Concerns raised from the Employer Link Service (ELS) arisen from the Opening Statements and NMC submission of evidence to the Thirlwall Inquiry

Following the Opening Statements to the Thirlwall Inquiry, the ELS team, including those named and discussed by the Inquiry (Kristian Garsed and Tony Newman), have expressed significant concerns regarding the NMC position and evidence that pertains to the ELS pre-referral activity and actions regarding LL.

These concerns are outlined in this document which includes a table identifying specific statements from Andrea Sutcliffe's witness statement, referred to in the opening address, and the corrections to these statements.

The past 10 days have caused a great deal of anxiety in the team. The feeling that the Inquiry is being misled is fundamental to these concerns; misleading the Inquiry includes misleading the families whose lives were devastated by the actions of LL. The suggestions that if this situation happened again, we (the NMC) would act differently, faster, or have a different lens of the bar for referral is simply not accurate and is damaging. There has also been a lack of support for those discussed beyond the professional practice directorate, this internal silence has felt damaging to the team and their confidence in the organisation.

Please note that the concerns raised here only allude to the ELS activity in these cases. We are not privy to any other submissions of evidence or learning that has occurred once the referral for LL was received.

1. **The accuracy of the submitted evidence**

There is no doubt that every event or series of events, especially ones as traumatic and devastating as this, requires in-depth reflection, scrutiny, review and learning. With this in mind, the ELS team independently undertook a learning review of all actions, advice and documentation that occurred pre-referral of LL and this review was submitted to and accepted by the executive Fitness to Practice Learning Board.

This review concluded unambiguously that ELS processes at the time were robust, and that the pre-referral advice was consistent and appropriate. The review found that today, in the same situation with the same set of circumstances, the advice provided by the ELS Regulation Advisers, which was in each instance peer reviewed and agreed by screening colleagues through the benchmarking arrangements already established at the time, would be the same today.

As we as an organisation have prepared for the Inquiry, Sam Donohue and PJ Mansell have provided this learning review, a full body of documentary evidence and met many times with the Inquiry team to provide accurate information. We also repeatedly voiced our concerns that the organisational stance to demonstrate learning through the suggestion of differing actions if this situation re-occurred was inaccurate and misleading.

We have set out some of the inaccuracies that appear in the statement and the ELS response in the table below:

	Statement	Our response
1	*'after it [ELS] first spoke to AK on 6 July 2016, it recognises that it would have been better to have been more proactive and to ask for an update on what decision had been made within a few days of AK making initial contact. The NMC also considers that ELS could have contacted AK before May 2017'*	This is incorrect. ELS had further contact with AK 29/11/2016 – where the subject was discussed. The note is on CMS and was included in the evidence provided.
2	*'The NMC recognises that retaining AK as the contact at CoCH after her own referral to the NMC is unlikely to have been appropriate'.*	This is not our current process – there are numerous senior nurses currently under investigation in our FtP processes and they remain our key contact in ELS unless there is a decision that their practice should be restricted. If they are referred themselves we would never discuss their own case with them. This issue was raised numerous time during the preparation for the Inquiry that if this is considered inappropriate there will need to be a corporate decision to change policy and communications to employers about the threshold for requesting a change in contact. This is different in the FtP processes where FtP teams will use a different contact for that specific senior professional referral.
3a	*The following changes have occurred in the ELS and its ways of working since LL's conviction:* *The team has increased in size from four Regulation Advisers (RAs) in 2016 to 12 currently.*	Incorrect. The RA team increased from 4 to 6 soon after its establishment then to 8 and finally to 12 in 2019. This did not happen 'since LL's conviction' and has no relationship with that event.
3b	*'The NMC has also acknowledged that there were some gaps in communication between the ELS and CoCH and record keeping could have been better'.* *Record keeping has*	ELS record keeping has always included all interactions with employers since the team's establishment and cannot be properly criticised in the context of the Inquiry. On review there is confidence that records were complete and accurate.

	improved to ensure all interactions are able to be recorded.	
3c	*A standard operating procedure for the ELS advice line has been created. This includes guidance on escalating certain categories of cases to other regulators and also details a strengthened process for internal escalation.*	The **existing SOP** has been strengthened since the LL conviction to provide a more detailed internal escalation route.
3d	*There are monthly peer-to-peer review sessions of advice provided by ELS to ensure consistency between RAs.* *There are monthly peer review meetings between RAs in ELS and clinical advisors to discuss complex cases or those where there are differing reviews.*	This has been in place since 2016 when the service was created, not since the conviction. This process ensures that the pre-referral advice provided at every point by ELS was reviewed and approved by the full team of Regulation Advisers. At this point this becomes our organisational advice. It is not correct to say this was brought in since LL's conviction. The monthly peer review meetings were in place in 2016; however, the clinical adviser team was not established until much later
3e	*There are monthly benchmarking meetings where ELS RAs, clinical advisers and staff from the Screening Team review cases and agree next steps.*	Incorrect. These meetings were in place at the time and the relevant benchmarking meeting confirming the initial pre-referral advice, took place on 24 August 2016 with screening colleagues who discussed a number of cases including this one and there is a record of the advice given by the RA being agreed. Again, the pre-referral advice given was endorsed not just by the full RA team, but also by screening. These processes confirm and collectivise the advice, and it therefore becomes the advice of the organisation.
4g	*The NMC is now actively involved in discussions around emerging risks and issues both regionally and nationally and works cross-collaboratively with other partners and regulators.*	It is not correct to say this has been happening since the conviction – it has been evolving since the establishment of the team and has increased as the team has over time. We were present at the regional quality oversight group where these concerns were discussed at the time.
4h	*The NMC is a signatory of the cross regulatory emerging*	It is not correct to say this has happened since the conviction as the protocol was established in 2018 and

	concerns protocol for England.	the NMC was a signatory from the beginning.

2. Access to the Andrea Sutcliffe's testimony and witness statements.

We have now had sight of the Opening Statements to the Thirlwall Inquiry, including the statement by Counsel to the Inquiry, and the NMC's statement. We have not however, been provided with a copy of the witness statement of Andrea Sutcliffe (AS).

We are seriously concerned that the comments and amendments we have previously supplied about the ELS activity relevant to this inquiry appear to have not been fully or accurately included, and instead the NMC's evidence, in particular the statement of AS, contains erroneous information and contentions.

Tony Newman has been supported, though not guided, by the Inquiry team when developing his statement and predicted to be called to give evidence to the Inquiry in late November. His statement is now potentially conflicted with AS's statement, however we cannot be sure as we have not been provided access to this information. Whilst we understand and recognise the concept of legal privilege, the body of evidence is now open to all members of the Inquiry and it feels suitable and prudent that this is extended to relevant members of the ELS team.

3. Other specific advice and concerns raised by the team

From what has been said at the Inquiry, it seems clear however that this witness statement theorises wrongly and unfairly that the Regulation Advisers involved, either applied, or gave the impression of there being, 'too high a bar for a referral', and that they should have utilised 'greater critical scrutiny' in relation to the information provided by the Trust. The latter suggestion appears to have been linked to the very recent introduction by the NMC, of the 'Culture of Curiosity' guidance. That guidance however appears from its wording to apply upon receipt of a referral, and as the NMC has no statutory investigative powers unless a fitness to practise case is commenced, would have been irrelevant to the role of the Regulation Advisers, even if it had been in place at the time.

In addition, there have been quotes from Andrea Sutcliffe's statement that *'the impression "may have been given" that evidence of deliberate endangerment had to be found before taking action, and that this was "too high a bar".* The note that this was extracted from was a conversation between the RA and AK where AK quoted the police about deliberate harm and the RA mirrored back that wording saying that would warrant referral. This 'bar' has never been the threshold for an RA advising to refer.

It is also an entirely irrelevant consideration, as the referral was requested as soon as LL was arrested, and before she was actually charged with any offence. The suggestion made by Counsel to the Inquiry, that the criticism of ELS made in Andrea

Sutcliffe's statement, indicates that ELS colleagues had 'inadequate regard to child safety' is completely misplaced and simply wrong in principle. An earlier referral would have made no difference at all either in terms of preventing actual harm, or further reducing the risk of harm, and would have made no difference to what the NMC actually did upon receiving the referral.

4. The impact on the team and relationship with employers

The regulation advisors provide complex advice to employers about potential FTP referrals. This advice happens on a daily basis through the well utilised employer advice line, via discussions with SPOCs (single points of contact) who may be Executive directors of nursing or their deputies and during ad hoc calls referred to us from professional bodies, known parties or system and national regulators.

The regulation advisors are professionally experienced individuals, trusted to assimilate complex discussions and formulate advice in often grey and non-rehearsed situations. Their advice moves from individual advice to collective organisational advice through the well-established quality assurance processes that surround the team.

These quality assurance processes include peer review, where regulation advisors review each other's advice, and monthly peer review meetings where advice requiring further discussion is raised and discussed with other FTP colleagues. The final process is a monthly benchmarking meeting (to note, not every advice to refer or not refer goes to the benchmarking but the LL case did. The benchmarking meeting includes a wider range of colleagues, including screening lawyers, clinical advisors (they were established in 2016, after the LL case) and the full ELS team to decide if a referral is warranted or not and the regulation advisors advice deemed appropriate. These meetings are professionally curious, challenging and robust and are a critical part of both quality assurance of advice and learning.

It is important that it is understood that these governance processes, in place at the time of the LL referral and now, mean that the advice given by individual Regulation Advisers, was adopted and endorsed by the full team of Regulation Advisers and additionally by our screening colleagues. The advice is collectively agreed, and so we are collectively responsible for the advice given externally, articulated by the Regulation Advisers but given on behalf of the NMC as a whole organisation.

This comment is from one of the regulation advisors and endorsed by the team:

"The criticism of the 'approach taken by ELS' and of specific colleagues has sadly resulted in a total loss of confidence that there is any corporate support or backing for the processes we have in place to quality assure our advice, or that we can confidently provide pre-referral advice to employers at all, without exposing ourselves as a team and as individual professionals, to a significant measure of risk which the NMC will not protect us from."

And another at last week's peer review meeting*:*

“I no longer feel confident to suggest that the employer holds and gains more information prior to referral. I can see we will just say, bring the referral in now. I have lost all confidence in the NMC and their support of my advice.”

This takes us in the wrong direction. ELS has worked diligently to support strengthening practice at source and advising to support appropriate referrals coming into the NMC. If employers begin to doubt the advice they are given or the Regulation Advisors start to advising more referrals then this is in complete conflict to the corporate improvement plans and our fundamental role as a regulator.

Following the culture review we have discussed as an organisation our need to create a culture of psychological safety where teams feel valued, respected and heard. There is a sound evidence base to suggest that these cultures support creative, skilled teams to flourish and be highly functioning. The manner in which the team’s voice was not listened to during the development of evidence and the lack of connection with the team following the opening of the Inquiry, beyond the executive director of professional practice indicates we have a way to go to closing the gap between rhetoric and behaviours. For this team to remain highly functioning they need to experience job satisfaction and be engaged with the NMC as an employer, this requires them to feel respected, valued and heard.

5. Next steps

I suggest we have an urgent meeting with members of the ELS team, General Counsel and the executives to discuss the content of this document and the next steps regarding the submission of evidence and the preparation necessary for the Inquiry.

The Employer Link Service team.