Nursing & Midwifery Council

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Annual Fitness to Practise Report 2017–2018

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Foreword

2017–2018 was a significant year for fitness to practise. In addition to sound operational performance, we introduced important changes to our legislation:

- In March 2017, we changed the way we regulate midwives by removing supervision from our legislation. Employers, patients and their families can now contact us directly if they have concerns about midwives. We are directly responsible for the regulation of midwives bringing them in line with how we regulate nurses. Our data shows that there has not been any significant change in the proportion of referrals about midwives since these changes.

- In July 2017, we introduced new powers for our Case Examiners to close cases by issuing warnings, giving advice or agreeing undertakings. These new powers enable us to resolve cases sooner and reduce the need for adversarial hearings which can have a significant impact on patients and families as well as nurses and midwives. We are pleased to see the positive impact of these new decision-making powers, including the financial benefits they have brought.

We recognise that we need to continue to make significant improvements to address the findings of the PSA's Lessons Learned Review into our handling of fitness to practise cases involving midwives at Furness General Hospital. We have already made significant progress in setting up a new public support service and taking a person-centred approach to fitness to practise, and we expect these to have a positive impact on patients and families in the years ahead.

We have recently set a new strategic direction for fitness to practise, *Ensuring patient safety, enabling professionalism*. Our focus is on reducing risks to patients and service users in the future by encouraging openness and learning, not on punishing nurses and midwives for past mistakes. The changes entail:

- putting people at the centre of what we do, so that we treat patients and families with compassion and respect, and properly listen to and resolve their concerns

- working more closely with employers so that as many issues as possible can be resolved quickly and effectively at a local level

- giving greater consideration to the context in which incidents occur, recognising the complex issues and pressures nurses and midwives face every day

- encouraging nurses and midwives to be open when things go wrong and supporting them to put things right

- making better use of hearings to reduce the impact on patients and families and on nurses and midwives.

Work has already begun to start implementing our new approach and we look forward to reporting on these exciting changes in next year's report.

Philip Graf
Chair, NMC
16 October 2018

Sue Killen
Interim Chief Executive and Registrar, NMC
16 October 2018

Overview of how we protect the public

About us

The Nursing and Midwifery Council (NMC) is the independent nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland. Our role is to protect the public and we seek to ensure that all our work delivers public benefit. We are accountable to Parliament through the Privy Council.

The Council's overarching objective in exercising its functions is the protection of the public, the pursuit of which involves the following objectives:

- To protect, promote and maintain the health, safety and well-being of the public.
- To promote and maintain public confidence in the professions we regulate.
- To promote and maintain proper professional standards and conduct for nurses, nursing associates and midwives.

Our regulatory responsibilities are to:

- Keep a register of all those who meet our requirements for registration.
- Set standards of education, training, conduct and performance so that nurses, nursing associates and midwives are able to deliver high-quality healthcare consistently throughout their careers.
- Take action to deal with individuals whose integrity or ability to provide safe care is questioned, so that the public can have confidence in the quality and standards of care provided by nurses, nursing associates and midwives.

The Professional Standards Authority for Health and Social Care (PSA) oversees our work and reviews our performance each year.

More information about the work we do to protect the public is available on our website: www.nmc.org.uk/about-us/.

Our register

We maintain a register of nurses and midwives who meet our standards and are allowed to practise in the UK.

At the end of March 2018, there were 690,278 nurses and midwives on our register – 495 fewer than at the end of March 2017.

The register is made up of 646,637 nurses (94%), 35,830 midwives (5%) and 7,811 who are registered as both a nurse and a midwife (1%).

A breakdown of the geographical location of our register is as follows:

Country of registered address	Percentage of the register
England	79%
Scotland	10%
Wales	5%
Northern Ireland	4%
Overseas	2%

We have clear and transparent processes to investigate concerns about nurses and midwives. If someone registered with us poses a risk to patients or the public, we can take action to restrict their right to work as a nurse or midwife until we are confident they meet our standards or to remove them from the register altogether.

Our register is publicly accessible and anyone can check whether a nurse or midwife is currently registered, or if they have any restrictions on their practice by visiting www.nmc.org.uk/search-the-register/ or by calling us or writing to us.

What is fitness to practise?

We say that a nurse or midwife is fit to practise when they have the skills, knowledge, health and character to do their job safely and effectively.

Our professional code, *The Code: Professional standards of practice and behaviour for nurses and midwives* (NMC, 2015) sets out the professional standards that

nurses and midwives must uphold in order to be registered, and maintain their registration, in the UK. The Code is available on our website: www.nmc.org.uk/code.

Our revalidation process requires every nurse and midwife to regularly demonstrate that they practise safely and live up to the standards set out in the Code.

If someone has concerns about the fitness to practise of a nurse or midwife, in the first instance they can raise their concerns with the employer to see if they can be resolved at a local level.

If the concerns can't be resolved at a local level, or if someone believes them serious enough to require immediate regulatory action, then they can raise their concerns with us. We look at what has happened and whether the nurse or midwife is fit to practise now and in the future. We then decide what action we need to take to protect the public.

How concerns get raised with us

Anyone can tell us at any time if they have concerns about a nurse or midwife's fitness to practise. We are also able to open cases ourselves if we need to.

Typically, we receive concerns from:

- 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
- the police
- a nurse or midwife referring themselves
- other healthcare regulators.

More information about making a referral is available on our website: www.nmc.org.uk/concerns-nurses-midwives/concerns-complaints-referrals/

Concerns we can and cannot consider

We can only consider concerns if they are about a nurse or midwife on our register. We can't consider concerns if they are about other healthcare workers, or members of the public. We will refer these concerns on to other regulators, or the police if it is appropriate.

Our role is to decide whether any concerns about a nurse or midwife's fitness to practise require us to take regulatory action to protect the public. The types of concerns we can consider include:

- misconduct (including clinical misconduct)
- lack of competence
- criminal convictions
- serious ill health
- not having the necessary knowledge of the English language.

We also investigate cases where it appears that someone has gained access to our register fraudulently or incorrectly.

How we deal with concerns that are raised with us

Steps we take to help us to assess concerns and decide whether regulatory action is required typically include:

- asking for more information from the person who raised the concern
- checking our records to see whether concerns have been raised about the nurse or midwife before
- asking the nurse or midwife's employer whether they have any other concerns about that person
- taking statements from witnesses and gathering other evidence
- asking the nurse or midwife for their response to the concerns and to explain any steps they have taken to put things right.

In some cases, we hold a hearing or meeting to decide whether regulatory action is required. Hearings and meetings are undertaken by independent panels. The panel will be provided with relevant evidence and may hear from witnesses and from the nurse or midwife against whom the allegations have been made.

More information about how we handle concerns is available on our website:

www.nmc.org.uk/concerns-nurses-midwives/dealing-concerns/

Regulatory action we can take to protect the public

If necessary, we can take urgent, temporary action to protect the public while we investigate concerns. We do this by asking an independent panel to apply an interim order. There are two types of interim order:

- An interim conditions of practice order, which imposes conditions the nurse or midwife must comply with.

- An interim suspension order, which temporarily suspends the nurse or midwife's registration.

More information about interim orders is available on our website:

www.nmc.org.uk/concerns-nurses-midwives/information-under-investigation/interim-orders/

Once we have investigated the concerns fully, our Case Examiners can:

- give advice to the nurse or midwife to remind them of the professional standards they are expected to uphold
- issue a warning to the nurse or midwife
- agree undertakings with the nurse or midwife, which are a series of agreed steps they must take in order to return to safe and effective practice
- close the case with no further action if there are no public protection concerns.

More information about action our Case Examiners can take is available on our website:

www.nmc.org.uk/concerns-nurses-midwives/hearings/our-panels-case-examiners/case-examiners/

In more serious cases, or where the nurse or midwife does not accept there are concerns about their practice, we will hold a hearing. At a hearing, an independent panel can:

- issue a caution order for up to five years
- impose conditions of practice which the nurse of midwife must comply with for up to three years
- suspend the nurse or midwife from the register for up to one year
- strike the nurse or midwife off the register
- close the case with no further action.

More information about action our independent panels can take is available on our website:

www.nmc.org.uk/concerns-nurses-midwives/hearings/our-panels-case-examiners/fitness-to-practise-committee/

In some circumstances, and only if we are satisfied that it is in the public interest to do so, we can allow a nurse or midwife to voluntarily remove themselves from our register without the need for a hearing or a meeting.

Public information about our decisions

Information about what we do and how we take decisions, including our guidance for decision-makers, is published on our website:

www.nmc.org.uk/concerns-nurses-midwives/

When we take regulatory decisions about a nurse or midwife's fitness to practise we explain our reasons to the person who raised the concerns with us and to the nurse or midwife.

In addition, if we decide to take regulatory action to protect the public, we publish information on our website so anyone can see the decisions we have taken and why:

- when a panel imposes an interim order, we publish the outcome and note it on the nurse or midwife's entry on the register
- when the Case Examiners issue a warning or agree undertakings, an explanation and reasons are published with the nurse or midwife's entry on the register
- when a panel decides to issue a caution, conditions of practice, suspension, or striking off order, we publish the panel's full reasons and note the outcome on the nurse or midwife's entry on the register.

In cases that relate to an individual's health, or contain other sensitive personal information, we still publish information but usually in less detail. That way we protect the public and respect the individual's privacy. When we decide to close a case with no further action, we don't normally publish information because there is no reason to do so to protect the public and we have a responsibility to protect the privacy of those involved.

Our register of nurses and midwives is online: www.nmc.org.uk/search-the-register/

Information about forthcoming hearings and recent panel decisions are on our website:

www.nmc.org.uk/concerns-nurses-midwives/hearings/hearings-sanctions/

2017–2018 statistical summary

Our key performance indicators

In every case, we aim to reach the outcome that best protects the public at the earliest opportunity. We have two key performance indicators which measure this.

Where necessary, we aim to impose 80 percent of interim orders within 28 days of receiving the referral. At the end of the year, our performance was 88 percent.

We aim to complete 80 percent of our cases within 15 months of receipt. At the end of the year, our performance was 81 percent.

Number of concerns

In 2017–2018 we received 5,509 new concerns, about 1 percent more than the 5,476 referrals we received in 2016–2017. The total number of concerns we received represents around 8 referrals for every 1,000 registrants.

Source of concerns

Table 1 shows the sources of concerns we received last year. The proportion of concerns referred to us from different sources in 2017–2018 remains broadly unchanged compared to 2016–2017.

Table 1: Source of concerns referred to us

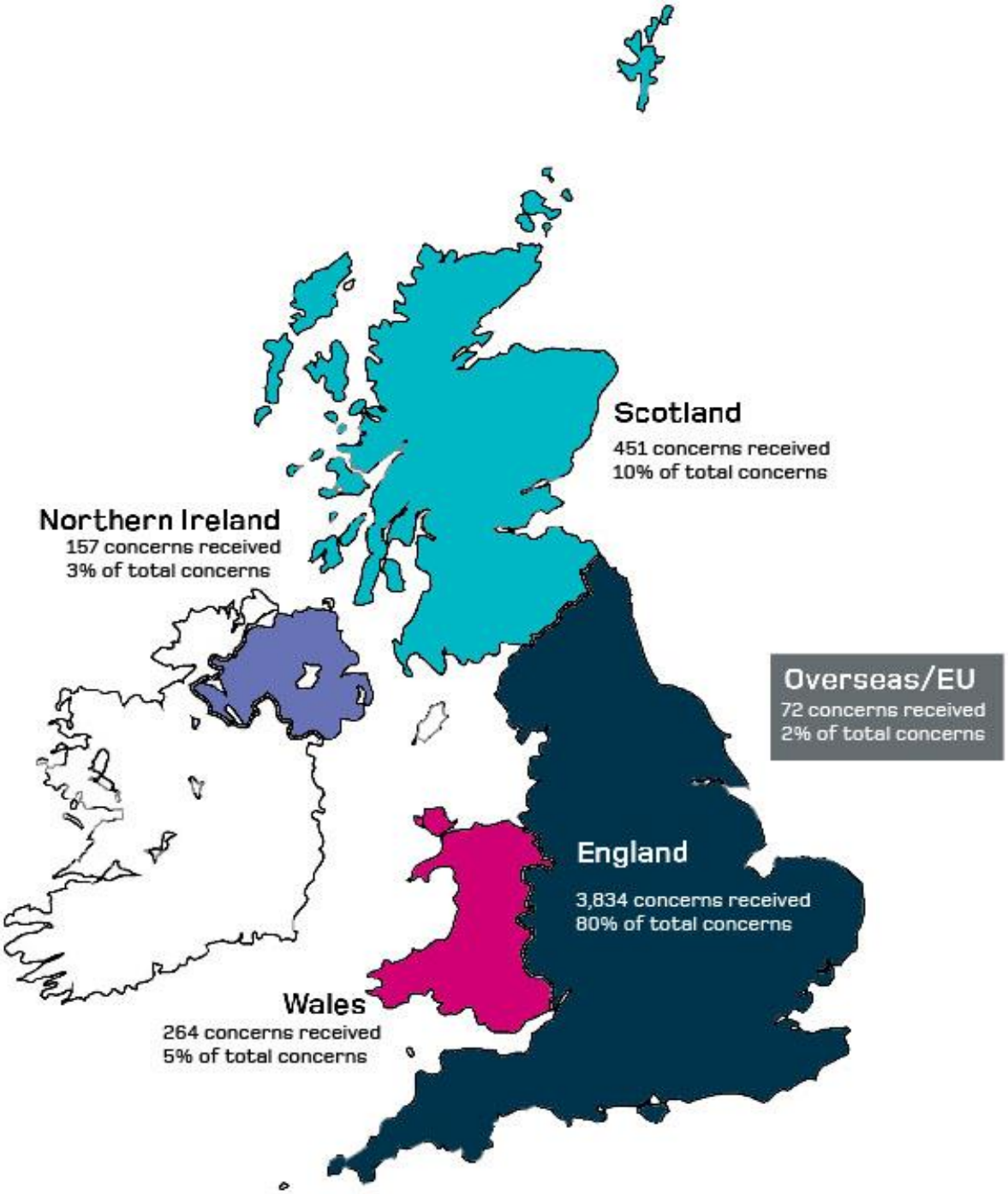
Who referred concerns to us	2017–18		2016–17
	Number of new concerns	Percentage of new concerns	Percentage of new concerns
Patient/public	1,470	27%	28%
Self-referral	538	10%	10%
Employer	2,178	40%	39%
Opened by the NMC	331	6%	6%
Another registrant	168	3%	3%
Other regulator	35	<1%	1%
Referrer unknown	213	4%	3%
Any other informant	576	10%	10%
Total	**5,509**		

We were not able to identify a registered nurse or midwife in 731 of the new cases raised with us. Some of those are cases we received at the end of the reporting period and where we will identify a nurse or midwife in 2018–2019. Others are cases

where we do not have authority to act because they do not relate to a registered nurse or midwife.

Concerns by country of registered address

The following diagram breaks down the 4,778 cases where we identified a registered nurse or midwife using the nurse or midwife's country of registered address. The proportion of concerns in each country broadly equates to the proportion of nurses and midwives on the register.



Concerns by registration type

An individual can be registered with us as a nurse, as a midwife, or as both a nurse and midwife (known as dual registration). Last year we reported the breakdown of dual registration data separately. This year, we have simplified our reporting by including the breakdown of dual registration data in the overall numbers for registration type. For more information, see the 'Notes on data' section later in this report.

Table 2 shows the number of new referrals broken down by registration type. There has been no material change in the proportion of referrals by registration type compared to 2016–2017.

Table 2: Concerns by registration type

Registration type	2017–18		2016–17
	Number of new referrals	Percentage of total referrals	Percentage of total referrals
Nurse	4,538	95%	92%
Midwife	240	5%	3%
Dual registration	-	-	5%
Total	**4,778**		

Initial assessment outcomes

In 2017–2018, we closed 3,081 cases after initial assessment either because we were unable to identify a nurse or a midwife on our register, or because the concerns raised were not serious enough to require regulatory action. The closure rate of 56 percent is a slight decrease on the closure rate of 60 percent in 2016–2017.

We refer concerns to other regulatory bodies where we believe they may need to take action to protect the public. In 2017–2018, we made 233 referrals to other organisations.

In 2017–2018, our panels imposed interim orders to protect the public while our investigations were ongoing in 583 cases (2016–2017: 705). Table 3 shows the break down between the two types of interim orders.

Table 3: Interim orders imposed

Interim order decisions	2017–18		2016–17	
	Number of interim orders	Percentage of interim orders	Number of interim orders	Percentage of interim orders
Interim conditions of practice	309	53%	326	46%
Interim suspension	271	47%	379	54%
Total	**580**		**705**	

Table 4 breaks down the number of interim orders imposed by registration type. There has been some change in the proportion of interim orders imposed by registration type. We have not identified any particular trends and will monitor changes in the future.

Table 4: Interim orders imposed by registration type

Interim order decisions	2017–18		2016–17		
	Nurse	Midwife	Nurse	Midwife	Dual
Interim conditions of practice	284 (52%)	25 (71%)	289 (45%)	20 (59%)	17 (57%)
Interim suspension	261 (48%)	10 (29%)	352 (55%)	14 (41%)	13 (43%)
Total	**545**	**35**	**641**	**34**	**30**

Case Examiner outcomes

In 2017–2018, our Case Examiners took 2,234 decisions (2016–2017: 2,709) at the end of an investigation. The volume of investigations completed was lower than expected and we will seek to address this during 2018–2019. Previously, Case Examiners had the power either to close a case with no further action or to refer it for a hearing or meeting. In August 2017, we introduced additional powers for Case Examiners to give advice, issue warnings, or agree undertakings.

Table 5 breaks down the total decisions by type. In 2017–2018, Case Examiners referred proportionally fewer cases for a hearing or meeting compared to 2016–2017. In part, this reflects the use of the new powers from August 2017. There has also been an increase in the proportion of cases closed with no further action. We have not identified any particular trends in relation to these cases and will continue to monitor the closure rate carefully.

Table 5: Total Case Examiner decisions

Case Examiner decisions	2017–18	2016–17
	Number of cases	Number of cases
Refer for hearing or meeting	819 (37%)	1,539 (57%)
Advice	24 (1%)	-
Warning	93 (4%)	-
Undertaking	28 (1%)	-
No further action	1,270 (57%)	1,170 (43%)
Total	**2,234**	**2,709**

Table 6 breaks down the number of Case Examiner decisions by registration type. The proportion of different types of decisions for nurses reflects the overall distribution (see Table 5). Relative to the overall distribution, cases about midwives appear marginally less likely to be closed with no further action or with one of the new disposal powers; however, given the small sample size at this stage, no firm conclusions should be drawn.

Table 6: Number of decisions by registration type

Case Examiner decisions	2017–18		2016–17		
	Nurse	Midwife	Nurse	Midwife	Dual
Refer for hearing or meeting	770 (37%)	49 (40%)	1,444 (57%)	56 (56%)	39 (71%)
Advice	22 (1%)	2 (2%)	-	-	-
Warning	87 (4%)	6 (5%)	-	-	-
Undertaking	22 (1%)	6 (5%)	-	-	-
No further action	1,211 (57%)	59 (48%)	1,110 (43%)	44 (44%)	16 (29%)
Totals	**2,112**	**122**	**2,554**	**100**	**55**

Case Examiners work in pairs. One is a registered nurse or midwife, and one is a lay person. If the Case Examiners are unable to agree on an outcome, they must refer the case to an independent panel of the Investigating Committee for a decision. No cases were referred to the Investigating Committee in 2017–2018 (2016–2017: 0).

Hearing and meeting outcomes

In 2017–2018, our panels reached 1,207 final decisions on cases (2016–2017: 1,513) through meetings and hearings. Table 7 breaks down the panel decisions by type. There is no material difference in the types of sanction imposed in 2017–2018 compared to 2016–2017.

There has been an increase in the proportion of cases resulting in a finding of no impairment. This may reflect better engagement with registrants at the hearing stage and a greater willingness on their part to provide evidence of remediation and insight. We continue to encourage nurses and midwives to remediate at the earliest opportunity.

Table 7: Panel decisions

Panel decision	2017–18		2016–17	
	Number	Percentage	Number	Percentage
Strike off	257	21%	344	23%
Suspension	372	31%	424	28%
Conditions of practice	165	14%	267	18%
Caution	129	11%	164	11%
FtP impaired – no sanction	0	0%	5	<1%
Sub-total	**923**	**77%**	**1,204**	**80%**
Facts not proved	5	<1%	31	2%
FtP not impaired	279	23%	278	18%
Total panel decisions	**1,207**		**1,513**	

Table 8 breaks down panel decisions by registration type. The proportion of different types of decisions for nurses reflects the overall distribution (see Table 7) and is broadly consistent in comparison to 2016–2017. Relative to the overall distribution, cases involving midwives are more likely to result in a strike off or suspension or in the facts not being proved; they are less likely to result in lesser sanctions or in findings of no impairment. No firm conclusions should be drawn, however, because the numbers are small and comparison with last year's data does not suggest a trend.

Table 8: Hearing outcomes by registration type

Panel decision	2017–18		2016–17		
	Nurse	Midwife	Nurse	Midwife	Dual
Strike off	243 (21%)	14 (27%)	322 (23%)	6 (22%)	16 (18%)
Suspension	355 (31%)	17 (33%)	384 (27%)	4 (15%)	36 (44%)
Conditions of practice	157 (14%)	8 (16%)	246 (18%)	7 (26%)	14 (16%)
Caution	127 (11%)	2 (4%)	153 (11%)	5 (19%)	6 (7%)
FtP impaired – no sanction	0 (0%)	0 (0%)	4 (<1%)	0 (0%)	1 (1%)
Sub-total	**882**	**41**	**1,109**	**22**	**73**
Facts not proved	5 (<1%)	0 (0%)	29 (2%)	5 (19%)	12 (14%)
FtP not impaired	269 (23%)	10 (20%)	261 (19%)	0 (0%)	2 (2%)
Totals	**1,156**	**51**	**1,399**	**27**	**87**

Fraudulent or incorrect register entries

Our panels consider allegations that a nurse or midwife has been added to the register incorrectly or fraudulently. If they find the allegation proved, the panel can direct the Registrar to remove or amend the entry on the register.

In 2017–2018, our panels directed the Registrar to remove a nurse or midwife from the register in 60 cases (2016–2017: 36). We updated our internal guidance for decision makers in 2015 to clarify when cases should be considered as fraudulent or incorrect register entries and when they should be considered as wider fitness to practise concerns. Since then, we have seen an increase in the number of cases considered as fraudulent or incorrect entries.

Voluntary removal

After a case has been referred for a hearing or meeting, nurses and midwives may apply to be voluntarily removed from the register. The Registrar will only approve applications where the nurse or midwife accepts the allegations and it is in the public interest for them to be removed from the register immediately.

Table 9 shows the number of applications received and granted in the last three years. The slight decrease in the number of applications since 2016–2017 reflects the decrease in the number of cases referred for a hearing or meeting (Table 5).

Table 9: Voluntary removal applications

Voluntary removals	2017–18	2016–17	2015–16
Number of applications	136	165	107
Applications granted	66	77	44
Applications rejected	70	88	63

The table below shows the breakdown in this year's voluntary removal decisions by registration type.

Table 10: Voluntary removal decisions by registration type

Voluntary removals	2017–18 total	Nurse	Midwife
Applications granted	66	52	14
Applications rejected	70	60	10

Reviews and appeals

We have the power to review the Case Examiners' decisions and anyone can request that we do so. Previously, we could only review decisions to close cases with no further action. Since August 2017, we have also been able to review decisions to give advice, issue warnings, or agree undertakings.

Reviewing a decision under this process is done in two stages:

- We decide whether or not to do a review.
- If we do review, we can decide either to uphold the original decision or that a new decision is required.

Table 11 shows the number of reviews of Case Examiner decisions in 2017–2018. The table shows the number of requests we received and the decisions we took during the year. The figures do not balance in-year because some decisions are reached in the year after the request was received. The number of requests we received has remained broadly similar and represents less than 3 percent of all Case Examiner decisions.

We do not believe the fluctuation in the number of second stage decisions resulting in a fresh decision is material. Learning from reviews is used to inform training and other quality improvement activities for Case Examiners and investigators.

Table 11: Reviews of Case Examiner decisions

Power to review stage	2017–18	2016–17	2015–16
Total requests for review received	64	69	90
First stage: request closed	35	57	37
Second stage: fresh decision required	20	2	14
Second stage: original decision upheld	17	5	2

Of the 20 cases where the Registrar decided a fresh decision was required:

- 18 were because there was a material flaw in the original decision
- one was because new information was available
- one was because of both a material flaw and new information.

A nurse or midwife is able to appeal against a decision of our panels. They must lodge their appeal within 28 days of the decision to either the High Court in England and Wales, the High Court in Northern Ireland, or the Court of Session in Scotland. The PSA can also appeal if it considers that a panel decision does not protect the public.

Table 12 shows the total number of appeals. The reduction in the number of appeal outcomes broadly reflects the reduction in overall panel decisions (Table 7) and represents just over 2 percent of all panel decisions. Learning from appeals is used to inform training for panel members and staff and other quality improvement activities.

Table 12: Outcomes of appeals of panel decisions

Outcome	2017–18	2016–17	2015–16
Total appeals lodged	32	54	49
Appeal upheld	12	22	18
Appeal dismissed	26	26	34

The table below shows the breakdown in this year's appeal of panel decisions by registration type.

Table 13: Appeal of panel decisions by registration type

	2017–18 total	Nurse	Midwife
Appeal upheld	12	10	2
Appeal rejected	26	25	1

Restoration to the register

A nurse or midwife who has been struck off by a panel can apply to be restored to our register after five years. Before they can re-join the register, they have to satisfy a panel that they are fit to practise. If their application is successful, they usually have to undergo a return to practice programme.

Table 14 shows the outcomes of restoration applications in 2017–2018. We have not identified any trends relating to the fluctuation in number of restoration applications over the last few years.

Table 14: Restoration application outcomes

Outcome	2017–18	2016–17	2015–16
Total applications received	52	35	25
Application accepted	21	5	18
Application rejected	15	5	8

Table 15 shows the breakdown in this year's restoration decisions by registration type.

Table 15: Appeal of restoration decisions by registration type

	2017–18 total	Nurse	Midwife
Application accepted	21	20	1
Application rejected	15	13	2

Notes on the data

Comparability

This is the second year we have reported using case numbers rather than nurses' and midwives' PINs as the identifier. For that reason, we only have two years' comparative data in tables 1 to 15.

Dual registration

Someone can be registered with us:

- as a nurse
- as a midwife
- as a nurse and a midwife (which we call dual registration).

If fitness to practise concerns are raised about someone with dual registration, we record whether the concerns have arisen in their practice as a nurse or as a midwife. If the concerns are not directly related to their clinical practice – for example because they relate generally to their professionalism – we record them as relating to their dual registration.

Last year we reported the breakdown of dual registration data separately. This year, we have simplified our reporting by including the breakdown of dual registration data in the overall numbers for registration type.

Reporting period

We do not conclude all cases received during the reporting period, therefore there will be differences between numbers received and outcomes for the year.

Equality, diversity, and inclusion

We publish equality, diversity and inclusion data in our annual equality and diversity report separately.

Improving effectiveness and efficiency

During 2017–2018, we made a number of changes to improve our effectiveness and efficiency in protecting the public.

Legislative change

In March 2017, changes to our legislation removed a requirement for statutory supervision of midwives. In fitness to practise, this means that we are now able to address concerns about midwives in the same way as we address concerns about nurses. We worked with midwives and employers to ensure a smooth transition. We have not seen any change in the proportion of referrals about midwives during the year (Tables 2 and 3).

During the year, we made changes to our fitness to practise legislation. These changes allow us to be more flexible in our approach to cases, from concluding them earlier in the process to more flexibility on where we can hold our hearings. The changes aim to deliver financial savings and make the process fairer and more proportionate.

Summary of changes	Benefits
We increased the amount of time between interim order reviews from three months to six months.	Between April 2017 and March 2018, we saved £801,000 in hearing costs.
A single Fitness to Practise Committee was created. Previously there had been two separate Committees; the Conduct and Competence Committee and the Health Committee.	We are able to protect the public more easily because different types of allegation can be heard together. We are now able to schedule cases more easily as we have more panel members available.
Previously the Committees were required to review all conditions of practice and suspension orders before their expiry. Panels can now state whether a review is required or not before the order finishes.	We can conclude cases more efficiently where an order is required to uphold standards or confidence in the profession but the nurse or midwife does not currently pose a risk to public protection.

Case Examiners were given new powers to give advice, issue warnings, and agree undertakings. Our power to review Case Examiner decisions was also extended to cover these new powers.	Concluding these cases earlier means there is less impact on all the people involved in cases, including patients and members of the public. Between August 2017 and March 2018, we have reduced our expenditure on hearings by £2 million using these new powers.
Hearings no longer have to be held in the country of the registered address of the nurse or midwife.	We can be more flexible in scheduling hearings, which can reduce the amount of travelling for witnesses, members of the public, and nurses and midwives.

Digital audio recording

We introduced a digital audio recording system at our hearing centres in London and Edinburgh. This has improved data security, efficiency, and the quality of transcripts from our hearings. Since the system was introduced, we have reduced our expenditure on shorthand writers by £667,000.

Employer Link Service and Regulatory Intelligence Unit

Our Employer Link Service (ELS):

- helps employers to decide whether they need to refer concerns about nurses and midwives to us,
- offers inductions for senior nursing and midwifery leaders and learning sets for their wider teams,
- works with other regulators and stakeholders to ensure risks are identified and managed by the right organisations,
- listens to employers' suggestions about ways to improve our processes.

We have continued to build on the success of ELS in its second year by strengthening relationships with employers and other regulators. This year we set up the Regulatory Intelligence Unit (RIU) to work alongside ELS. Their work means we are able to deliver a more targeted approach to our engagement with employers and other regulators.

The work of the RIU includes improving our data collection and how we share data with other regulators to give us a better understanding of the wider healthcare and regulatory landscapes and systems. The work of RIU also better informs ELS about

data trends ahead of their engagement with employers. We will publish a separate annual report about the work of ELS and RIU.

PSA Lessons Learned Review

In May 2018, the PSA published its Lessons Learned Review of our handling of concerns about midwives at Furness General Hospital. We welcome the report and fully accept that the way we handled these cases was unacceptable. Our management of the cases and our approach to engaging with the patients and families involved did not live up to our values as an organisation. We have apologised to patients and families for the significant and traumatic impact our mistakes had on them.

In recent years, we have made many improvements to the way we work. We recognise there are things we must do differently and better to continue to improve and to embed our values throughout the organisation. The priority areas where we wish to make a significant change in the way we work are:

- treating everyone who comes into contact with us with respect
- improving our approach to transparency and making sure that we are open with people when things go wrong
- embedding a culture of openness and learning throughout the organisation.

A new strategic direction

Looking to the future, we know there is more we can do to improve the way we deal with concerns about nurses and midwives. In April 2018, we launched a public consultation about our plans to set a new strategic direction for fitness to practise: *Ensuring patient safety, enabling professionalism*.

Professional regulation is about managing risks to public protection, not about punishing people for things that have gone wrong. Regulators have a key role to play in fostering a just culture in the health and care sector. Subject to the outcome of the consultation, we intend to:

- Improve the way we deal with concerns raised by members of the public and provide more support for them to engage effectively with the fitness to practise process.
- Work more closely with employers so they are able to resolve more concerns locally first, without the need for us to take regulatory action.
- Make sure that the context in which patient safety incidents occur is properly considered so that we only focus on issues that raise genuine regulatory concerns about an individual’s actions.

- Engage sooner with nurses and midwives where we have regulatory concerns about their practice to discuss how they can put things right.
- Seek to resolve as many issues as possible by consent and to focus panel hearings on resolving matters that have not been agreed.

Our proposals mean that there are likely to be fewer full panel hearings in public. When we take regulatory action to protect the public, we will always publish our reasons openly and transparently.

During the consultation, we engaged with patients and the public, as well as with employers, nurses and midwives, regulators, and other key stakeholders across the UK. We will finalise our new strategic approach, taking account of views and feedback, in July 2018 and begin implementation in 2018.

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