Nursing & Midwifery Council

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Annual Fitness to Practise Report 2016–2017

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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

July 2017

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Foreword

The NMC exists to protect the public by ensuring that nurses and midwives on our register practise safely and in accordance with professional standards. The vast majority of our registrants do so. In 2016–2017, less than 1 percent of our registrants had a concern raised about them. In such cases, it is important that we act quickly to resolve the concerns proportionately and fairly to ensure that, if a registrant continues to practise, they do so safely and appropriately.

The number of concerns raised with us continued to rise, though not as steeply as in previous years. Our sources of referral remained consistent, with employers contributing almost 40 percent to our total number of referrals, and patients and public adding a further 28 percent.

Our aim is to reach the outcome that best protects the public at the earliest opportunity. In 2016–2017 we strengthened our first line decision making process, closing 60 percent of cases at that stage. We have also made great strides with our Employer Link Service (ELS) who have now met with every NHS Trust and Board across the four countries and continue to work with them to help ensure that concerns referred to us are appropriate.

In managing our caseload we have focused our energies and resource this year on both reducing its size and prioritising older cases. Where the public is at immediate and serious risk it is important that we take prompt action. We consistently exceeded our target of imposing 80 percent of interim orders within 28 days, ending the year with an average of 91 percent.

We were pleased to have finally secured important changes to our legislation. These will help us resolve cases earlier in the public interest; focus on the most serious cases; and streamline parts of our processes. Whilst they are long overdue, these changes go some way to support our strategy to become a leading, dynamic regulator. We look forward to further engagement with the Government about the urgent need for more radical regulatory reform in the sector.

Dame Janet Finch
Chair, NMC
5 July 2017

Jackie Smith
Chief Executive and Registrar, NMC
5 July 2017

Introduction

Who we are and what we do

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 are accountable to Parliament through the Privy Council.

Our role has always been to protect the public. This has been made more explicit by the Health and Social Care (Safety and Quality) Act 2015. 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 nursing and midwifery professions.
- To promote and maintain proper professional standards for members of the nursing and midwifery professions.

Our regulatory responsibilities are to:

- Keep a register of all nurses and midwives who meet the requirements for registration.
- Set standards of education, training, conduct and performance so that nurses 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 and midwives.

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

Protecting the public

Our register

We maintain the register of nurses and midwives who are legally allowed to practise in the UK. Only a nurse or midwife who meets our standards can be admitted to, and remain on, the register. Only we can take action to stop a nurse or midwife from practising in the UK by suspending or removing them from the register or by restricting how they practise.

On 31 March 2017, there were 690,773 nurses and midwives on our register. This is a decrease of 0.27 percent from the number on the register on 31 March 2016.

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.

Fitness to practise

All qualified nurses and midwives must follow our professional code, *The Code: Professional standards of practice and behaviour for nurses and midwives* (NMC, 2015). The Code 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.

Being fit to practise means that a nurse or midwife has the skills, knowledge, health and character to do their job safely and effectively. Through revalidation, every nurse or midwife is required to regularly demonstrate that they practise safely and fully live up to the standards set out in the Code.

If someone has concerns about the fitness to practise of a nurse or midwife, they can raise them with us and we will decide what action we need to take to protect the public. In every case, we aim to reach the outcome that best protects the public interest at the earliest opportunity.

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 also have the power to open cases ourselves if we consider it necessary.

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 can refer 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 are only able to consider concerns about nurses and midwives who are on our register, and cannot consider concerns about other healthcare workers or members of the public. If we do receive concerns about other healthcare professionals (or other individuals who are not regulated) we refer them to their own regulators or to the police if it is appropriate to do so.

We consider concerns about whether a nurse or midwife is fit to practise. Our role is to decide whether a concern means that regulatory action is required to protect the public. The types of concerns we 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.

Other concerns about a nurse or midwife should normally be resolved by the individual's employer or the appropriate authority.

How we deal with concerns that are raised with us

When a concern is raised with us, we take the following steps:

- We make an initial assessment of the allegation to establish whether we can identify a registered nurse or midwife, assess the seriousness of the matter, and decide whether urgent action is required. If we consider the allegation on its own is not sufficiently serious to require regulatory action, we may contact the employer of the nurse or midwife to confirm whether they have any

concerns about the individual's fitness to practise. If they do not, the case can usually be closed.

- If necessary, we conduct an investigation to gather the evidence that is required to make a full assessment of the allegation.
- At the end of the investigation, if the Case Examiners or the Investigating Committee find there is a case to answer, we hold a hearing or a meeting to reach a final decision and determine what action, if any, should be taken.
- In some circumstances, and only if we are satisfied that it is in the public interest to do so, we allow a nurse or midwife to voluntarily remove themselves from our register without the need for a hearing or a meeting.

Who our decision makers are

Decisions about our cases are taken by independent panel members drawn from one of our practice committees:

- Investigating Committee
- Conduct and Competence Committee
- Health Committee

Panel members are recruited and appointed through an open and transparent process overseen by the Appointments Board. The Appointments Board is a committee of the Council. To ensure its independence, its members are not also members of the Council.

In 2017 new legislation will be introduced to enable the Conduct and Competence Committee and the Health Committee to be combined to form a single Fitness to Practise Committee which will be able to make decisions on all cases sent through to a final hearing. Further information on this committee can be found in the future focus section of this report.

Case Examiners have largely replaced the function of the Investigating Committee in deciding, at the end of the investigation, whether a case should be referred for a final hearing or meeting. Case Examiners are members of staff who exercise their decision making powers independently.

More information about our decision makers is available on our website: www.nmc-org.uk/concerns-nurses-midwives/hearings-and-outcomes/-our-panels-case-examiners

Action we take if a nurse or midwife is not fit to practise

At a final hearing or meeting, a panel of independent decision makers consider whether a nurse or midwife's fitness to practise is impaired. The panel will be provided with evidence and will hear from witnesses and from the nurse or midwife against whom the allegations have been made. The panel will decide whether the nurse or midwife's fitness to practise is currently impaired. In some cases the panel may decide that no action is necessary given all the circumstances of the case. If the panel decides that action is necessary, it can make one of the following orders:

- Caution order
- Conditions of practice order
- Suspension order
- Striking-off order

More information about these orders is available on our website: www.nmc.org.uk/concerns-nurses-midwives/hearings-and-outcomes/restrictions-sanctions/.

Improving our efficiency and effectiveness

During 2016–2017, we made some significant improvements to our ways of working, which support our aim of reaching the outcome that best protects the public interest at the earliest opportunity in every case.

Employer Link Service

The Employer Link Service (ELS) works with employers in healthcare to ensure referrals of nurses and midwives are appropriate, include all relevant information and are timely and efficient. Over the last year the ELS has continued to meet with and develop relationships with nursing and midwifery employers in all 279 NHS trusts and boards in the UK, and has expanded the service to include over 20 of the largest independent sector healthcare providers in the UK.

An NMC advice line was established for employers to discuss individual concerns with a regulation adviser who has specialist and in depth regulatory knowledge and experience.

Approximately 2,000 calls were received during 2016–2017 and advice was given on a broad range of issues. The majority of calls were from employers seeking advice on potential fitness to practise referrals. In each instance regulation advisers carefully consider the circumstances of the case before providing advice on whether referral is necessary or the case is not of regulatory concern and should be managed locally.

Of the calls from employers received by the regulation advisers in 2016–2017:

- 49% were advised to refer
- 25% were advised not to refer
- 26% were advised to conclude the local investigation before a decision is made on whether a referral is necessary

The service has been widely welcomed by employers and customer satisfaction surveys indicate that:

- 95% agree that ELS will be beneficial to them in their role
- 94% would recommend ELS to a colleague

ELS also work with other organisations to better understand trends and to get a better picture of the regulatory landscape. This is achieved by sharing intelligence and the identification of trends and issues within specific healthcare settings. Through this exchange of information ELS are better able to help our leadership

team steer the strategic direction of the organisation and to provide timely information for progressing cases and protecting the public.

First stage decision making

When we first receive a concern, a team of lawyers screen all of the referrals to decide whether or not the concern raised requires regulatory intervention. If not, the case can be closed. Over the last year we have continued to strengthen our early stage decision making by:

- Improving our screening risk assessment, including comprehensive training for decision makers
- Benchmarking the decisions on referrals made through ELS
- Increasing management focus through the creation of smaller teams
- Improving the process of identifying high profile cases at an early stage, and increasing the capacity of our team that deals with these cases

We have also updated and enhanced our guidance for the public and employers about making referrals. This guidance can be found on our website: https://www.nmc.org.uk/concerns-nurses-midwives/concerns-complaints-and-referrals/make-a-referral/

Further guidance on the preliminary assessment of allegations is available on our website: www.nmc.org.uk/globalassets/sitedocuments/concerns/preliminary-consideration-of-allegations-guidance.pdf

These changes better able us to identify and close cases which do not raise public protection concerns at the earliest opportunity, and concentrate our resources on investigating only serious cases which require regulatory action.

Digital audio recording

In December 2016 we introduced a new digital audio recording (DAR) system in our hearing centre in Stratford. This new system has provided cost savings of £50,000 in the last quarter of 2016–2017 and will provide an estimated £600,000 of savings in 2017–2018 as we remove the need for onsite shorthand writers. The system brings us in line with other healthcare regulators, and has improved our data security, our efficiency and the quality of our transcripts.

Substantive order compliance

Substantive orders may be handed down at the end of a fitness to practise hearing by a panel. The team who manage the reviews of these orders introduced a pilot aimed at increasing public protection by working with registrants, employers and representatives to ensure compliance with conditions of practice orders (CoPOs).

The pilot has been very well received by registrants, representatives and employers and feedback received so far indicates that registrants find it helpful to have expectations set out from the beginning of an order.

Substantive order reviews

In 2016 we introduced the review of a substantive order at a meeting rather than at a hearing. The public interest is maintained throughout this process, as the full range of options are available to the panel and the outcome of meetings are published in the same way as those of hearings. As meetings are held in private, with agreement from the registrant, there is no requirement to specify the date, time or venue where they will take place, and there is no requirement for a notice period. 345 cases have been reviewed at meetings rather than hearings, and this has saved over £345,000 through efficiently managing the attendance fees of panellists, legal assessors and shorthand writers.

Hearing costs

Through efficiencies to our processes in 2016–2017 the average cost of a hearing fell from £25,000 to £18,000. This reduction in cost has freed up resource and helped us to increase the number of final decisions made from 960 in 2015–2016 to 1,513 this year.

Equality and diversity

We commissioned the University of Greenwich to undertake research to help identify the extent to which black and minority ethnic (BME) nurses and midwives are represented in FtP cases. The report made a number of findings, the most significant being that BME nurses and midwives are more likely to be referred to us than their white counterparts. It highlighted that employers were the largest source of referrals and these referrals were most likely to progress through to the later stages of the FTP process. However, BME nurses and midwives are less likely to be struck off or suspended than white nurses and midwives. We are meeting with patient groups, employers, professional bodies and other regulators to drive forward positive changes in this important area and have committed to repeating the research once the first cycle of revalidation has concluded in 2019. The full report is available on our website: www.nmc.org.uk.

2016–2017 statistical summary

Our data this year is aligned with that which we provide to the Professional Standards Authority (PSA). We report by case number where a personal identification number (PIN) has been identified. This means that if a registrant has more than one case with us, all cases attributed to that registrant have now been counted. In previous years we have reported on the number of people who are going through our process and therefore when a registrant had more than one case open with us, only one was counted.

The advantage of this approach is greater consistency between publicly available sources of information about our performance, and the reporting of a more accurate picture of our workload. The disadvantage is that comparative data is not available for most sections of the report for this year only. We will reintroduce comparative data in next year's report.

Number of concerns

In 2016–2017 we received 5,476 new referrals, which is a 1 percent increase on the 5,415 referrals we received in 2015–2016 and a much lower increase than we have seen in the last five years. The total number of concerns we received represents 0.8 percent of the total number of nurses and midwives on our register, or around 8 referrals for every 1,000 registrants.

The table below shows the source of the concerns we received last year.

Table 1: Source of concerns referred to us in 2016–2017

Who referred concerns to us	Number of new concerns	Percentage of concerns
Patient/public	1,537	28
Self-referral	572	10
Employer	2,153	39
NMC Registrar	311	6
Another registrant	147	3
Other regulator	69	1
Referrer unknown	171	3
Any other informant	516	10
Total	**5,476**	**100%**

In 705 of the concerns we received last year we were unable to identify a registered nurse or midwife. Some of these referrals came in at the very end of our reporting period and will be reported on next year. Others were referrals made to us where we had no authority to take action. The next table shows a breakdown of the 4,771 cases we were able to open last year by country of registered address.

Table 2: Referrals by country of registered address 2016–2017

Country	Percentage of register	Number of concerns	Percentage of concerns
England	79	3814	80
Scotland	10	433	9
Wales	5	308	6
Northern Ireland	3	128	3
Overseas and EU	3	87	2
Unknown	0	1	0
Total	**100%**	**4,771**	**100%**
Unidentified referrals		705	
Total referrals		**5,476**	

Concerns by registration type

An individual can be registered with us as a nurse, or as a midwife, or with dual registration.

Table 3: Referrals by registration type 2016–2017

Registration type	Percentage of register	Number of new referrals	Percentage of total referrals
Nurse	90	4,383	92
Midwife	5	143	3
Dual	5	245	5
Total	**100%**	**4,771**	**100%**

In November 2015, we began to record the area of practice (i.e. nursing or midwifery) of the dual registered nurse/midwife at the time of the incident reported to us. This enables us to identify the area of practice being called into question by those who are registered as both nurse and midwife. We are now able to share the area in which the individual was practising from initial assessment of referral to the Case Examiner stage of our process. Over time this data will become more comprehensive and also cover final hearings.

The next table shows the breakdown of concerns received about registrants with dual registration. When the incident referred to us is not related to clinical practice, the registrant is identified as both nurse and midwife.

Table 4: Area of practice 2016–2017

Area of practice	Number of new referrals	Percentage of total referrals
Nurse	108	44
Midwife	94	38
Nurse/Midwife	43	18
Total	**245**	**100%**

Initial assessment

We screen all new referrals to establish whether the individual is a nurse or midwife on our register, and whether the concerns raised amount to allegations we can investigate. Following this initial assessment:

- If we can identify a registered nurse or midwife and the concerns raised amount to an allegation that their fitness to practise is impaired, we conduct an investigation.
- If we cannot identify a registered nurse or midwife and/or the concerns raised do not amount to an allegation that their fitness to practise is impaired, we close the case.

In 2016–2017 we closed 3,556 cases at the initial assessment stage. This represents an overall closure rate for 2016–2017 of 60 percent, an increase on the 51 percent closure rate in 2015–2016. The increase in the closure rate reflects our commitment to reach the outcome that best protects the public at the earliest opportunity and our investment in effective early-stage decision making.

When a concern is raised with us we search our register, using variations of the name, and make enquiries with any person or organisation that may have information that would assist, in order to try and identify a registered nurse or midwife from the information provided. Decisions to close cases are signed off by a lawyer. If we cannot identify a nurse or midwife, we can refer the concern to another organisation it if is appropriate to do so. In 2016–2017 we made 131 referrals to other organisations.

Taking urgent action to protect the public

We have the power to prevent nurses and midwives from practising in the UK if they present a risk to public safety. If public safety is at immediate and serious risk, we can impose an interim order to restrict the way in which a nurse or midwife can practise or prevent them from practising until we have fully considered their case.

An interim order can be imposed by a practice committee at any point during the fitness to practise process if information becomes available which gives us reason to believe public safety may be at risk.

Information about our interim orders process can be found on our website: www.nmc.org.uk/concerns-nurses-midwives/hearings-and-outcomes/restrictions-sanctions/interim-orders/

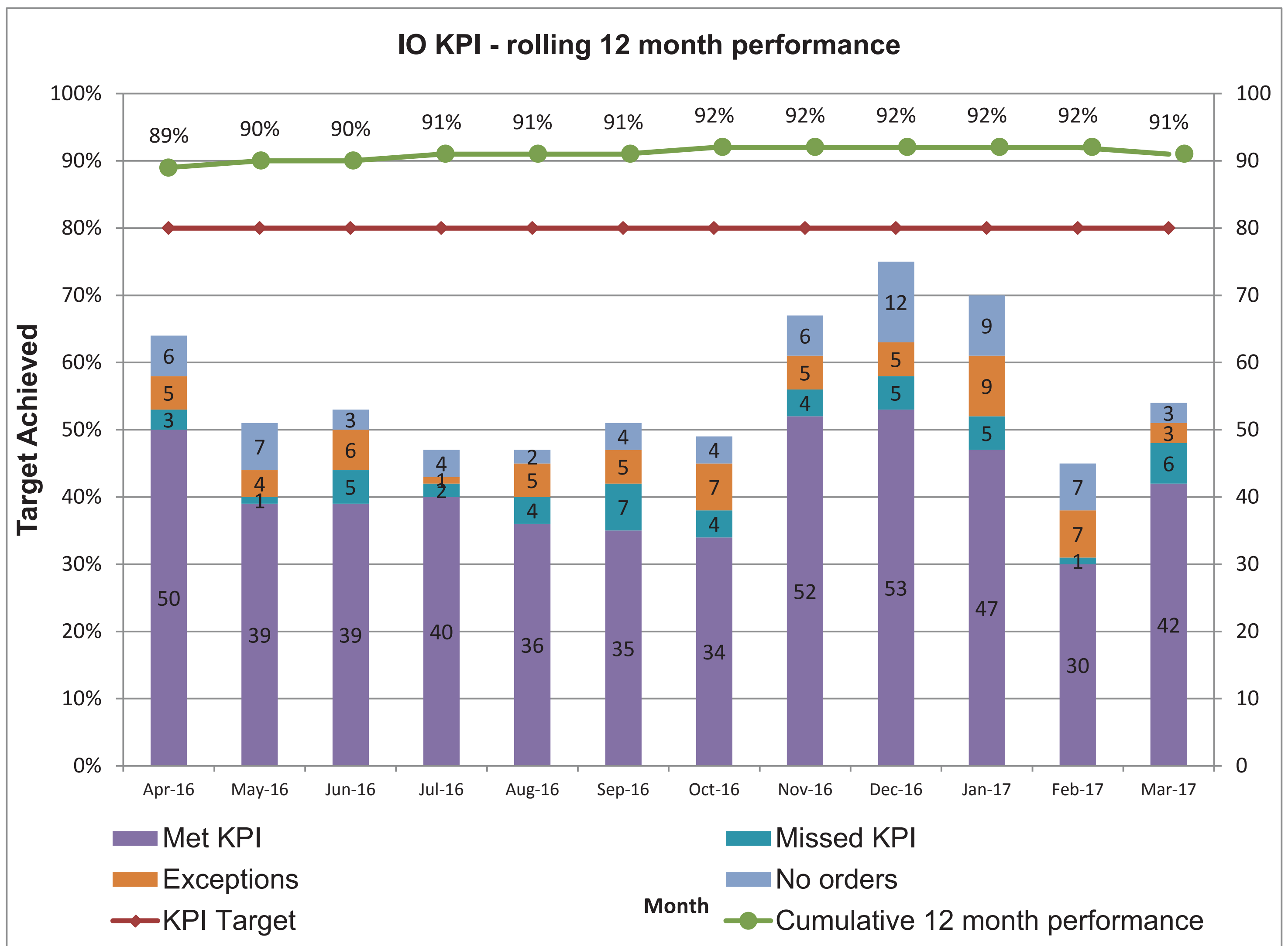
Interim order performance

Imposing interim orders is an important way for us to protect the public. We aim to impose interim orders within 28 days of receipt of the concern, in cases where it is necessary to do so.

To ensure public protection, our Council has set us a target of imposing orders where necessary within 28 days of receipt of referral in 80 percent of cases. In 2016–2017 we continually met and exceeded this target, ending the year with an average of 91 percent.

The next chart shows our performance in 2016–2017 against our target of 80 percent.

Chart 1: Interim order rolling 12 month performance 2016–2017



Interim order outcomes

There are two types of interim order:

- Interim conditions of practice orders, which temporarily restrict the way in which a nurse or midwife can practise
- Interim suspension orders, which temporarily prevent a nurse or midwife from practising

The table below shows the type of interim order imposed in 2016–2017.

Table 5: Interim orders imposed 2016–2017

Interim order decisions	Number of interim orders
Interim conditions of practice order	326
Interim suspension order	379
Total	**705**

The table below shows the type of interim order imposed in 2016–2017 by registration type.

Table 6: Interim orders imposed by registration type 2016–2017

Registration type	Interim conditions of practice order	Interim suspension order
Nurse	289	352
Midwife	20	14
Dual	17	13
Total	**326**	**379**

Table 7: Interim orders imposed by area of practice 2016–2017

Order	Nurse	Midwife	Nurse/Midwife
Interim conditions of practice order	293	25	8
Interim suspension order	356	17	6
Total	**649**	**42**	**14**

Investigations

During an investigation, we gather the evidence that is needed to make a full assessment of the allegations. The majority of investigations are undertaken by our in house investigation teams. A small percentage of investigations are carried out by external law firms.

At the end of the investigation, the Case Examiners review all the evidence and decide whether or not the case should be referred for a hearing. A case must be referred for a hearing if it raises an issue of fitness to practise and there is a realistic prospect that a panel will determine that the nurse or midwife’s fitness to practise is impaired.

It is not in the public interest for cases to proceed to a hearing if there is no realistic prospect that a panel will determine that the nurse or midwife’s fitness to practise is impaired. In those circumstances, the Case Examiners will close the case. The next set of tables show Case Examiner decisions in 2016–2017.

Case Examiner decisions

The table below shows the total number of Case Examiner decisions in 2016–2017.

Table 8: Total Case Examiner decisions 2016–2017

Case Examiner decisions	Number of cases
Refer to Conduct and Competence(CCC)/Health Committee (HC)	1,539
No case to answer	1,170
Total Case Examiner decisions	**2,709**

Table 9: Number of decisions by registration type 2016–2017

Registration type	Number of cases
Nurse	2,506
Midwife	64
Dual	139
Total	**2,709**

Table 10: Case Examiner decisions by area of practice 2016–2017

Sanction	Nurse	Midwife	Nurse/Midwife
No case to answer	1,110	44	16
Refer to CCC	1,374	54	38
Refer to HC	70	2	1
Total	**2,554**	**100**	**55**

Investigating Committee decisions

The Investigating Committee is responsible for taking decisions in cases where the Case Examiners cannot agree on an outcome. No cases were referred to the Investigating Committee for decision in 2016–2017.

Reviewing no case to answer decisions

Since March 2015, we have been able to review decisions to close a case at the investigation stage without recourse to judicial review. The process works in two stages:

- We decide whether or not to undertake a review.
- If we undertake a review, we decide whether to uphold the original decision or whether a fresh decision is required.

Requests for review can come from the NMC or members of the public. The table below shows the number of requests for review and their outcomes between April 2015 and April 2017. The number of reviews undertaken does not correlate with the number of reviews requested as not all reviews reach a conclusion within their reporting period.

Table 11: Power to review decisions 2015–2016 and 2016–2017

Power to review stage	2015–2016	2016–2017
Total requests received	90	69
Total number of first and second stage reviews carried out	53	64
Number closed at first stage	37	57
Total second stage reviews concluded where registrar decided fresh decision required	14	2
Total second stage reviews concluded where registrar upheld the original Case Examiner decision	2	5

Fraudulent or incorrect register entries 2016–2017

The Investigating Committee continues to consider allegations of fraudulent or incorrect entry onto the register. A panel will decide whether the allegation is proved, and if so, will direct the Registrar to remove or amend the entry on our register.

In 2016–2017 there were 36 fraudulent or incorrect entry cases where the panel directed the person's name be removed from our register, or the entry changed. In 2015–2016 there were 12 cases.

Hearings

Most cases referred by the Case Examiners for adjudication are considered by a panel of one of our practice committees:

- Conduct and Competence Committee
- Health Committee

The panel is responsible for reaching a final decision about whether a nurse or midwife's fitness to practise is currently impaired and determining what sanction, if any, is needed to protect the public. Most cases are heard at public hearings which anyone can observe. Some hearings – including all cases before the Health Committee – are conducted in private.

In some cases panels may decide a case is best dealt with at a substantive meeting. Meetings are held in private and the nurse or midwife does not attend. A registrant submits written evidence and the panel considers the case on the papers alone.

Meetings will only take place if the panel agrees this is a suitable way of dealing with a case, and if the registrant has not requested a full hearing.

We publish all panel decisions where a sanction has been imposed on a nurse or midwife's registration on our website. Sanctions are also marked on the public register.

More information about the work of our practice committees, information on how to attend public hearings, and the outcomes of hearings are available on our website:

www.nmc.org.uk/concerns-nurses-midwives/hearings-and-outcomes/

Hearing outcomes

The next table shows the total number of hearing and meeting outcomes in 2016–2017.

Table 12: Hearing outcomes in 2016–2017

Sanction	Number	Percentage
Striking-off orders	344	23
Suspension orders	424	28
Conditions of practice orders	267	18
Caution orders	164	11
Fitness to practise impaired – no sanction	5	0
Total	**1,204**	**80%**
Facts not proved	31	2
Fitness to practise not impaired	278	18
Total hearing outcomes	**1,513**	**100%**

Table 13: Hearing outcomes by registration type 2016–2017

Sanction	Nurse	Midwife	Dual
Strike off	322	6	16
Suspension order	384	4	36
Conditions of practice order	246	7	14
Caution order	153	5	6
FtP impaired – no sanction	4	0	1
Total	**1,109**	**22**	**73**
FtP not impaired	261	5	12
Facts not proved	29	0	2
Total hearing outcomes	**1,399**	**27**	**87**

Voluntary removal

The voluntary removal process allows a nurse or midwife to apply to be permanently removed from the register without a full public hearing. In order to achieve this outcome the registrant must apply to the registrar who will make a decision on whether removal is in the public interest. If an application is granted the nurse or midwife will be listed on our public register with the status 'voluntarily removed'. The next table shows the number of applications received and applications granted in 2016–2017.

Table 14: Voluntary removal decisions

Year	Number of applications	Applications approved
2013–2014	194	92
2014–2015	191	93
2015–2016	107	44
2016–2017	165	77

Appeals against our decisions

A nurse or midwife can appeal against the sanction imposed by a panel. The appeal must be lodged within 28 days of the panel's decision. 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, dependent on the country of the nurse or midwife's registered address. The Professional Standards Authority may also lodge an appeal if it believes that a decision does not protect the public. The person who referred the concern to us cannot appeal against a panel's decision, but they may seek a judicial review if they are unhappy with the process by which the decision was reached. The Courts have the power to dismiss the appeal, or to overturn the original panel's decision and substitute their own decisions or refer the case back to the NMC to be re-heard by a fresh panel.

Table 15: Appeals against our decisions[1]

Outcomes of appeals	2015–2016	2016–2017
Allowed or remitted to Practice Committee by the Court	18	22
Dismissed by the Court	34	26
Total	**52**	**48**

[1] These are outcomes of appeals where the Court made a decision in 2016–2017. Some of the appeals may have been lodged before 2016–2017.

Restoration to the register

If a nurse or midwife is struck off by a panel, they must wait a minimum of five years before they can apply to be restored to our register.

Before they can be restored, they must satisfy a panel of the Conduct and Competence or Health Committee that they are fit to practise. If the panel is satisfied that they are fit to practise, in most cases, the nurse or midwife will be required to undergo a return to practice programme before their name is restored to the register. It is this rigorous process that continues to ensure that the public is properly protected from those individuals whose fitness to practise has previously been found to be impaired.

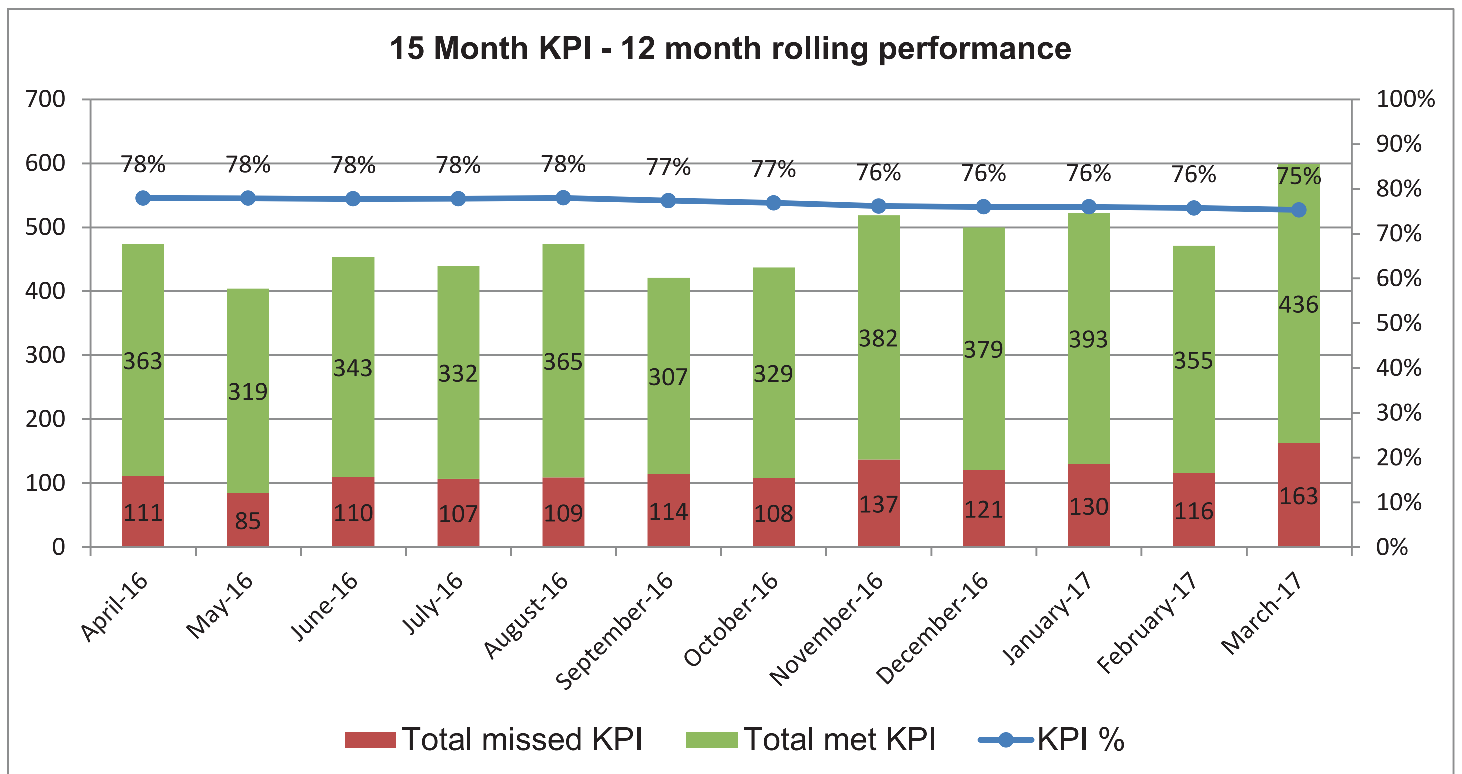
Table 16: Restoration application outcomes 2016–2017

Restoration cases considered	2015–2016	2016–2017
Application accepted	18	5
Application rejected	8	5
Total	**26**	**10**

Resolving cases quickly (15 month KPI)

Performance against the 15 month end to end KPI remained consistent at 78 percent for the first six months of the year against our target of 80 percent, and then decreased slightly by the end of the year. This was indicative of our push to progress older cases. We remain committed to concluding older cases within our control and reaching optimal caseloads in 2017–2018.

Chart 2: 15 month case closure performance 2016–2017



Future focus

Section 60

Following a decision by ministers to allow changes to our legislation, the Department of Health led a consultation on amendments to the Nursing and Midwifery Order 2001 (‘the Order’). In October 2016, we carried out an eight week public consultation on amendments to the Fitness to Practise Rules including hosting engagement events with key stakeholders in each of the four UK countries.

Changes to the Order came into effect on 31 March 2017, and the changes to our Rules which will come into effect later this year will allow us more flexibility in our approach to fitness to practise cases, enable us to respond in a more proportionate way to less serious cases and remove some restrictions / requirements around how we operate our fitness to practise function. This will help us achieve our aim of reaching the outcome that best protects the public at the earliest opportunity.

These changes are:

- **Case Examiner powers to issue undertakings, warnings and advice** – This change will allow us to dispose of certain cases without the need for a hearing by issuing warnings, giving advice, or agreeing undertakings with the nurse or midwife.

- **Single FtP panel** – This change will allow all cases, both health and conduct and competence to be heard by one panel. Health cases will still be heard in private, and safeguards over sanctions will remain.

- **Interim order reviews** – This change will remove the requirement to hold a review of an interim order every three months. A registrant however can still ask for a review at any stage and we can schedule an early review of a case if we receive new information which leads us to believe the public is not adequately protected.

- **Substantive order review removal** – This change will allow a panel which imposes a substantive order to direct that it is not necessary to review that order before it expires. A registrant will still be able to request a review however this runs the risk of a reviewing panel extending or changing their order.

- **Location of hearings –** This change removes the requirement for the NMC to hold a hearing in the country where the registrant lives. The NMC is seeking this change not to inconvenience registrants, but to hold those hearings where a registrant has not engaged or is not attending in one of our official hearing centres where cost can be maintained.

- **Interim order extensions/appeals –** This change gives the court more power and flexibility when the NMC seeks an extension. A judge will have the ability to change the order. Representatives could therefore argue for a conditions of practice order instead of a suspension.

- **Notice requirements** – The NMC is currently required to alert the administrations of all four UK countries when Case Examiners refer a case to a practice committee. This change will remove that requirement.

The new powers will allow us more flexibility when dealing with cases, and remove cumbersome restrictions on our process, making it timelier, less expensive and more proportionate.

Regulatory Concerns

On 3 April 2017 we adopted a new case management approach called 'Regulatory Concerns.' Identifying the regulatory concern allows us to articulate the issues in a case at a much earlier stage in the process. This in turn enables more proportionate and focused investigations, and promotes meaningful engagement with registrants and representatives.

Allegation and employer setting coding

Our Employer Link Service is looking to build on what has been achieved and develop further to:

- Support an evidence and risk based approach to regulation.

- Develop capacity to understand the risks around our objective to protect, promote and maintain the health, safety and well-being of the public.

We delivered two projects in 2016–2017 which have improved the quality of our data. Firstly we implemented nationally recognised codes for all employer settings which have been applied to all of our cases. We also introduced allegation coding which allows us to better understand the types of cases referred to us. Together, this data will enable us to analyse FtP issues by healthcare setting, geographical location and allegation type and help us to better deliver our regulatory functions and protect the public.

On 1 January 2017 we began to code allegations at three stages in FtP: screening, investigation and adjudication and at three levels of increasing detail. The table below shares the first release of that information at the first level of detail. This can then be broken down further. For example 'behaviour and violence' can be broken down into more detailed categories and include instances of bullying and harassment, discrimination, verbal abuse and violent behaviour. Over the course of

the next year, we will consider the best level of analysis to include in our reporting going forward.

Table 17: Level 1 screening assessment stage allegation coding 1 January – 31 March 2017

Allegation	Number of allegations received
Behaviour or violence	44
Communication issues	24
Criminal proceedings	56
Dishonesty	40
Employment and contractual issues	27
Information access	5
Investigations by other bodies	12
Management issues	24
Motor vehicle related	26
NMC registration and proceedings	20
Not maintaining professional boundaries	11
Other allegations	9
Other crimes and offences	14
Patient care	136
Prescribing and medicines management	126
Record keeping	53
Registrants health	58
Sexual offences	15
Social Media	6
Total	**706**

Case conferences

Teleconferencing between our lawyers and lawyers representing the nurse in all cases where the RCN is acting was trialled in December 2016. The aim of the pilot was to improve engagement between the NMC, the nurse and their representative, and to avoid issues which can occur on the first day of a hearing which can sometimes contribute to cases being adjourned or going part-heard.

Throughout this pilot, we have been working closely with staff from UNISON, Unite, the Royal College of Nursing and the Royal College of Midwives to roll out Adjudication led case conferences in all cases where the nurse or midwife is represented. We believe that these conferences will not just benefit the timeliness and completion rate of our hearings, but will help to ease what can be a stressful process for registrants, and build better relationships with our colleagues from other organisations.

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