Item 7
NMC/18/56
25 July 2018

Council

Lessons Learned review: Putting patients and the public at the heart of what we do

Action: For decision.

Issue: This paper sets out our proposals for learning lessons from our handling of fitness to practise concerns about midwives at Furness General Hospital. It also takes into account the key learning we have identified from the Gosport Independent Inquiry.

Core regulatory function: All regulatory functions.

Strategic priority: All strategic priorities.

Decision required: **Recommendation: the Council is invited to discuss and approve our proposed approach and our programme of work (paragraph 23).**

Annexes: The following annexe is attached to this paper:

- Annexe 1: Programme of work

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 On 6 June 2018, the Council fully considered and discussed the Professional Standards Authority's (PSA) Lessons Learned Review of the NMC's handling of concerns about midwives' fitness to practise at Furness General Hospital, during which the Council apologised unreservedly to the families for not listening to them; not acting on credible evidence and for the multiple missed opportunities. Our failures to act and subsequent delays meant some midwives continued to practise who may not have been safe to do so and mothers and babies may have been at risk during this period.

2 Since the Council's last meeting, the Gosport Independent Inquiry Report was published on 20 June 2018. We have reviewed that report to consider what action is necessary. Themes in the report resonate with the Lessons Learned review, particularly around our engagement with families and relatives. We have written to the families involved and hope to work with them as we take forward next steps.

Four country factors:

3 Not applicable for this paper.

Discussion:

4 Since the publication of the lessons learned review, we have written to all the families affected by the tragic events and said sorry for the way in which we treated them. We have offered to meet with all of them either as a group or individually, and some meetings have taken place. Hearing from the families and asking them to share their experiences with us is the first and most important stage in helping us shape our future strategy of putting patients and families at the heart of what we do.

5 At pace, we are committed to a wide ranging programme of work to move forward in response to the lessons identified in the review.

6 Our immediate activity has focused on the two key priorities identified in the lessons learned review, that of improving how we engage with and listen to patients and the public day to day, specifically in the context of fitness to practise, and being open and transparent.

7 Underpinning this work we are:

7.1 Taking a person-centered approach through our new Fitness to Practice strategy, and by setting up the Public Support Service.

7.2 Putting a presumption of transparency at the heart of our corporate values and developing new approaches to ensure we are open and honest when things go wrong.

7.3 Putting a renewed and reinvigorated emphasis on the importance of living our values and behaviours.

7.4 Engaging systematically with patients and public groups to inform our work going forward across all areas of the NMC.

7.5 Scoping a programme of work to engage with stakeholders about the value of patient and public voices in regulation.

7.6 Committing to maintaining and continually reviewing areas which were identified in the PSA report as having improved.

8 As part of our approach to being as transparent as possible we will be reporting to the Council on an ongoing basis as we deliver our programme of work. We will have clear plans for each of our specific proposals setting out how they will be achieved, the timelines involved, how we will measure success and who will be responsible for delivery. The Council will wish to update and share progress with the PSA.

Putting patients, families and those who raise concerns at the heart of what we do

A new strategic direction for Fitness to Practice

9 Our proposals for a new strategic direction for fitness to practise are on the agenda for the July Council meeting. We have undertaken a full public consultation, completed qualitative research with members of the public and other stakeholders, and have considered carefully the learning from the Lessons Learned Review. Our proposals will protect the public by:

- Putting individual patients and families at the centre of how we work.
- Contributing to a just culture in health and social care.
- Supporting nurses and midwives to practise safely and professionally.

The Public Support Service

10 We have set up a Public Support Service (PSS) which will lead our work to embed a person-centered approach in the organisation to:

10.1 Put patients, families, carers and the public at the heart of the way we operate and the support we offer.

10.2 Support people who are involved in our cases to make sure they are protected, valued, cared for, respected and held as important partners throughout the fitness to practise process.

11 In the lessons learned review, this service was seen as integral to us being able to show that we have genuinely learned from these

events. To achieve this, the Council will want to be assured of the aims and objectives and how they are being measured. We have scheduled a discussion with the Council on the Public Support Service for September 2018. The steps we are taking to set up the service include:

11.1 Having appointed a Head of the PSS, we are now recruiting the core public support team. We expect to have completed this by September 2018.

11.2 Setting up a steering group including patient groups and experts to guide set up and delivery of the service.

11.3 Training fitness to practise colleagues to identify vulnerable people and to support them appropriately.

11.4 Improving the information we provide for patients, families, and the public. Improved information will be published on our website by the end of July 2018. We are also producing a film for witnesses which we expect to publish on our website in August 2018.

11.5 We have developed a tailored needs assessment for individual members of the public who make referrals to us. The needs assessment will ensure that we are listening to and addressing each individual person's needs and concerns and it will drive improved communication throughout the case lifecycle. We will start to introduce this, together with an introductory telephone call from the case officer at the point we receive a referral, from August 2018.

11.6 Designing a pilot programme offering meetings at the start and end of the investigation with members of the public who have made a referral. We expect the pilot to begin in October 2018 and to last for 12 months. We will review the outcomes of the pilot before deciding whether to implement in full.

Improving the way we communicate with people every day

12 We are only as good as our last letter, phone call, contact and face to face meeting. In the lessons learned review, our letters to the bereaved families were cold and unhelpful. In many cases, it was difficult for the person on the receiving end to know what was going to happen and by when. The language we used was bureaucratic and legalistic. At pace, we will review all our correspondence and letters to make sure they are clear, empathetic and offer the right level of support. We have begun work on a new "tone of voice' which will help shape all our communication across the NMC.

Improving our approach to transparency

Being open, approachable and helpful

13 A strong theme emerging from the lessons learned review was that we failed to be open with the families when things went wrong. We had opportunities which we failed to seize upon when we knew things had gone off track. We must make sure that in the future we are open with people when things go wrong.

14 As such, we are now putting at the heart of our corporate values a presumption of transparency. This means that when people ask us for information or make a complaint about something we have done, our starting point must be that we will be as transparent as we possibly can be. This applies to all aspects of our work including, especially, handling corporate complaints from which we can learn many lessons about us and our procedures and how we can do better.

15 At pace, we will implement a new approach to handling enquiries, information requests and corporate complaints with a focus on effective triage, first line resolution, mediation, quality investigations and customer focused responses. We want to support people to gain access to the information they need before they need to put in a formal request or raise a complaint. We will also explore options for an independent third party to review our handling of corporate complaints at the end of the process.

Values and Behaviours

16 What the lessons learned review showed us was that we failed to engage with and listen to those who come into contact with us. There was very clear evidence that we were either dismissive or we ignored concerns from bereaved and distressed families. Never again should we find ourselves in the position where we are ignoring those who most need our help in a time of need. This clearly demonstrates that we have an urgent need to work with our employees to discuss the findings of the review in detail and what changes we need to make together so that we demonstrate empathy and understanding for those we are working with and supporting.

17 Ensuring we treat individuals with respect every day goes to the very heart of our values. Our work in this area will start with a reprioritisation of our People Strategy so that our immediate focus is a programme of events across the organisation to work with our teams to embed our values and behaviours in our work.

Other priorities

Giving the Council more assurance and oversight of fitness to practise

18 One of the questions the Council debated at the meeting in June 2018 is how to gain greater assurance in the work of fitness to practise. In other words: how could the Council assure itself that these events will never happen again.

19 As part of the development of the new strategic direction for fitness to practise, we have consulted on the key principles that will guide our approach, as well as a programme of work for fitness to practise. We have reflected on the Lessons Learned Review in developing our final proposals for Council's approval elsewhere on the agenda.

20 There is scope for greater independent assurance of the fitness to practise process to be available to management and to the Council. We are developing a plan for the Audit Committee to approve in October 2018 aimed at ensuring there is the right level of independent assurance over our performance against learning from the Lessons Learned Review and the PSA Standards of Good Regulation.

Considering the lessons learned in everything we do

21 **Annexe 1** summarises the key things we are doing now to incorporate the lessons across our work.

22 The learnings from what happened at Morecambe Bay will also inform the work we are doing to reshape the future of midwifery education in the UK. The learning will be part of the evidence base that informs the development of the new midwifery proficiency standards.

23 **Recommendation: the Council is invited to discuss and approve our proposed approach and our programme of work.**

Public protection implications:

24 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:

25 The new activity we are proposing and the re-prioritisation of other activity will have resource and capacity implications. These will be discussed with the Council separately.

Equality and

26 We recognise we need to engage on our future plans as widely as

diversity implications:		possible to ensure all sections of our workforce and the wider community have the opportunity to contribute. Working across diverse groups will be built into our detailed plans.
Stakeholder engagement:	27	We hope to continue to engage with the families as we take forward our programme of work, which also commits us to a wider programme of public and patient involvement as we develop our plans.
Risk implications:	28	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. As we take forward the action plan, we will reflect any new controls in our assessment of the risk.
Legal implications:	29	All changes we make will be discussed with our legal team to ensure they remain in line with our statutory obligations.

Item 7: **Annexe 1**
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Lessons Learned: Proposed Programme of Work

What we are doing now

Lessons learned	How we are responding	What does success look like?	When we will report back
Putting patients, families and those who raise concerns at the heart of what we do	• We are taking a person-centred approach to fitness to practise. • We are setting up a Public Support Service. We have appointed an experienced lead who is already supporting fitness to practise colleagues to engage better with individual members of the public. Recruitment of the core public support team is expected to be complete by September 2018. • We are setting up a steering group, including patient groups and experts, to guide set up and delivery of the service. The first meeting of this group will take place in September 2018. • We established a network of 55 public support champions in the fitness to practise directorate in July 2018. They will receive full training on our approach in August 2018. • We are engaging with fitness to practise	Taking a person-centred approach to fitness to practise will help us to properly understand what has happened, to make sure concerns raised by patients and families are properly listened to and addressed, and to explain to them what action we can take and why.	Full report to Council in September 2018

	colleagues and panel members in July 2018 to seek their input and ideas for change and improvement. • All fitness to practise employees will receive training from September and this will be built into our standard induction and development going forward. • We have reviewed the information about fitness to practise we provide for members of the public. Improved information will be published on our website by the end of July 2018. • We are producing a film for witnesses which we expect to publish on our website in August 2018. • We have developed a tailored needs assessment for individual members of the public who make referrals to us. The needs assessment will ensure that we are listening to and addressing each individual person's needs and concerns and it will drive improved communication throughout the case lifecycle. We will start to introduce this, together with an introductory telephone call from the case officer at the point we receive a referral, from August 2018. • We are designing a pilot programme offering meetings at the start and end of the investigation with members of the public who have made a referral. We expect the pilot to begin in October		

	2018 and to last for 12 months. We will review the outcomes of the pilot before deciding whether to implement in full.		
Improving the way we communicate with people every day	• We are reviewing all our correspondence and communication to make sure it is clear, helpful and easy to understand. • We have increased the pace of this programme of work, which includes providing guidelines, training and a network of champions to help colleagues improve how they communicate with all those who come into contact with us.	We will adopt a consistent, empathetic and clear approach in all our communications that reflects what it means to be a modern regulator: • We are approachable • We show empathy • We are helpful	We will report to the Council on progress in November 2018
Being open, approachable and helpful	• Being open and honest when things go wrong by putting a presumption of transparency at the heart of our corporate values. • Implementing a new approach to handling corporate complaints with a focus on: o Effective triage o First line resolution o Mediation o Quality investigations • Exploring options for an independent third party to review our corporate complaints at the end of the process if the complainant does not feel we have addressed the issue.	A new process for capturing and analysing customer feedback from across the organisation. We will have greater transparency and understanding of the information people want from us and the reasons they complain. We will be sharing more information on our website, informed by what our customers want to know.	Interim improvements bringing key work into one team during August 2018 First changes to our approach to requests for information in August 2018 Full proposals for change to Council in September

		We will have fewer complaints and greater levels of customer satisfaction.	2018.

Strategic next steps

Lessons learned	How we are responding	What does success look like?	When we will report back
Values and behaviours	• Renewing our commitment to treat everyone who comes into contact with us with respect, compassion and empathy by firstly revising approach to our People Strategy. • We will reprioritise the People Strategy focusing on: o delivery of a programme of events across the NMC to work with employees on embedding our values and behaviours. o A refreshed approach to recruitment and induction with a greater emphasis on our values and behaviours.	Our employees and the people we recruit will respect and empathise with everyone we engage with. All staff will have discussed the Lessons Learned Review and input into next steps. On annual employee appraisals will assess whether people have demonstrated the values and behaviours we expect.	Employee event programme will be developed in August and September 2018 Programme launch October 2018 All employee Conference November 2018 New recruitment and induction in place October 2018
Strategic engagement with	• We are developing a programme to listen to	The voices of patients,	We will discuss

patients, families, and members of the public	patients, families, and public groups to inform our work going forward across all areas of the NMC. • We will work with other regulators, representative groups and individuals to develop our approach to valuing patient and family voices in regulation.	families, and the public will shape what we do. The patient safety community working with us to change and improve regulation.	our plans with the Council in September 2018

How we will maintain and improve

Lessons learned	How we are responding	What does success look like?	When we will report back
Governance	• We have consulted on the key principles that will guide our approach and a programme of work for a new approach to fitness to practise. • We are developing a plan for greater independent assurance for the executive and the Council regarding our performance in fitness to practice against the lessons learned and the PSA Standards of Good Regulation.	Council has greater assurance and oversight of the way we do fitness to practise.	Fitness to Practise Strategy to Council July 2018 For Audit Committee approval – October 2018
Record-keeping	• We have introduced a common objective for fitness to practise teams to ensure that decisions and rationales are clearly recorded. We will monitor this through our quality management framework. • Our new ICT strategy places greater emphasis on	We continue to improve our record keeping.	Reporting through standing Council reports. Council will consider the IT

	the quality and accuracy of the data that we hold. This will enable better record keeping and quicker reporting.		Business Case at its July 2018 meeting
Identification of the issues	• We are recruiting dedicated clinical advisers and are creating a toolkit for colleagues so they can recognise when clinical advice is required and can access it appropriately. • We will evaluate the progress of the complex and high profile cases team and decide whether any changes need to be made as part of the business planning process for next financial year. • We are retendering for investigation services. We have updated the invitation to tender so that it includes a requirement for firms to adopt a patient/family centred approach.	Colleagues have access to clinical advice and other specialist input they need to help them identify regulatory concerns and manage cases effectively.	Clinical advice: September 2018. Complex and high profile cases team: as part of business planning cycle. Investigations tender: September 2018.
Working with third party investigators	• We have reminded staff about the criteria for putting cases on hold and are undertaking additional management checks. • We will undertake an internal quality assurance review on managing cases subject to third party investigations in Q2 2018–2019.	Our proceedings go ahead without delay. Cases are only put on hold where there are clear and compelling reasons to do so.	Exception reporting through standing Council reports.

Looking beyond individual cases	• The Employer Link Service was established in 2016 and the Regulatory Intelligence Unit was established in 2017. • The annual report on the Employer Link Service and Regulatory Intelligence Unit will enable the Council to have assurance over activities in 2017–2-18 and plans for 2018–2019. • To expand our network, we have recruited two new Regulation Advisers who will join the Employer Link Service on 20 August 2018.	We share intelligence internally and with other regulators to make sure that patient safety concerns are identified and dealt with effectively.	The Council will discuss the annual report on the Employer Link and Regulatory Intelligence Service in September 2018.
Working with others	• We have memoranda of understanding in place with a range of different organisations so that we can better share information. • We will report on our work with other regulators as part of the Employer Link Service and Regulatory Intelligence Unit annual report.	Closer working with others in the health and care system to address concerns about patient safety.	The Council will discuss the annual report on the Employer Link and Regulatory Intelligence Service in September 2018.