There was a delay of 16 months between the Investigating Committee's decisions to refer the cases of Midwives 1, 2, 3, 4 and 6 to the CCC in November 2014 and the hearings of the CCC, which did not begin until March 2016. This was because it was necessary to deal with a number of points that had been raised by the defence about whether it would be possible to hold a fair hearing, given the delay and the publicity surrounding the cases. There were also arguments about whether the cases should be heard together or separately.

4.76 The CCC originally met to consider the arguments in July 2015 and adjourned until October 2015 to enable them to be fully addressed. Once its decisions were made, fresh hearings had to be scheduled and the final hearings did not begin until March 2016, with the case against Midwife 6 heard in January 2017 (because she was out of the country).

4.77 As we have said, the process for assessing fitness to practise is likely to take a long time where, as here, facts are disputed and expert evidence is needed.

Indeed, the Government is looking to address this in its plans to reform the regulation of health care professionals. While the NMC cannot be criticised for the structural problems with the process or the problems that it faced in dealing with the Trust, its own failure to identify key matters to be investigated and its decision to postpone work because of external investigators were the key reasons behind the length of time taken to deal with these cases.

Communication with the families

4.78 We have set out our concerns (paragraphs 4.18-4.21) about the way in which the NMC engaged with the concerns raised by the families. We now look more closely at the way in which the NMC kept them informed of progress and provided support where they were witnesses. All of the families suffered the loss of the child, mother or both, or significant harm. As the NMC's Chief Executive and everyone else we spoke to accepted, the cases were terrible, life-changing tragedies for the families. It is understandable that those families will want to understand what went wrong and to have any problems addressed so that they do not happen again. It is also the role of the NMC to investigate and take action to ensure that the public is protected.

Mr B

4.79 In Mr B's case, the NMC failed to carry out the initial investigation of the complaint adequately so that it considered that it was unable to open it again in the light of the Ombudsman's report. Moreover, the way in which the NMC communicated with Mr B fell well below acceptable standards of treatment. Our concerns are:

- When Mr B tried to raise his concerns himself, he was met with a confusing response[76] and, ultimately, a refusal to open a complaint on the grounds that the decision had already been taken by the Investigating Committee
- When the case was re-opened in early 2014 together with Mr B's other concerns, the NMC took almost seven months to act on its internal legal advice that it could not look again at the clinical aspects of the complaint
- When that decision was taken, it was also decided not to inform Mr B of this until the Investigating Committee had come to a conclusion on his other complaints
- When he was informed of the decision about the clinical case, he was told that it had been delayed because 'new allegations or new evidence may have been identified that would have required us to further consider [Midwife 9's] fitness to practise.'[77]

[76] The emails of 9 August 2013 between Mr B and NMC, for example, suggest uncertainty on the NMC's part about whether he could raise a complaint or not.
[77] Letter to Mr B dated 13 November 2014 setting out the Investigating Committee's decision.

4.80 The correspondence that we have seen from the NMC to Mr B is confusing and cannot have been helpful to him. There are frequent long gaps where there is no evidence that he was being given information about progress. At no point does anyone seem to have recognised that he is a bereaved husband and father, that his recollection of the events ought to have been investigated properly by the NMC or that he was entitled to be taken seriously by the NMC.

4.81 We were particularly concerned by the way in which the NMC communicated with Mr B after it had re-opened the clinical complaint against Midwife 9 and then closed it again. The NMC was unable to provide us with a reason for the instruction to delay telling Mr B about this decision. There is no documentary evidence to support its statement to him that the delay was because it was awaiting further information. It has told us that it is not unusual for additional information to come to light in cases involving a number different parties before a complaint is considered by the Investigating Committee. We accept that, but it is hard to see how this would have applied to Mr B's complaint because it had been closed at screening on the basis that the Investigating Committee had already taken a decision on it and the legal advice was that the whole events at the birth of Mr B's child could not be re-opened. The matters being considered by the Investigating Committee were not connected to the birth. The NMC agrees that the treatment of Mr B was unacceptably poor. It did not give him a full picture of the handling of this complaint. The NMC never explained to Mr B that its original investigation had been flawed and never apologised to him for this.

Mr A

4.82 The handling of Mr A's complaints raised similar concerns. As we have said, he provided regular and significant contributions to the NMC. The concerns he identified about the clinical practice, the distorted responses to investigations and the inquest were supported by the Kirkup report. Yet we found little evidence of the NMC or its external lawyers seriously engaging with the points that he raised or using them to question the accounts given by the midwives concerned.

4.83 We found that the information provided to Mr A in response to his requests for information about progress, particularly before 2014 was confusing and contradictory.

4.84 The first time that Mr A was given any information about the substance of the complaints that the NMC was taking forward was following the Investigating Committee's decisions in November 2014.[78] This information was provided to him in a number of letters about each of the registrants about whom he had raised a complaint or where he was noted as an interested party. Those letters reproduced the Investigating Committee's decisions, based on the allegations considered by the external lawyers. It cannot have been easy to correlate these

[78] Letters to Mr A setting out the Investigating Committee's decision in respect of each registrant of 13 November 2014.

to the allegations that he had asked to be investigated. We were not surprised that he remarked that he 'did not find them easy to understand'.[79]

4.85 We found that the way the NMC provides reasons for the decisions by the Investigating Committee and also by Case Examiners is likely to be difficult for complainants to follow. This is because the decision is simply pasted into the letter to the complainant. The decisions are written following a report of the investigation and relate to that investigation. Any complainant reading them will have no information as to the intervening history, why some matters raised were not investigated, or how other matters were linked to the existing complaint. This does not assist the complainant to understand or have confidence in the process.

4.86 Mr and Mrs A were witnesses at the hearing in respect of Midwives 1 and 2. We have quoted Mr A's views of his experience at paragraph 3.56. We note that the panel was not provided with the chronology that supported his statement that he and Mrs A had told 'the midwives' of her illness. Mr A was, however, generally complimentary about the support that he received from the NMC in preparation for that hearing and at the hearing. From the documents we have seen, we agree that the NMC made strong efforts to provide appropriate support. Mr A told us that Mrs A also found the experience distressing.

4.87 Giving contested evidence is inherently distressing; however, it is not possible to deny registrants whose careers are at risk the right to cross-examine witnesses robustly. However, the fact that this happens and the manner in which it is sometimes done is a significant problem with the fitness to practise process and we consider this at paragraphs 4.132-4.136 below.

4.88 Further concerns arise in respect of the Consensual Panel Disposal (CPD) in the case of Midwife 7 where she admitted a number of charges and agreed that she should be struck off. The NMC's rules require that referrers of complaints are consulted about the appropriateness of a CPD. In this case, the agreement as to the wording of the CPD was reached on the Friday before the hearing was due to begin. Mr A, Mr B and Mrs F, who were interested parties, were informed of the proposal that afternoon and asked for their comments by the following Monday. The charges which Midwife 7 had accepted were not disclosed.

4.89 In our view, it is unreasonable to expect families to comment on CPDs in this limited amount of time. Ten days had been set aside for the hearing and it would have been possible to delay the start of the hearing in order to give the referrers adequate time to consider the CPD. We also consider that it would have been open and transparent to allow them to understand the charges particularly where, as here, significant matters that they had raised were not included. We note that, in error, the charges were made available to the press before the families saw them.

[79] Email from Mr A to the NMC 16 November 2014.

The NMC's approach to Mr A

4.90 Mr A had close contact with the NMC throughout these cases and was a vigorous critic of it as a body. He made a Subject Access Request for the information held about him by the NMC. We discuss the approach the NMC took to that request at paragraphs 4.104-4.128 below.

4.91 We looked at the following documents as well as those on the complaints files:

- Briefings to the Chair and Chief Executive and Council members about correspondence and meetings with him and events that he was attending
- Copies of documents showing that the NMC monitored his Twitter feed, gathered quotes from him in the press and set up Google Alerts about him
- Internal email discussions about how to 'handle' him and his complaints from a corporate communications point of view
- Internal email discussions about the media reporting of individual complaints
- Internal email discussions about communicating with him
- Other email discussions where his name appears to have come up as a possible speaker at an event or as an individual with an interest or a contribution to make
- A very small number of moderately offensive comments about him between some members of staff.

4.92 It is clear from these documents that he was regarded as someone who was hostile to the NMC corporately and who needed to be handled with considerable care. In one Council briefing he is referred to as 'a high profile individual'. This is understandable. He has written a book,[80] speaks regularly about his experience and is a regular user of Twitter. As is his right, he makes occasional trenchant comments about the NMC and its Chief Executive. We can understand that the NMC would wish to inform itself of what he is saying publicly about it and that, given his high profile, its Chair and Chief Executive would wish to be briefed about him.

4.93 In our view, the documents that we saw generally demonstrated a professional approach to Mr A. We would, however, make the following observations:

- There are a very small number of emails between staff members which suggest that they found Mr A a nuisance to deal with, were disrespectful about him and gave the impression that he was not seen as someone who had lost a child or had anything helpful to give to their investigations. The then Deputy Director of Fitness to Practise apologised to Mr A for the unprofessional tone of some of these, though others were not disclosed to Mr A.

[80] *[Mr and Mrs A's son]'s Story: Uncovering the Morecambe Bay scandal* (2015).

- The internal documents indicate a very cautious approach towards dealing with Mr A and a nervousness about the tactics of approaching him.[81]

4.94 By the end of the process, the NMC's relationship with Mr A had broken down. We asked the NMC for its reflections on this.[82] The NMC noted that Mr A had had significant levels of contact with staff there at all levels, including the Chief Executive. It recognised the tragic experience that Mr A had had and apologised to him for the delay. The Chief Executive said 'what we failed to do, and when we did it was too late, was manage his expectations. So it was clear to me at the beginning of 2014 he had expectations we wouldn't be able to meet. And six years had passed and the die was set'. She suggested that, amongst other things, 'we could have taken every opportunity to remind him what we could and couldn't do, and to make it clear that the thing that he wanted, which I believe was the big systemic review and investigation, was never going to be delivered by this organisation.' We do not believe that Mr A was asking the NMC to do that. We think that Mr A was asking the NMC to look at serious and evidenced concerns about the competence and conduct of the midwives at the FGH and whether they were safe to practise. We do not think that it was unreasonable for him to expect that the NMC would do so. The problem was that the NMC did not take proper account of his concerns, did not communicate well with him and was not open with him about the problems with their investigations in the early years.

Other families involved

4.95 We have set out the experiences of other families at paragraphs 3.73-3.98 above. They show a picture of individuals whose interest in the cases was not seen as a priority by the NMC. They were not kept well-informed of progress or of the status of cases. The comments that we have quoted from two of the families attest to the fact that they found the NMC's processes opaque and unhelpful. While there were examples of individuals at the NMC providing helpful and supportive advice and information and some sympathetic and thoughtful letters, most of the communication appeared to us to be impersonal and did not engage with the real concerns of the families. They were infrequent and showed no evidence that the NMC was considering the impression that it was giving to those families. It is understandable that the families were disappointed in the NMC as a regulator.

4.96 The NMC gave the impression to the families that they were of limited relevance to its fitness to practise process. We found that:

- Information and concerns raised by the families were ignored
- There was no attempt to play back the families' concerns to them, so that the NMC could be sure that it understood them
- The NMC did not seek to cross-check registrants' responses with the families

[81] For example, internal emails – document numbers 58278198, 5193557, 5192658, 5192244.
[82] Interviews with Chief Executive and Director of Fitness to Practise, January 2018.

- Due weight was not placed on evidence provided by the families
- Correspondence with the families was confusing and irregular
- The NMC has not been transparent with the families about why matters went wrong or about its processes.

4.97 The NMC has argued that it could not have been transparent with the families because, until 2014, it was not in a state to recognise what had gone wrong. This may be the case but at no point after 2014 has it done so. For example, the flaws in the original investigation of Mr B's complaint must have been apparent in 2014 but he was never told about them. The flaws in the investigation of Mr A's cases must have been apparent when the NMC reviewed the cases in 2014 but it has never been open about them to Mr A. Despite Mr A's requests, he was never told in writing what had happened to the chronology. Given this continued failure to be open with the families, we cannot say that members of the public raising complaints with the NMC will feel confident that their concerns are being addressed or treated with an appropriate level of respect or that the NMC will be frank with them where things go wrong. This will apply even if the investigation carried out by the NMC in fact addresses all the concerns.

The transparency of the NMC as an organisation

4.98 We considered two matters which are relevant to the transparency of the NMC as an organisation:

- The request for advice on whether it ought to have sought an interim order in respect of Midwife 4 at an earlier stage
- The Subject Access Request from Mr A.

The review of whether an interim order ought to have been sought

4.99 As we have mentioned, the NMC commissioned a review from a senior barrister as to whether it had missed opportunities to seek an interim order restricting the practice of Midwife 4. We commend the NMC for commissioning this review which shows an intention to review its actions and learn lessons from them.

4.100 Mr A asked, when he heard that the report had been commissioned, whether he would be able to see the report. The NMC did not provide a clear answer to that. He asked again when he was told that it had been received. The NMC offered him the opportunity to see a copy of the report in private, provided that he kept it confidential. Mr A did not agree to that condition. As mentioned at paragraph 3.77 above, the NMC also informed him what conclusions the senior barrister reached. The Information Commissioner has said that the NMC's 'brief description of the conclusion accords with that advice'.

4.101 A journalist sought disclosure of the report under the Freedom of Information Act. The NMC refused to provide the report and this approach was endorsed by the Information Commissioner. We understand that the matter is being considered by

the Information Tribunal and that the Tribunal's decision awaits the publication of this Review.

4.102 In the light of the NMC's assertion of legal professional privilege, it would be inappropriate for us to discuss the content of the report or to opine on the legal position. The NMC has the right to refuse to publish information if it is covered by an exemption under the Freedom of Information Act, though it is not compelled to do so. We note that it has a written policy covering its approach to such requests.

4.103 It would have been very difficult for Mr A to comply with the requests to keep a private examination of the document confidential. He comments frequently on the events at FGH and the NMC and it could, practically, have been difficult to keep his knowledge of the findings of the report separate. Following the litigation, we would suggest that the NMC reconsider whether, in fact, there would be any danger to it in publishing the report and whether it should, in fact, do so. If the matter, is covered by privilege, it is obviously entitled to rely on that. However, organisations are able to publish documents even if they are covered by privilege. The NMC told Mr A that the purpose of the review was to 'identify lessons for the future'. The NMC might improve its transparency and public confidence in its willingness to learn if it did publish the document.

Mr A's Subject Access Request

4.104 On 14 September 2016, Mr A submitted a Subject Access Request (SAR) to the NMC seeking disclosure of material held by the NMC in respect of him and members of his family.

4.105 The NMC noted that the request potentially covered a very significant amount of correspondence and paperwork covering 35 fitness to practise cases, 20 registrants and around 10,000 emails. The documentation also included information about a very significant number of other individuals (registrants, NMC staff and many other people) who had rights under the Data Protection Act. Other documents were covered by legal professional privilege and it would be entirely proper for the NMC not to disclose these. It was clearly a complex task to provide documents that complied with Mr A's rights while respecting the rights of others. Many documents required significant redaction to protect those rights. The NMC decided to instruct solicitors to undertake the detailed work required to comply with the request.

4.106 The solicitors wrote to Mr A asking if he was able to narrow down his request and pointing out that there might be difficulties if Mrs A did not give her consent to her data being included in the request, because many documents referred to 'Mr and Mrs A' and it would be impossible to redact these in a way which protected Mrs A's identity. There does not appear to have been a response from Mr A to that request. No attempts appear to have been made to chase a response or, indeed, to correspond with Mrs A separately to seek her consent.

4.107 The then Deputy Director of Fitness to Practise told us that he had a conversation with Mr A in November 2016. From that, he understood that Mr A was interested in what the documentation showed about 'the NMC's culture'. In response to this the Chief Executive and the then Director of Fitness to Practise waived their rights under the Data Protection Act so that Mr A could see the full extent of their correspondence. We commend them for doing so.

4.108 The NMC told us that the solicitors[83] looked at material which underwent three stages of review. Documents where the legal reviewers had queries for the NMC to resolve were reviewed by the NMC and the NMC made the final decision as to how the document should be redacted. There followed a final check by the solicitors before the documents were disclosed to Mr A. The NMC has told us that it takes responsibility for the decisions taken.

4.109 More than 1500 documents were disclosed to Mr A in a redacted form. Some of these included several different emails in one document. The then Deputy Director of Fitness to Practise wrote to Mr A to apologise that some of the comments in some documents appeared disrespectful to him. In subsequent correspondence, he identified four documents which fell within this category.[84]

4.110 Mr A was concerned that a number of the documents were very heavily redacted. Indeed, some pages were blank apart from his name.

Our review

4.111 The NMC provided us with access to an electronic folder containing copies of the original documents plus the redacted versions as sent to Mr A.

4.112 We were assured by the NMC that these were all the documents that were forwarded to its solicitors for advice. We were also assured that these were the complete documents that had been discovered from their database using what appeared to us to be reasonable criteria. In our review of other documents, we noticed some which appeared to refer to Mr A by implication but we recognise that these did not contain his personal data and so would not have been picked up and did not need to be disclosed.

4.113 The documents that we received were not in a form that was easy for us to review. Not all of the redacted documents (and very few of them in category 3 below) were clearly linked to the original documents and there was a delay while the solicitors provided us with the information that we needed. Apart from the initial instructions, we saw no information about discussions that might have been had between the NMC and the solicitors and no reasoning as to why individual redactions had been made. In particular, we were not shown any document from the solicitors or the NMC which described the approach or the principles guiding the redaction of the documents.

[83] NMC's response to our questions, December 2017.
[84] Email to Mr A dated 21 December 2016.

4.114 We initially reviewed all the documents to divide them into categories. These were:

1. Publicly available information (such as news reports, Twitter conversations and other matters)
2. Correspondence which was directly related to individual complaints, most of which we had seen on the complaints files and much of which had been sent to Mr A as the complainant
3. Documents which we had not seen on the files, most of which were internal to the NMC which referred to communications with Mr A, discussions about him and other matters where his name was mentioned (for example, as an attendee at a conference).

4.115 We looked at a sample of the documents in categories 1 and 2 to satisfy ourselves that the redactions appeared to be broadly appropriate. We looked at every document in category 3. We then set out our understanding of the law relating to SARs and invited the NMC to comment on its reasoning for redacting some documents.

Our approach in reviewing the documents

4.116 We are not experts on the law governing SARs and Data Protection. It is not our role to rule on whether individual redactions complied with the law. The Information Commissioner exists to do that and it would be wrong for us to make judgements which are properly the function of that office. Any opinions that we express below should be treated as informed opinions, not as definitive statements as to whether or not the NMC carried out its duties appropriately.

4.117 In looking at the documents, however, we took into account:

- Our general understanding of the law and what is regarded as good practice, which informed our opinions on individual documents
- The NMC's instructions to its solicitors that it wished to be as transparent as possible
- The NMC's understanding of Mr A's wish to get a picture of the 'culture of the NMC'
- The practicalities involved in redacting the information, and
- The content of the documents themselves.

Our understanding of the law

4.118 Our understanding of the relevant law and good practice is as follows:

- Information under a SAR must be provided in an intelligible form or with an explanation – so, if a decision is taken to redact a document to the extent that only the portion relating directly to that individual is included, then

explanation is needed about the context as to why the personal information was being held. The NMC has told us that, having taken legal advice, it is satisfied that it complied with this

- Where the information reveals personal information about other individuals then the information need not be disclosed unless there is consent or it is reasonable to do so. It is likely to be reasonable to do so where the individual is a senior public figure, such as a Minister or senior member of the organisation. Where it is not reasonable, the organisation should consider whether the information could be redacted so that the information could be disclosed without identifying the other individual
- Where information is included in a document which is not personal information, but is not subject to the exemptions and where other individuals' personal information can be redacted, it is regarded as best practice not to redact the document further
- It is good practice to consider the principles of Freedom of Information as well as the Data Protection Act when considering a request.

4.119 We also bore in mind that there is often no single right answer in these circumstances and that organisations have a significant level of discretion as to how much information they provide to individuals. In that context, we noted the NMC's stated desire to act transparently.

What we found

4.120 We found that the documents that we looked at in categories 1 and 2 above appeared to have been appropriately redacted. Those within category 2, in particular, contained substantial personal information about registrants and other third parties which it would have been entirely inappropriate to disclose.

4.121 We also found a number of minor errors in the redactions and matters which had not been properly picked up in the work. In the context of the large number of documents that were considered, we did not think these were significant or failed to disclose information of importance to Mr A.

4.122 We had, however, concerns about the approach taken to documents in category 3, which contained much more information that was internal to the NMC and included draft documents, reports to its Council, internal discussions about the PR handling of individual cases and some general emails.

4.123 We raised these concerns with the NMC and asked for its comments. The NMC assured us[85] that all redactions were made following legal advice and provided some limited explanations where we asked for them. We have taken these into account in our comments below.

4.124 We noted two documents which were disrespectful of Mr A which were not disclosed. These were emails which, in our judgement, referred to his personal

[85] NMC's response to the Authority's questions, December 2017.

data. These contained low-level, in one case puerile, disrespectful comments about him between members of staff at the NMC. The NMC told us that the decision not to disclose the documents was made by one of its legal advisers. We do not accept the NMC's comments that it was not clear that Mr A was being referred to in one of the documents. In the other, we disagree that it was not possible to redact the information so that the members of staff concerned were not identifiable. We consider that it is regrettable that these were not disclosed, given Mr A's interest in the culture of the organisation.

4.125 We also noted a number of documents where, in our view, insufficient information about the context was given. In one letter to the Secretary of State for Health, the name and address of the Secretary of State had been unnecessarily redacted along with much other content and, in our judgement, there was entirely insufficient context given to enable Mr A to understand why the document had his name in it. In another document, the only part that was sent to him contained the two words of his name so it was impossible to understand the context. In a number of others, it appeared to us that the NMC could have revealed either the whole document or significantly more of it without compromising others' personal information.

4.126 We were perplexed by this because the documents involved were innocuous and did not reveal anything that should reasonably have caused the NMC embarrassment. Many of the documents were corporate documents, including information which, in our view, could have been disclosed without breaching the NMC's other obligations or its right to legal professional privilege.

4.127 We commend the approach of the Chief Executive and then Director of Fitness to Practise in waiving their own rights under the DPA. It tangibly demonstrated a wish to be transparent and this should be recognised. However, we consider that the NMC and its solicitors might have been able to achieve greater transparency by:

- Making further efforts to contact Mr A about refining his request
- Making further efforts to establish whether or not Mrs A was content to waive her rights under the DPA
- Addressing more closely some individual documents and considering whether it would be possible to provide more information without breaching other peoples' rights.

4.128 The NMC's approach may have complied with the law. However, it appears to us that it would have been possible for the NMC to have provided significantly greater context by a more nuanced approach to redaction. There were a relatively small number of documents where this could have been appropriate. We considered that, had there been a commitment to transparency throughout the organisation, the documents could have been redacted in a more proportionate way. This would have provided greater confidence in the NMC's statements that it wished to be a transparent organisation.

4.129 We link our comments in this section to the points we made about the NMC's approach to the families in paragraphs 4.78-4.97. We identified there that the NMC has not disclosed the problems that arose with its handling of the cases, even though it has told us that it agrees that there were 'failings' in its handling of the cases, particularly before 2014.[86] This is not consistent with the NMC's aim to be a transparent organisation.

4.130 We also noted that the NMC failed to address the history of what had happened to the chronology in its correspondence with Mr A which suggests either disrespect for him or a reluctance to be open about what had happened to it. Its correspondence with us and with the Secretary of State was capable of being understood as saying that the NMC had given full consideration of whether to include the chronology at a stage well before the point that Mr A provided it. We could see no evidence of the NMC seeking to satisfy itself as to what had happened about the chronology at the time, even though Mr A had raised the question with the Chief Executive directly.[87]

4.131 The NMC also refused to disclose the report it commissioned from the senior barrister. In our view, public confidence is likely to be greater in organisations which are transparent and admit mistakes.

The fitness to practise system

4.132 The Kirkup report suggested that there were significant clinical and cultural concerns about the midwifery unit at FGH. After its investigations, the NMC found concerns about the fitness to practise of the midwives proved in four cases. Of those, one midwife was struck off 11 years after the first concerns about her practice arose, a second was struck off five years after she had retired and a third was suspended for nine months even though the panel found that there were no longer any concerns about the safety of her practice. The fourth was struck off having also retired. Interim Suspension orders were imposed on three midwives (two of whom were subsequently struck off). Further avoidable deaths occurred while the NMC were considering the complaints.

4.133 Our review of these cases has strengthened our view that the fitness to practise process is not well suited, of itself, to deal with the range of concerns that arose at FGH. Immediate problems of clinical competency and problems of culture and attitude should be addressed by the employer so that swift action can be taken to address the concerns. The CQC is the body in England that should deal with problems that arise out of systemic failings within the Trust or employer. The Authority has recently published its views on the future of fitness to practise in the context of possible reform of the regulation of health care professionals.[88]

[86] NMC response to our request to examine cases – 5 October 2017.
[87] Email from Mr A to the NMC of 11 March 2016.
[88] Professional Standards Authority 2017, *Right-touch reform.* Available at: www.professionalstandards.org.uk/latest-news/latest-news/detail/2017/11/23/authority-releases-special-report-on-regulating-health-workforce [Accessed: 24/04/2018].

The NMC cannot itself be expected to take full responsibility for dealing with all of these concerns.

4.134 The fitness to practise process was originally developed by the professions to deal with very serious allegations of the sort that we saw in these cases – often involving dishonesty or serious clinical malpractice. The registrant's career was at stake and, inevitably and rightly, strong protections were needed to ensure fairness. This has resulted in the following features:

- It is adversarial – the vocabulary is one of 'allegations', 'prosecution', 'defence' and 'sanction' – and owes a lot to the criminal law
- It is lengthy which, as the RCM and the families told us, adds to the distress for all concerned – the NMC, when it considered the cases that we referred back to it considered that, even with its improved processes, it was still likely to take up to nine months for most of the investigations to be completed and that hearings would take even longer
- It does not encourage regulators to look at the whole picture of a registrant's practice which means that wider concerns may be missed
- Registrants inevitably feel that they are being held to account and their livelihoods are at stake and this encourages a defensive approach
- It involves hearing and testing the witnesses' evidence which caused, as we have seen, significant distress to the families and registrants
- It tends to focus on a single incident or group of incidents – if that incident is not proved then there is no further examination of the registrant's fitness to practise. It is not unusual for facts not to be proved because of prosecution failings, because witnesses fail to turn up or for other technical reasons which have nothing to do with the registrant's actual fitness to practise
- There is a very high bar before an interim order can be obtained against a registrant who may be a risk to patient safety
- It encourages a legalistic approach to complaints – we saw a number of excellent legal analyses of cases which focussed on whether facts could be proved and the likely outcome; they did not consider wider fitness to practise questions about the registrant or the culture at the hospital.

4.135 None of these features are conducive to addressing concerns early or encouraging an open culture. While there will continue to be cases where the facts are such that a process of this sort is the only reasonable approach, we hope that future reforms will encourage regulators and employers to work together so that, where it is possible and appropriate, concerns are addressed locally and resolved quickly. Regulators should not automatically put complaints into the fitness to practise process where a more proportionate approach will protect the public. We discuss these matters further at paragraphs 5.50-5.52.

5. Changes at the NMC and lessons

5.1 The NMC received the first concerns about the midwifery unit at FGH in February 2009. It completed the last of the cases in June 2017. Formal sanctions were imposed against four midwives, one of whom had retired in 2012. Cumbria Police identified seven cases which had arisen since 2009 where it had concerns about the care. The Trust received 19 claims in respect of untoward events which arose after 2009 (some of these may have been the same as those investigated by the police). From our study of the files we were aware of at least two further untoward incidents and one death under the care of midwives who were already under investigation after 2013.

5.2 We do not know whether any of these could have been prevented but, in our view, before 2014 the NMC did not take credible information which it received about the midwives at the FGH seriously or take action to satisfy itself that the midwives were fit to practise. Its handling of the cases before 2014 generally was frequently incompetent. Even after that:

- Cases took longer to be investigated than was necessary causing distress to families and registrants
- The full range of the conduct allegedly involved – clinical concerns, collusion and individual dishonesty – was not fully explored
- The families we spoke to were dissatisfied and our study of the files showed that all of the bereaved families were unhappy with aspects of the way in which they were treated or their cases handled by the NMC.

5.3 In our view the major problems were:

- The NMC's record-keeping was poor
- Individuals did not analyse cases properly or consider the implications of them
- Information from third parties or elsewhere in the NMC was not properly analysed or acted upon
- The NMC did not take information from the families seriously or engage with them properly
- When criticised or asked to provide information, the NMC adopted a defensive approach, even if it intended to be transparent
- The fitness to practise system itself is unsuitable for dealing with a number of the concerns noted in the Kirkup report.

5.4 We recognise that the NMC faced several problems dealing with the cases. The Trust was, during the early years of the period, facing significant challenges. It did not assist the NMC to identify problems with midwives' practice. The CQC was in the early stages of its life and, as the Kirkup report noted, was also not best placed to assist the NMC. The NMC itself was, as our audits at the time and

as the Chief Executive herself recognised, not in a position to deal competently with those cases at least until 2014.

5.5 In this section we consider how the NMC has addressed the issues and identify the lessons that can be learned.

The NMC

5.6 The NMC has changed significantly during the years covered by this Review, partly in response to the Authority's reviews and also of its own initiative. It participated fully in changes to the system for midwifery supervision and implemented these. The NMC's Chief Executive also told us that, in her view, it was not until 2014 that the NMC could be regarded as beginning to address the concerns that we have identified. We have borne this in mind in looking at the lessons we have identified in this review and in assessing how far our concerns still apply to the NMC.

The NMC's analysis of the cases

5.7 We invited the NMC to look at six of the cases that troubled us and identify where its handling had gone wrong and how it addressed the problems that it identified. These were all cases that were opened in 2012 or earlier. The NMC provided a full and frank response to us and it was clear from our correspondence that it fully accepted a number of the criticisms that we make above. It was clear that it had looked at the cases openly and in considerable detail. It noted that the cases showed:

- Record-keeping failures
- Failures to identify key concerns and assess risk
- Lack of clarity in decision-making
- Internal communication failures
- Poor communication with families.

Further action taken by the NMC

5.8 The NMC also pointed to a number of areas where it considered that it had changed its structures in ways that would meet the concerns. These are:

- The High Profile Cases Unit
- The Employer Link Service and more flexible ways of working with Trusts
- The Risk and Intelligence Unit
- Improved support for witnesses
- The Public Support Service.

5.9 We looked at the High Profile Cases Unit, the Employer Link Service and the Risk and Intelligence Unit, and spoke to members of the NMC Fitness to Practise team.

High Profile Cases Unit

5.10 The High Profile Cases Unit was established in 2014. It oversees the work on cases which fit particular criteria which make it likely that they will be complex or controversial. The aim appears to be to ensure that such cases receive the right level of handling and that appropriate briefing about them is provided to senior members of the NMC executive. The team seeks to provide strong case management and holds regular meetings to discuss progress on cases and the issues that arise. Some cases are run directly by the team. Others are run by other teams but in close liaison with the unit.

5.11 It is clear that the FGH cases would now fall within its remit because the criteria for cases suitable for the unit includes cases involving maternal or baby deaths. The team told us that they have significantly greater ownership of cases than was the case previously, that they are aware of the issues and liaise closely with case managers, internal and external lawyers over the investigation of the cases.

5.12 We noted that this team had been responsible for handling the latter stages of the Morecambe Bay cases. We saw an improvement, albeit with some significant limitations, in the handling of those cases in the later years. In particular, the cases against Midwives 7 and 11 showed improved analysis and record-keeping.

Employer Link Service

5.13 The NMC established its Employer Link Service (ELS) in 2016, following a recommendation in the Francis Report. We were told that the ELS aims to establish relationships with employers so that employers can be more open with the NMC and better aware of when it needs to report incidents. The ELS meets regularly with other stakeholders, such as the CQC with the aim of establishing relationships to share information and intelligence and feeding this back within the NMC.

5.14 We were impressed by the ELS team which appeared to have a clear understanding of its purpose. We considered that there was potential for it to:

- Establish relationships with Trusts so that Trusts report concerns to the NMC, understand the work of the NMC and work with the NMC where there are concerns about registrants
- Bring intelligence to the NMC if it becomes aware of concerns about culture or other issues within a Trust
- Establish relationships and share intelligence with other stakeholders, such as the CQC.

5.15 We received positive views about the ELS from the Trust, though the representative of the CQC that we spoke to felt that there was scope for more

work at local level between the CQC and NMC[89]. We noted that the Service has a relatively small staff covering the United Kingdom.

Risk and Intelligence Unit

5.16 In 2017, the Risk and Intelligence Unit (RIU) was added to the ELS. It exists to analyse information from fitness to practise cases and elsewhere to identify trends and risks and to relay these to the rest of the NMC. Like the ELS, we consider that it has the potential to be a source of information about trends and about individual areas of practice where risks may be emerging.

Individual members of staff

5.17 We spoke to individuals in the NMC who had been involved as case managers and lawyers for the cases we looked at. They were unanimous that there has been a change in their roles, that their workload has been reduced and that they have greater ownership of cases. They spoke to a major culture change within the NMC and of being better supported and trained and with much greater access to guidance.

5.18 We were also pointed to examples of significantly more nuanced approaches to potential fitness to practise cases. We noted one where the NMC is clearly working closely with the relevant Trust to address and manage risks arising out of concerns about an individual midwife's fitness to practise. We found this encouraging.

The Public Support Service

5.19 The NMC is in the process of establishing a Public Support Service (PSS) and has appointed a Head of that Service. It told us that the aim of that service is to:

- Improve the information available to the public about the fitness to practise process
- Explain to complainants how the process works and deal with concerns that they may have
- Identify good practice and provide advice to the Fitness to Practise directorate about improvements to the service provided to public complainants and
- Support witnesses before panel hearings.

[89] Interview with the team, October 2017.

Lessons from this review

5.20 We now look at the lessons that we think can be learned from the review and consider how far they have been addressed by the NMC. Although these lessons are drawn from our examination of these particular cases, we have drafted the lessons widely because we think that they contain points for all regulators to bear in mind.

5.21 In what follows, we have attempted where possible to indicate where we consider that the NMC has already addressed the concerns and to set out areas which we think that it still needs to address. We are cautious in doing so because we only looked at a very small number of cases in the context of the NMC's overall caseload. Where relevant, we have drawn on learning from our own performance reviews to lend weight to our views.

5.22 We also stress that many of the initiatives that the NMC has adopted are relatively new. We have not had the opportunity to see them working in practice or to assess their effectiveness. We would raise two caveats about these. The first is that the initiatives have involved establishing new units and teams. This may well be appropriate, but there is a danger that those units may become isolated and not properly integrated into the organisation. It is essential that the good practice in the High Profile Cases Unit and the forthcoming Public Support Unit is replicated across the NMC so that their culture becomes the norm and that the work of the Employer Link Service and the Risk and Intelligence Unit continues to be communicated to and relevant to the work of the rest of the organisation. Secondly, many of the problems that we noted rely on the identification by individuals of issues of concern and taking appropriate action on those. The NMC needs to monitor the work of these teams as they develop.

Record-keeping

Accurate and complete record-keeping is essential to keep sight of the issues in a case and its development and to enable the organisation to maintain a full audit trail of actions.

5.23 In our view, the NMC has taken significant steps which have, broadly, addressed the record-taking concerns. However, by its nature, record-keeping is only as a good as the individuals keeping the records and we continued to see occasions where record-keeping could have been better right up to the conclusion of the cases. The NMC may wish to consider whether there are ways in which it can monitor or encourage staff further to maintain complete records of documents, conversations and decisions on the relevant files.

Identification of the issues

Those analysing and investigating complaints need to have the time, expertise and support, including access to clinical advice to enable them to identify the concerns properly and to follow them through.

5.24 We found significant improvements in the investigation and analysis of complaints, particularly in respect of the later cases. There appears to be greater ownership of cases and the new teams established by the NMC, particularly the High Profile Cases team, have the potential to deal more consistently with cases and identify the wider issues.

5.25 Ultimately there will be no substitute for an intelligent analysis of a complaint by staff who have the time, skills and access to the right advice to ensure that the right concerns are identified and taken forward. This means that the NMC needs to ensure that staff:

- Have the right expertise
- Are properly trained and supported
- Have access to expert advice, particularly clinical advice
- Are able to manage and criticise the work of external lawyers.

5.26 We conclude that the NMC has made significant steps to address the problems that we have identified. It may wish to consider whether:

- Its arrangements for obtaining clinical advice either internally or by its external lawyers in fact ensure that that such advice is obtained in the cases where it is needed
- Further training or support needs to be given to ensure that staff looking at cases continue to be able to identify and investigate any wider concerns about registrants' practice where there is evidence to suggest that the concerns may go beyond a single case.

Working with third party investigators

Regulators should work closely with other investigators and regulators to ensure that, so far as possible, they are able to act to protect the public and unnecessary delays are not caused by other investigations.

5.27 The NMC told us that, in 2011, it had no guidance on what approach should be taken when there were external investigations. Such guidance now exists. Its starting position is that, in all cases, the investigation should take place without delay. There must be clear and compelling reasons for an investigation to be put on hold and the case owner will need to record why doing so is considered to be in the public interest. Such reasons might include prejudice to the external

investigation, practicality and efficiency. The guidance makes clear that the NMC must liaise with the third party investigator and confirm their position in writing.[90]

5.28 The existence of this guidance is an important step. However, each case is different and the approach to be taken will vary with the individual facts. They will all require thoughtful analysis by properly supported staff who are familiar with the cases and the issues and who communicate clearly with the third party investigators. We have not seen further examples of cases where there have been third party investigations and so have not had the opportunity to see how they work in practice. In line with our view on analysing the issues, we think that the NMC is in a significantly better position to reach appropriate decisions than it was in 2012. The NMC may wish to ensure that it is satisfied that its staff are properly familiar with its guidance and that decisions are made at the appropriate level.

Looking beyond the individual cases

Regulators should ensure that their processes enable them to take account of all available and relevant information about cases and that intelligence is properly shared.

5.29 The NMC has told us that the Employer Link Service and the Risk and Intelligence Unit are likely to provide considerably greater intelligence for the Fitness to Practise team. Those teams have access to wider intelligence and have the potential to inform the work of the Fitness to Practise team. The NMC has also made improvements to its ability to share information within the organisation.

5.30 We did not look closely at these new teams but we agree that, in principle, they should address many of the problems we saw. We refer to the caveats set out in paragraph 5.22 because it is essential that the units remain relevant to the work of the NMC and fully integrated in its organisation. As we have suggested in the previous lessons, their success will depend up on the staff making up these teams and in the leadership and guidance they receive. The overall approach appeared to us to be appropriate. The NMC may wish to monitor the work of these teams to ensure that they provide right level of information to the rest of the organisation.

5.31 The NMC may also wish to consider whether it is appropriate to examine lessons from fitness to practise cases to see whether they provide information which should lead to changes to its rules or where it or other bodies might issue guidance. We understand that learning from the FGH cases is being fed into its review of education standards for midwives and we found this encouraging.

[90] NMC response to our questions.

Working with others

Regulators must work with others in the health and care system to address concerns about patient safety.

5.32 Since 2011, the NMC has entered into Memorandums of Understanding with other regulators in the system. We also saw some strong examples of it working closely with Trusts and other regulators which suggest that this lesson has to a great extent been taken on board. We consider that the Employer Link Service has the potential to achieve strong relationships with key stakeholders including Trusts and the CQC, though we note the points raised by the CQC about there being greater scope for working together at local level. The ELS has a relatively small staff.

5.33 We therefore consider that the NMC has taken strong steps to address this lesson. It may wish to monitor the work of the ELS to satisfy itself that the service has sufficient resources to manage its work and is able to ensure that relations on the ground are strong enough.

5.34 In addition, there remains a concern about what the NMC's position should be if a Trust or other regulator is failing to recognise a problem and whether it has powers to protect the public adequately in those circumstances. The Government is currently considering reform to the regulatory system for health and care professionals. It and the NMC may wish to consider whether any further powers are needed which are proportionate and would better enable the NMC to address concerns about the practices of individual registrants.

The treatment of the families

Regulators must engage with patients and service users, ensure that they are informed of the process and progress, and analyse and take their evidence seriously if they are to properly identify problems and hold public confidence.

5.35 The NMC recognised that its communications with the families were poor, sporadic and often confusing. It has made major improvements to its work in providing support to witnesses at hearings and it also began steps, before this review was announced, to establish the Public Support Service.

5.36 We saw some evidence of improvements in the regularity with which complainants were contacted after 2014. We also considered that the NMC provided considerable support for witnesses appearing in front of panels and we commend that. The Public Support Service has yet to be fully established and we are not in a position to judge how its work will affect that of the NMC.

5.37 Our review of the cases suggested significantly more serious concerns. 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. There are some specific points it needs to consider.

Information for complainants

5.38 The families we spoke to told us they knew little about the NMC's process. While the NMC's website provides information for those referring a complaint it did not appear to us to be tailored well towards patients who might not be familiar with the process. We understand that the new Public Support Service will be reviewing this information.

Sharing registrants' responses with complainants

5.39 We produced policy advice to regulators in 2009[91] where we made it clear that, in our view, the benefits of sharing registrants' responses with complainants outweigh the risks.

5.40 The NMC told us that, following publication of the policy paper, it did adopt a process for sharing initial responses. Where it is aware of a registrant's position on the facts of the allegation, and a patient/family member is likely to be able to comment and/or provide evidence on a material point, it ensures that it obtains their evidence during its investigation process. It suggested that routinely sharing responses to complaints with the complainant could add delay. It mentioned that many registrants include their response to the local investigation and it may not be appropriate for the NMC to reveal this since its rules only permit it to disclose the response to the NMC. It told us that it followed its legislation which set out the times when it must inform complainants of particular findings or facts.[92]

5.41 We consider that, on the latter point, the NMC may be taking an unnecessarily restrictive view of its rules. The fact that the registrant has sent the response to the local investigation to the NMC suggests that it is part of the registrant's response to the NMC and so could be disclosed. We are also not convinced that addressing discrepancies when interviewing complainants later is sufficient. Complainants may not be able to identify all the clinical concerns that might exist, but they are in a good position to say what did and did not happen. A registrant may well provide an account which suggests that good practice was followed, but if that is shown to a complainant, the complainant's recollections may well suggest this was incorrect and this may indicate further clinical concerns. Early identification of such disputes might suggest further areas of investigation and would enable case examiners to be better informed. It will also provide complainants with greater confidence that they are being taken seriously and have a part in the system.

[91] Professional Standards Authority (2009). *Handling complaints: sharing the registrant's response with the complainant.* Available at: www.professionalstandards.org.uk/publications/detail/handling-complaints-sharing-the-registrant-s-response-with-the-complainant [Accessed: 14/05/2018].
[92] Interview with the Director of Fitness to Practise, January 2018.

Mr A

5.42 We understand that the NMC accepts that setting Google Alerts on Mr A was taking its monitoring of him too far. It told us that guidance has been issued to its communications team. We recognise that representatives of the NMC, including the Chief Executive spent a significant amount of time in correspondence with Mr A and that apologies were given both for the delay and the experience that Mr A had while in front of the panel as a witness.

5.43 We think that it is important that the NMC should consider, from Mr A's point of view, how its actions have looked and whether it can work with him to gain further learning about providing support to complainants and, in the process, demonstrate that it has learned lessons.

The Public Support Service (PSS)

5.44 The establishment of the PSS has the potential to be hugely positive and could be crucial in assisting the NMC to address the very serious concerns we have identified. In the light of our examination of these complaints we suggest that it ought to look at the following matters urgently:

- The information given to the public about the fitness to practise system
- How the NMC ensures that it properly understands the concerns of patients and families and addresses them
- Ensuring that people who have an interest in cases are kept in touch with key decisions and, where appropriate, consulted about them.
- Communication of decisions to complainants – in particular, we think that there needs to be greater empathy shown to complainants who have lost loved ones and more accessible explanations of decisions reached at the various stages
- Dealing honestly and openly with complainants.

5.45 The NMC has yet to demonstrate tangibly that it has properly addressed the need to deal appropriately with patients and families who complain. This is the key area where we consider that work needs to be done. The Public Support Service may provide it with the opportunity to achieve this, particularly if it addresses the points that we have raised above. We should stress, however, that it will be essential that this culture is properly embedded throughout the NMC as whole. The formation of the new service will be pointless if the approach taken by people dealing on a daily basis with patients, families and their complaints is not radically changed.

Transparency

Regulators should aim to publish as much as they legitimately can so that they can improve public confidence through transparency.

5.46 The NMC said it wished to be a transparent organisation. We saw examples of it demonstrating transparency. It was frank to us about the mistakes that it made with the cases before 2014. The Chief Executive and then Director of Fitness to Practise waived their rights in providing their emails to Mr A unredacted. However, it was not frank about mistakes that arose in its handling of the complaints to either Mr A or Mr B. Its approach to the bulk of the Subject Access Request material and to the report from the senior barrister was, in our view, not transparent.

5.47 The NMC told us that taking a different approach to the SAR would have significantly added to the costs of an already expensive operation. It considered that it had complied with its legal obligations and did not appear to accept that any other approach would have been appropriate.

5.48 In our view, transparency involves being open about mistakes, demonstrating learning and can include providing information even where the organisation is not required to do so or where a more restrictive approach is permissible. The NMC's registrants owe a duty of candour and the approach that the NMC took to Mr A's chronology and to the SAR did not convince us that the NMC was applying that duty to itself.

5.49 We consider that the NMC needs to look critically at its approach to providing information to the public in a way which goes beyond its published guidance and which actively attempts to be as open as it legitimately can without damaging its own or other people's rights.

Flaws in the fitness to practise system

Regulators should work closely with employers and other stakeholders to deal with concerns which can be remedied without fitness to practise procedures and should avoid those processes where this can be done without compromising patient safety or the public interest.

5.50 The NMC also told us that it felt that the system and legislation covering fitness to practise was not fit for purpose. It did not provide us with examples of how the system should be changed to improve it, though it has now made submissions about this in its response to the Government's consultation paper on the future of

regulation.[93] It has also launched a consultation on changes to its fitness to practise process[94] which we hope this review will inform.

5.51 We recognise the difficulties of this particular scenario where the employer was part of the problem and the CQC was not in position to take strong action. This has changed and protocols and Memorandums of Understanding are in place with the key stakeholders. However, our view is that, for the future, when concerns of this sort are raised, regulators should:

- Seek information from the employer about the registrant's practice generally and whether there are any other concerns which ought to be addressed
- Analyse the information from the employer critically and, if necessary, look directly at the other information available
- Consider with the employer whether it is possible to address those concerns by action at the local level without the need for regulatory procedures and, if so, monitor progress with the employer
- If there are concerns about the employer, involve the CQC at an early stage to address those concerns
- Only use the fitness to practise process where it is clear that the employer is not taking satisfactory action or the employer does not have the levers to do so or if there are concerns about deep-seated incompetence, behaviour or attitudes which call into question whether the registrant should remain in the profession.

5.52 We saw evidence that the NMC is beginning to approach cases in this way and we commend this. What will be crucial is for the NMC to do so in a way which keeps families and patients properly informed and maintains their confidence and which does not mean that serious cases are treated inadequately.

Finally

5.53 The NMC has made major changes to its organisation and processes in the years covered by this review. As our performances reviews have recognised in recent years, its processes, structures and arrangements for record-keeping have improved significantly. Its support for witnesses before panels appeared to us to be strong. We consider that the changes, particularly in respect of the new teams that have been established, have the potential to reduce the risk of many of these concerns arising again. It is important that the NMC monitors and provides support for the work that it is undertaking in respect of:

[93] The NMC response to the consultation was in their recent Council papers – www.nmc.org.uk/globalassets/sitedocuments/councilpapersanddocuments/council-2018/council-papers-jan-2018.pdf Item 8, p.37 [Accessed: 14/05/2018].
[94] Nursing and Midwifery Council consultation on changes to fitness to practise function, *Ensuring patient safety, enabling professionalism*. [Online] Available at: https://www.nmc.org.uk/about-us/consultations/current-consultations/ensuring-patient-safety-enabling-professionalism/ [Accessed: 24/04/2018].

- Ensuring that there is proper identification of issues by its staff and external lawyers and that action is taken where risks are identified
- Improving relationships with Trusts and other regulators
- Identifying intelligence and wider learning from cases.

5.54 However, in our view, the NMC needs to address very serious concerns about the way in which it deals with families and patients and whether it is a transparent, open organisation. It needs urgently to review and improve:

- Its engagement with patients and families who complain so that it engages with their evidence, provides appropriate information to them, keeps them informed and dealing openly with them
- Its approach to transparency about its errors and its approach to individuals.

5.55 Taking these actions forward will need energy and commitment and will require some cultural change within the organisation. These matters are serious and need to be addressed urgently if the NMC is to maintain public confidence in it as a regulator. The Authority will be monitoring and reporting on progress as part of its annual performance reviews of the NMC.

Annex A: Chronology of the main events surrounding the NMC's handling of the FGH midwives' cases

Date	External events	NMC Work
2004	Death of Mrs D's baby. Midwife 11 involved in care.	
2005	Death of Mrs E and her baby. Concerns about Midwife 7's root cause analysis.	
2008	Deaths of Mrs B and her baby and the babies of Mr and Mrs A, Mrs F and Mrs G. Independent investigation into the death of Mr and Mrs A's baby.	
2009	Inquests into deaths of Mrs B and her baby, Mrs F's baby and Mrs G's baby. Jan-July: Root cause analysis and LSA report by midwife 7. Aug: 'NMC shit' email sent. Between 2009 and 2012, 7 further incidents subsequently investigated by Cumbria Police.	Feb: Complaint by Mr A. The NMC's first indication of concerns. July: Complaints opened against Midwives 3, 4, 5, and 6. Sept: Complaints referred to external solicitors. Oct: Mr A raises concerns about the LSA report.
2010	March: Midwife 7 retires. June: Inquest into the death of Mr and Mrs A's baby announced. LSA report reviewed by Midwife 8 at request of NMC.	May: Witness statement signed by Mr and Mrs A. June: Work on Mr A's complaint placed on hold. July: NMC midwifery team identify concerns in Midwife 8's report.

Date	External events	NMC Work
	Nov: Mr A seeks more information about the 'NMC shit' email.	Nov: Mr A identifies discrepancies in midwives' accounts. Inadequacies in LSA report identified by Trust, NMC and Mr and Mrs A.
2011	 June: Inquest into the death of Mr and Mrs A's baby. July: Cumbria Police investigation commences.	Jan: Mr A complains to NMC about the 'NMC shit' email. June: NMC considers inquest findings. July: NMC notes concerns about culture at FGH. Sept: Investigations put on hold because of police investigation.
2012		April: Cumbria Police provide a list of cases that concern them. Mr A provides further information about possible collusion. May: Case opened in respect of 'NMC shit' email. June: Cases opened in respect of alleged collusion at the inquest and either closed immediately or put on hold. Nov: Cumbria police refer cases of Mrs B and her baby to NMC. Dec: NMC Investigating Committee closes 'NMC shit' email cases in respect of the data breach and offensive title.
2013		Jan: Mr B's case in respect of Midwife 9 referred to external lawyers.

Date	External events	NMC Work
	April: Police decide to take no action in respect of allegations of collusion. Sept: Kirkup Investigation established. Dec: Police investigation concluded. Ombudsman publishes reports in respect of Mr B's concerns.	July: No case to answer for Midwife 9 in respect of Mr B's case. Aug: Mr B complains about Midwife 9. Oct: Mr B's complaint closed. Complaints opened in respect of Midwife 11 following media report. Dec: Trust refers Midwife 11 to NMC in respect of other incidents.
2014	Feb-April: Ombudsman publishes further reports in respect of Mr A's concerns.	Jan: Interim order obtained against Midwife 11. Jan-April: NMC reviews all FGH cases and reopens some cases which had been closed, including those of Mr B. Investigations into Mr A's complaints resume. April: Complaints opened in respect of Midwives 1 and 2. Oct: Further case opened in respect of Midwife 7. Nov: Investigating Committee takes no action in respect of allegations of collusion but refers Midwives 1, 2, 3, 4 and 6 to the CCC.
2015	March: The Report of the Morecambe Bay Investigation published ('the Kirkup report')	April: NMC consults Kirkup team about its concerns about individual registrants.

Date	External events	NMC Work
		May: Midwife 11 struck off the register. July: Pre-meeting of CCC in respect of Midwives 1, 2, 3, 4 and 6 adjourned. Oct: Resumed meeting of CCC to deal with defence concerns and case management.
2016	March: Death of Mrs C's baby. April: Midwife 4 suspended by the Trust.	Feb: New statements taken from Mr and Mrs A in respect of Midwives 1 and 2. March-April: CCC hearings in respect of Midwives 1 and 2. No case to answer and no misconduct found. May-June: CCC hearing in respect of Midwives 3 and 4. June: Interim order in respect of Midwife 4 following death of Mrs C's baby. Sep: Midwife 3 suspended. Oct: Midwife 4 struck off. Dec: Case Examiners refer Midwife 7 to the CCC.
2017	Coroner announces inquest into death of Mrs C's baby.	Jan: No case to answer found in respect of Midwife 6. May: Midwife 3's case reviewed: no longer impaired and suspension lapses. June: Midwife 7 struck off the register.

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professional standards authority

Item 7
NMC/18/45
6 June 2018

Council

Chief Executive's report

Action: For information.

Issue: The Council is invited to consider the Chief Executive's report on (a) key developments in the external environment and (b) key strategic engagement activity.

Core regulatory function: This paper covers all of our core regulatory functions.

Strategic priorities: Strategic priority 3: Collaboration and communication.

Decision required: None.

Annexes: None.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

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Context:

1 This is a standing item on the Council agenda and reports on (a) key developments in the external environment; and (b) key strategic engagement activity.

2 The PSA published its Lessons Learned Review on our handling of the Morecambe Bay cases on 16 May 2018. We have apologised for the mistakes we made and the impact they had on the families affected. We have accepted all the recommendations and our proposed actions to address the lessons are set out in the previous agenda item.

3 Other strategic engagement during the period covered by the report has been primarily focused around the ongoing consultations on nursing associates and the fitness to practise (FtP) strategy.

Discussion: **Nursing associates**

4 In April 2018, we launched the consultation into how we propose to regulate nursing associates. We promoted the consultation widely to ensure we reached our key audiences across the health and social care sector and patient and public groups.

5 As at 9 May 2018, the consultation has received over 578 responses, 59 percent from registered nurses and 22 percent from trainees. Our consultation hub on our website has received over 30,000 views.

6 We are holding three workshops with 80 attendees each in Manchester, London and Birmingham. Two additional patient and public workshops will be held in London and Manchester, and we are holding further focus groups with children and young people and people with learning disabilities, to ensure we hear from hard to reach groups. We are also engaging with a wide audience through twitter chats, twitter ‘power hours’ and webinars. Our online engagement has received a positive level of interaction and interest, and our trainee newsletter has now been signed up to by more than 1,400 subscribers.

7 Over the next two months, we will continue to build on this engagement by working with third party organisations to promote the consultation and proactively reach stakeholders through a range of channels, including media case studies, a film of interviews with senior nurses, registered nurses and trainee nursing associates, newsletters and presenting at external events. We will also be preparing for our Countdown to Regulation campaign, which will aim to share key messages with employers, educators, test sites and trainees on how to be ready for the opening of our register.

8 The consultation period closes on 2 July 2018.

Legislative issues

9 On 11 May 2018, the Department of Health and Social Care (DHSC) confirmed that the Nursing Associate Section 60 Order had been laid in Parliament. The Order will now be formally considered by the Joint Committee on Statutory Instruments and the dates for debates in the House of Commons will be set in the next few weeks.

Department of Health and Social Care

10 The Chief Executive continues to engage with senior officials at the DHSC on a range of issues. This includes discussions with the Director of Workforce on 23 April 2018 and the Director for Acute Care and Workforce on 20 April 2018.

11 We continue to work closely with the DHSC on developing an approach to changes to the recognition of professional qualifications arrangements for EEA nurses and midwives and the required amendments to our legislation after the UK leaves the EU.

NHS England

12 The Chief Executive met the Regional Chief Nurse, NHS England on 23 May 2018 to discuss her project on the definition of a nurse.

Chief Nursing Officers

13 The Chief Executive continues to engage with the UK Chief Nursing Officers (CNO) on a range of issues, including discussions with:

13.1 Fiona McQueen, the CNO for Scotland on 29 March, 9 April and 23 April 2018.

13.2 Jane Cummings, the CNO for England on 23 April 2018.

13.3 Charlotte McArdle, the CNO for Northern Ireland on 22 March and 23 April.

13.4 Jean White, the CNO for Wales on 24 April 2018.

Engagement with Parliamentarians

14 On 28 March 2018, we shared a briefing with Dr Sarah Wollaston MP, Chair of the Health and Social Care Select Committee on Brexit and the NMC's EU and international registration process.

15 Information on the make up of the NMC register was sent to Lord Willis in advance of a debate in the House of Lords on 14 May 2018.

16 Following a request from his office, a briefing was provided to Stephen Barclay MP, Minister of State for Health, on revalidation and continuing professional development for nurses and midwives

on 10 April 2018.

17 On 25 April 2018, we attended a meeting of the All Party Parliamentary Group (APPG) on Continence, chaired by Rosie Cooper, MP. The APPG have commented positively on our engagement with them about their wish to see this area of care explicitly stated in our new standards.

18 In May 2018, we provided a briefing to the authorities in Guernsey in advance of the debate on a private members' bill on the introduction of legislation to support assisted dying.

Future Nurse

19 On 17 May 2018, we hosted an event in the House of Commons to mark the publication of:

19.1 Future nurse: standards of proficiency for registered nurses

19.2 Standards framework for nursing and midwifery education

19.3 Standards for student supervision and assessment

19.4 Standards for pre-registration nursing programmes

19.5 Standards for prescribing programmes.

20 The event at the House of Commons was attended by over 100 guests and was introduced by Bambos Charalambous, MP, who sponsored the event. Other speakers included the Chair of the Council of Deans of Health and Lord Willis.

21 Further publication events on the new standards are planned for Edinburgh, Cardiff and Belfast in June and July 2018.

Midwifery

22 The Chief Executive chaired the latest meeting of the Midwifery Panel on 19 April 2018. The Panel agreed to a request from the Council to provide oversight and assurance on progress and development of the Future Midwife Standards. The Panel also discussed the approach to engagement with the midwifery profession and agreed to review its terms of reference to help support the oversight of the review of the future midwife standards.

23 On 30 April 2018, the Chief Executive met Professor Mary Renfrew who is leading the work on the development of new midwifery standards along with the Director of Education and Standards to discuss progress with the first phase of the project.

24 On 17 April 2018, Donna Ockenden, the Chief Executive's Senior Midwifery Advisor and Council members, Sir Hugh Bayley and Marta

Phillips, visited the maternity unit at Chelsea and Westminster Hospital NHS Foundation Trust. They experienced first-hand the busy antenatal, labour and postnatal wards, as well as the midwifery led birthing centre and had the opportunity to talk to staff. They also saw how midwives at the trust are being trained in home birth clinical scenarios using realistic simulation settings, working alongside and in partnership with the London Ambulance Service.

25 The Trust has also introduced a new case loading team, helping to support continuity of care for women and families and we have been invited to return in a few months' time to see how this project is progressing.

26 Further similar visits at sites around the UK, led by the Senior Midwifery Advisor and involving Council members are planned over the coming months.

NMC register data release

27 On 24 April 2018, we published the third set of data showing the numbers of nurses and midwives joining and leaving the register.

28 The figures showed a significant – and continuing - rise in the number of EU nurses and midwives leaving the register and a dramatic drop in those joining from the EU.

Fitness to Practise Strategy consultation

29 On 4 April 2018, we launched a consultation on our proposed new FtP strategy. We have been engaging with stakeholders to enable them to feed into our proposals since last summer. We informed them of the launch via email, media, website and social media updates.

30 We held the following events to discuss the consultation:

30.1 Nurses and midwives webinar – 8 May 2018

30.2 NHS employer trade associations roundtable – 15 May 2018

30.3 Directors of Nursing webinar – 16 May 2018

30.4 Nurses and midwives webinar – 17 May 2018

30.5 Independent employers and their trade associations roundtable – 18 May 2018

30.6 Patient organisations roundtable – 22 May 2018

30.7 Trade unions roundtable – 29 May 2018

31 A range of organisations including: Action Against Medical

Accidents, Barchester Healthcare, Mind, Mencap, the National Childbirth Trust, NHS Employers, the Royal College of Nursing, the Shelford Group and Virgin Care have participated in our events.

32 In addition, the FtP Director and Deputy Director have held individual meetings with stakeholders across the UK. For example, on 30 April 2018, the FtP Director visited Northern Ireland to meet with the Regulation and Quality Improvement Authority (RQIA), the Northern Ireland Social Care Council (NISCC) and the RCN. On 8 May 2018, the Assistant Director of casework presentation and preparation met the Chief Nurse and other members of staff at Marie Curie to discuss how our new strategy could benefit Marie Curie's nurses and service-users.

33 On 27 April 2018, the FtP Director met senior colleagues at healthcare improvement organisations and the Scottish Government to discuss areas of mutual interest relating to FtP.

Changes to our fitness to practise legislation

34 We continue to evaluate the impact of the FtP rules changes implemented under our Section 60 Order in July 2017. This included the introduction of warnings, undertakings and advice.

35 We held a meeting with the representative bodies – RCN, RCM, UNISON and Unite – on 29 May 2018 to discuss the impact of these new procedures and how we can continue to work together to implement them successfully.

Overseas review

36 We have begun a review of our entire overseas registrations process. We need to update the process to reflect the new education standards for nurses and the introduction of nursing associates. We will also be taking the opportunity to ensure it is more straightforward and user friendly.

37 We are still at the early stages of our planning but we want to make the application process quicker and simpler. We are looking at a new online system that will allow applicants to prepare and submit their application to us and track its progress. We are also looking to make improvements to streamline and automate parts of the process.

38 We will be working closely with our applicants, employers, recruiters and trade unions to get their views on the current process and what they think should improve. We may then need to consult on some of the changes we want to make.

Engagement with professional bodies

39 The Chief Executive discussed a range of issues with the RCM Chief Executive on 23 April 2018 and the RCN Chief Executive on 2 May

2018.

NHS Improvement (NHSI)

40 On 23 April 2018, the Chief Executive met the Executive Director of Nursing at NHSI for a wide-ranging discussion, including reference to the register data release.

Queen's Nursing Institute

41 On 23 April 2018, the Chief Executive gave a presentation to the Queen's Nursing Institute Event which took place in London. The presentation focused on a number of our key workstreams, including new nursing standards and the launch of the FtP strategy consultation.

Visit to Bradford

42 The Chief Executive visited Bradford District Care NHS Foundation Trusts for their nursing celebration event on 4 May 2018. While there, she met with members of the nursing team and took part in a Q&A session.

Collaboration

43 We continue to work with colleagues at the General Medical Council (GMC) on joint parliamentary engagement on regulatory reform and developing a shared approach to Brexit by healthcare regulators.

44 The Chief Executive continues to engage regularly with the GMC's Chief Executive, including discussions on 18 April, 2 May and 24 May 2018.

Public protection implications: 45 No direct public protection implications.

Resource implications: 46 No direct resource implications.

Equality and diversity implications: 47 No direct equality and diversity implications.

Stakeholder engagement: 48 Stakeholder engagement is detailed in the body of this report.

Risk implications: 49 No direct risk implications.

Legal implications:	50	No direct legal implications.

Item 8
NMC/18/46
6 June 2018

Council

Performance and Risk report

Action: For discussion.

Issue: Reports on performance and risk management for 2017–2018.

Core regulatory function: All regulatory functions.

Strategic priority: All.

Decision required: The Council is asked to discuss our financial, KPI and corporate commitment performance for April 2017 to March 2018 (paragraph 24).

Annexes: The following annexes are attached to this paper:

- Annexe 1: Performance reports including year to date progress update against corporate KPIs.
- Annexe 2: Corporate risk summary.

Further information: If you require clarification about any point in the paper or would like further information please contact the author or the director named below.

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Context:

1 This report provides an overview of performance and risk for the 2017–2018 year. There are a number of additional annexes that have been provided to show the year-end position which will not be included in future reports.

2 In order to present a holistic view of full year performance, we have brought together financial and non-financial performance into a single report. The financial information and detailed commentary can be found in **Annexes 1a and 1b** and non-financial reporting, including KPIs, in **Annexes 1c–1i**.

3 Further improvements in reporting about performance and risk are intended for 2018–2019.

4 As indicated in the report on the PSA Lessons Learned review, we will be addressing the findings and recommendations in the year ahead and recognise that there are areas where we have much to do. Reporting against 2018–2019 priorities will begin at the July 2018 Council meeting.

Four country factors:

5 Four country factors are taken into account in considering our risks and through our operational performance.

Discussion:

2017–2018 Performance

Overview

6 Our income and expenditure account shows us as breaking even at the year end. This compares to a budgeted deficit of £2.2m (**Annexes 1a and 1b**).

7 We delivered all five of our corporate KPIs to target (**Annexe 1c**).

8 Of the 12 corporate commitments within our business plan; eight were delivered to plan, two commitments have been rated as amber, and two were closed due to refocusing our plans and managing risk as part of Transformation (Contact Centre and Customer Relationship Management) (**Annexe 1d**).

Finance

9 Detail on income and expenditure is presented at **Annexes 1a** and **1b**. This is the full comparative of 2017–2018 income and expenditure versus the forecast budget.

10 Income and expenditure was break-even:

10.1 There was £85.6 million income (a variance of less than 1% against budget). The majority of income is from registrant fees which decreased marginally by 1% (£0.6m) compared to 2016–2017. This decrease was less than anticipated earlier in

the year.

10.2 There was £85.6 million expenditure (a variance of 4% less than budget).

11 Despite the break-even position, expenditure was £2.6 million less than planned, driven by underspends in Business As Usual (BAU) of £1.3 million (1% against budget) and £1.3 million (20% against budget) against programmes and projects. The main reason for this is that activity did not keep pace with original plans. Where this has occurred within strategic programmes, this has been carried over into the 2018–2019 plans (for example, within the education programme for the QA model implementation). Despite underspends, nearly all corporate commitments and all corporate KPIs were delivered. Whilst some project slippage has resulted in pressure points in 2018–2019, we are planning to meet these within the existing budgets.

12 Our income forecasting was cautious driven by concerns about a reduction in registrant numbers. Equally, our activity planning, particularly on projects, was optimistic, resulting in budget being ring-fenced and underspent at the end of the year. We will seek to mature our approach to forecasting and planning during 2018–2019.

13 Detailed commentary is provided at **Annexe 1b**.

Corporate KPIs

14 Progress against corporate KPIs is presented at **Annexe 1c.** All corporate KPIs met targets for the year as a whole. Where performance has fallen below the target during part of the year, this has been attributed to either staff shortages – in KPIs 1 to 3 – or prioritisation of older cases for KPI 5.

15 Progress against our corporate KPIs for UK initial registration applications finished the year above target. The final average performance for UK registrations within 10 days (**KPI 1**) was 97.9% against our target of 95%, and UK registrations within 30 days (**KPI 2**) 99.7% against our target of 99% (**Annexe 1e**).

16 The percentage of EU/Overseas registrations applications (**KPI 3**) assessed within 60 days finished with an average of 98.5% (**Annexe 1e**).

17 Call answering rates finished the year with an average of 91.2% against our target of 90% (**Annexe 1e**).

18 On **KPI 4**, we continue to exceed our 80% target for imposing Fitness to Practise (FtP) interim orders within 28 days, finishing the year with a year-end average of 87% as shown at **Annexe 1f**.

19 For **KPI 5**, conclusion of FtP cases within 15 months of being opened, we finished the year above the 80% target at 81% (**Annexe 1f)**.

Fitness to Practise

20 **Annexe 1g** is the FtP Performance Summary, highlighting the key commitments delivered. These include reducing the overall caseload by 12.3%, achieving the timeliness KPIs, and successfully implementing legislative change for case disposals.

Staff indicators

21 Staff turnover results are presented at **Annexe 1i**. At March 2018, staff turnover was at its lowest level since April 2017, reducing from 25.4% at April 2017 to 21.9% at March 2018 (a decrease of 14%). There were seven continuous months of reduced turnover compared to the previous year. Leaver reasons remain consistent with those reported to Council previously.

22 The volume of leavers with less than six months' service rose steadily until March 2018, reaching 27.8%, and then reduced to 25.0% in April 2018. Actions being taken to mitigate departures within six months include:

22.1 One month reviews with new joiners to check how the induction process is working.

22.2 Post induction reviews to promote strong staff engagement and problem solve issues.

22.3 A recent relaunch of our recruitment and career website to drive greater appeal of available roles and set expectations about NMC careers before people join.

23 We will continue to monitor whether these improvements drive a reduction in leavers over the next 6-12 months.

24 **Recommendation: The Council is invited to discuss our financial, KPI and corporate commitment performance for April 2017 to March 2018.**

Corporate risks (annexe 2)

25 Our corporate risk summary for 2017–2018 is provided at **Annexe 2** and reflects events and changes to the register for the period of January 2018 to March 2018 and the Council's discussion at the March 2018 private session. The key change to the register was the addition of a new risk which covers ICT. There were no other

significant changes to note.

26 The Council will consider issues and risks in more detail in confidential session, taking account of recent developments, including the Lessons Learned review.

27 A revised corporate risk register will be developed for discussion at the July 2018 public Council meeting.

Public protection implications: 28 Public protection implications are considered when reviewing performance and the factors behind poor or good performance.

Resource implications: 29 Performance and risk reporting are a corporate requirement and are resourced from within BAU budgets. We do not anticipate future additional costs unless we make refinements to our framework which will be fully costed. No external resources have been used to produce this report.

Equality and diversity implications: 30 Equality and diversity implications are considered in reviewing our performance and risks.

Stakeholder engagement: 31 None

Risk implications: 32 The impact of risks is assessed and rated within our corporate risk register.

Legal implications: 33 None.

Annexe 1 - progress and performance

Time period:
Feb – Apr 2018

This cover page is an overarching summary of progress and performance.

The accompanying reports within Annexe 1 contain the detail.

Contents of Annexe 1:

Item 8: **Annexe 1a**
NMC/18/46
6 June 2018

NURSING AND MIDWIFERY COUNCIL FINANCIAL MONITORING REPORT

March 2018

INCOME AND EXPENDITURE (£'m)	Full Year 2017-2018 v Budget			
	Actual	Budget	Variance to budget	% of budget
NMC Income	**85.6**	**86.0**	**(0.4)**	**(0%)**
Directorates - BAU				
Fitness to Practise	42.5	42.2	(0.3)	(1%)
Resources	16.8	17.5	0.7	4%
Registration & Revalidation	5.2	5.9	0.6	11%
Education Standards & Policy	3.2	3.8	0.6	17%
Office of the Chief Executive	3.9	3.4	(0.5)	(15%)
People and Organisational Development	2.3	2.4	0.1	4%
Total Directorates - BAU	**73.9**	**75.2**	**1.3**	**1%**
Programmes & Projects				
Transformation	2.2	2.5	0.3	12%
Education Programme	1.2	1.9	0.7	38%
Registration & Revalidation Projects	0.3	0.9	0.6	69%
FtP Section 60	1.3	0.8	(0.4)	(48%)
People Strategy	0.5	0.5	0.0	7%
TBI Projects	0.3	0.3	0.0	11%
Overseas Programme	0.1	0.1	0.0	24%
FtP Change Strategy	0.1	0.0	(0.1)	(100%)
Nursing Associates	0.0	0.0	0.0	0%
Total Programmes & Projects	**5.8**	**7.1**	**1.3**	**20%**
Corporate expenditure				
Depreciation	3.3	3.3	0.0	0%
PSA Fee	1.8	1.8	0.0	0%
Contingency & Other*	0.9	1.0	0.1	12%
Total Corporate/Central	**5.9**	**6.0**	**0.1**	2%
Total Expenditure	**85.6**	**88.3**	**2.6**	**4%**
Surplus/(Deficit)	**0.0**	**(2.2)**	**2.2**	**101%**
Capital Projects	**0.5**	**0.3**	**(0.2)**	**(62%)**

*Includes actuarial adjustments to pension payments made at year end

PAY vs NON-PAY EXPENDITURE (£m)	YTD Mar.18 v Budget			
	Actual	Budget	Variance to budget	% of budget
Staff Sals & Other Staff	44.8	43.6	**(1.2)**	**(3%)**
Non staff expenditure	40.8	44.6	**4.3**	**10%**
Total Expenditure	**85.6**	**88.3**	**3.1**	**4%**

RESERVES ANALYSIS (£m)				
	Actual	Budget	Variance	% of budget
Available free reserves (latest actuarial basis)	22.3	20.2	2.1	**10%**
Available free reserves (cash committed basis)	24.3	21.4	2.9	**13%**

BALANCE SHEET	31/03/2018 £'m	31/03/2017 £'m
Fixed Assets		
Tangible assets	18.9	21.7
Total fixed assets	18.9	21.7
Current assets		
Debtors	4.1	3.9
Investments (short-term deposits)	65.5	59.7
Cash at bank and in hand	16.7	22.6
Total current assets	86.3	86.2
Liabilities		
Creditors: Amounts falling due within one year	-51.8	-53.0
Provisions: Amount falling due within one year	-0.1	-0.1
Net current assets	34.4	33.1
Total assets less current liabilities	**53.4**	**54.9**
Creditors: Amounts falling after more than one year	-0.1	-0.6
Provisions for liabilities	-0.4	-0.9
Net asset excluding pension liability	52.9	53.4
Defined benefit pension scheme liability	-11.7	-12.2
Total net assets	**41.2**	**41.2**
The funds of the NMC		
Restricted income funds	0.0	0.0
Unrestricted funds	41.2	41.2
Total funds	**41.2**	**41.2**

Financial Monitoring Analysis to 31 March 2018

Summary year end financial position for 2017–2018

1 At the end of 2017–2018 our overall financial position was break-even as follows:

1.1 £85.6 million income (less than 1% below budget);

1.2 £85.6 million expenditure (4% below budget);

1.3 We planned for a deficit of £2.2 million but as a result of lower expenditure on business as usual (BAU) and Programmes/Projects compared to budget, we improved our financial performance to break-even.

Income

2 Income was £0.4 million (1%) below budget due to shortfall in registrant income. Compared to 2016–2017 this a drop of £0.6 million (1%).

Expenditure

3 There was a £2.6 million underspend against the operational budget. Of this £1.3 million related to BAU and £1.3 million related to strategic programmes and projects as described below.

4 In addition we spent £0.5 million on capital projects, £0.2 million more than budget. This was for work on the core registration system and the purchase of additional digital audio recording (DAR) equipment for FtP hearing rooms. These investments generate financial benefits to the NMC. For example, annualised savings of £0.8 million for DAR will be realised through reducing the use of shorthand writers.

Business as Usual Expenditure

5 We underspent by £1.3 million on BAU, 1% lower than budget. Key areas were:

5.1 **Education Standards and Policy**: we undertook a lower volume of quality assurance activity of Approved Educational Institutions (AEI) than initially anticipated. This has not impacted on our level of assurance. It reflects that AEIs are preparing for the new standards in 2018–2019. We have budgeted for an appropriate volume of assurance activity in 2018–2019;

5.2 **Resources**: we deferred the planned maintenance work to the NMC estate until next financial year. This will not impact on the operational effectiveness of the estate and this is funded in 2018–2019;

5.3 **Registrations and Revalidation**: we made efficiency gains by moving some Registration and Revalidation activities online and making substantial savings on postage as well as temporary staff.

6 Other budget variances including: Fitness to Practise over budget by 1% at £0.3 million and the Office of the Chair and Chief Executive over budget 15% at £0.5 million. This is consistent with the position since early in the financial year and these were offset by underspends in other areas.

Strategic Programmes and Projects Expenditure

7 We underspent by £1.3 million on programmes and projects, 20% lower than the allocated budget. Key areas were:

7.1 **Transformation**: we underspent due to de-risking and re-focusing the programme during the year as previously been discussed by Council. Key areas of work are being taken forward through projects budgeted for in 2018–2019;

7.2 **Education Programme**: we underspent mainly due to slippage of some IT development costs into next year relating to the quality assurance model. This has not impacted on the overall delivery timelines for the programme. The slippage has been managed within the 2018 budget for Strategic Projects;

7.3 **Registration and revalidation projects:** we underspent due to slippage of relating to some systems improvements. This improvement programme has continued into the new financial year and is funded from the Strategic Projects Portfolio budget in 2018–2019.

8 Two programmes were over budget. These were:

8.1 **FtP section 60:** due to systems development costs that were not included in the budget at the start of the year.

8.2 **FtP Change Strategy:** to cover development of a new FtP strategy which were not anticipated when budgets were set.

Forecasting

9 We have undertaken significant work to provide financial forecasts for the Council during the year. For 2017–2018 forecasts have generally taken a more pessimistic view of financial performance resulting in variances between forecast and actual year end position. There were two contributing factors for variances:

9.1 Cautious forecasting of registrant income. Recently published registrant figures have demonstrated that the drop in nurse and midwife registrant numbers appears to have levelled out;

9.2 We were overly optimistic about the delivery of all planned activities for BAU and strategic programmes and projects.

10 For 2018–2019 we will improve our forecasting through deeper challenge with delivery teams and in particular of projects and programmes. We will undertake joint scrutiny by Finance, the Programme Management Office and delivery teams to ensure all forecasts are reliable and agreed.

Implications for delivery of the 2017–2018 corporate business plan reflected in the financial outturn

11 We met all five corporate KPIs as set out in Annexe 1c. Of our twelve corporate commitments for 2017–2018 we have met eight, closed two, and rated two as amber as set out in Annexe 1d. The financial outturn reflects this delivery.

12 Two commitments were closed during the year due to the refocusing and derisking of transformation.

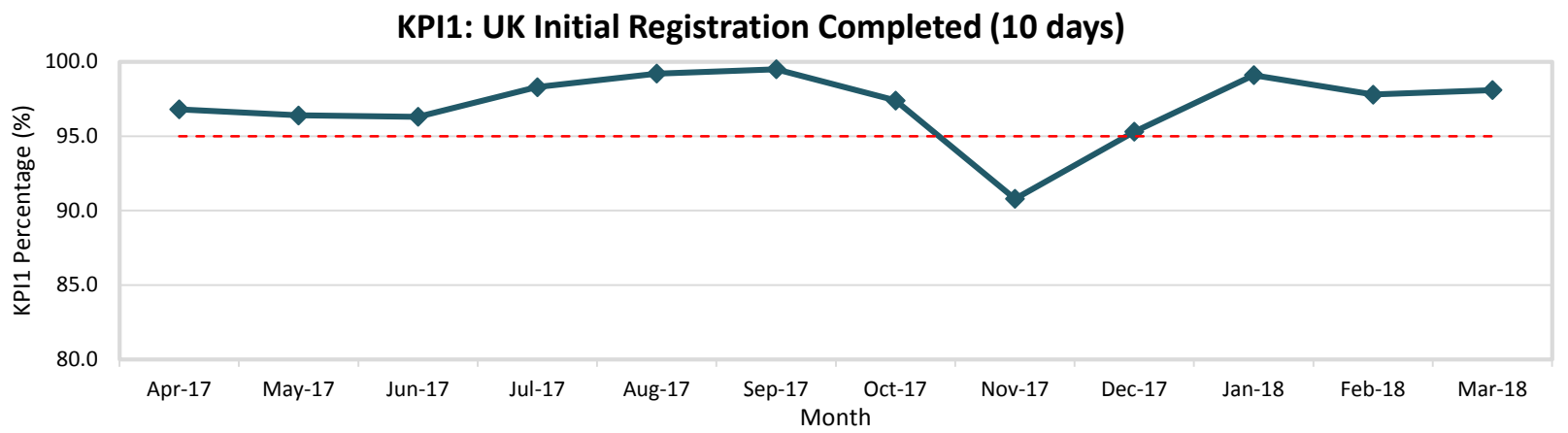
13 We did not fully achieve our timetable to deliver a new model for quality assuring approved education institutions. Although a new model has now been approved by the Council and is planned to be ready for September 2018, as discussed above, a proportion of the anticipated costs for 2017–2018 are now reflected in budgets for 2018–2019.

14 Although we reported on satisfaction survey results throughout the year, we rated this commitment amber, as we know we need to make improvements following the Lessons Learned Review.

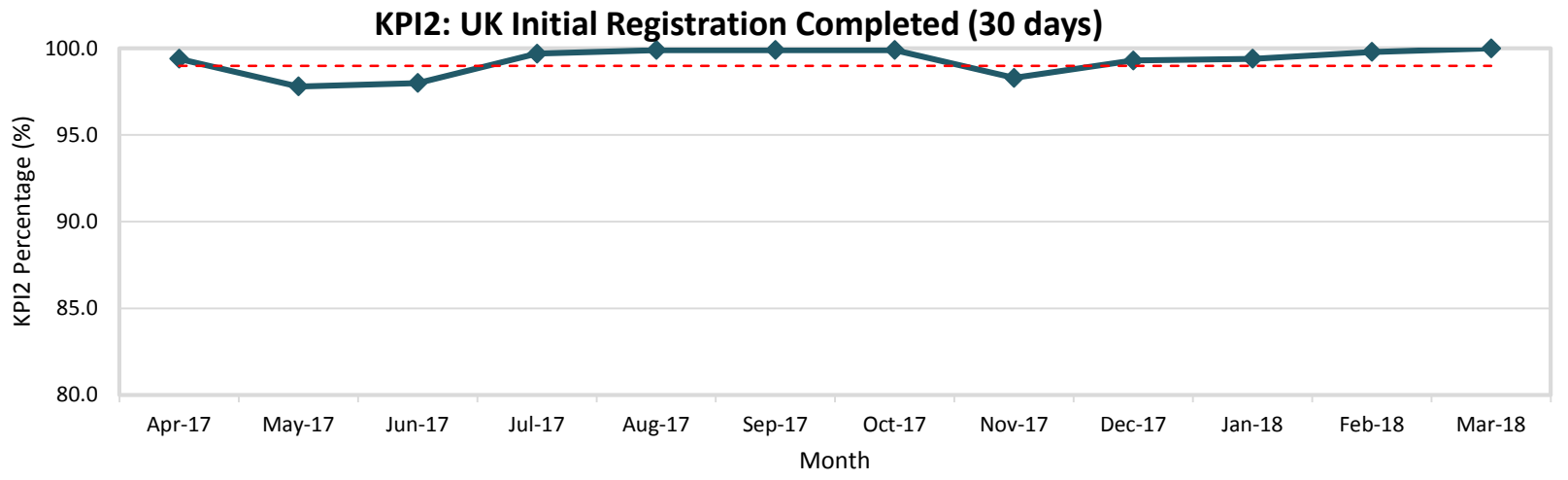
Corporate KPIs – 2017–2018 Review

All corporate KPIs are on course for the year. This annexe provides an overview of the 12-month summary.

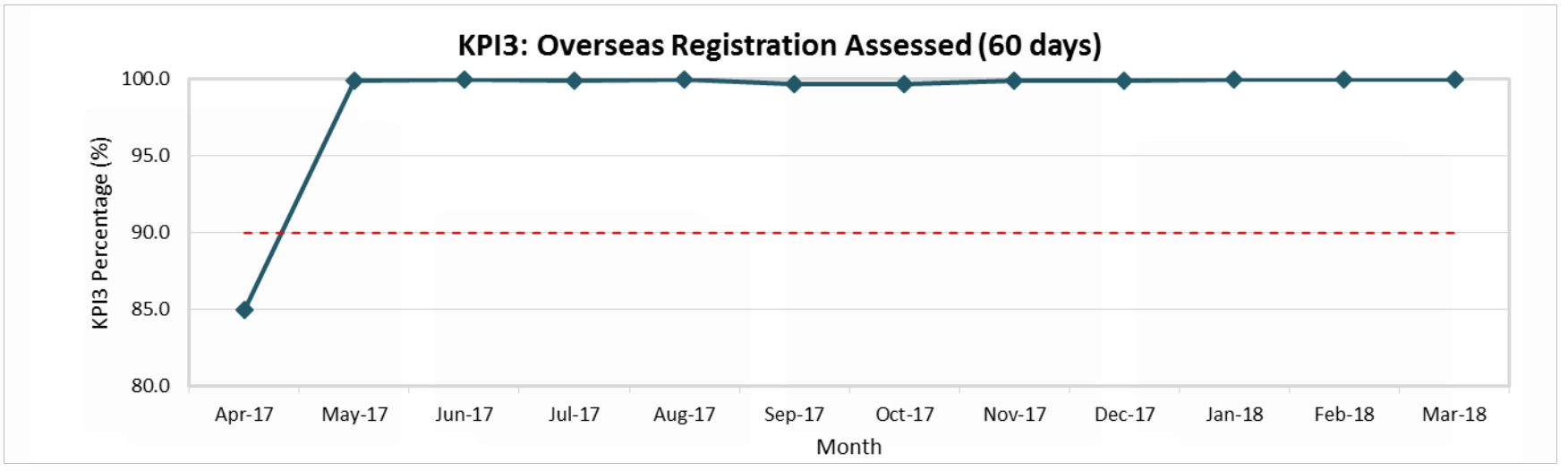
Registration and Revalidation



KPI1 Commentary
Performance dipped in November 2017 due to an increase in complex cases coupled with a dip in capacity due to vacant posts.



KPI2 Commentary
Dip in performance due to staff vacancies in May and June 2017, and then again in November due to the increase in complex cases coupled with a dip in capacity due to vacant posts



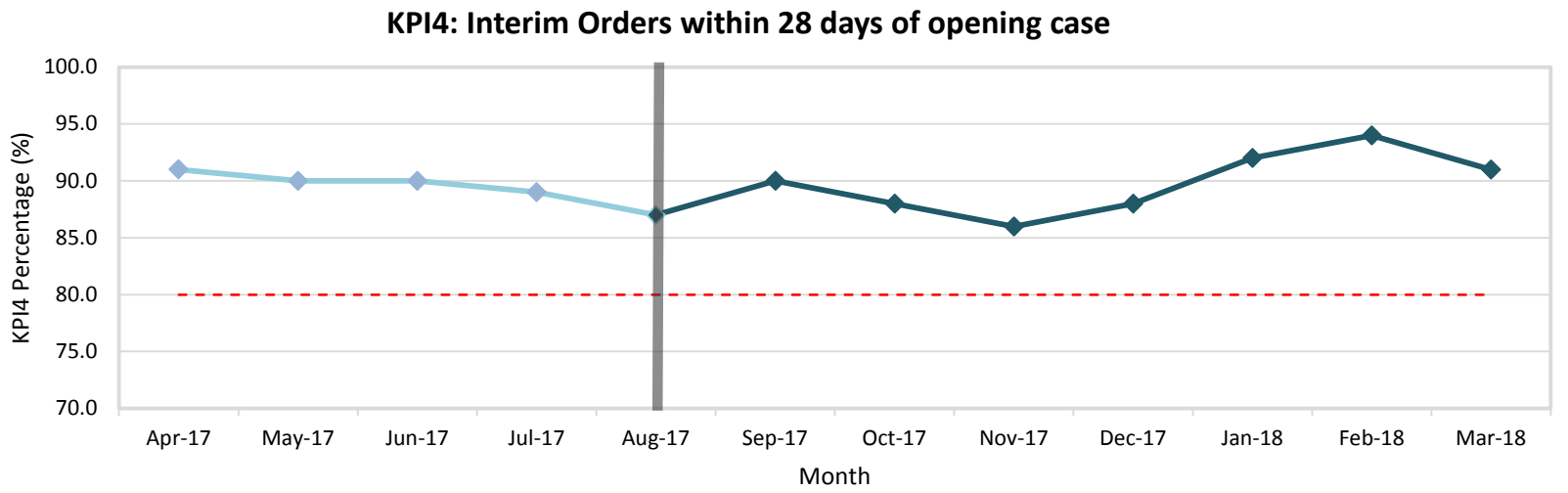
KPI3 Commentary
Below target in April 2017 due to departmental vacancies, but has subsequently not fallen bellow 99.7%.

Dashed red line denotes KPI target
Solid line is 12 month rolling average performance.

Time period:
Apr 2017 – Mar 2018

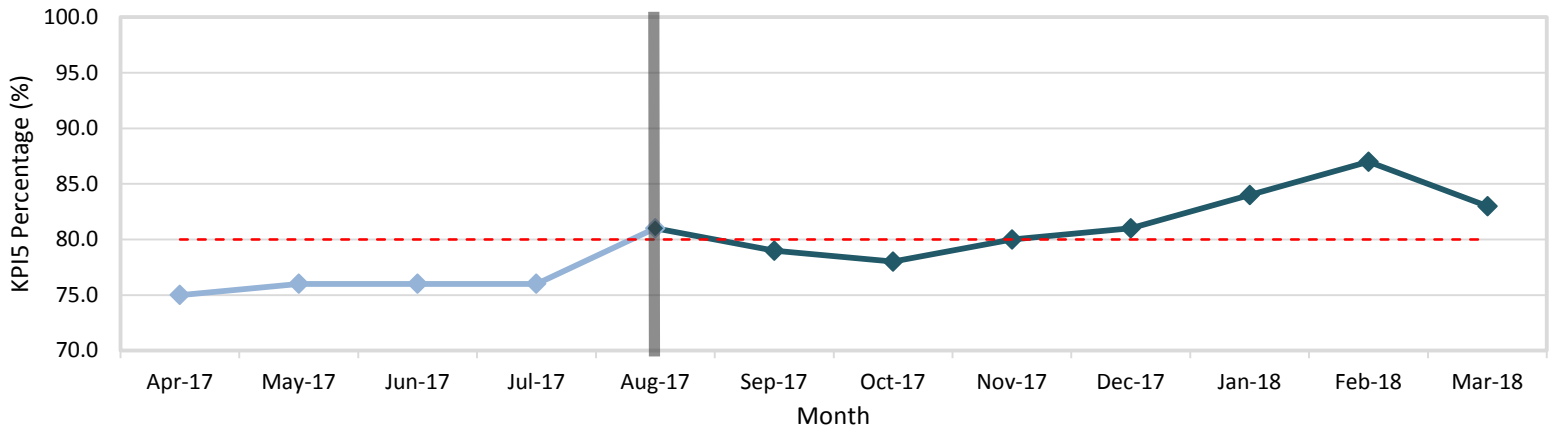
Corporate KPIs – 2017–2018 Review

Fitness to Practice



KPI4 Commentary

Performance has remained above the target throughout 2017-2018.



KPI5 Commentary

Due to prioritising older cases as part of our timeliness pathway, performance during Q1 and Q2 was below target but improved in Q3 and Q4.

Dashed red line denotes KPI target
Lighter solid line (April – August 2017) denotes period when figures presented were calculated on a basis of 12 month rolling average performance. Darker solid line after August 2017 denotes reporting of month actual performance.

12 month summary of corporate KPIs

	Corporate KPI	2016-2017 Average	Target	2017-2018 Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2017-2018 Average
1	% of UK reg applications completed within **10** days	**98.2%**	**95%**	**96.8%**	**96.4%**	**96.3%**	**98.3%**	**99.2%**	**99.5%**	**97.4%**	**90.8%**	**95.3%**	**99.1%**	**97.8%**	**98.1%**	**97.9%**
2	% of UK reg applications completed within **30** days	**99.2%**	**99%**	**99%**	**97.8%**	**98.0%**	**99.7%**	**99.9%**	**99.9%**	**99.9%**	**98.3%**	**99.3%**	**99.4%**	**99.8%**	**100.0%**	**99.7%**
3	% of EU/OS reg applications assessed within 60 days	**n/a***	**90%**	**85.0%**	**99.9%**	**100.0%**	**99.9%**	**100.0%**	**99.7%**	**99.7%**	**99.9%**	**99.9%**	**100.0%**	**100.0%**	**100.0%**	**98.5%**
4	% of interim orders imposed within 28 days of opening the case*	**91%**	**80%**	**91.0%**	**90.0%**	**90.0%**	**89.0%**	**89.0%**	**90.0%**	**88.0%**	**86.0%**	**88.0%**	**92.0%**	**94.0%**	**91.0%**	**87.0%**
5	Proportion of FtP cases concluded within 15 months of being opened*	**75%**	**80%**	**75.0%**	**76.0%**	**76.0%**	**76.0%**	**81.0%**	**79.0%**	**78.0%**	**80.0%**	**81.0%**	**84.0%**	**87.0%**	**83.0%**	**81.0%**

**KPI4 and KPI5 changed from 12 month actual rolling data to month actuals from August 2017*

Note for consideration - The Corporate and Risk team propose removing this data table from Annexe 1c in favour of the charts presented on the previous two pages as these better represent the trend against target

Item 8: **Annexe 1d**
NMC/18/46
6 June 2018

Year-end progress against the corporate plan commitments for 2017–2018

Report period: April 2017 – March 2018

Red	Corporate plan commitment was not met.
Amber	Parts of this corporate plan commitment were not met, possibly due to the changing nature of the work, realignment of activities with a shift in focus or other tolerable and agreed reasons.
Green	Corporate plan commitment was met.
Closed	Commitment closed during the year

2017-2018 Deliverable	Current status
Strategic Priority 1	
1. Education	
(1.a) Nursing: published new competency based pre-registration education standards ready for full roll-out by September 2019, taking into account the views and feedback from the public, patients and all our stakeholders.	**G**
Year-end Status: Commitment met Following significant engagement with the public, patient groups and all our stakeholders and a full analysis of the responses of our public consultation the Council approved new outcome focused standards of proficiency for registered nurses in March 2018 with plans in place for implementation in 2018-2019.	
(1.b) Midwifery: prepared draft new competency based pre-registration education standards ready for us to begin testing with midwifery professionals, educators, women, the public and other stakeholders.	**G**
Year-end Status: Commitment met The Council approved a revised timeline for the drafting of new standards of proficiency for registered midwives. At this stage and following our early engagement listening events with stakeholder representatives an early outline draft for developing new standards of proficiency has been developed and will be tested during 2018-2019.	
2017-2018 Deliverable	**Current status**
(1.c) Nursing and midwifery education programmes: publish a new education framework setting out the requirements for institutions seeking to deliver approved programmes, taking into account the views and feedback from the public, patients, the profession and stakeholders.	**G**

2017-2018 Deliverable	Current status
Year-end Status: Commitment met The new education framework that includes standards for nursing and midwifery education, standards for student supervision and assessment and programme standards for pre-registration nursing, and nurse and midwife prescribing programmes were approved by the Council in March 2018. A plan for communication and engagement during 2018 is in place.	
(1.d) Nursing and midwifery education quality assurance: continued development of our approach to the quality assurance (QA) of education.	**A**
Year-end Status: Partially met The Council approved a new QA framework in March 2018. Amber status reflects a number of interdependencies. This includes the need to review capacity for operational delivery of QA via the outsource QA supplier to meet the forecasted increase in volume of approvals against the new standards and in approving new nursing associate (NA) programmes for the first time. Amber status also reflects the IT developments necessary to accommodate changes in line with the IT strategy. New QA criteria against the new standards are in development ready for the first approvals against the new standards in September 2018.	
(1.e) Nursing and midwifery post-registration standards: reviewed prescribing, medicines management, and return to practice standards, taking into account the views from the public, patients and stakeholders, and revised these standards if appropriate.	**G**
Year-end Status: Commitment met Delivery of new nursing and midwifery prescribing programme standards adoption of the Royal Pharmaceutical Society's (RPS) competency framework for all prescribers as our nurse and midwife prescriber standards of proficiency was agreed by the Council at its March 2018 meeting. The Council also agreed to the withdrawal of the standards for medicines management (SMM). A plan for communication and engagement during 2018 is in place.	
2. Nursing Associates	
(2) Developed and consulted on both standards of proficiency and standards for education for nursing associates. In doing so, we will consult with and listen to the views of patients, the public and our stakeholders.	**G**
Year-end Status: Commitment met We are currently out for consultation on our regulatory tools and processes. The consultation closes on 2 July 2018. We have a patient and public version of the consultation document available and have scheduled events with patients and service users during the consultation period. We are on track for Council to discuss and make a decision on the NA proficiencies and other regulatory tools and processes.	

2017-2018 Deliverable	Current status
3. Section 60	
(3) Implemented legislative changes to address fitness to practise concerns proportionately and quickly having taken into account the views of patients, the public, and our stakeholders. Case examiners will have begun to use new powers to give advice, issue warnings and agree undertakings in cases as appropriate.	**G**

Year-end Status: Commitment met

Legislative changes were introduced under a section 60 order to increase the flexibility of our FtP rules. This enabled us to strengthen public protection by taking a more proportionate approach and focusing on the most serious cases.

The first phase of legislative change was successfully implemented on 31 March 2017 and included: removing regulatory supervision for midwifes; the power for NMC to select the location of fitness to practise hearings, resulting in more flexibility; removing the need for a three-monthly review of interim orders; and provision for the High Court to vary interim orders on appeal.

The second phase of S60 was successfully implemented on 31 July 2017 and included:

- New powers for Case Examiners to issue warnings and advice to, and agree undertakings with registrants
- Removing the need to review substantive orders based only on public interest
- Introduction of a single fitness to practise committee capable of hearing both health and conduct cases.

The final system release to support the monitoring of undertakings and the Rule 7A power to review process was successfully completed in February 2018. The first undertaking has recently been assessed as complete.

4. Business As Usual Performance	
(4.a) Maintain strong performance against our key targets for Registration and Fitness to Practise.	**G**

Year-end Status: Commitment met

All of our corporate KPIs have been met within target.

Improvements delivered in 2017–2018:

1) FtP: The impact of new powers for case examiners will be fully understood during 2018–2019.

2) Registrations and Revalidations: During the year we moved more of our registration processes online. This improved the experience for nurses and midwives registering with us for the first time and those renewing their annual registration. Changes meant that new nurses and midwives could be registered within 24 hours of providing the necessary information. This also enabled the team to manage the traditional annual volume peak in the autumn more efficiently so that the majority of new nurses and midwives were registered a month earlier, in September.

2017-2018 Deliverable	Current status
(4.b) Continue to report on our customer service performance and improvements introduced as a result of customer feedback.	**A**

Year-end Status: Commitment met

Throughout 2017-2018 we have continued to report on our customer satisfaction to individual business units, the executive team and the Council (via the public Performance and Risk Report). The customer response rate to our surveys has improved and a plan is being developed to increase the level of response to ensure that this is more representative of the customer population. This will continue into 2018-2019.

We recognise that there is more we need to do to improve how we treat those who have contact with us. We will be addressing the findings and recommendations of the PSA Lessons Learned review with a priority focus on this area.

Strategic Priorities 2, 3 and 4

5. Effective Organisation

(5.a) Delivered the first phase of the contact centre, including procurement of appropriate accommodation.	**Commitment closed during the year**

Year-end Status: Commitment closed

Transformation was closed in September 2017 due to the high level of risk that was involved. This commitment was therefore closed as it was no longer relevant. Council members have previously been briefed regarding the outcomes of transformation for 2017–2018.

(5.b) Delivered the first phase of a new customer relationship management system and associated new technology.	**Commitment closed during the year**

Year-end Status: Commitment closed

We originally intended to deliver this corporate commitment via the transformation programme which was closed in September 2017. A new commitment for 2018-2019 will focus on developing our ICT strategy with a view to invest in core systems over the next 18 months.

(5.c) Implemented the first elements of the People Strategy, including improved HR and OD capacity and delivery to support staff and managers through the first phase of transformation.	**G**

Year-end Status: Commitment met

The people strategy continues at good momentum with excellent uptake in the ongoing leadership development programme. All HR policies have now been re-written and the strategy overall remains on track. A full update on progress and upcoming initiatives is included as a separate agenda item.

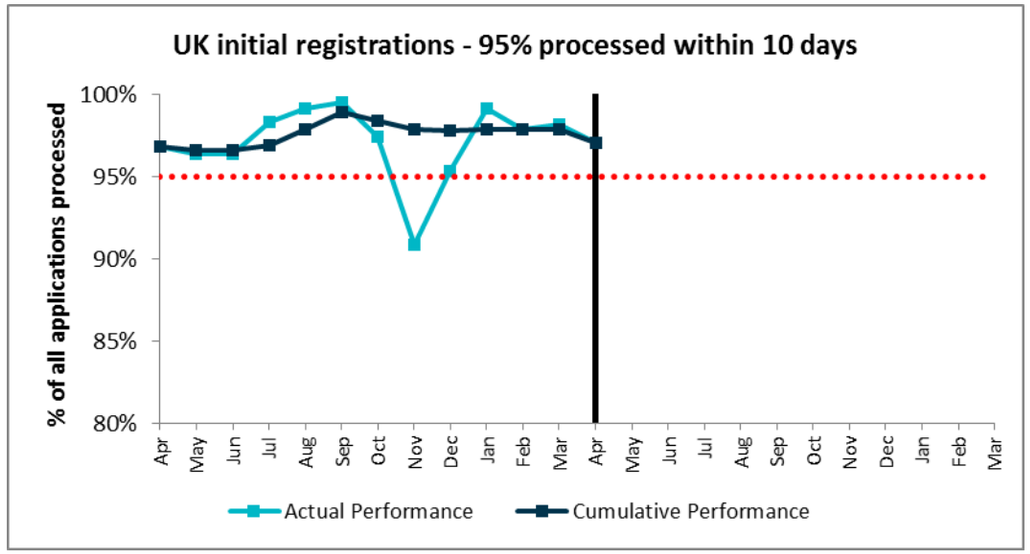
Registration and Revalidation performance – corporate KPIs

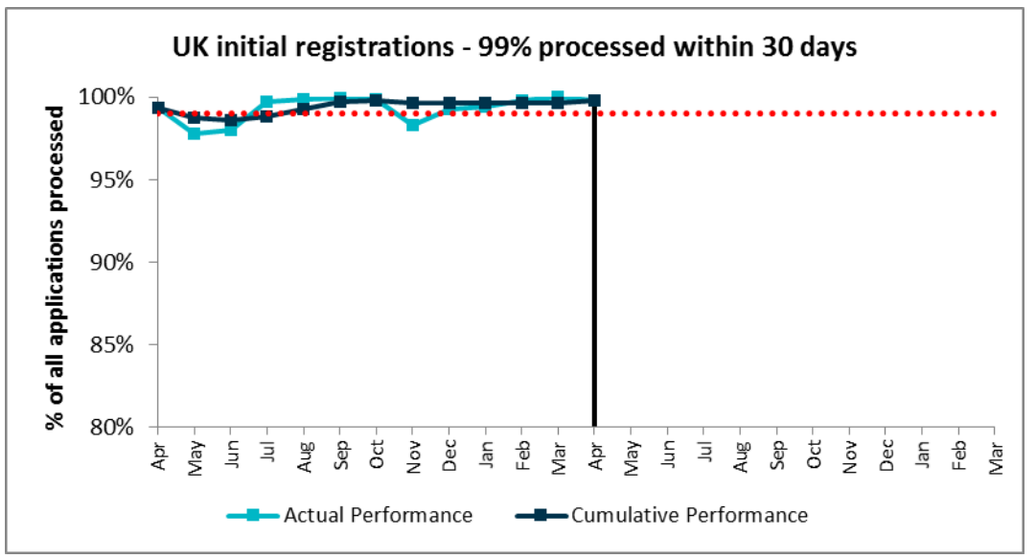
Time period:
Feb – Apr 2018

	KPIs 1 and 2 - Percentage of UK initial registration applications completed								
KPI	**Average for 2017–18**	**February 2018**		**March 2018**		**April 2018**		**Year to date average**	**Year end average target**
		No.	As a %	No.	As a %	No.	As a %		
KPI 1 10 Days	**97.9%**	906	**97.8%**	1,591	**98.1%**	884	**97.0%**	**97.0% (Green)**	**95% within 10 days**
KPI 2 30 Days	**99.7%**	924	**99.8%**	1,621	**100.0%**	909	**99.8%**	**99.8% (Green)**	**99% within 30 days**

Commentary:
Performance remained strong throughout the final quarter, which included the anticipated spike in volume of initial applications received in March 2018. We completed the year with both targets having been met.

Rating definitions:	Green	Amber	Red
KPI 1 – 10 days	≥ 95.0%	90.0% – 94.9%	≤89.9%
KPI 2 – 30 days	≥ 99.0%	98.9% – 94.0%	≤93.9%

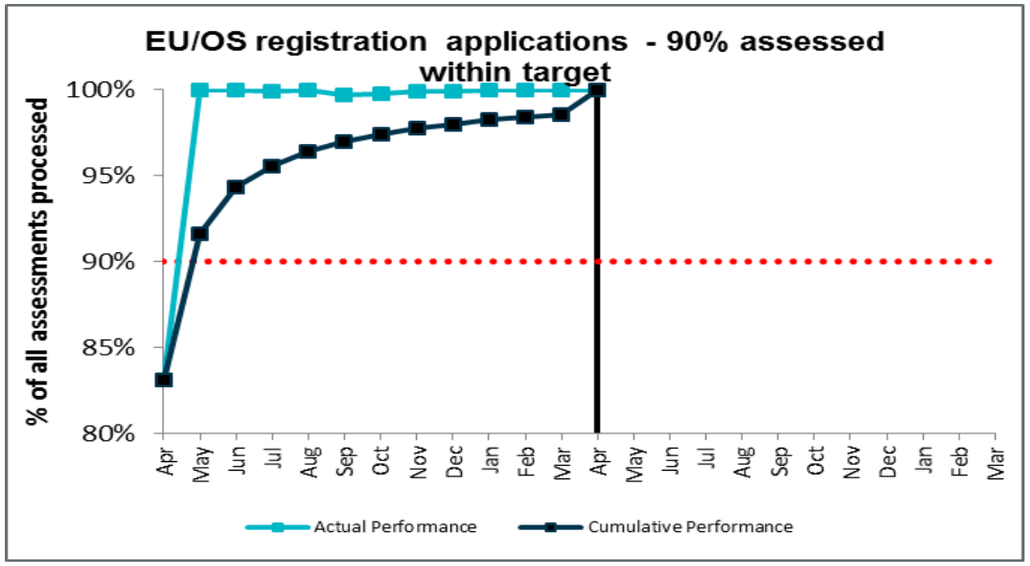




	KPI 3 - Percentage of EU/Overseas registration applications assessed within 60 days							
Average for 2017–18	**February 2018**		**March 2018**		**April 2018**		**Year to date average**	**Year end average target**
	No.	As a %	No.	As a %	No.	As a %		
98.5%	1,073	**100.0%**	1,085	**100.0%**	1,008	**100.0%**	**100.0% (Green)**	**90%**

Commentary:
There was a high level of performance for almost all of the year, resulting in the year end target being met.

Rating definitions:	Green	Amber	Red
KPI 3 – 60 days	≥ 90.0%	85.0% – 89.9%	≤84.9%

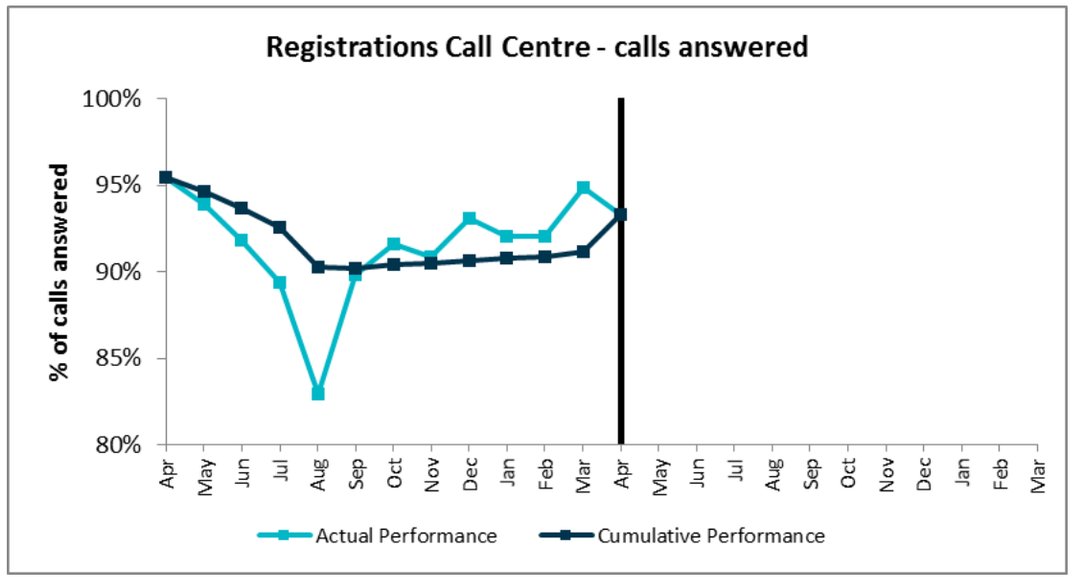


Registration and Revalidation performance – supplementary information

Time period:
Feb – Apr 2018

Call Centre

Percentage of calls answered				
Average for 2017–18	**February 2018**	**March 2018**	**April 2018**	**Year to date**
91.2%	**92.0%**	**94.9%**	**93.3%**	**93.3%**
	19,403 / 1,544 offered/abandoned	**19,590 / 997** offered/abandoned	**18,885 / 1,256** offered/abandoned	



Commentary:
We met our year end target.

We continue to see a drop in calls due to NMC online self-service. April 2017 compared to April 2018 shows a decrease of 6% in calls offered with an increase in call duration of 23 seconds. The numbers over the three month period were consistent and do not show the peak in calls that we have had in previous years. Self-service appears to have started to smooth our peak volumes.

Revalidation

Percentage of revalidation rates for each UK country				
	England	Scotland	Northern Ireland	Wales
February	**94.7%**	**95.9%**	**91.0%**	**95.7%**
March	**93.6%**	**91.7%**	**93.9%**	**95.4%**
April	**92.8%**	**90.8%**	**92.3%**	**92.7%**

Revalidation volumes and percentages - whole register			
	February	March	April
Number	**13,977**	**23,655**	**14,116**
As a percentage (of those due to revalidate)	**94.0%**	**92.9%**	**91.8%**

Note:
Both tables show monthly revalidation rates, with the whole register table including those based outside of the UK.

Commentary:
Revalidation rates for this period continue to be in line with historical averages and are consistent with the same period last year.

Verifications:
All applications verified in this period were compliant with the requirements.

Fitness to Practise performance – corporate KPIs

KPI 4 – Percentage of interim orders (IO) imposed within 28 days of opening the case

12 month rolling performance March 2017	February 2018*	March 2018*	April 2018*	12 month rolling performance April 2017 - March 2018	12 month rolling performance Target
91%	94%	91%	89%	87% Green	80%

KPI 5 - Percentage of FtP cases concluded within 15 months of being opened

12 month rolling performance March 2017	February 2018*	March 2018*	April 2018*	12 month rolling performance April 2017 – March 2018	12 month rolling performance target
75%	87%	83%	87%	81% Green	80%

***** *Figure shown is monthly actual*

Commentary

KPI4: Interim Orders

We kept our rolling performance above the 80% target throughout the whole of 2017-2018. The rolling 12 month performance remains on target.

KPI5: Cases concluded within 15 months:

We met the KPI target for the first time in February 2018 and have maintained that performance in March and April 2018.

Red/Amber/Green rating: Red - cumulative performance for previous 12 months is less than 72%; Amber - between 72% and 80%; Green - greater than or equal to 80%

Item 8: **Annexe 1g**
NMC/18/46
6 June 2018

Fitness to Practise Performance Summary: March – April 2018

Performance summary

1. At the start of 2017–2018, we set a forecast for caseload reduction and a timeliness pathway and reported against these at every Council meeting. Key successes during the year were:

    - Reducing the overall caseload by 430 cases
    - Meeting the 15 month end to end KPI in February and March 2018
    - Successfully implementing legislative changes

2. Underlying that, however, output at the investigation stage was a particular challenge, with the result that:

    - Investigation caseload rose during the year
    - Overall caseload did not decrease as much as planned
    - The timeliness pathway was not fully achieved

3. In 2018–2019, we will continue to focus on reducing our caseload and improving timeliness. Performance at the investigation stage remains a risk. Following the issues reported at the last meeting, staffing has stabilised to an extent and 50 of 53 (94%) investigator posts are now filled. Working with an external supplier, we have identified key internal goals relating to the timeframe for completing investigations and improving skill mix and retention of investigators. At this stage, we are forecasting no significant change in caseload at the investigation stage during the year as we embed the new approach.

4. The Case Examiners are using undertakings, warnings, and advice in around 10% of cases. This assumption has been used for the 2018–2019 budget.

5. At the last meeting, we reported on the post-adjudication caseload, i.e. cases with substantive orders that are subject to further review by a panel. The post adjudication caseload continues to reduce gradually. At the end of April 2018, there were 911 cases with a substantive order (February: 929), of which 500 were suspension orders and 411 were conditions of practice orders.

6. There are no other significant matters about our operating performance to draw to the Council's attention.

Notes on the dashboard – Annexe 1h

7. Graph A1 shows the historical caseload data for comparison. Caseload has reduced significantly over the last three years.

8. Graph A2 shows the caseload forecast for 2018–2019. We expect the caseload to be broadly stable during the year. At the end of the financial year 2017–2018, we

adjusted the Case Examiner caseload (a decrease) and investigation caseload (a corresponding increase) to better reflect the operational hand over point.

9. Graph A3 shows the referral rate, which remains slightly under our maximum capacity of 500 referrals / month.

10. Graphs B1 to B3 show the median ages of cases in the caseload and at the key decision points.

11. Graphs C1, C2, C3, and C4 reflect the ages of the cases at each stage of the process, split between active cases and cases on hold because of third party proceedings. The dotted lines reflect the timeliness pathway: we are aiming not to have any active cases older than the dotted line at each stage. As noted at the last meeting, the pathway has been realigned from 32 to 33 weeks for investigations, to better reflect the operational handover points. Achieving the timeliness pathway is largely dependent on improving output at the investigation stage.

Other performance data

12. We have made two changes in order to simplify the way we report performance data:

    12.1. The timeliness pathway is reflected on the dashboard (graphs C1, C2, C3, C4) so we plan no longer to provide the data as a separate table.

    12.2. The use of new Case Examiner powers is now business as usual and reflected in our business plan and budget so we plan no longer to provide a separate data table on the number of undertakings, warnings, and advice applied. We will continue to report by exception and will do a full impact assessment once the powers have been in use for a year.

PSA lessons learned review

13. We received the PSA's report on 16 May 2018 and accept all of the lessons learned. We are determined to use the learning provided in the report to improve the way we work. There is a separate item on the Council agenda which covers the report and our proposed actions to address the findings in more detail.

New FTP strategic direction

14. The public consultation on the proposed new strategic direction began on 4 April 2018 and will conclude on 30 May 2018. We have promoted the consultation through our newsletters, media, and social media, and to date we have received more than 350 responses.

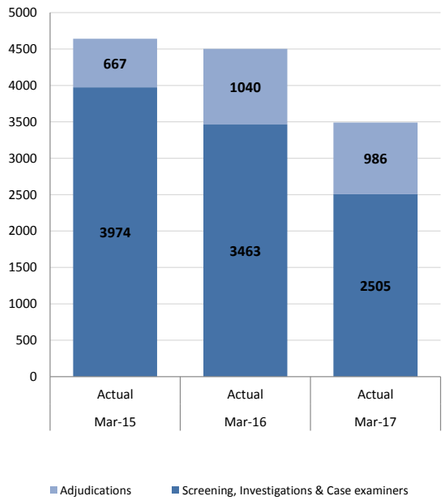
15. We are engaging widely with stakeholders across the UK. As part of this, we have held roundtables with patient organisations, NHS employers, independent employers, and the representative bodies.

16. Research is proceeding in parallel to ensure we hear a range of views from patients and the public, employers, and registrants. Workshops have been held in the four constituent nations of the UK. We have set targets for diversity of participants.

17. When we report back on the consultation to the Council in July we will also demonstrate how we have taken account of the PSA's lessons learned review.

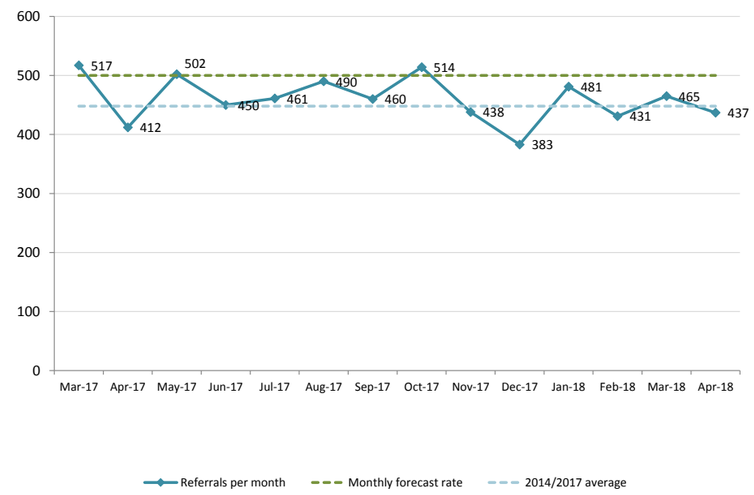
FtP performance dashboard April 2018

A1 **Historic caseload**



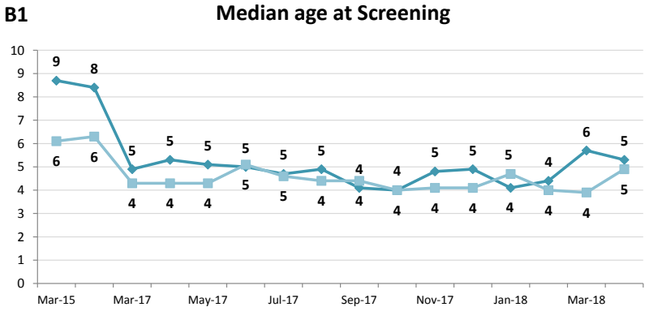
A2 **FtP caseload**

A3 **New referrals**

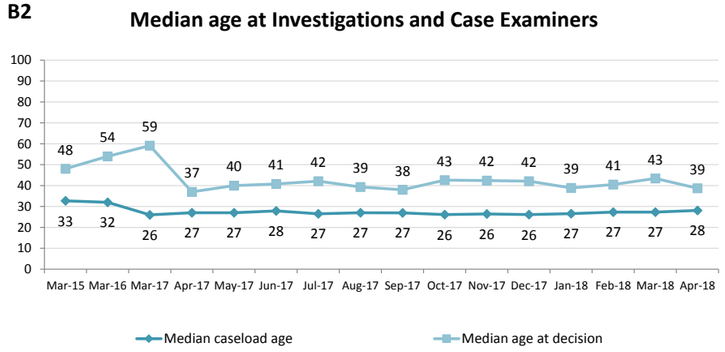


Note: The Case Examiner and Investigation caseloads have been realigned to better reflect the operational handover point between the two case stages. Case Examiners has decreased and Investigations has increased when compared to previous reports.

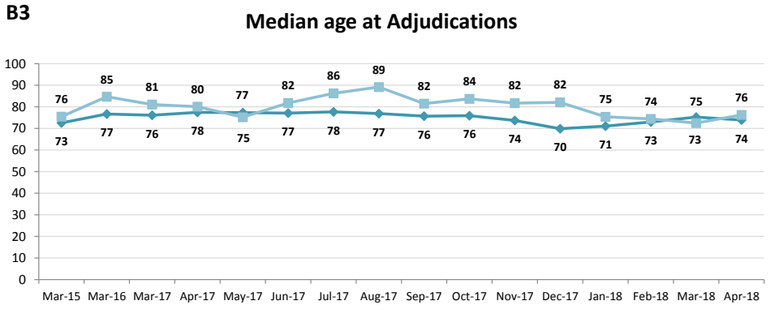
B1 **Median age at Screening**



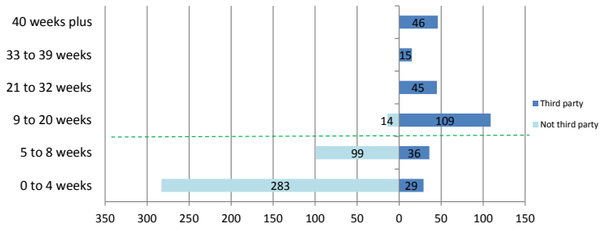
B2 **Median age at Investigations and Case Examiners**



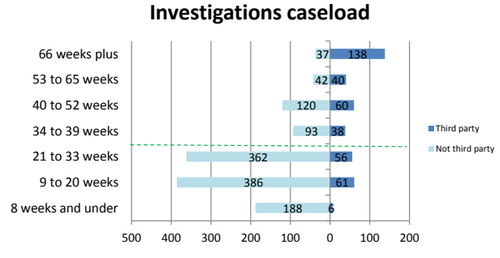
B3 **Median age at Adjudications**



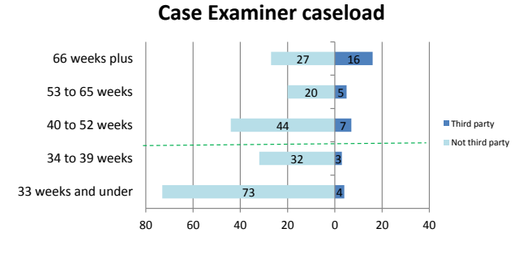
C1 **Screening caseload**



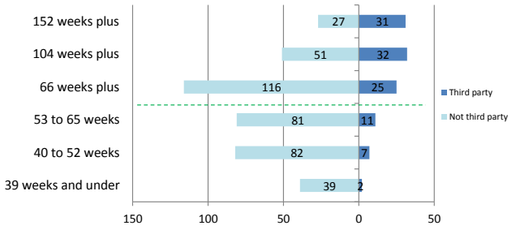
C2 **Investigations caseload**



C3 **Case Examiner caseload**



C4 **Adjudication caseload**



Caseload Movement Summary April 2018

Opening caseload 3,061

437 cases received

460 cases closed

3,038 Closing caseload

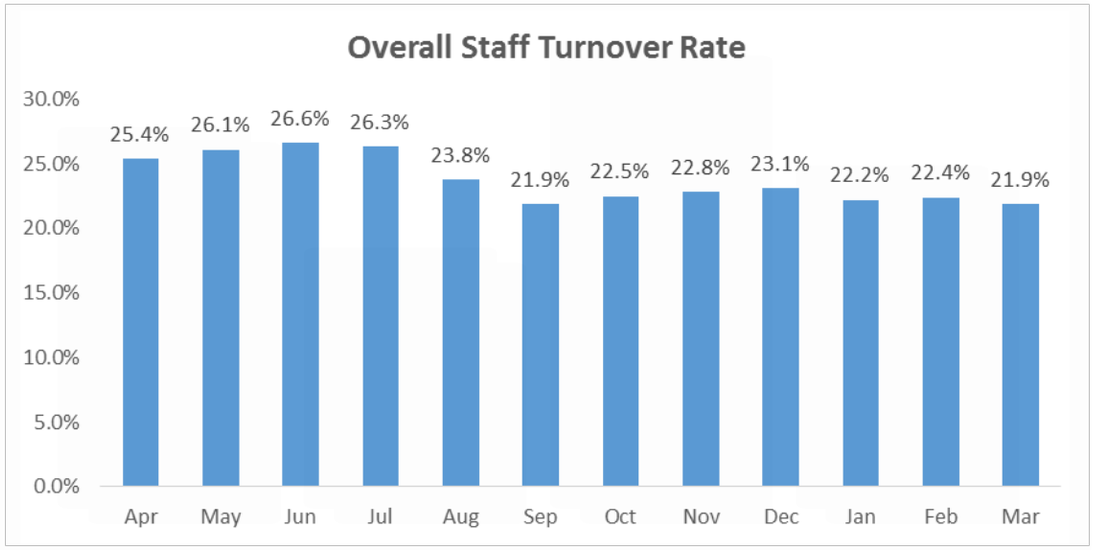
People – Staff turnover

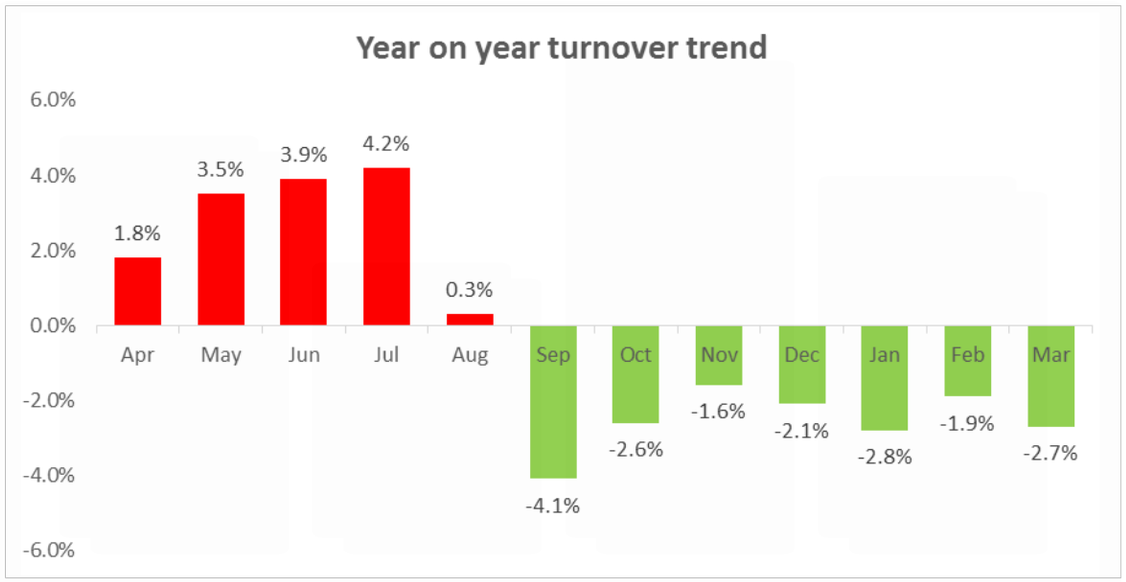
Overall Staff Turnover Rate		
Feb-2018	**Mar-2018**	**Apr-2018**
22.4%	21.9%	20.2%

Commentary

Turnover is at it lowest rate for the last 5 Years.

↓ NMC turnover has decreased to 20.2% from 22.4% since February 2018 (2.2%). In the same period permanent headcount has increased from 696 to 714 employees.



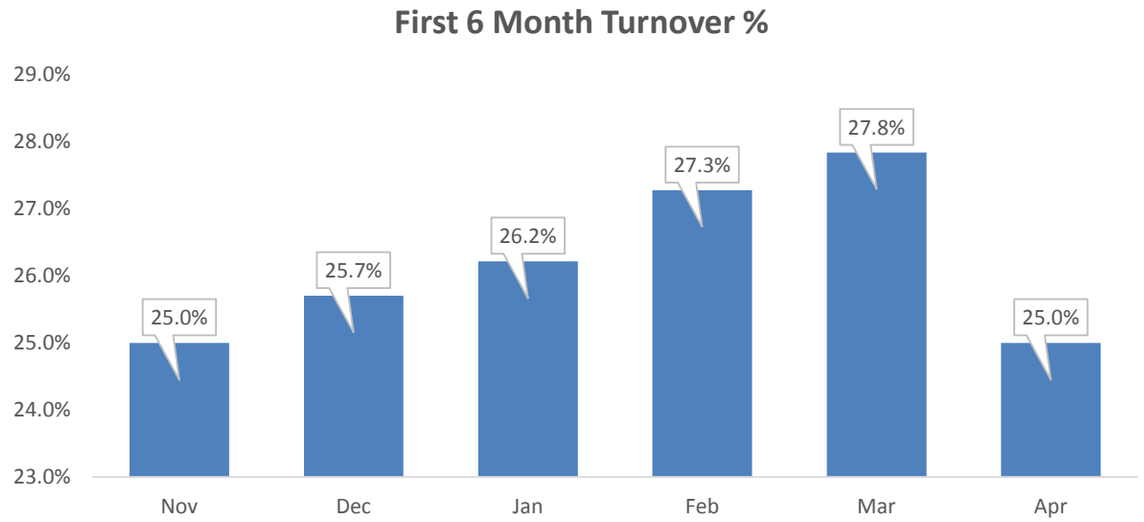


The most common leaver reason given in exit interviews was **career progression**.

Staff Turnover Rate: Less than 6 month service	
February 2018	**April 2018**
27.3%	25.0%

Commentary

↓ Currently 25% of new starters left within their first 6 months of service. This is down 2.3% on February 2018 due to the volume of leavers reducing. This is the first decrease since November 2017.



Action being taken to mitigate new starters leaving within 6 months

- **Focus on corporate risk 3, capacity and capability:** It is currently too early to draw conclusions from the interventions that have been taken by management, which include how we recruit and induct new joiners into the NMC. These will be monitored over the coming 6–12 months and the outcomes of these interventions will become clearer over that period.

Corporate risk summary (January 2018 – March 2018)

This summary reflects events and changes to NMC's corporate risk register for the period of January 2018 to March 2018. The Council discussed the corporate risk register at their private Council session in March 2018 and changes from the discussion have been included below.

Current rating = a rating of the risk as it currently stands (with mitigation in place).
Movement = score movement since last review / meeting

Risk Number	Corporate Risk	Rating	Movement
1	Risk that we may register, or may have registered people who do not meet our requirements or standards	Amber	◀▶
2	Risk that we may fail to take appropriate action to address a regulatory concern	Amber	◀▶
3	Risk that we may have insufficient capacity and resilience to deliver change programmes and business as usual	Red	◀▶
5	Risk that there may be adverse incidents related to business continuity and health and safety	Amber	◀▶
6	Risk of information security and data protection breaches	Amber	◀▶
7	Risk that we may lack the right capability to influence and respond to changes in the external environment	Amber	◀▶
8	Risk that we may not meet external expectations of us (reputation and perceptions)	Amber	◀▶
9	Risk that ICT failure impedes our ability to deliver effective and robust services for stakeholders or value for money for the organisation	Red	NR

[Please note that Green-rated risks are dealt with at the Business Unit level and therefore not included within the Corporate Risk Register]

	Corporate risks	Current rating	Movement	Status - mitigations in place and planned
1	**Risk that we may register, or may have registered people who do not meet our**	**Amber** High impact, low likelihood	No change	**In place:** • Registration and revalidation processes to ensure only those who meet requirements join the register or revalidate. • Identity and quality checks for UK, EU, Overseas initial

	Corporate risks	Current rating	Movement	Status - mitigations in place and planned
	requirements or standards			registrants. • Strengthened reconciliation process. • Increased automation of processes. • Quality assurance framework to assure education providers. • Strengthened staff induction, training and communication. • Stronger links between Serious Event Reviews and complaints and assurance controls. • Business-wide legal compliance review. **Planned:** • Data and systems work to improve robustness. • Further automation of processes to reduce human errors. • Strengthening of process for early identification of failures and risks. • Strengthening of delegation of decision making. • Continued improvements to training. • Review of Overseas registrations process. • Updated guidance to Higher Education Institutions.
2	**Risk that we may fail to take appropriate action to address a regulatory concern**	**Amber** High impact, low likelihood	No change	**In place:** • Existing Fitness to Practise (FtP), Registrations and Education processes and controls. • Employer Link Service and engagement with employers and other stakeholders improves knowledge of FtP processes supporting early engagement. • New powers for case examiner disposals to manage FtP cases quickly and effectively. • Staff induction, training and Learning & Development. • Information sharing regarding processes and risk. **Planned:** • Implement identified process improvements between Registration and FtP to address areas of potential weakness. • Focused approach to providing intelligence to stakeholders. • Implement actions arising from Professional Standards Authority Lessons Learned Review.
3	**Risk that we may have insufficient capacity, resilience and capability to deliver change**	**Red** High impact, probable likelihood	No change	**In place**: • Limit placed on commitments in corporate plan 2017–2018. • Department of Health funding to deliver new Nursing Associates role.

	Corporate risks	Current rating	Movement	Status - mitigations in place and planned
	activities (service improvements, projects and programmes) and business as usual			• Corporate portfolio management office and related processes strengthened to manage change initiatives. • Robust recruitment processes for staff and contractors. • Trend analysis of declining register built into assumptions underpinning corporate budgeting process. **Planned:** • Strengthening of Executive Board with new directorates established for People and Organisational Development and External Affairs. • Staff recruitment and retention analysis to identify capacity and capability pressure points and targeted action plan to reduce risks locally. • Targeted recruitment for key roles. • Updated staff reward strategy. • Implement employee engagement action plans. • Complete leadership development programme. • Review of NMC employer brand to attract the best staff. • Implement action plans for identified low capacity areas.
5	**Risk that there may be adverse incidents related to business continuity and health and safety**	**Amber** High impact, possible likelihood	No change	**In place:** • Business Impact Assessments. • Business continuity and disaster recovery plans. • IT infrastructure disaster recovery arrangements. • Business Continuity Working Group. • Training and desktop exercises. • Fire Risk Assessments across all premises. • Lockdown procedure in event of an emergency. **Planned:** • Implement updated business continuity policy. • IT infrastructure disaster recovery test planned.
6	**Risk of information security and data protection breaches**	**Amber** High impact, possible likelihood	No change	**In place:** • Information security risk register and treatment plan. • Technical controls e.g. updating patches, IT security measures, encrypted email. • Staff awareness. • Audit action plans implemented. • Oversight by Information Governance and Security Board. • Maintaining and strengthening controls. Insurance cover for cyber security threats. **Planned:** • GDPR project which will deliver updates required to meet data protection regulations.
7	**Risk that we may lack the right capability to influence and respond to changes**	**Amber** High impact, possible likelihood	No change	**A. Mitigations for external risks:** We have some influence over likelihood but focus remains on controlling the impact of external changes by anticipating and planning for possible eventualities.

	Corporate risks	Current rating	Movement	Status - mitigations in place and planned
	in the external environment			**In place:** • External monitoring. • Brexit scenario planning via working group. • Strengthened leadership of external affairs. **B. Mitigations for internal risks** **In place:** • A Regulatory Intelligence unit providing critical regulatory intelligence for internal and external stakeholders. **Planned**: • Detailed stakeholder mapping.
8	**Risk that we may not meet external expectations of us (reputation and perceptions)**	**Amber** Medium impact, possible likelihood	No change	**In place:** • Ongoing engagement with key stakeholders. **Planned:** • Delivery of commitments we have publically made.
9	**Risk that ICT failure impedes our ability to deliver effective and robust services for stakeholders or value for money for the organisation**	**Red** High impact, probable likelihood	New Risk	**In place:** • Management plan for systems failures. • External review of recent failures and updated escalation plan. • Penetration and vulnerability testing. • Automated payments process in place with robust controls. **Planned:** • Investment plan to resolve cyber risks. • IT infrastructure disaster recovery test. • Full penetration testing. • IT strategy an implementation plan. • Plan to improve cyber and other vulnerabilities. • Secure a satisfactory contract with Fortesium.

Key to the risk ratings

The rating table below provides a summary of what the red / amber / green ratings mean. The following scoring tables demonstrate how the scores and therefore ratings are determined. Each risk is assessed and given a likelihood and an impact score.

Rating definitions

Red	A high likelihood that the risk could happen and a huge impact on public protection and the achievement of our objectives if the risk happened.
Amber	A medium to high likelihood that the risk could happen and/or moderate to major impact on public protection and the achievement of our objectives if the risk happened.
Green	A low likelihood that the risk could happen and a low impact on public protection and the achievement of our objectives if the risk happened.

Risk movement

- **No change**: Risk rating has experienced no movement since previous Council meeting.
- **Increased**: Risk rating has increased (either likelihood or impact or both) since previous Council meeting.
- **Reduced**: Risk rating (either likelihood or impact or both) has reduced since previous Council meeting.

Risk scoring

1. Rating the likelihood

Likelihood of risk occurring			
Term	**Score**	**Guidance**	**Evidence**
Very high	**5**	There is **strong evidence (or belief)** to suggest that the risk **will** occur during the timescale concerned. **Typical likelihood of 81-100%**	A history of it happening at the NMC. Expected to occur in most circumstances.
High	**4**	There is **some evidence (or belief)** to suggest that the risk **will** occur during the timescale concerned. **Typical likelihood of 51-80%**	Has happened at the NMC in the recent past. Expected to occur at some time soon.
Medium	**3**	There is **some evidence (or belief)** to suggest that the risk **may** occur during the timescale concerned. **Typical likelihood of 21-50%**	Has happened at the NMC in the past. Can see it happening at some point in the future.
Low	**2**	There is **little evidence (or belief)** to suggest that the risk **may** occur during the timescale concerned. **Typical likelihood of 6-20%**	May have happened at the NMC in the distant past. Not expected to occur for years.
Very low	**1**	There is **no evidence (or belief)** to suggest that the risk **may** occur at all during the timescale concerned. **Typical likelihood of 0-5%**	No history of it happening at the NMC. Not expected to occur.

2. Rating the impact (consequence)

Impact if risk occurs		
Term	**Score**	**Guidance**
Critical	**5**	Critical impact on the achievement of business, project and public protection objectives, and overall performance. Huge impact on public protection, costs and/or reputation. Very difficult to recover from and long term consequences.
Major	**4**	Major impact on costs and achievement of objectives. Affects a significant part of the business or project. Serious impact on output, quality, reputation and public protection. Difficult and expensive to recover from and medium to long term consequences.
Moderate	**3**	Significant waste of time and resources. Impact on operational efficiency, output and quality, hindering effective progress against objectives. Adverse impact on public protection, costs and/or reputation. Not easy to recover from and medium term consequences.
Minor	**2**	Minor loss, delay, inconvenience or interruption. Objectives not compromised. Low impact on public protection and/or reputation. Easy to recover from and mostly short term consequences.
Insignificant	**1**	Minimal loss, delay, inconvenience or interruption. Very low or no impact on public protection, costs and/or reputation. Very easy to recover from and no lasting consequences.

3. Scoring likelihood against impact

Impact							
	CRITICAL	**5**	**5**	**10**	**15**	**20**	**25**
	MAJOR	**4**	**4**	**8**	**12**	**16**	**20**
	MODERATE	**3**	**3**	**6**	**9**	**12**	**15**
	MINOR	**2**	**2**	**4**	**6**	**8**	**10**
	INSIGNIFICANT	**1**	**1**	**2**	**3**	**4**	**5**
		Score	**1**	**2**	**3**	**4**	**5**
			VERY LOW	**LOW**	**MEDIUM**	**HIGH**	**VERY HIGH**
			Likelihood				

Risk scores: **1-8** Green **9-15*** Amber **16-25** Red

* due to their 'Critical' impact, an amber rating is also given to risks which score 5 for Impact and 1 for Likelihood

Item 9
NMC/18/47
6 June 2018

Council

Audit Committee report

Action: For information.

Issue: Reports on the work of the Audit Committee.

Core regulatory function: Supporting functions.

Strategic priority: Strategic priority 4: An effective organisation.

Decision required: No decision required.

Annexes: None.

Further information: If you require clarification about any point in the paper or would like further information please contact the author named below.

Secretary: Fionnuala Gill
Phone: 020 7681 5842
fionnuala.gill@nmc-uk.org

Chair: Marta Phillips

Context:

1 Since the last report to Council, the Audit Committee met on 25 April 2018.

2 The Committee noted that this was Maureen Morgan's last meeting as a member of the Audit Committee and thanked her for her valuable contribution to the Committee's work.

Four country factors:

3 None directly arising from this report.

Discussion:

Audit Committee training and effectiveness

4 The Committee undertook its annual review of its own effectiveness, assessing itself against the National Audit Office checklist for Audit Committee effectiveness.

5 Members of the Committee agreed to look further at training needs with a view to ensuring the continuing improvement of the Committee.

Internal Audit effectiveness for the year to March 2018

6 The Committee considered the annual review of Internal Audit effectiveness, reflecting performance in the year to 31 March 2018. Some areas for improvement were identified, including for management, and these will be taken forward with the new Internal Auditors.

Internal Audit work programme 2017–2018

7 The Committee considered an update on the Internal Audit work programme 2017–2018 and was pleased to note that all programmed audits had been completed. There were two audit reports outstanding which will considered by the Committee in June 2018.

8 The Committee considered four Internal Audit reports. These covered Fitness to Practise (FtP) hearings costs, core controls in Human Resources (HR), contract management and Internal Audit recommendations follow up. The Committee also considered Internal Audit management letters following reviews of the accruals process for FtP legal costs and the accruals process for directorates.

9 The Committee received an update on actions taken to address Internal Audit recommendations in relation to incident management, communication and IT systems. The Committee continues to maintain a strong focus on this area and is monitoring progress closely.

10 The Committee was pleased to note that the recommendations of Internal Audit were being taken seriously and that the reports showed improvements across a number of areas. In future the Committee has asked that more detail be included in the reports on the management response to each recommendation. The Committee continues to monitor progress on clearing Internal Audit recommendations.

Internal audit work programme 2018–2019

11 The Committee approved the Internal Audit work programme for 2018–2019, which reflected changes requested by the Committee in February 2018.

Cyber security

12 The Committee continues to monitor the mitigation of risks identified in the Infrastructure and Capability Internal Audit review of September 2017.

13 The Committee was pleased to receive a report on a self-assessment of our cyber security framework against the National Audit Office guidance: *Cyber security and information risk guidance for Audit Committees*, which it had previously asked to be undertaken.

Annual review of risk management effectiveness

14 The Committee considered an end of year review of the effectiveness of risk management. The Committee suggested further focus on risk ownership below Council and Executive level, staff awareness of escalating risks and staff training in risk management.

Draft Internal Audit Opinion and draft Annual Governance Statement 2017–2018

15 The Committee reviewed a draft of the annual Internal Audit Opinion and report for 2017–2018. The Committee noted the Internal Auditor's view that the risk and control environment remained at the same level as 2016–2017.

16 Some key areas were identified as requiring sustainable improvements in risk and control resilience, which would need to be embedded and sustained.

17 The Committee recognised the draft annual Internal Audit Opinion as a fair and accurate reflection of the current position.

18 The Committee also considered a draft of the annual governance statement for inclusion in the statutory annual report and accounts. Some suggestions and additions were proposed by the Committee which will be taken on board in the next iteration.

Whistleblowing annual review and report 2017–2018

19 The Committee considered the annual report on the use of the whistleblowing policy during 2017–2018 and noted that there had been no invocations of the policy during the year.

20 The Committee was pleased to note that Whistleblowing training provided by Public Concern at Work had been rolled out to staff

throughout April 2018. The Committee asked that attendance at the training sessions be monitored to ensure that all staff who should attend take advantage of the opportunity to do so.

Anti-fraud, bribery and corruption annual review and report 2017–2018

21 The Committee considered a report on issues and actions in 2017–2018 in relation to fraud, bribery and corruption.

22 The Committee was pleased to note that there had been no instances of fraud, bribery or corruption reported during 2017–2018.

Serious Event and Data Breaches report

23 The Committee considered a report on serious events and data breaches during the period January 2018 to March 2018. The Committee noted the themes and issues arising from an analysis of the events reported and requested that further assurance be provided at its next meeting on two of the events.

Single tender actions cumulative register

24 The Committee considered a report on single tender actions (STAs) from the period April 2017 to March 2018 and potential forthcoming STAs. The Committee requested further information and will continue to scrutinise rigorously.

Public protection implications: 25 No public protection issues arising directly from this report.

Resource implications: 26 No resource implications arising directly from this report.

Equality and diversity implications: 27 No direct equality and diversity implications resulting from this report.

Stakeholder engagement: 28 None.

Risk implications: 29 No risk implications arising directly from this report.

Legal implications: 30 None identified.