Nursing & Midwifery Council

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Annual Fitness to Practise Report 2013–2014

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Presented to Parliament pursuant to Article 50 (2) of the Nursing and Midwifery Order 2001, as amended by the Nursing and Midwifery (Amendment) Order 2008

October 2014

Any enquiries regarding this publication should be sent to the Nursing and Midwifery Council, 23 Portland Place, London, W1B 1PZ.

This publication is available at www.nmc-uk.org

Print ISBN 9781474110815
Web ISBN 9781474110822

Printed in the UK by the Williams Lea Group on behalf of the Controller of Her Majesty's Stationery Office

ID 19091402 10/14 43515 19585

Printed on paper containing 75% recycled fibre content minimum

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Foreword

The Nursing and Midwifery Council exists to protect the public. We do this by ensuring that only those who meet our requirements are allowed to practise as a nurse or midwife in the UK. We take action if concerns are raised about whether a nurse or midwife is fit to practise.

This report describes how we have dealt with concerns raised with us about the fitness to practise of nurses and midwives during 2013–2014. It should be read alongside our *Annual report and accounts 2013–2014 and strategic plan 2014–2017*, which covers all the work we do to protect the public.

On 31 March 2014, there were 680,858 registered nurses and midwives in the UK. The vast majority of nurses and midwives practise safely. This report focuses on the very small number, around 0.7 percent, who came to our attention because there was a concern about them. An even smaller proportion – 0.2 percent – received some sort of sanction following our investigations.

We are investing substantially in improvements to our fitness to practise functions – 78 percent of our budget is now spent on this. We have increased our staff capacity and capability; we now investigate the majority of our cases in-house; we have expanded the number of panel members; and we hold some 30 meetings and hearings each day to resolve cases.

We are pleased that this investment is delivering results. During 2013–2014, we resolved over 1500 of our oldest and most complex cases and significantly cut the time taken to complete investigations. We are on track to meet our target for cases to reach adjudication more quickly by December 2014. Importantly, we are continuing to protect the public in the most serious cases by putting interim orders in place within four weeks in 84 percent of cases while we investigate.

Our fitness to practise function, as with all our work, has been influenced by the Francis report and the commitments we have made to learn from, and apply, the findings. We welcomed the Government's promise following the Francis report to modernise our legal framework and are disappointed that this is not going to happen in the current parliament. Major legislative change is essential if we are to bring our processes up to date and provide the agile response the public expects. In the meantime, we are determined to do all we can to improve. We are working with the Department of Health to put in place changes within the existing legal framework so that we can introduce case examiners. Implementing this change in 2015 should help us improve the consistency and speed of decision making in cases.

We are also looking at how we can provide a regional capability to work more closely with employers and nursing and midwifery leaders on the ground to ensure that the right cases reach us. We have begun to improve the support we provide to witnesses in our cases and are seeking to improve our customer service. Along with a relentless focus on resolving cases more quickly and improving the quality and efficiency of our work, these will be our priorities during the year ahead.

Mark Addison CB
Chair
NMC
9 October 2014

Jackie Smith
Chief Executive and Registrar
NMC
9 October 2014

Introduction

This report explains the work we do to protect the public from registered nurses and midwives whose fitness to practise is impaired. It explains:

- who we are and what we do;
- how we deal with concerns raised with us about nurses or midwives;
- the number and sorts of cases we looked at and what happened in those cases; and
- the steps we are taking to improve how we carry out this work.

Who we are and what we do

We are the independent nursing and midwifery regulator for the UK.[1] It is our job to protect the public by making sure that all practising nurses and midwives have the skills, knowledge, good health and good character to do their job safely and effectively.

To do this, we:

- require all nurses and midwives who practise in the UK to be registered with us;
- set standards of education, training, conduct and performance so that nurses and midwives can deliver high-quality healthcare consistently throughout their careers;
- ensure that nurses and midwives keep their skills and knowledge up to date and uphold our professional standards; and
- have clear and transparent processes to investigate nurses and midwives who fall short of our standards – our fitness to practise work.

This report focuses on our fitness to practise work. You may also find it helpful to read our *Annual report and accounts 2013–2014 and strategic plan 2014–2017*, which covers all the work we do to protect the public. This can be found on our website at www.nmc-uk.org/About-us/Annual-reports-and-statutory-accounts.

Equality and diversity information

Equality and diversity information, including an analysis of the data that we hold in relation to fitness to practise cases, is available as part of our *Equality and diversity annual report 2013–2014* at www.nmc-uk.org.

Oversight of our work

Our work is subject to oversight by the Professional Standards Authority for Health and Social Care (PSA). Each year, the PSA looks at a number of aspects of our work.

1 Established by the Nursing and Midwifery Order 2001 SI 2002/253 (as amended)

- It reviews our overall performance and reports on this to Parliament.
- It can audit a sample of the fitness to practise cases we have closed at an early stage.
- It reviews all final adjudication decisions in fitness to practise cases. If it thinks a decision is unduly lenient, it can ask the High Court, or the Court of Sessions in Scotland, to look at the case. It may also provide feedback on our adjudication processes and decisions by way of learning points.

The PSA's reports on our work can be found at www.professionalstandards.org.uk/regulators/overseeing-regulators.

We are accountable to Parliament, through the Privy Council, for what we do. The Health Select Committee exercises this role on behalf of Parliament and scrutinises our work at an annual public hearing. The Committee publishes a report on its findings and our response to its recommendations. These are available at www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/.

Protecting the public

Our register

Fundamental to everything we do to protect the public is keeping the register of nurses and midwives who are legally allowed to practise in the UK. Only those who meet our standards can be admitted to, or remain on, the register. Registration provides assurance to patients, employers and the public that a person is fully qualified, trained, capable of safe and effective practice and worthy of trust and confidence.

Only we can stop a nurse or midwife from practising in the UK by removing them from the register or take action to suspend or restrict how they practise.

On 31 March 2014, there were 680,858 nurses and midwives on our register. Anyone can check whether a nurse or midwife is currently registered by visiting www.nmc-uk.org/search-the-register or by calling us or writing to us.

Fitness to practise

All qualified nurses and midwives must follow their professional code, *The Code: Standards of conduct, performance and ethics for nurses and midwives* (NMC, 2008);[2] our standards; and be fit to practise, so that patients and the public can trust them with their health and wellbeing. We are currently revising the Code to ensure it reflects the recommendations of the Francis report and to support our plans to introduce revalidation. More details can be found in our annual report mentioned earlier.

Being fit to practise means that a nurse or midwife has the skills, knowledge, good health and good character to do their job safely and effectively without restriction.

When someone has concerns about the fitness to practise of a nurse or midwife they can bring these to us.

2 You can read this at www.nmc-uk.org/code.

We investigate various allegations including:

- misconduct;
- lack of competence;
- criminal behaviour; and
- serious ill health.

If a nurse or midwife fails to comply with the standards we set, this does not automatically mean that their fitness to practise is impaired – we have to look at all the circumstances involved.

We also investigate cases where it appears that someone is on our register fraudulently.

When we can and cannot investigate

We can only investigate complaints about:

- A nurse or midwife who is on our register. We cannot consider complaints about healthcare assistants or other healthcare workers.
- Whether a nurse or midwife is fit to be on our register. Any other complaints or concerns about a nurse or midwife should normally be resolved by the employer or some other authority.

Action we take if a nurse or midwife is unfit to practise

When a nurse's or midwife's fitness to practise is impaired, we may decide that no regulatory action is necessary given all the circumstances of that case. If action is necessary, we will make one of the following orders.

Caution order	This can be imposed for periods of between one to five years. It is shown as an entry on the public register but does not restrict the nurse's or midwife's practice.
Conditions of practice order	This restricts a nurse's or midwife's practice for up to three years. They must comply with the restrictions in order to practise. For example, they may be restricted from carrying out some aspects of the job without supervision. The order must be reviewed before the expiry date and may be replaced, varied or revoked.
Suspension order	The nurse or midwife is suspended from the register and cannot practise for a set period of time which, at first, will not exceed one year. The suspension order must be reviewed before the expiry date and may be replaced, varied or revoked.
Striking-off order	The nurse or midwife is removed from the register and they are not allowed to practise as a nurse or midwife in the UK.

Voluntary removal

In 2013, we introduced a process called voluntary removal. This provides for a nurse or midwife to apply to be removed permanently from the register without a full public hearing. Such applications are only considered if:

- the nurse or midwife admits that their fitness to practise is impaired;
- the nurse or midwife does not intend to continue practising;
- the public interest does not warrant a full public hearing; and
- the public will be best protected by the immediate removal of the nurse or midwife from the register.

Our work in 2013–2014 at a glance

4,687 referrals received

0.7 percent of **680,858** registered nurses and midwives

An increase of **14%** compared to 2012–2013

768 interim orders imposed to restrict or suspend a nurse's or midwife's practice for a period pending the outcome of the case or an appeal

4816 cases closed or concluded

1503 cases closed on initial assessment (screening)

1404 cases closed by the Investigating Committee

1805 cases concluded at adjudication

92 cases concluded through voluntary removal

12 cases of fraudulent or incorrect entry on the register

1405 cases sent for adjudication by the Investigating Committee

1325 sent to the Conduct and Competence Committee

80 sent to the Health Committee

1805 adjudication decisions

404 fitness to practise found not to be impaired

1401 fitness to practise found to be impaired

- **537** striking off orders
- **357** suspension orders
- **261** conditions of practice orders imposed
- **240** caution orders imposed
- **6 cases** no sanction imposed

55 appeals considered

- **14** allowed
- **41** dismissed

19 applications for restoration to the register

- **8** applications successful
- **11** applications unsuccessful

How do concerns get raised with us?

Anyone can tell us if they have a concern about a nurse's or midwife's fitness to practise.

They might be:

- a patient or someone using the services of a nurse or midwife;
- a member of the public;
- the employer or manager of the nurse or midwife;
- someone who works with the nurse or midwife;
- the police; or
- other organisations involved in regulating healthcare, such as the Care Quality Commission.

We also have the power to open a case ourselves if we consider it necessary.

There is no time limit on when a referral can be made but the sooner concerns are brought to our attention, the more likely we are to be able to consider them fully and obtain all the evidence we need.

Making sure the right cases reach us

We expect employers and colleagues of nurses and midwives to let us know if they are concerned about a nurse's or midwife's fitness to practise. We constantly remind nurses and midwives that they have a duty under the Code to tell us if they have concerns about a colleague.

As the majority of our cases come from employers (45 percent last year), we work closely with those who employ nurses or midwives so that they know when to refer cases to us. Directors of nursing, heads of midwifery, and local supervising authority midwifery officers can call our dedicated helpline to seek advice or information on possible referrals. During 2013–2014, we undertook a wide-ranging programme of visits and meetings across the four countries to discuss our work with those on the ground to help them understand better when to refer cases to us.

This included engaging with over 150 nurse leaders in England with the help of the Trust Development Authority. We also visited each of the Trusts identified in the Keogh Mortality Review. We were able to hear directly from nurse leaders about the improvement work underway and the challenges of nurse leadership in trusts under scrutiny. After each visit we shared data with each Trust about referrals we had received from them and undertook further visits to discuss in more detail when and how to make fitness to practise referrals to us.

The visits helped strengthen our engagement at this level, provided an opportunity for input to our work from senior nurses and midwives and raised the profile of our work, including the review of the Code, revalidation and education.

We also work with patients and patient support groups so they can better understand which cases we can look at and can therefore improve the advice they give to patients and others. We organised a visit to one of our hearings venues for our patient and public engagement forum members. The forum received a presentation on our fitness to practise processes and how hearings work.

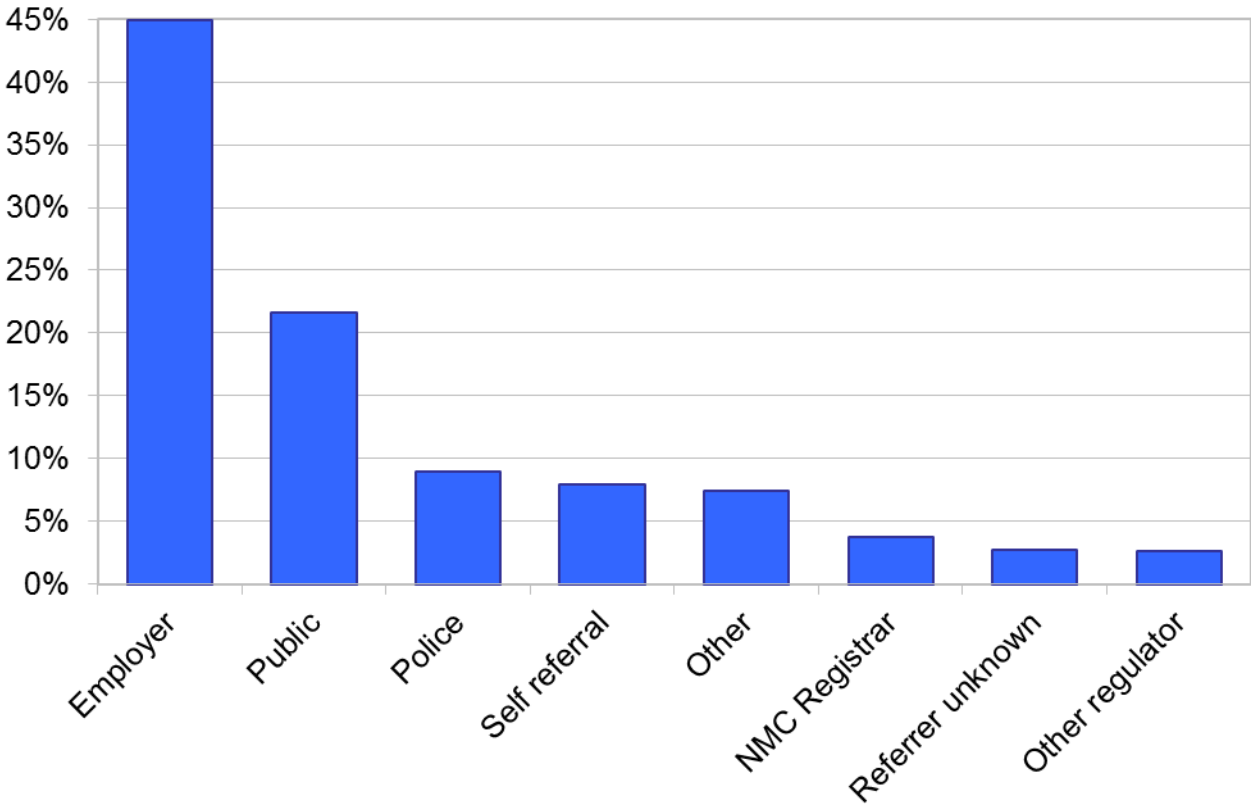
Our new booklet, *Raising concerns about nurses and midwives* (2013), produced with help from our patient and public engagement forum, aims to improve the help these groups can give to patients, service users and other members of the public. This is available at www.nmc-uk.org/supporting-patients.

Table 1: Who referred cases to us in 2013–2014?

During 2013–2014, we received 4,687 new cases (an increase of 14 percent from 2012–2013). Some cases have more than one referrer, so the number of people or organisations referring cases to us is slightly higher than this, as shown below.

Who referred cases to us	Number of new referrals	Percentage
Employer	2,141	45%
Member of public, service user or patient	1,029	22%
Police	428	9%
Self referral	376	8%
Other (including lawyers, coroners and colleague referrals)	354	7%
NMC Registrar	178	4%
Referrer unknown	131	3%
Other regulatory or professional body	127	2%
Total	**4,764**	**100%**

Chart 1: Who referred cases to us in 2013–2014?



How we deal with concerns raised with us

When we receive a referral, we take the following steps:

- An initial assessment (screening) of the allegation or complaint, including determining whether urgent action is required.

  If during the initial assessment stage we consider that the allegation, on its own, is not sufficiently serious to require regulatory action, we contact the employer of the nurse or midwife to confirm that they have no fitness to practise concerns. After establishing this, the case can generally be closed.

- Where necessary, conduct an investigation of the allegation or complaint: the 'investigations' stage.

- Where necessary, convene a hearing or meeting to reach a final decision and determine what action, if any, should be taken. We call this 'adjudication'.

Last year we implemented two changes to our processes and rules to help us progress cases more quickly and efficiently:

- **Voluntary removal** – allows a nurse or midwife who admits that their fitness to practise is impaired and does not intend to continue practising to apply to be removed permanently from the register without a full public hearing. Such applications will only be granted where the public interest does not warrant a full hearing and the public will be best protected by the nurse or midwife being immediately removed from the register.

  Decisions on applications for voluntary removal are made by the Registrar. Where an application for voluntary removal is not agreed, the case will progress through the fitness to practise process in the normal way.

  During 2013–2014, we received 194 applications for voluntary removal and approved this in 92 cases.

- **Consensual panel determinations** – a means of concluding a case by consent. If a nurse or midwife accepts that their fitness to practise is impaired, we can agree a sanction to be considered by a panel at a public hearing. The panel retains the right to make the final decision but this process has enabled us to reduce the hearing time in appropriate cases. These cases are included in the outcomes at adjudication stage.

The chart on page 14 shows what happens to cases after we receive them.

Practice committees

Cases are considered by our practice committees. There are three types of practice committee:

- **Investigating Committee** – decides whether there is a case to answer. If it decides there is, it will send the case to the Conduct and Competence Committee or the Health Committee for a decision.

- **Conduct and Competence Committee** – makes decisions on cases involving allegations relating to the conduct and/or competence of the nurse or midwife.

- **Health Committee** – makes decisions on cases involving allegations about the physical and/or mental health of the nurse or midwife.

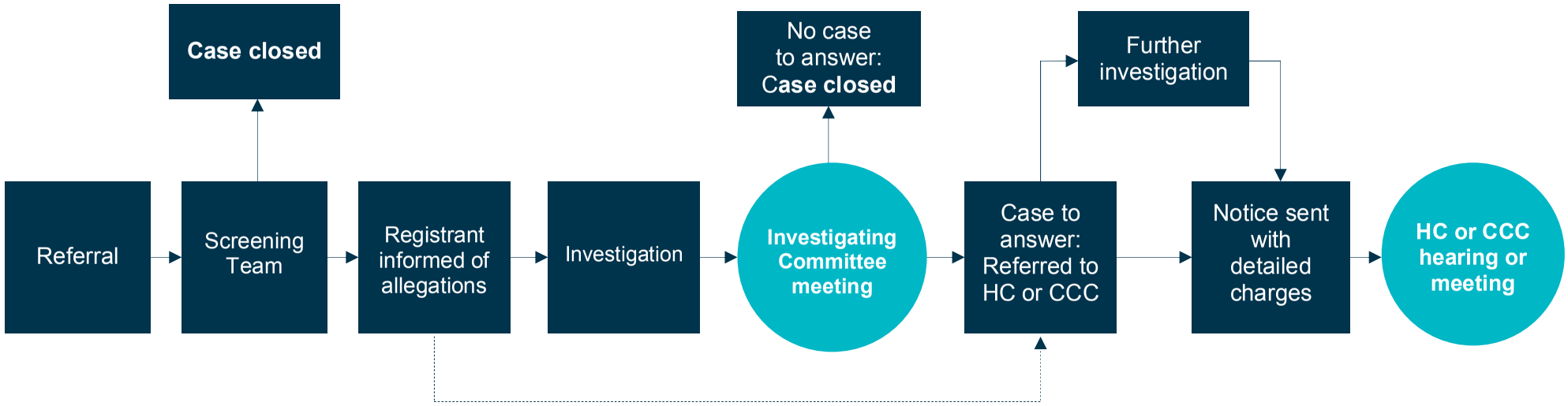
Individual cases are considered by a panel of the relevant committee. The panel members are made up of nurses, midwives and lay people from outside the professions. Each panel will consist of a chair, a lay member and a nurse or midwife member. All panellists are recruited through an open and transparent process overseen by the Appointments Board.

The Appointments Board is a committee of the Council. It is made up of five members, none of whom is a Council member. The members of the Appointments Board are also recruited through an open and transparent process.

Fitness to practise panel members are supported by the Panel Support Team. All panel members are provided with training and guidance on how to carry out their role.

More information about how panels work can be found on our website at www.nmc-uk.org/Hearings/How-the-process-works.

Fitness to practise process



Explanation of terms and chart styles

HC – Health Committee
CCC – Conduct and Competence Committee

Initial assessment

When we receive a new referral, we first investigate whether the individual complained about can be identified as a nurse or midwife who is on our register. If, after an initial assessment (screening), we cannot identify the individual as a registered nurse or midwife, or the allegations could not lead to an impairment of fitness to practise, we close the case. We closed 1,503 cases at the screening stage during 2013–2014.

During 2013–2014, we received 4,687 new referrals.

Table 2: New referrals received between 1 April 2009 and 31 March 2014

Month	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014
April	233	393	294	321	438
May	181	331	342	351	416
June	249	337	390	315	371
July	231	352	403	353	408
August	239	278	383	330	372
September	186	394	377	312	345
October	242	302	378	351	421
November	244	333	419	366	483
December	279	291	356	317	258
January	266	365	378	363	367
February	262	473	315	368	465
March	374	362	372	359	343
Total	**2,986**	**4,211**	**4,407**	**4,106**	**4,687**

Chart 2: New referrals received between 1 April 2009 and 31 March 2014

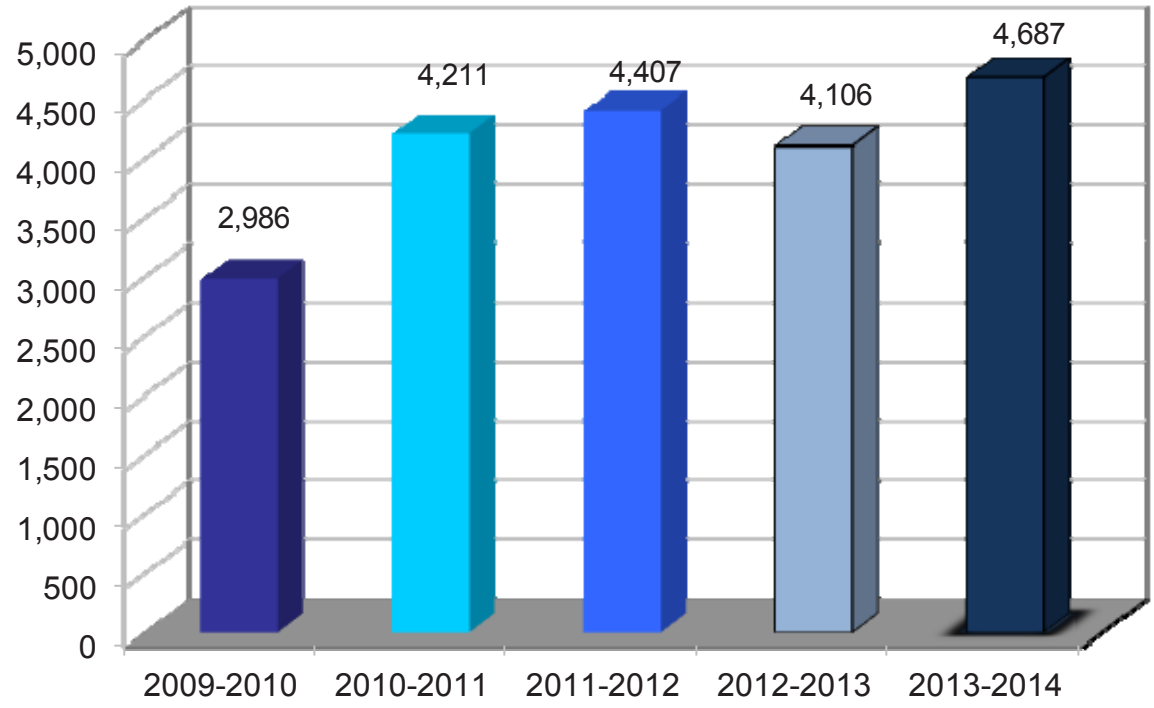
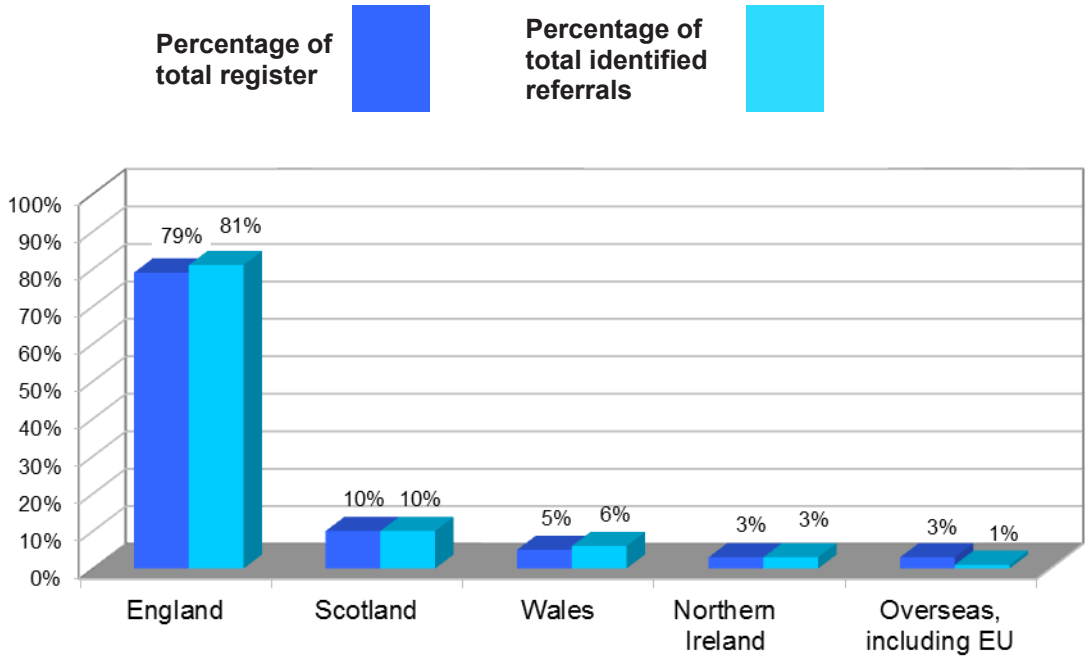


Table 3: New referrals by country compared to registration by country[3]

The total number of referrals represents approximately 0.7 percent of registered nurses and midwives. At 31 March 2014, there were 762 unidentified referrals. This number includes referrals that were received and closed during 2013–2014 because a registered nurse or midwife could not be identified. It also includes cases where we had yet to identify a registered nurse or midwife by 31 March 2014. Some of these will be identified in the next reporting period.

Country	Number on register	Percentage of register	Number of referrals	Percentage of referrals
England	537,140	79%	3,164	81%
Scotland	68,050	10%	374	10%
Wales	34,259	5%	230	6%
Northern Ireland	23,291	3%	122	3%
Overseas (including EU)	18,118	3%	35	Less than 1%
Total	**680,858**	**100%**	**3,925**	**100%**
Unidentified referrals	–	–	762	–
Total referrals	**–**	**–**	**4,687**	**–**

Chart 3: New identified referrals by country compared to registration by country



[3] Refers to the country in which the registered address of a nurse or midwife is situated.

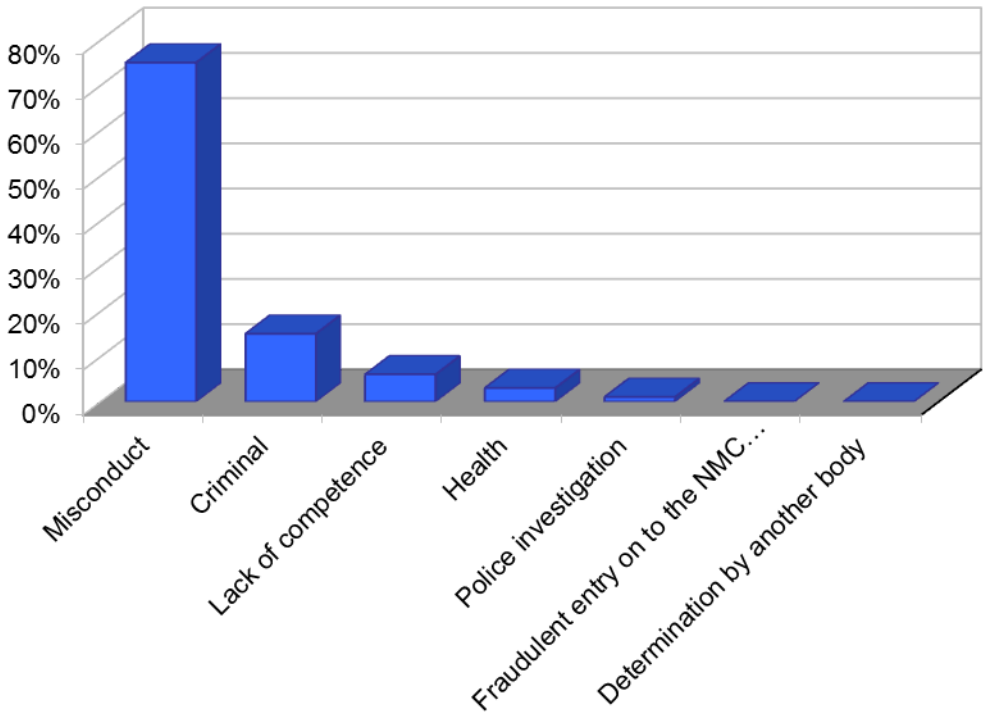
Nature of allegations referred to us

The table below shows the main types of allegations made in new referrals we received during 2013–2014. Many cases involve more than one type of allegation about a particular nurse or midwife.

Table 4: Types of allegations made in new referrals received in 2013–2014

Types of allegations	Percentage
Misconduct	75%
Criminal	15%
Lack of competence	6%
Health	3%
Police investigation	Less than 1%
Fraudulent or incorrect entry in the register	Less than 1%
Determination by another body (for example, Irish Nursing Board or Health and Care Professions Council)	Less than 1%
Total	**100%**

Chart 4: Types of allegations made in new referrals received in 2013–2014



Taking urgent action to protect the public

We are the only organisation with the power to prevent nurses and midwives from practising in the UK if they present a risk to patient safety.

Where the public's health and wellbeing is at immediate and serious risk, we can take urgent action – called 'interim orders'. In this situation, a practice committee panel will look at whether to suspend the nurse or midwife straight away, or restrict how they can practise, until we can thoroughly investigate the case.

We constantly assess all cases throughout the process, so that if new information comes to light at any time which suggests that there is a serious immediate risk to the public, we can consider whether an interim order is needed.

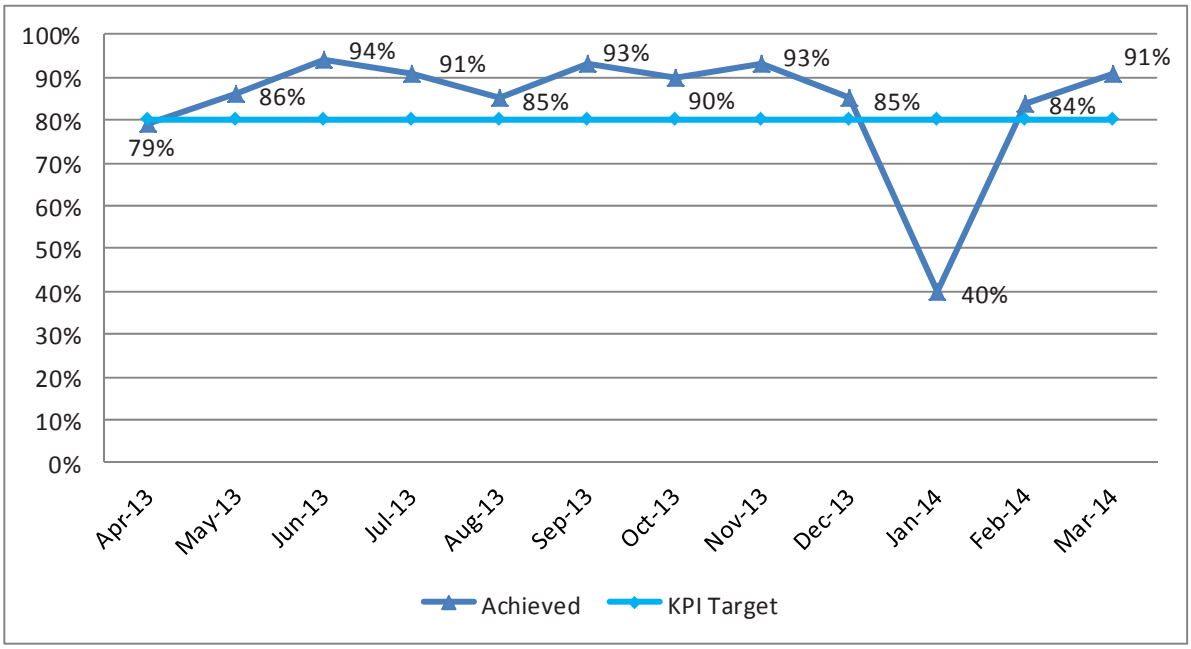
Hearings to consider an interim order take place in public. A panel will consider whether the interim order is:

- necessary to protect the public;
- in the public interest; and
- in the nurse's or midwife's interest.

Our performance in 2013–2014

Our key performance indicator (KPI) is to impose interim orders within 28 days of receiving a case where we identify that urgent action to protect the public is needed. We have set a target to achieve this in 80 percent of cases. We met our target consistently throughout most of 2013–2014, although there was a drop in performance during January, primarily due to ICT system issues. Performance against this KPI is shown in the graph below.

KPI: Percentage of interim orders imposed in 28 days
Target for 2013-2014: 80 percent

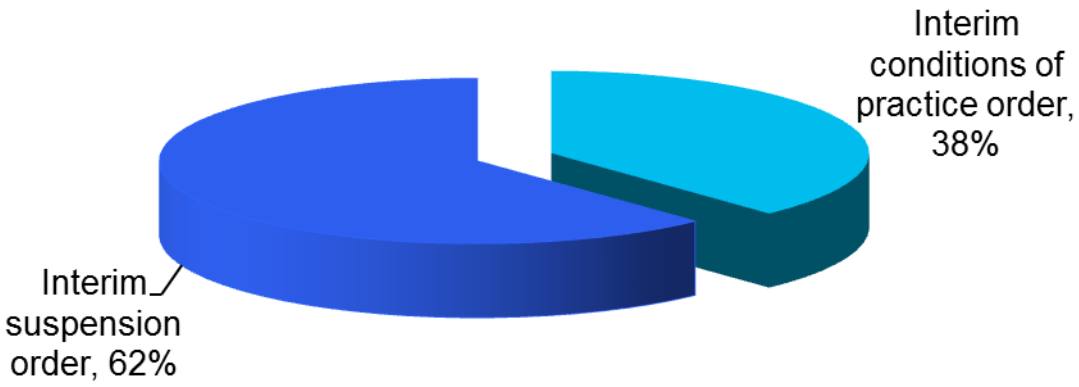


Interim order outcomes

Table 5: Interim orders imposed 2013–2014

Interim order decisions	Number of interim orders	Percentage
Interim conditions of practice order	289	38%
Interim suspension order	479	62%
Total interim orders imposed	**768**	**100%**

Chart 5: Interim orders imposed 2013-2014



Investigations

Once we are satisfied that the case is one for us to deal with and we have carried out an investigation, the case is considered by a panel of the Investigating Committee (IC). The IC panel decides if there is a case to answer. This means that they must decide whether there is a real prospect that the allegation could be proved at the adjudication stage.

If an IC panel decides there is no case to answer, the matter is closed. However, the case can be reopened if another referral is made about the same nurse or midwife within three years.

If a panel decides there is a case to answer, it sends the case to the Conduct and Competence Committee (CCC) or the Health Committee (HC), depending on the nature of the allegations.

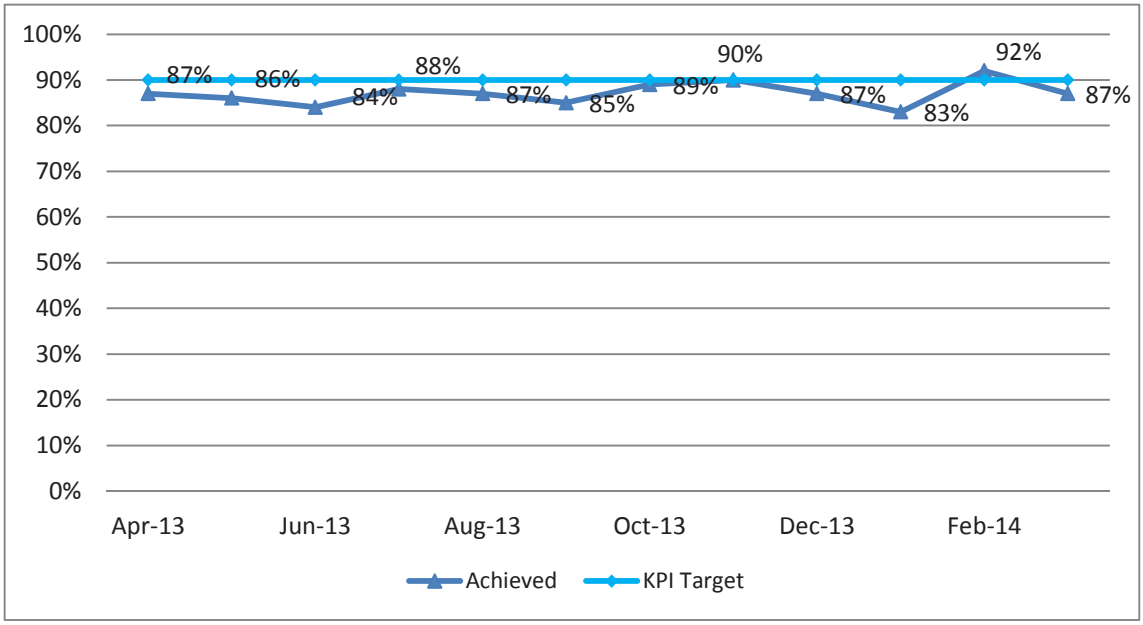
In 2013–2014, the IC considered 2809 cases.

- 1404 (just under half) were closed as the IC found no case to answer.
- 1405 (just over half) were sent for adjudication.
- 12 fraudulent or incorrect entries were removed from the register.

Our performance in 2013–2014

Our key performance indicator is to complete investigations in 12 months. We set a target to complete 90 percent within 12 months by March 2014. We achieved 87 percent in March, just missing our target, although we met or exceeded it at times during the year. This is due to our caseload containing a mix of both old and new cases. On average, during 2013–2014, we completed 87 percent of investigations in 12 months, a significant improvement compared to an average of 68 percent in 2012–2013.

KPI: Percentage of investigations completed within 12 months
Target: 90 percent by March 2014



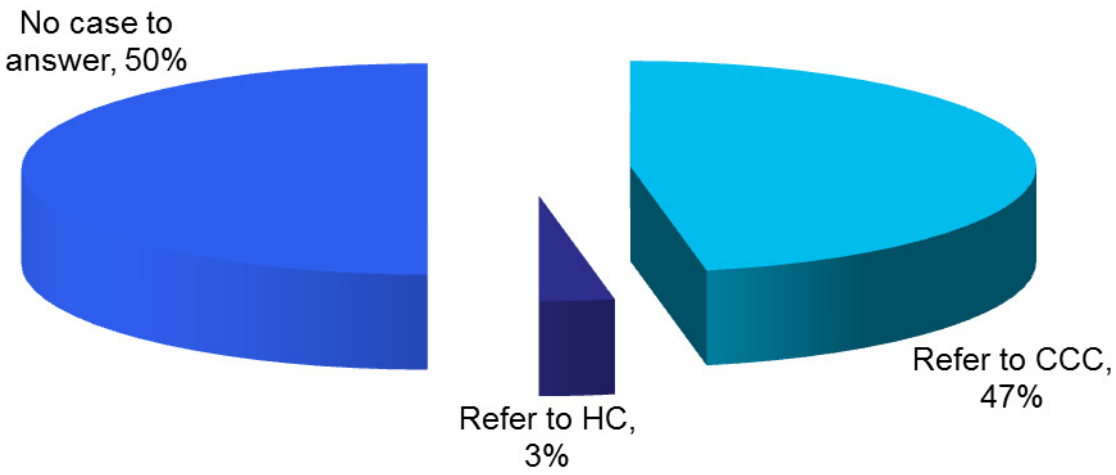
Investigating Committee outcomes

Table 6: Investigating Committee final outcomes 2013–2014

The total number of cases referred for adjudication represents approximately 0.2 percent of the total number of registered nurses and midwives.

Investigating Committee final outcomes	Number of cases	Percentage
Refer to Conduct and Competence Committee (CCC)	1,325	47%
Refer to Health Committee (HC)	80	3%
Total referred for adjudication	**1,405**	**50%**
No case to answer	1,404	50%
Total Investigating Committee final outcomes	**2,809**	**100%**

Chart 6: Investigating Committee final outcomes 2013–2014



Fraudulent or incorrect register entries 2013–2014

Investigating Committee panels also deal with allegations of fraudulent or incorrect entry in the register. The panels decide whether the allegations are proved and, if so, direct the Registrar to remove or amend the entries on the register.

In 2013–2014, there were 12 fraudulent or incorrect entry cases where the person's name was removed from the register.

Adjudications

Cases referred by the Investigating Committee for adjudication are considered by a panel of the Conduct and Competence Committee or the Health Committee at a hearing or meeting. The purpose of the hearing or meeting is to determine if the person poses a risk to the public.

The panels review the information put before them, take expert advice, and question witnesses, who could include the originator of the complaint, employers or the nurse or midwife concerned (or their representative). After considering all the evidence, the panel will decide whether or not the nurse's or midwife's fitness to practise is impaired.

Where the panel finds that fitness to practise is impaired it will then decide the appropriate action to take. In some cases, a panel may decide that, even though the nurse's or midwife's fitness to practise is impaired, after taking into account all of the circumstances of the case, no sanction should be imposed.

If a sanction is considered appropriate, the panel will consider in turn whether each of the available sanctions as set out on page 5 is the most appropriate to protect the health and wellbeing of the public. In doing so, the panel will take into account guidance on indicative sanctions. This can be found at www.nmc-uk.org/Documents/FtP_Information/Indicative-Sanctions-Guidance.May-12.pdf

Health cases are generally heard in private, due to the confidential nature of the medical evidence considered. Conduct and competence cases are usually heard in public. Anyone is welcome to observe public fitness to practise hearings. Information on how to attend can be found at www.nmc-uk.org/hearings**.** Here you can also find final hearing decisions where a sanction has been imposed and the reasons for them.

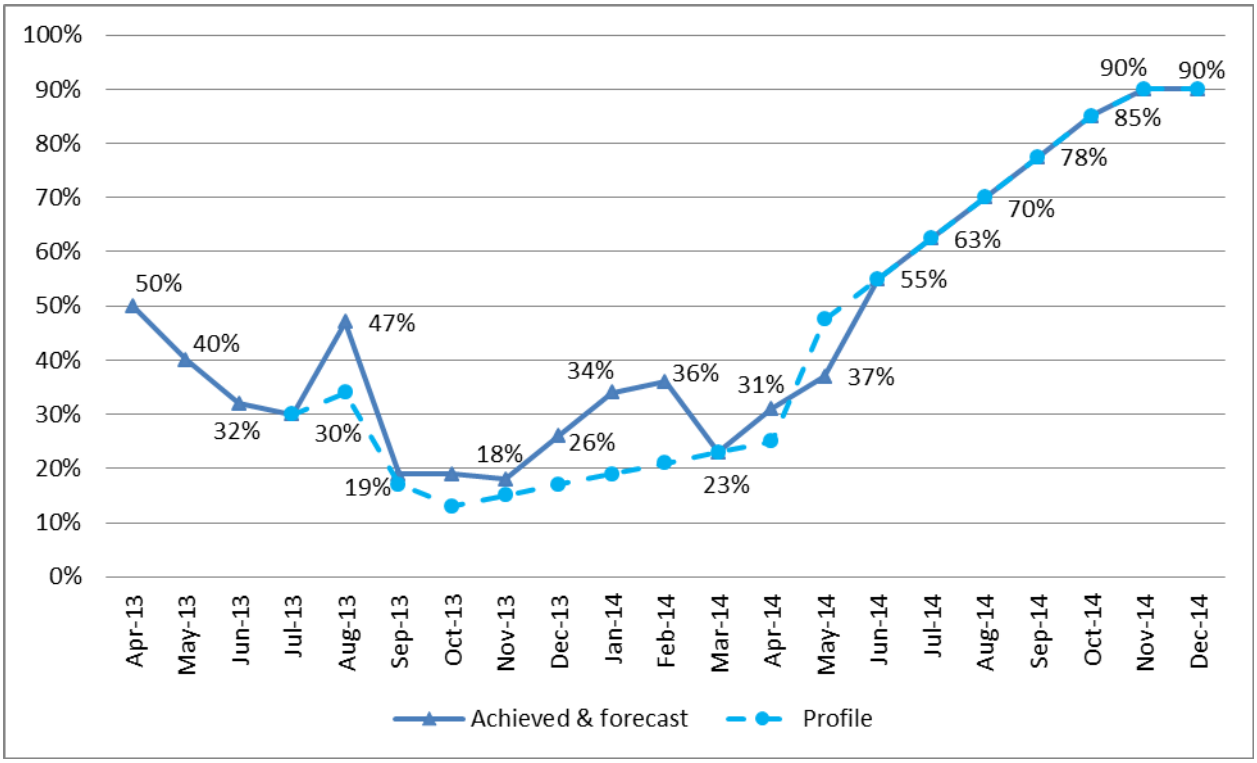
Our performance in 2013–2014

Our key performance indicator is for cases to reach the first day of an adjudication stage hearing or meeting within six months of the conclusion of the investigation. We have set a target that 90 percent of cases will reach this stage by December 2014. This is because of the age mix of the cases awaiting adjudication.

As we do not expect to approach the target until December, we have forecast progress towards meeting the target. We assess our performance by the extent to which we have met or performed better than forecast throughout 2013–2014, as shown in the following graph. During 2013–2014 our performance was generally in line with our forecast: this means that we are on track to meet the target by December 2014.

KPI: Percentage of cases progressed from completion of investigations to the start of a hearing or meeting in six months

Target: 90 percent by December 2014



Conduct and Competence Committee and Health Committee final outcomes

The Conduct and Competence Committee (CCC) considers and makes final decisions on cases involving concerns about the conduct or competence of a nurse or midwife. The committee can send a case to the Health Committee (HC) for a decision if it considers that the issues raised are more properly matters for that committee, provided that the allegations are not serious enough that they could result in a striking-off order.

The Health Committee considers cases where a nurse or midwife's fitness to practise may be impaired due to physical or mental health issues. It can send a case to the Conduct and Competence Committee for a decision if it considers that the concerns raised are more properly about a nurse or midwife's conduct or competence not relating to health issues.

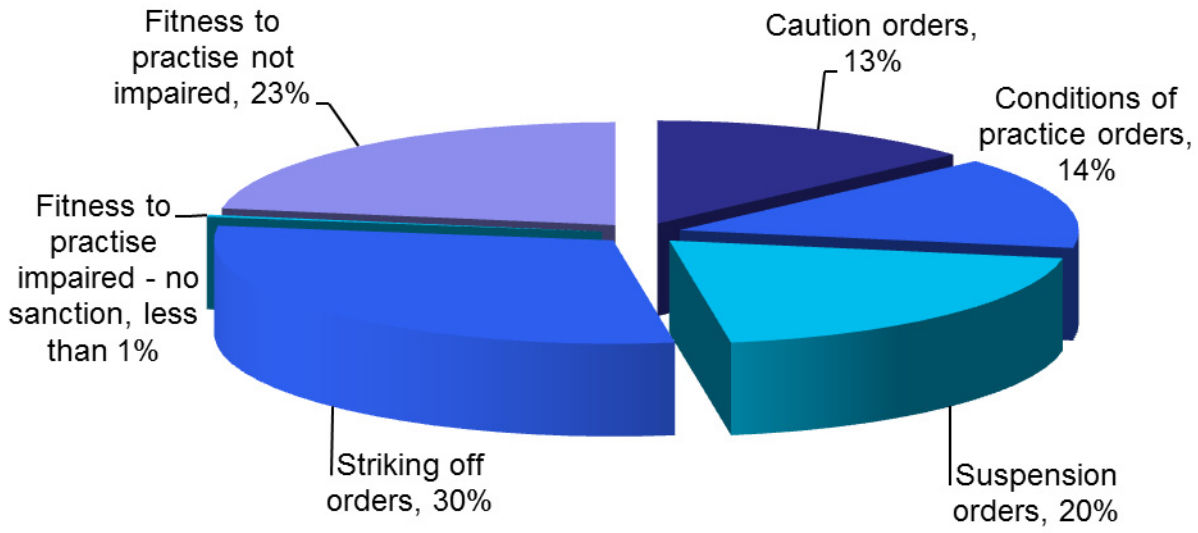
Table 7: CCC and HC final adjudication outcomes in 2013–2014

The total number of cases in which fitness to practise was found to be impaired and a sanction imposed represents approximately 0.2 percent of the total number of registered nurses and midwives. A small proportion of these were resolved through consensual panel determinations.

CCC and HC final adjudication outcomes*	Number of decisions	Percentage
Striking-off orders	537	30%
Suspension orders	357	20%
Conditions of practice orders	261	14%
Caution orders	240	13%
Fitness to practise impaired – no sanction	6	Less than 1 %
Total	**1,401**	**77%**
Fitness to practise not impaired	404	23%
Total final outcomes	**1,805**	**100%**

***** These include decisions made on review of a substantive order imposed at an earlier stage in the same case.

Chart 7: CCC and HC final adjudication outcomes 2013–2014



Appeals against our decisions

A nurse or midwife can appeal against the sanction we imposed. The appeal has to be made within 28 days. Appeals are heard in the High Court of Justice in England and Wales, the Court of Session in Scotland or the High Court of Justice in Northern Ireland, depending on the country of the nurse's or midwife's registered address.

The originator of the case cannot appeal against our decision, but they can seek a judicial review if they are unhappy with the process by which the decision was reached.

The PSA can appeal our decisions if it considers a decision unduly lenient: four such appeals were lodged in 2013–2014. One of the appeals was referred proactively by us to the PSA, as we were concerned at the leniency of the sanction imposed. Subsequently, this case was resolved by the individual agreeing to be struck off.

Table 8: Appeals against our decisions

Outcomes of appeals *	Number
Allowed or remitted to Practice Committee by the Court	14
Dismissed by the Court	41
Total	**55**

***** These are outcomes of appeals where the Court made a decision in 2013–2014. Some appeals may have been lodged before 2013–2014.

Restoration to the register

Nurses and midwives who have been struck off must wait five years before they can apply to be restored to the register.

A nurse or midwife must first satisfy a panel of the Conduct and Competence Committee or the Health Committee that they are fit to practise. If they are able to satisfy the panel that they are fit to practise they will normally be required to undergo a return to practice programme before they can be allowed to go back on the register. We consider that these stringent tests help ensure that the public is properly protected.

Table 9: Restoration application outcomes

Restoration cases considered	Outcome
Application accepted	8
Application rejected	11
Total	19

Fitness to practise efficiency and effectiveness 2013–2014

During 2013-2014, we continued to progress our major programme to improve the effectiveness and efficiency of our fitness to practise processes. We have supported this with substantial investment: some 78 percent of our budget was spent on our fitness to practise function this year. This enabled us to increase both staffing levels and the amount of activity we undertake, as well as introduce new processes and improve existing ones.

Key developments during the year included:

- Investigating on average 80 percent of cases internally, rather than sending these for external investigations.
- Increasing to 30 the number of meetings and hearings held each day.
- Expanding the number of panel members who can consider cases and improving the training, support and guidance to both members and panel secretaries.
- Rolling out new processes to resolve cases and provide alternatives to a full hearing where particular criteria are met: voluntary removal and consensual panel determinations. We have refined and improved these processes during the year, as we have learnt from their operation in practice and will continue to do so. We have also taken account of learning from the Professional Standards Authority's initial stages audit report in 2013.

Our performance in 2013–2014

Despite a 14 percent increase in referrals, we have seen significant improvements in performance. Our key performance indicators and targets are focused on protecting the public quickly and improving the speed with which we resolve cases.

As indicated earlier in the report, we:

- exceeded our target for protecting the public through interim orders (page 18);
- only slightly undershot our target for completing investigation of cases (page 20); and
- met or exceeded the level of planned performance for the time taken for cases to reach adjudication. This means we are on track to meet our target in December 2014 (pages 22-23).

Other significant achievements in 2013–2014 included:

- Since February 2013, concluding 1,583 of our oldest and most complex cases. We have now concluded all our historical cases (those dating from before our improvement programme began in January 2011) except six held up by factors outside our control.
- Better handling of cases at initial stages and consistent application of risk assessment processes, as recognised by the Professional Standards Authority in its initial stages audit report 2013.
- Improving the experience of witnesses involved in our cases. We now offer witnesses and registrants a chance to visit our hearings venues in advance and provide more information on our website about what to expect at a hearing. We also put our customer feedback form online, in response to requests for this. We

are also improving our customer service more generally, including through staff training and are beginning to see higher customer satisfaction feedback as a result.
- Ensuring that 99 percent of those involved in a case were notified of the final decision within five working days.
- Receiving positive feedback from the professional bodies and unions about customer service, improvements in our processes and how we are engaging with them on changes introduced or planned.

We have developed a performance and quality-management framework which sets standards for our work and against which we can quality assure and assess the outcomes we achieve. This will be fully operational by autumn 2014.

Ensuring efficiency

We are conscious that we need to make the best use of our available resources both to ensure value for money and to direct our resources towards the most serious cases which present the greatest risks to public protection.

During 2013–2014, we delivered over £11.3 million efficiency savings in Fitness to Practise through:

- Investigating 80 percent of cases in-house.
- Revising our interim order and Investigating Committee processes.
- Introducing voluntary removal and consensual panel determinations, reducing the number of full public hearings we need to hold. As each public hearing costs an average of £13,000, these initiatives release resources to redeploy elsewhere.
- Changing how we use shorthand writers and reducing the number of cases where transcripts are required.
- Ongoing business and system improvement initiatives to review and improve business processes and our Case Management System.

We are committed to driving out further efficiencies whilst also improving our effectiveness and managing a challenging day-to-day workload.

Future focus

We know that we have more to do. Over the next three years we have an ambitious programme to improve the quality of our work including our decision making, our customer service, how we protect the information we hold and the speed of case progression.

Continuing to improve the experience of all who engage with us on fitness to practise cases is a priority for us. We will be looking at how we can further improve support to witnesses, including considering good practice from elsewhere. We will also be assessing and reporting on customer feedback and using this to identify the scope for further improvements across all aspects of our work.

Reducing further the time taken to resolve cases is a key priority. The legislation which currently governs our work militates against our achieving radical reductions in timescales. But we are determined to do all we can to improve while we wait for the major legislative change promised by the Government. We will introduce case examiners in early 2015, through the more minor changes which can be secured under our existing legal framework. This will help improve the speed with which we can resolve cases at the early stages, as well as the consistency of decision making.

Once we meet our adjudication target in December 2014, we will set a target based on resolving cases from start to finish within 15 months. We will start to measure and publicly report on the percentage of cases completed within 15 months from July 2014. This will provide the information for us to set a target for 2015-2016 which is challenging, whilst being realistic and honest about what we can achieve.

In 2015, we also plan to introduce a regional liaison capacity to enable us to work more effectively with employers, nurse and midwifery leaders on the ground. This will enhance our wider work such as communication and engagement and the introduction of revalidation. It should also strengthen our ability to gather data on risks, issues and trends to support both our own work and our collaboration with other professional and systems regulators.

We will continue to examine all aspects of our work to identify the scope for further efficiencies, including ensuring that we realise all the benefits of our improvement programme, to deliver the cost effective and high quality service the public deserves.

ISBN 978-1-4741-1081-5