THE ROYAL COLLEGE OF MIDWIVES

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ANALYSIS OF RCM MIDWIFERY CASES AT NMC

A report for RCM staff, activists and Heads of Midwifery.

INTRODUCTION

The Nursing and Midwifery Council (NMC) regulates midwives and nurses in England, Northern Ireland, Scotland and Wales. It exists to protect the public, through setting standards of education, training, conduct and performance, by investigating allegations that an individual has fallen short of those standards and taking appropriate action. Every midwife and nurse is expected to be able to demonstrate her/his fitness to practice through possessing the skills, knowledge, good health and good character to do their job safely and effectively. Failure to be able to demonstrate fitness to practise can ultimately lead to removal from the register and therefore the inability to work as a midwife or nurse.

A referral to the NMC's Fitness to Practice investigation process is therefore a very serious matter; it is potentially career ending. The Royal College of Midwives (RCM) is the professional body and trade union representing the UK's midwives and maternity team. Our role is to represent members referred to the NMC, to ensure that they experience an open, transparent and fair process, that they have every opportunity to give account of themselves and their actions and that justice is done. The RCM does not defend poor practice and indeed may choose not to represent a member in circumstances that would bring the RCM and profession into disrepute, for example a midwife already found guilty of a serious criminal charge.

Until very recently the NMC has not been able to distinguish between nurses referred to the NMC and the much smaller number, given their much smaller overall number, of midwife referrals. It has therefore been impossible to analyse the causes and characteristics of midwife referrals and learn lessons that might prevent future cases.

The RCM represents 91% of the UK's midwives; it is therefore likely that we represent a significant proportion of midwives referred to the NMC. This gives us access to a wealth of data on the demographics and experience of midwives referred and the opportunity to review whether the process works fairly and justly for all midwives.

METHODOLOGY

A senior experienced midwife with a background both in professional advice and employment relations was asked to review all RCM held case files for NMC referrals closed as completed between January 2013 and June 2015. A research template was developed to allow standardised collection of data covering the personal characteristics of the midwives referred, the causes and background to referrals, the progress of each case through to its conclusion and outcomes. The RCM's data analyst conducted both single and multi-variable analysis in order for us to build a picture not just of the most common or average factors associated referral but also to test some implicit assumptions.

RESULTS

1. The sample

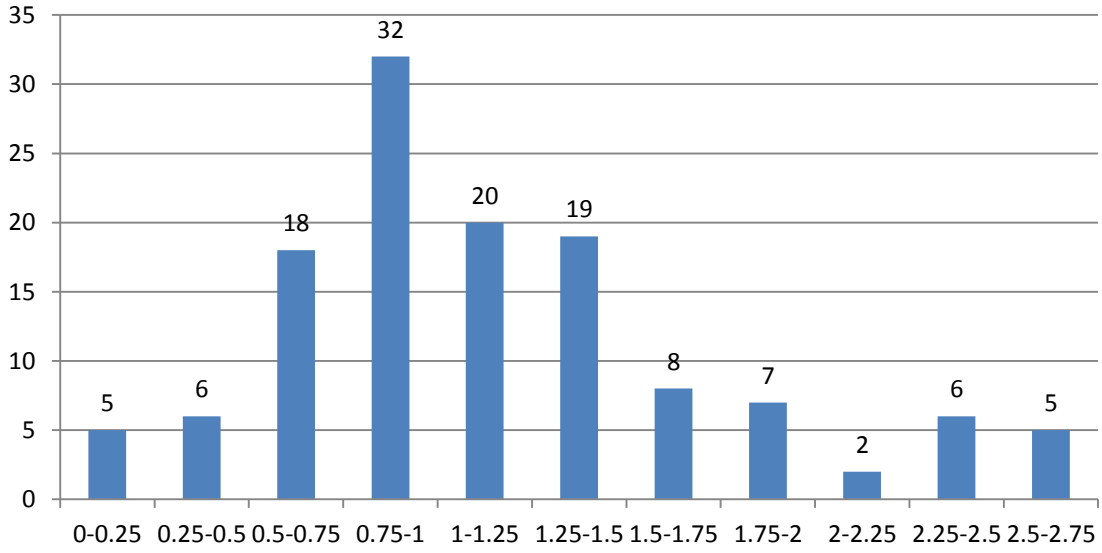
Our 149 cases comprised RCM members whose referral to the NMC was completed and the case closed, at any point between January 2013 and June 2015. This included both recent and historic referrals.

Table 1: Date of Referral

Date	Count	%
Before 2010	11	7%
2010	6	4%
2011	27	18%
2012	39	26%
2013	33	22%
2014	31	21%
2015	2	1%

With almost 30% of these cases made up of referrals made before January 2012, we wanted to know how long cases take from point of referral to point of resolution.

Figure 1: Length of case from referral to completion in months
n=146 (3 cases omitted due to inaccurate data)



This indicates that only 55% of all NMC midwifery cases are being processed within their own target of 15 months. This is highly significant in terms of the effectiveness of the

regulator in protecting the public and in terms of the personal impact referral has on individual midwives. Both deserve a swifter process. Later we explore whether there are common factors linking the cases which are taking the NMC so long to action.

2. General profile of Midwives Referred.

From the data available we have built a simple profile of the characteristics of a midwife referred to the NMC.

The average midwife referred to the NMC is 50 years old and has been practising for 20 years. She is white British and works full time as a Band 6 hospital midwife. She is more likely than to be dual qualified, i.e. also hold a nursing qualification, works a mixed shift pattern and has already been subject to a disciplinary or supervisory investigation. Referrals originate in roughly equal numbers from employers, the LSA and the public and most referrals are ultimately found no case to answer. The proportion of cases referred by the public fell significantly in 2014 but rose again in 2015. Overwhelmingly the incident(s) promoting referral occurred during the midwife's current employment. It is most likely that the result of referral will be a finding of no case to answer.

The most common factors associated with all midwife referrals are:

- Lack of competence
- Attitude and behaviour
- Failure to escalate/failure to seek medical advice
- Failure to monitor mother/baby adequately or failure to perform observations
- Inadequate record keeping
- Medication errors
- Failure to interpret CTGs

It is uncommon for midwives to be referred for:

- Theft
- Inappropriate use of social media
- Fraud
- Breaching confidentiality
- Sleeping on duty
- Health

Figure 2: Age at Referral
n=149

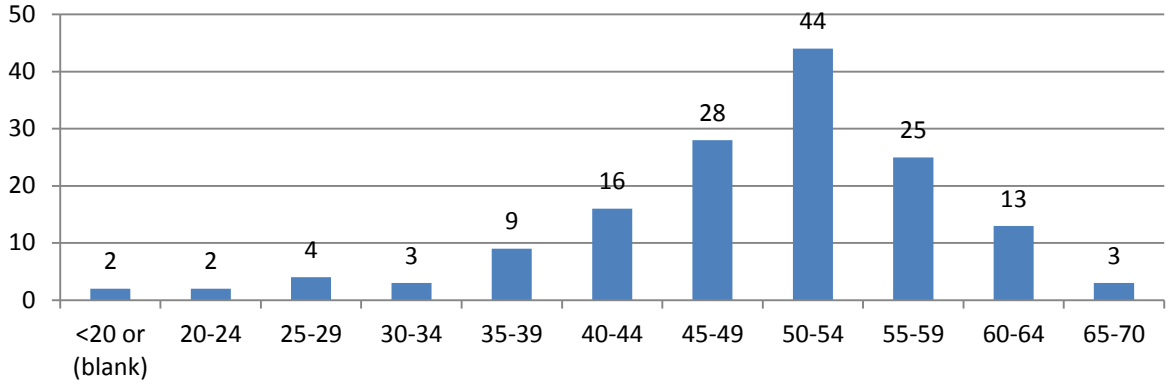


Figure 3: Total Years Practicing
n=149

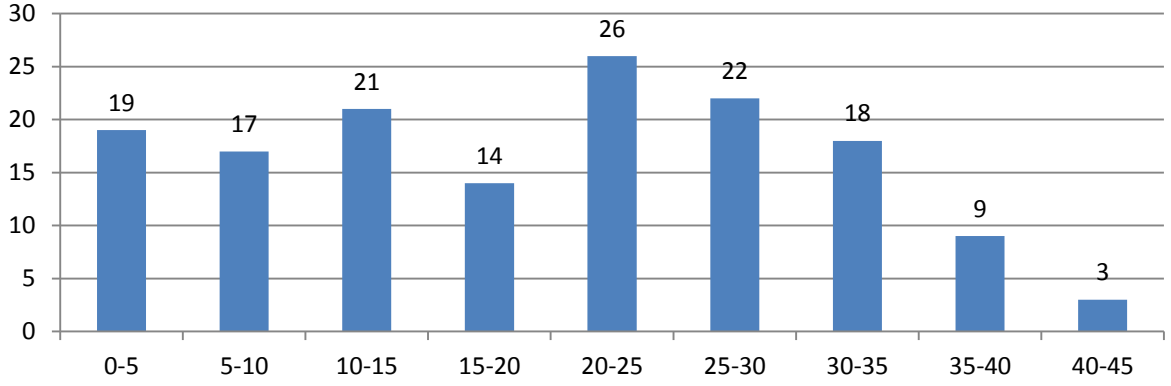


Figure 4: Banding
n=149

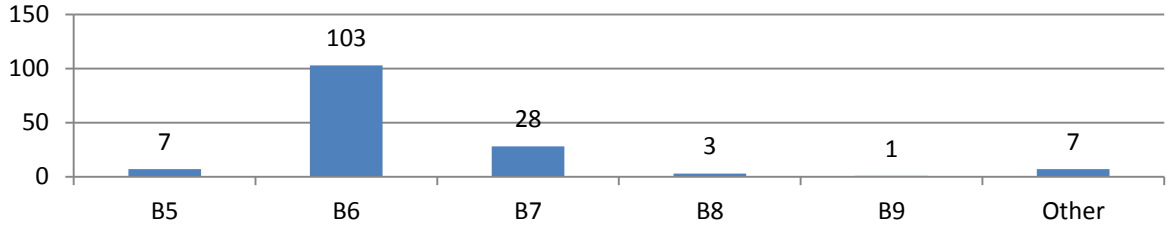


Figure 5: Working Hours
n=149

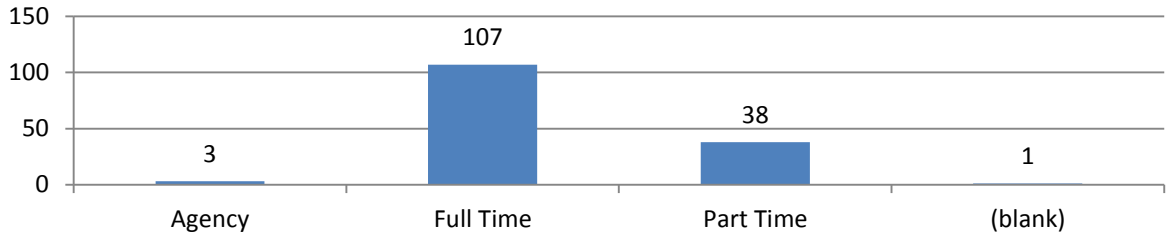


Figure 6: Ethnicity of midwives referred to the NMC
n=149

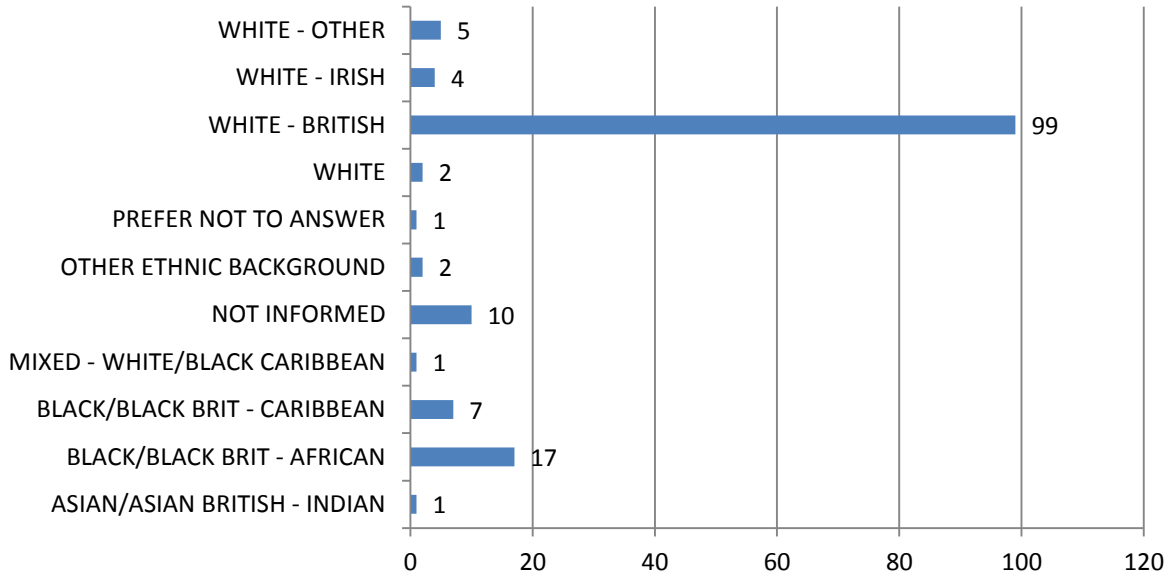


Figure 7: Shift pattern
n=149

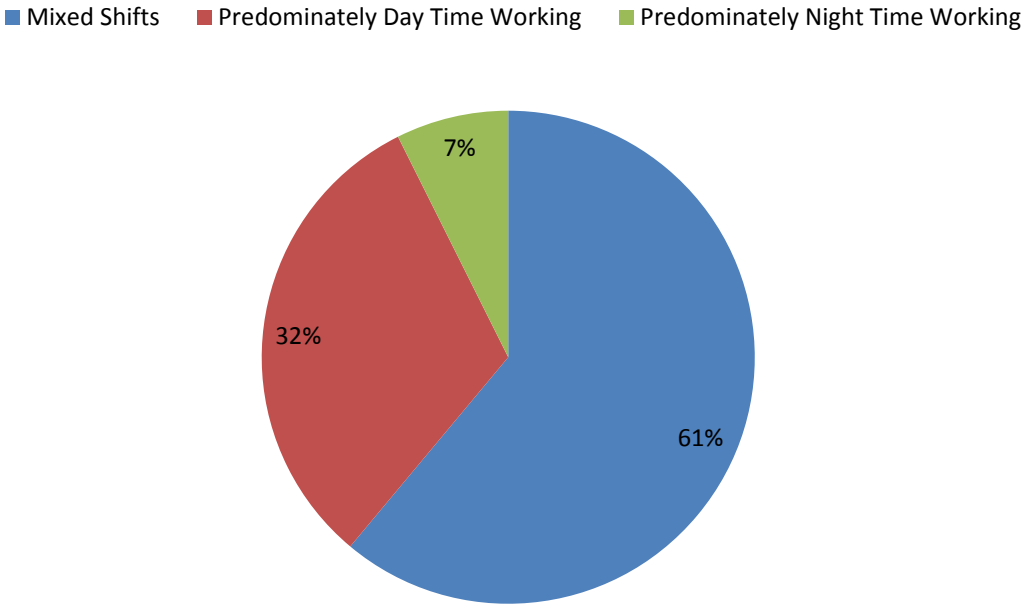


Figure 8: Qualification Status; midwife vs midwife/nurse
n=149

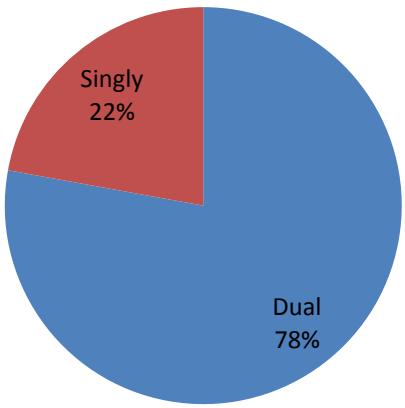


Figure 9: Previous supervisory investigation
n=149

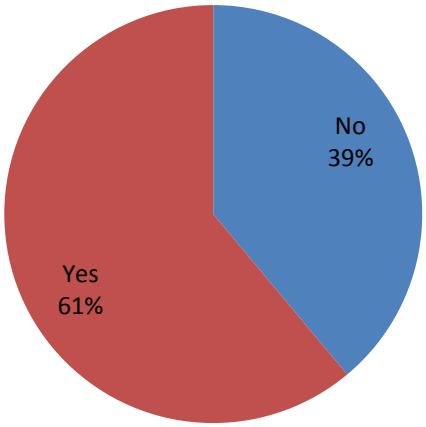


Figure 10: Source of Referral
n=149

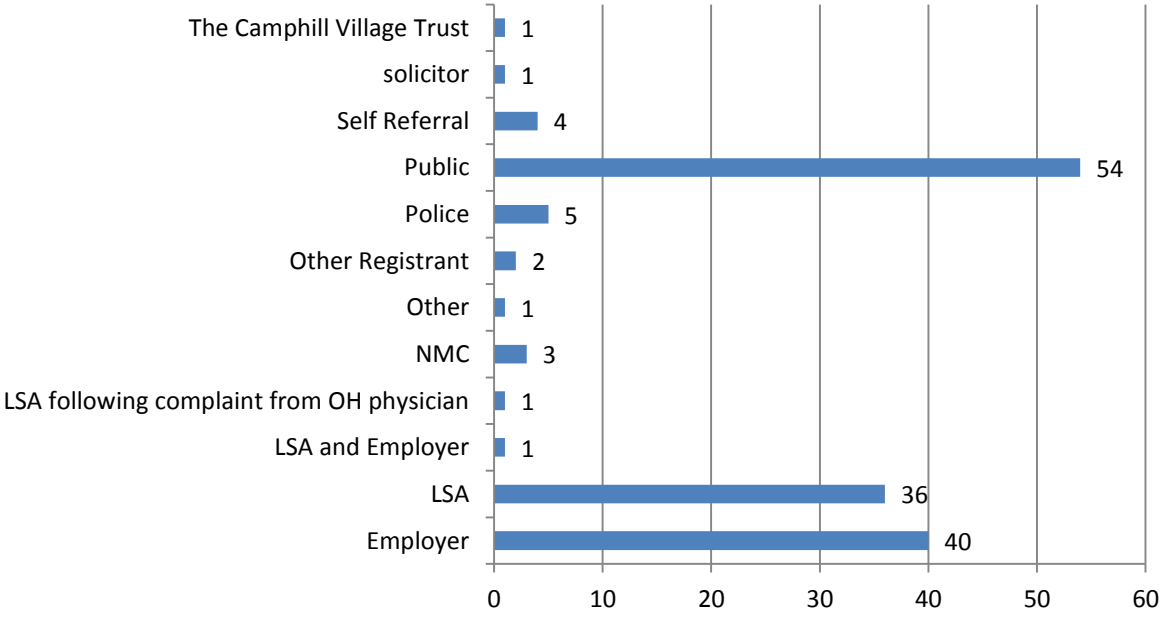
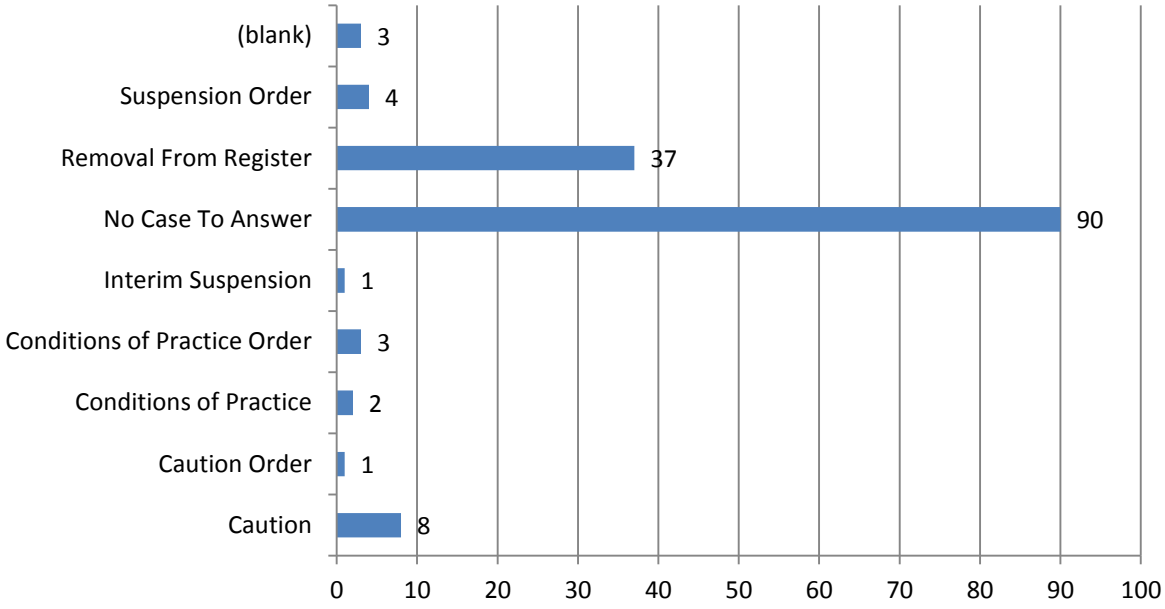


Figure 11: Case Outcomes
n=149



ANALYSIS

1. The link between age and experience?

Our analysis indicates that it is generally older and more experienced midwives who are referred to the NMC. Younger midwives and those at the beginning of their careers are much less likely to be referred, only 5% of referrals are to midwives under 30 years and less than a quarter are to midwives practising for less than 10 years. This would tend to suggest that these midwives are less likely to be challenged about their practice. However, if we look only at the 22% of referrals to singly qualified midwives, those without a nursing qualification, the picture is somewhat different. Of this cohort, 15% are under 30 and 58% have been practising midwifery for less than 10 years.

We compared the age profile of members referred to the NMC with the age profile of RCM qualified members (excluding students and MSWs) generally and this confirms that younger members are significantly less likely to be referred.

Figure 12: Age at Referral (n=149)

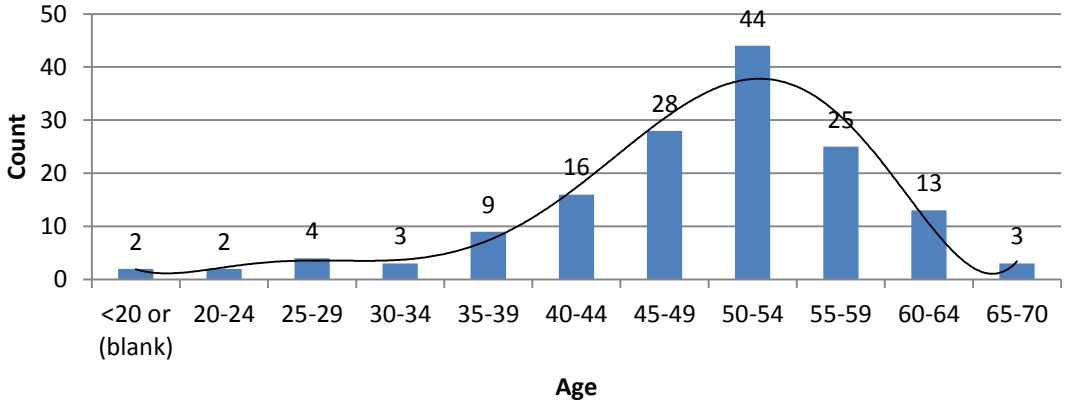
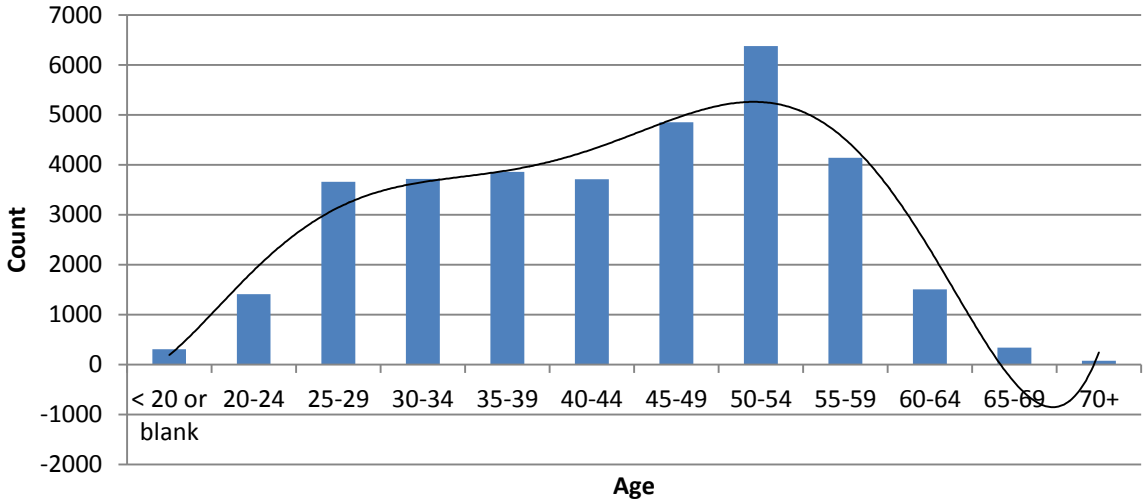


Figure 13: RCM Membership Age Distribution*



2. The experience of Black and Minority Eethnic (BME) midwives

Previous work by the RCM indicates that BME midwives in London are more likely to face disciplinary investigation and dismissal than non-BME midwives. We therefore wanted to explore the experience of the 28 BME midwives included within the sample.

Table 3 below indicates that 66% of all referrals were to midwives describing themselves as white British, (74% to midwives describing themselves as white) and 19% to midwives of BME background with 7% not declaring. Two thirds of the BME referrals came from London

Although BME referrals make up only 19% of referrals to the NMC, in comparison to the RCM's overall membership, it would appear that BME midwives are more likely than non-BME midwives to be referred. However, this finding must be taken with great caution as over 30% of RCM members prefer not to give information on their ethnicity, leaving the RCM's membership data incomplete and this weakens any comparison.

Table 3: NMC Referrals by Ethnicity compared to total RCM Membership Ethnicity

Ethnicity	Number of Referrals	% of Referrals	% of RCM Membership	% Midwifery Workforce HSCIC
Asian/Asian British - Indian	1	0.67%	0.53%	1.8%
Black/Black Brit - African	17	11.41%	2.26%	7.3%
Black/Black Brit - Caribbean	7	4.70%	1.53%	
Mixed - White/Black Caribbean	1	0.67%	0.36%	
Not Informed	10	6.71%	-	5.2%
Other Ethnic Background	2	1.34%	0.47%	0.7%
Prefer Not To Answer	1	0.67%	31.25	
White	2	1.34%	-	85%
White - British	99	66.44%	59.24%	
White - Irish	4	2.68%	2.61%	
White - Other	5	3.36%	2.75%	

The characteristics of the BME referrals are broadly similar to the non-BME referrals in terms of age, banding and working pattern. None of the BME midwives referred was qualified only as a midwife. They are more likely to be referred slightly earlier in their careers and more frequently by their employer than by the public. BME midwives' cases are more likely to take a long time to complete and they are more likely to be removed from the register. As we will see later when we explore the causes of referral, BME midwives are more likely than non-BME midwives to be referred for issues 'attitude and behaviour'.

Table 4: Comparison of key referral characteristics by ethnicity

Characteristic	BME Referrals	Non BME referrals	All Referrals
% Aged > 50yrs	54%	55%	57%
% Practising >20yrs	43%	55%	53%
% Band 6	79%	65%	71%
% Working Full Time	71%	73%	72%

Characteristic	BME Referrals	Non BME Referrals	All Referrals
% Working Predominantly Mixed Shifts	61%	60%	61%
% Dual Qualified	100%	72%	78%
% Subject To Previous Supervisory Investigation	71%	60%	61%
% Referred By Employer	36%	25%	28%
% Referred By LSA	29%	25%	25%
% Referred By Public	25%	37%	36%
% Case Exceeds 15 Months	75%	37%	46%
% No Case To Answer	50%	62%	60%
% Removed From The Register	37%	25%	25%

3. The experience of midwives by route of referral

Of the 149 referrals, 132 (89%) originate from one of three sources: employers, usually but not always following dismissal or disciplinary processes, the LSA Midwifery Officer following a supervisory investigation and action and from the public who may refer on the basis of concern or complaint about a midwife's actions.

The experience of RCM staff representing members is of an increase in the number of referrals from members of the public and this impacting onto the ability of the NMC to meet its KPI for timely consideration and completion of investigations of 15 months from completion to decision. Our analysis does confirm that the most significant difference between cases and the route of referral is in the length of the case and its eventual outcome.

Table 5: Case length by Referral Route

N=132

	Employer	LSA	Public	Grand Total
Unknown		1	1	2
<= NMC KPI of 15 Months	13.5[1]	15.5	43	72
> NMC KPI of 15 Months	27	21	10	58
Grand Total	**40.5**	**37.5**	**54**	**132**

[1] 1 Joint LSA and Employer referral has been split

- 67% of cases referred by employers are NOT completed within 15 months
- 56% of cases referred by the LSAs are NOT completed within 15 months
- 19% of cases referred by the public are NOT completed within 15 months.

The faster turn around of cases referred by the public correlates with the outcomes, with many more cases referred from the public being resolved at an early stage, most commonly with a decision at an early stage in the process that there is no case to answer.

In almost 87% of cases referred by the public the NMC found no case to answer compared to less than 40% of employer-referrals and a little over 27% of LSA referrals.

Table 6: Route of Referral

Route of Referral	Number	% found no case to answer	% removal from the register
Employer	40.5	40%	40%
LSA	37.5	27%	43%
Public	54	87%	4%

It is interesting to note that BME midwives appear to be less likely to be referred by the public, see table 2 earlier. If they are therefore over-represented in the referrals from employers, this could go some way to explaining why they have higher rates of removal from the register. In 100% of the public referred cases of BME midwives, the NMC found no case to answer. By contrast 100% of the BME midwives referred by the LSA proceeded through to Conduct and Competency Committee Hearings and in 38% of these was 'no case to answer' found. All other characteristics appear to be broadly similar regardless of the referral route, with the exception that the LSA referrals contain a higher proportion of part-time midwives: 33% as opposed to 20% amongst employer-referrals and 22% amongst public-referrals.

4. The experience of midwives by geography

Also interesting to note is the regional distribution of referrals. Overall compared to our membership size, midwives in London, in Wales and the North of England are more likely to be referred to the NMC. Table 7 shows how in n London there is on average 1 referral for every 175 members, whereas in Midlands and East of England it is only 1 referral for every 314 members.

Table 7 Regional Comparison referrals and RCM membership

Region	Total of NMC Cases	% of total NMC Cases	RCM membership 01/02/15	% of RCM membership in that Region	Case: Member Ratio
London	27	18.12%	4737	14.45%	1:175
Midlands & East	25	16.78%	7842	23.93%	1:314
N.I	5	3.36%	1329	4.05%	1:266
North	39	26.17%	7471	22.79%	1:192
Scotland	11	7.38%	2905	8.86%	1:264
South	29	19.46%	6849	20.90%	1:236
Wales	8	5.37%	1564	4.77%	1:196
Unknown	5	3.36%	78	0.24%	-
Grand Total	149	100.00%	32775	100.00%	1:220

Figure shows the variation of route of referral by geography. In London referrals by employer, LSA and the public are broadly equal, whereas in NHS Midlands and East there is a far higher proportion of referrals from employers. In NHS North midwives are more likely to be referred by the public and in NHS South and Scotland by the LSA. In Northern Ireland there were no referrals by either the LSA or the public.

Figure 13:

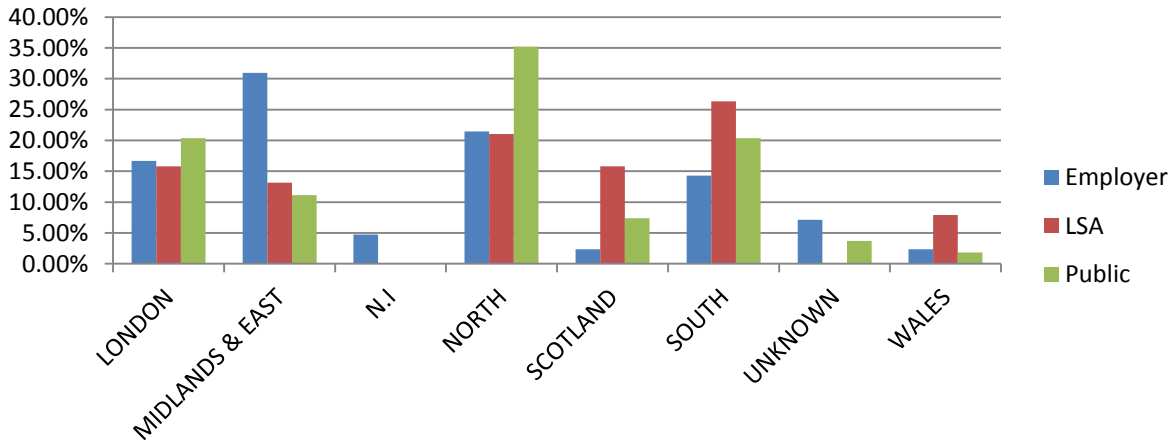


Table 8: Breakdown of Removals from the Register by Region

N=37

Region	Number of midwives removed	% of all removals
London	4	10.8%
Midlands & East	10	27.0%
N.Ireland	2	5.4%
North	5	13.5%
Scotland	1	2.7%
South	11	29.7%
Wales	4	10.8%

The likelihood of referral to the NMC is much greater from oidwives living in the North of England and London. However, the likelihood of being removed from the register is much less for midwives in these areas. Despite the much lower rate of referral, proportionately more of the midwives removed from the register come from Midlands/East and the South of England. All of this would suggest that there are different thresholds and criteria for making referrals operating across the UK.

- 15% of referrals from London were removed
- 40% of referrals from Midlands & East were removed
- 40% of Northern Ireland referrals were removed
- 13% of referrals from the North of England were removed
- 9% of referrals from Scotland were removed
- 38% of referrals from South of England were removed
- 50% of referrals form Wales were removed

This is significant for the operation of the NMC processes and for the behaviour of employers. Furthermore, it is worthy of note that 24% of the cases in our sample related to midwives employed in only 7 NHS trusts. Of these, 3 of the 7 NHS trusts were rated as inadequate by CQC and 2 as requiring improvement. There may therefore be some relationship between poorly performing organisations and the frequency of midwife referral to the NMC. Of this subset 61% were public-referrals and in 86% no case to answer was found. This would suggest that these clusters of referrals may lie in specific local issues.

5. Reason for Referral and Case Outcome.

Referral to the NMC on the grounds of Fitness to Practise covers a wide range of allegations from clinical incompetence or failure through to professional behaviour. A single referral can contain more than one allegation

Table 9: Referral Reason

Referral Reason	Number	% Referrals containing allegation
Failure to monitor mother/baby adequately or to perform observations	70	47%
Inadequate record keeping/documentation	63	42%
Failure to escalate/failure to seek medical advice	56	38%
Lack of competence	45	30%
Attitude and behaviour	34	30%
Dishonesty	25	17%
Failure to interpret ctgs	27	18%
Medication errors	22	15%
Criminal arrest, caution or similar	9	6%
Health issue (mental health)	7	5%
Substance abuse	7	5%
Breaching confidentiality	3	2%
Fraud	2	1%
Inappropriate use of social media	2	1%
Sleeping on duty	2	1%
Theft	1	1%
Health (physical health)	1	1%

This breakdown of reasons for referrals can be found reflected amongst midwives from the 7 trusts with the most referrals, singly qualified midwives, midwives by length of practice and midwives subject to previous supervisory investigations suggesting a pretty consistent pattern of referral triggers, irrespective of where and how the midwife works. It also raises the possibility that conditions surrounding an incident that triggers referral may be linked to staffing levels. Issues of failure to undertake duties: monitoring, recording and escalating are associated with high workload and little chance for fresh eyes to spot a colleague struggling.

6. Experience through the NMC process

The NMC investigatory process is staged with referrals initially screened, then considered by a committee following preliminary investigation that may or may not decide to proceed to a full inquiry. Midwives who are deemed to be potentially a risk to the public can be suspended from practice and therefore denied the ability to work for some or all of the duration of the investigatory process. Table 10 below indicates that just over half of all referrals are closed before reaching the final stage of the Conduct and Competence Committee

Table 10: Stage of Case Closure

n=145 (4 missing records)

Case Closed	Number	%
Case examiners	17	12%
At first response	42	29%
At second response	16	11%
At CCC	66	45%
At health committee	4	3%

Table 11 below illustrates how the majority of cases referred to the NMC result in a finding of no case to answer and less than a quarter attract the ultimate sanction of removal from the register. Furthermore, table xx demonstrates how even looking only at those cases that make it all the way through to the Conduct and Competence Committee, only just over half result in removal from the register, with almost 20% of these cases being found no case to answer. This would suggest that the NMC still has some way to go in earlier screening and resolution of cases.

Table 11: Outcomes for all cases

N= 149

Outcome	Count	%
Caution	9	6.0%
Conditions of Practice	5	3.4%
No Case To Answer	90	60.4%
Removal From Register	37	24.8%
Suspension Order	5	3.4%
(not recorded)	3	2.0%
Total	149	100.0%

Table 12: Outcomes for cases reaching Conduct and Competence Committee

N=66

Outcome	Count	%
Caution	8	12%
Conditions Of Practice	5	8%
No Case To Answer	12	18%
Removal From Register	36	55%
Suspension Order	5	8%

Over 80% of those removed from the register had been subject to a previous supervisory investigation and 87% of removals originated from employer or LSA referrals, with only 5% of removals originating from public-referrals. By contrast, of the 90 referrals found 'no case to answer', 58% originated from the public and less than a third from employers and LSA.

76% of the referrals resulting in removal form the register took longer than 15 months to process as compared to less than a quarter of the referrals determined as no case to answer. This may suggest that the NMC cases are not sufficiently robust to deal with the more serious and complex cases within the time limits it has itself determined.

Within this period, the NMC introduced 2 new processes aimed at speeding up the investigatory process by allowing midwives ready to admit to the allegations made against them, to apply for voluntary removal of the register so obviating the need for a full hearing. It also introduced a process of Consensual Panel Determination aimed at resolving cases much more quickly where registrants agree to the imposition of a temporary sanction ahead of a full CCC hearing. The benefit of both of these processes is that it saves registrants, and potentially the public, going through a lengthy procedure when the outcome can be predicated fairly accurately.

In our sample of 149 cases the RCM applied for voluntary removal in 17% of cases and it was granted in 62%. The RCM applied for Consensual Panel determination in 7% of cases and this was granted in 90%.

CONCLUSIONS

This snap shot survey provides a bench mark for future years about the number and characteristics of midwives referred to the NMC.

For our members it is encouraging in suggesting that whilst referral can be personally traumatic, the likelihood of removal form the register is low.

For our workplace representatives and colleagues it confirms that it is issues relating to midwives competence, not their personal conduct that are most likely to trigger a referral and suggests that more needs to be done to support midwives struggling in their practice, through CPD, mentoring and local remedial action. Given the over representation of midwives in their 50s, there is much here for employers to consider in terms of supporting midwives, for example the impact of working longer, the support given through the menopause and continuing professional development.

The findings relating to our BME members are ambiguous given the paucity of our comparable data on BME membership generally. However there is enough here to raise alarm bells that would suggest BME midwives are more likely to be referred by their employers and more likely to be referred for issues relating to attitudes and behaviours.

In our relations with the NMC we will continue to highlight that more needs to be done to reduce the length of NMC proceedings and with so many findings of 'no case to answer' more work early on to determine whether or not to close a case.

The RCM will repeat this exercise in 3 years.

August 2016