Analysis of potential learning for the GDC from the PSA’s investigation into the NMC in relation to events at Barrow-in-Furness General Hospital

<table>
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<tr>
<th>Purpose of paper</th>
<th>This paper provides an analysis of the potential learning for the GDC from the PSA’s Investigation into NMC in relation to events at Barrow-in-Furness General Hospital (Morecambe Bay)</th>
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<tr>
<td>Status</td>
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<td>Action</td>
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| Corporate Strategy 2016-19 | Patients - Objective 1: To gain a full understanding of patients’ needs and expectations so these can be reflected in all the work we do.  
Professionals - Objective 1: To gain a full understanding of the implications for dental professionals, and current dental practice, of the regulatory decisions we take.  
Professionals - Objective 5: To take timely, fair and proportionate action through our fitness to practise process when dental professionals do not meet the required standards.  
Partners - Objective 3: To work with partners to improve the overall system of handling patient complaints about dental care  
Performance - Objective 3: To be transparent about our performance so that the public, patients, professionals and our partners can have confidence in our approach |
| Business Plan 2018 | 7.1 StB: Improving engagement - Audience engagement and tone of voice  
10.1. StB: Refocussing FTP – End-to-End Review. |
| Decision Trail   | None                                                                                                                                 |
| Next stage       | Further analysis of the PSA’s findings to ensure that relevant considerations are incorporated into the GDC’s End-to-End Review of Fitness to Practise and other initiatives. |
| Recommendations  | The Council is asked to:  
• Note issues and improvement areas identified by the PSA; |
Executive Summary

1.1. In May 2018 the PSA published a ‘lessons learned’ review of the Nursing and Midwifery Council’s (NMC) handling of complaints about midwives at the University Hospitals of Morecambe Bay NHS Foundation Trust (Morecambe Bay) and particularly the Furness General Hospital where 13 babies and mothers died due to poor care provided by midwives between 2004 and 2014.

1.2. The PSA looked at the NMC’s approach to managing complaints; the administration of the cases; and the regulator’s management of relationships with witnesses, registrants and other key stakeholders.

1.3. The PSA found substantial failings in the NMC’s fitness to practice (FtP) processes and concluded that these failings prevented the regulator from acting on allegations of impaired FtP, which delayed the taking of any action to prevent further harm and caused additional distress and suffering to grieving families.

1.4. In their review the PSA identified many issues that have wider application across regulation, and which the GDC needs to consider as we develop work to support Shifting the balance and the End-to-End Review of Fitness to Practise.

1.5. Several of these issues were matters that we had already identified as being of key importance during the development of Shifting the balance and the exploratory work on the End-to-End Review.

1.6. The review also identified issues with the NMC’s fitness to practise process that have direct relevance to the GDC’s own process, some of which are due to the governing legislation. Many of these are matters that we have identified during the discovery phase of the End-to-End Review, through discussions with the public, registrants, stakeholders and staff.

1.7. These include the adversarial nature of the system, and the defensive behaviour which this engenders, the focus on single allegations as opposed to a broader assessment of overall competence/conduct, and the legalistic approach to complaints without adequate consideration of wider fitness to practise questions.

1.8. This paper sets out in further detail key failings identified by the PSA in NMC’s processes, lessons drawn by the PSA from their review for all regulators, and the initial analysis of GDC’s response to these lessons.

2. Introduction and background

2.1. Concerns about deaths of mothers and babies at Morecambe Bay arose between 2004 and 2014 and were subject to several reports, inquests, police investigations, Ombudsman reports and the NMC’s own reports. Independent investigation conducted by Dr Bill Kirkup CBE concluded in 2015 that poor care was provided in cases that resulted in at least 20 deaths of mothers and
babies and in stillbirths at Morecambe Bay and that at least 13 of these were avoidable. A further inquest found that poor care was involved in the death of a baby as late as 2016.

2.2. Three midwives were erased from the register as a result of NMC investigations. One was erased some seven years after her retirement and eight years after the NMC first received a complaint about her; another some eight years after the initial complaint; and the third some 11 years after she was involved in the first death of the baby investigated by Dr Kirkup. Another midwife was suspended, but her suspension subsequently lapsed. During that time, all but the retired midwife continued to practice and were linked to further deaths.

2.3. As the final FtP hearing of a Morecambe Bay midwife approached, the Secretary of State for Health asked the Professional Standards Authority (PSA), which oversees the healthcare professional regulators, to undertake a 'lessons learned' review of NMC’s handling of concerns about midwives at Morecambe Bay.

2.4. The PSA noted at the start of the review that the NMC had a ‘difficult performance history’. Problems with the NMC’s handling of FtP cases had been highlighted by the PSA in each of its performance reviews from 2009 to 2016, in the PSA's investigation of the NMC in 2008 and in the 2012 Strategic Review.

2.5. The PSA began their work in July 2017, after the last hearing concluded, publishing the final review in May 2018. During that time the PSA examined a total of 51 NMC cases relating to Morecambe Bay. They also spoke to the families involved, the police, Dr Kirkup, and the NMC.

2.6. The PSA review found failings in NMC’s processes between 2009 and 2014, and shortcomings in the changes that NMC had introduced since then, including in response to the Kirkup report and the PSA’s Strategic Review in 2012.

2.7. The PSA also sets out a series of ‘lessons learned’ about fitness to practise processes and wider culture within the regulators, to which all regulators should have regard. This learning focuses on:

- record keeping and case management;
- use of and access to clinical expertise;
- better information assessment and management;
- better working with other regulators and stakeholders;
- better engagement with and support for patients and witnesses;
- greater transparency;
- greater focus on effective handling of concerns at local level.

3. **Failings in handling of complaints by the NMC**

3.1. The NMC received their first complaint about a Morecambe Bay midwife in 2009, following the death of a baby in late 2008. The grieving parents complained to the NMC about the poor care provided by several midwives and alleged collusion of midwives with each other and with senior supervising midwives.

3.2. The PSA concluded that in handling this case the regulator failed to appreciate the seriousness of the parents’ allegations of dishonesty and collusion and failed to act even after the coroner suggested in 2011 in their inquest that the midwives ‘colluded’ in their evidence, and even when in 2012 the parents obtained further evidence of collusion and provided it to the NMC.

3.3. The report also concluded that the NMC relied too heavily on its lawyers’ interpretation of its regulatory remit. When the parents asked the NMC to investigate an email which could support their allegation of collusion to cover up poor care, the NMC took their lawyers’ advice to limit the investigation to looking if the language used by midwives in that email was offensive and not to assess possible collusion.

3.4. The PSA listed many missed opportunities to act on the allegations and noted that although during that time NMC did investigate some of the aspects of this complaint, it had repeatedly...
failed to engage with the parents' evidence and to assess critically other evidence available to them.

3.5. In looking at this and other cases the PSA highlighted several issues with NMC’s FtP processes. The issues broadly fall into these categories:

- poor record-keeping
- badly-designed internal processes and FtP structures
- poor communication with patients and inadequate engagement with them and their evidence.

3.6. The PSA’s overarching concern was that the NMC used a very formulaic approach and narrow interpretation of its remit, and that as a result, its FtP process were ineffective in handling large scale serious allegations. This was highlighted by many examples that the PSA had discovered:

- The NMC failed to appreciate the seriousness of allegations of dishonesty and especially allegations of a cover up of poor care and failed to appreciate how these allegations related to patient safety and to public confidence in the profession, these being the NMC’s chief remit. The NMC also failed to use the full breadth of instruments available to them (e.g. interim suspensions) for protection of the public.
- When investigating allegations of poor care NMC took for granted the threshold of proof and availability of information and to inquire if further evidence required to meet the threshold of seriousness existed.
- Where further information became available later, the NMC sought legal advice on whether to re-open cases. When it was advised not to re-open them, the NMC did not consider this against their duty to protect the public.
- In cases where the NMC decided that allegations were serious but outside its remit, no action was taken to make referrals to systems regulators, even though on one occasion the referral were explicitly discussed in a meeting.
- When investigating cases, the NMC often placed too much weight on recollections and evidence of registrants, and side with them when patients’ recollections contradicted it.
- There was widespread lack of communication within and between teams, evidenced by lack of clarity in case histories, lack of understanding by case officers of the severity of cases they were dealing with, lack of capacity to make connections between cases, and several missed opportunities to pursue serious concerns. The PSA notes how on one occasion, the FTP team ignored advice of the midwifery team about a report relevant to a serious allegation of poor care.
- The NMC was reluctant to act on information it had received from the police, even when it related to cases already on NMC’s radar. When the NMC did act, it stayed within the narrow confines of the police investigations. In some cases, NMC ignored statements made by patients to the police or failed to recognise discrepancies between patient and midwife statements in police reports. When deciding to launch own investigations, the NMC did not inform patients who had given statement to the police and did not take new statements from them.
- By delaying their investigations, the NMC put patients at risk of harm as midwives with impaired FtP continued to work for many years. During that time, some of them provided care in further cases of avoidable deaths and some had retired, and the allegations against them could not be investigated. Investigation of cases that had re-opened in 2014 were rushed through, to make up for the delay.
- The design of FtP was not conducive to learning. If a midwife had left the register (either through erasure or retirement), she could not be investigated by the NMC.
This meant that some patients and their families never found out what happened, and that neither the hospital nor the NMC could learn from those cases.

- Poor record keeping meant that it was hard to establish how some decisions within NMC were made and by whom. For instance, the PSA frequently could not find minutes of crucial meetings and conversations referred to in emails in case files.
- Early stages of investigations were hampered by the lack of clinical expertise. As a result, concerns about practice were sometimes not identified and investigated, and clinical experts did not see the full breadth of allegations, as their advice was sought only later in the process, after lay investigators had formulated the allegations.

3.7. When looking specifically at the experience of patients, the PSA found that the NMC failed to consider patients’ recollections, statements and views at appropriate times. This had serious repercussions. In one case, the NMC failed to share registrants’ responses with complainants. Had the responses been shared, the patients would have been able to point out significant discrepancies between their recollections and the registrant’s.

3.8. Some patients told the PSA that they were not kept informed throughout the process and were not provided with adequate information about procedures, which caused them a lot of distress. In several examples, patients who attended hearings did not know that they would be asked questions and cross-examined. In another example, a grieving mother arrived to an NMC hearing in London only to find out that it had already been cancelled.

3.9. Many told the PSA that NMC staff did not treat them as grieving parents or as patients who had come to significant harm, did not provide appropriate support, and often showed no compassion or understanding. Some said they were treated by the NMC with suspicion and as a nuisance, especially if they challenged the regulator.

3.10. In the case of one parent, NMC staff were, to each other, frequently and openly disrespectful when referring to them in internal emails. As investigations progressed, the parent was treated with increasing suspicion and hostility. Their request for subject information access received a poor, if compliant, response, with many documents needlessly redacted or withheld. The NMC’s treatment of this bereaved parent significantly contributed to his stress and suffering and to his loss of confidence in the regulator and contradicted the NMC’s stated aims to be transparent and open.

4. **PSA’s lessons learned and their application to the GDC**

4.1. Concluding the review, the PSA drew several 'lessons learned' about FtP and other processes for consideration by the NMC and other regulators. A number of matters were highlighted as important. These were:

- Accurate and complete record-keeping to maintain focus on the issues and actions in a case;
- Access to expertise, clinical advice and support, and adequate time for those who investigate and analyse cases to identifying the concerns and following them through properly;
- Close working with other regulators and stakeholders to ensure that other investigations don’t cause delays;
- Looking at all available and relevant information and better sharing of intelligence from any source;
- Working with other regulators to address concerns about patient safety;
- Engagement with patients, witnesses and service users, of informing them of the process and of analysing and taking their evidence seriously, to help better identify problems and hold public confidence;
4.2. The publication of the report provides the GDC and other regulators with potentially useful insight into the impact that an over-reliance on rigid procedures and mechanisms can have on the outcome of investigations and, therefore, on the meeting of our statutory objectives.

4.3. As set out above, there were many issues identified by the PSA that have wider application across regulation, and which we need to consider in the development of the work to support Shifting the balance and the End-to-End Review of Fitness to Practise.

4.4. Several of these issues were matters that we had already identified as being of key importance during the development of Shifting the balance and the exploratory work on the End-to-End Review.

4.5. The End-to-End Review Programme Board at its meeting in July commissioned a ‘gap analysis’ to be undertaken to ensure the scope of the programme adequately provided a robust response to identified issues requiring action. The methodology that will be adopted is as follows:

4.6. All learning points will be evaluated to identify if:

- The current FtP operation is robust in the face of feedback;
- Currently planned activities within the programme fully address any current shortfall in an acceptable timescale;
- Insight would suggest a change of emphasis or priority for action or;
- Additional activity would be required to ensure our performance would meet requirements.

4.8. This analysis together with any subsequent proposal for the change of programme scope with associated resource reallocation is planned to be completed by 13th August.

4.9. Initial consideration of these issues suggests that we should incorporate them into existing work programmes/business as usual in the following ways:

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<tr>
<th>Topic</th>
<th>Lessons learned</th>
<th>Initial GDC response/action</th>
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<tr>
<td>Record-keeping</td>
<td>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.</td>
<td>To ensure this is underlined through standard operating procedures, staff training and the development of processes as part of the End-to-End Review.</td>
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<td>Identification of the issues</td>
<td>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.</td>
<td>This has been addressed to a significant degree by the GDC through the introduction of clinical advisers and the changes implemented within the initial assessment team, particularly the Initial Assessment Decision Group. This daily meeting of a clinician, lawyer, member of policy, casework manager and caseworker provides very early insight and shape to subsequent FtP activities. In addition, one output from this meeting is that all cases are subsequently</td>
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“streamed” according to various parameters including seriousness, urgency and linked cases. As the End-to-End Review develops such a collaborative decision-making body may be deployed further in the process at Assessment stage.

<p>| 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. | This will be addressed as a key consideration of the work on developing a model for complaints handling under the <em>Shifting the balance</em> programme. It is also an important part of the work that has taken place under the auspices of the Regulation of Dental Services Programme Board (RDSPB), which continues to be monitored via the Risk and Oversight Group, chaired by the GDC and attended by the CQC, the NHS Business Services Authority and NHS England. Similar mechanisms should be established in each of the four nations, as per the ambition set out in <em>Shifting the balance</em>. |
| 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. | Again, this has been addressed in part via the work undertaken by the RDSPB. Further work on the use of data and intelligence, particularly in feeding learning from FtP back to the profession and using it internally will be undertaken as part of the data and intelligence action plan, which will be developed once key staff are in post. Within FtP the GDC has begun deploying a monthly Registrant Management Committee. This committee considers all registrants who have a threshold number of active cases within FtP to ensure our response is proportionate and focused at a strategic level. This has seen an enhanced focus and understanding of broader matters of concern. |
| Working with others | Regulators must work with others in the health and care system to address concerns about patient safety. | One of the four pillars of <em>Shifting the balance</em> relates specifically to better partnership working: with employers, with the NHS, and with system regulators in each of the four nations. The work ongoing under this pillar, including the development of referral protocols, risk management structures (with the CQC and NHS in England), as well as the development of guidance for employers at least partially addresses this. Work is underway to develop more comprehensive systems across the UK. This aspect of the report will be taken to the <em>Shifting the balance</em> programme board |</p>
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<th>Section</th>
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<th>Involvement</th>
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<td>The treatment of the families</td>
<td>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.</td>
<td>This is being addressed under both our audience engagement project and as part of the work on the End-to-End Review. It was a key element highlighted by staff and by patients in the discovery phase of the End-to-End Review and it will be incorporated into relevant workstreams.</td>
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<td>Transparency</td>
<td>Regulators should aim to publish as much as they legitimately can so that they can improve public confidence through transparency.</td>
<td>This was one of the issues that was highlighted in <em>Shifting the balance</em> and formed a significant part of the rationale for our work to improve the information available to members of the public about our processes, as we recognised the need to provide information about processes, possible outcomes and expectations. The scale of that work is significant and ongoing. The findings of the report will be incorporated into that work programme. The End-to-End Review will address our whole communication strategy including all publicly facing information, our website together with all written and spoken communication to aid transparency.</td>
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<td>Flaws in the fitness to practise system</td>
<td>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.</td>
<td>Again, this is a key element of <em>Shifting the balance</em> and resonant with the work on developing the concept of seriousness, and the mechanisms we have for working with partners, only deploying our FtP powers where they are needed. The findings of the report will be used to inform the various workstreams that it speaks to.</td>
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<td>Adversarial nature of the system</td>
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<td>The communications aspects of the End-to-End review will directly address tone of voice and the impact of the current adversarial nature of processes, protocols and practises and seek to evolve these as appropriate in accordance with the direction set within <em>Shifting the Balance</em>.</td>
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<td>Defensive behaviour</td>
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<td>The organisation is actively considering a variety of initiatives regarding building consensus across the profession incorporating matters of seriousness, candour and insight/remediation to find common cause for all parties involved in Fitness to Practise proceedings wherever</td>
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possible and thereby reduce or avoid defensive behaviour.

Looking beyond the single allegation

In addition to the work of the Registrant Management Committee the End-to-End Review is seeking to unlock far more intelligence from the significant body of knowledge and insight gathered during Fitness to Practise investigations as a means of identifying patterns, trends and anomalies/outliers that would merit further investigation.

Narrow vs Broad focus

We continue to evolve our approach within the Shifting the Balance programme to ensure that we deploy the fullest possible set of tools and techniques at our disposal both to gain insight into individual or linked matters and from this to draw broader conclusions/insight that can positively impact the frequency and seriousness of deficient practise or conduct. By example, our work in association with Professor Simon Wright into Human Factors as a cause of error and patient harm with the subsequent opportunity to take positive action to prevent the frequency and extent of harm arising from these issues.

5. Risks and considerations

5.1. We are alive to the opportunity presented by this rich analysis of a whole range of issues, many of which have directly analogous equivalents within our remit. The Executive are mindful of the need to balance speed of action, quality and depth of analysis and impact on other work priorities when making commitments in response to the PSA review.

5.2. The initial response to focus on the Shifting the Balance and End-to-End Review programmes seeks to strike an appropriate balance and this will be further assessed once the gap analysis outlined above has been completed.

6. Recommendations

6.1. The Council is asked to note the summary of the report and the initial analysis of the ‘lessons learned’ as they apply to the GDC and its processes.

7. Internal consultation

7.1. The initial summary and analysis has been shared with the Executive management team and discussed at the most recent meeting of the End to End Review Project Board meeting.

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<tr>
<td>Cross-departmental</td>
<td>End to End Review Project Board, 9 July 2018</td>
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