Nursing & Midwifery Council

Nursing and Midwifery Council: Annual Fitness to Practise Report 2010-2011

Nursing and Midwifery Council

Annual Fitness to Practise Report 2010 – 2011

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Foreword

The Nursing and Midwifery Council (NMC) registers almost 670,000 nurses and midwives working in the UK. All registered nurses and midwives are bound by a professional code – *The code: Standards of conduct, performance and ethics for nurses and midwives* (called 'the code' in the rest of this report).

The vast majority of nurses and midwives act in accordance with the code and consistently meet the high standards expected by the public. Less than 0.3 percent of registered nurses and midwives have their conduct investigated through fitness to practise hearings. However, when this does happen, both they and the public, can be assured that the investigation will take place according to the processes determined by the Nursing and Midwifery Order 2001 (as amended)[1] and the Nursing and Midwifery Council (Fitness to Practise) Rules 2004[2].

Despite the very small percentage of nurses and midwives who are referred to us, Fitness to Practise (FtP) is the largest directorate in the NMC and the largest area of expenditure.

During 2010-2011, the NMC received an unprecedented number of new cases, which suggests increasing confidence on the part of the public, employers and others to refer cases to us.

The FtP directorate saw considerable change this year, with the appointment of a new director and three assistant directors, together with a major reorganisation of the directorate designed to improve our efficiency and effectiveness. We have also put in place major work programmes, including providing support and training for our staff, to help us continue to make progress across all aspects of our work.

We are committed to continual improvement of our services, ensuring that all registered nurses and midwives are fit to provide safe and effective nursing care**,** and that the public know what to do when they feel the care they receive has not been of a satisfactory standard. We will continue to work with employers in order to ensure that they are aware of their responsibilities in ensuring that their employees comply with the code**.**

Nursing and Midwifery Council
July 2011

[1] SI 2001/253 (as amended)
[2] SI 2004/1761 (as amended)

What is the NMC?

We are the nursing and midwifery regulator for England, Wales, Scotland, Northern Ireland and the Islands.

- We exist to safeguard the health and wellbeing of the public.
- We set standards of education, training, conduct and performance so nurses and midwives can deliver high quality healthcare consistently throughout their careers.
- We ensure that nurses and midwives keep their skills and knowledge up to date and uphold their professional standards.
- We ensure that midwives are safe to practise by setting rules for their practice and supervision.
- We have clear and transparent processes to investigate complaints made against nurses and midwives.

Purpose of Fitness to Practise

The NMC registers almost 670,000 nurses and midwives eligible to work in the UK. The vast majority act in accordance with their professional code and consistently meet the high standards expected by the public. Only 0.6 percent of registered nurses and midwives are referred to the NMC each year. Only 0.3 percent of registered nurses and midwives have their conduct investigated by Fitness to Practise (FtP) annually, and only 0.1 percent are given a sanction. However, when this does happen, both they and the public can be assured that the investigation will take place according to the processes determined by the Nursing and Midwifery Order 2001 (as amended) and the Nursing and Midwifery Council (Fitness to Practise) Rules 2004.

Despite the very small percentage of nurses and midwives who are referred to us, FtP is the largest directorate in the NMC and the largest area of expenditure.

We describe fitness to practise as a person's suitability to be on the register without restrictions.

Suitability to be on the register without restrictions includes:

- achieving the standards of proficiency required for entry to and maintenance on the register
- the maintenance of good health and good character to enable safe and effective practice
- adherence to the principles of good practice set out in the code and other guidance provided by the NMC.

We investigate and, if necessary, take action on substantiated allegations that a nurse or midwife's fitness to practise is impaired.

We receive many complaints about nurses and midwives that do not concern their fitness to practise. When we do not investigate these complaints, we are not saying they are unjustified or we do not believe them. It is simply that the issues raised do not concern the nurse or midwife's fitness to practise. Often the employer or some other authority can and should resolve these complaints. We cannot act as a form of appeal for people who have been disappointed by the outcome of a local complaints procedure.

How can fitness to practise be impaired?

We are concerned only with allegations that fitness to practise is impaired by:

- misconduct
- lack of competence
- a conviction or caution for a criminal offence
- physical or mental health
- a finding of impairment by another health or social care regulator
- a barring by the Independent Barring Board in England or Wales or Northern Ireland or inclusion in the children's list or adults' list in Scotland (this provision is not yet in force).

Failure to comply with the standards set out in the code does not automatically mean that the nurse or midwife's fitness to practise is impaired.

Who can refer an allegation to us?

Anyone can make an allegation to us about a nurse or midwife's fitness to practise – we call this a 'referral'. Some people are under a legal or professional duty to refer nurses or midwives to us, for example, the police are required to report nurses and midwives who have been convicted or cautioned for a criminal offence.

What if the incident occurred abroad or when the person was not registered?

We can consider allegations about conduct or performance that occurred outside the UK or when the nurse or midwife was not registered.

Is there a time limit for raising concerns?

There is no time limit for referring an allegation about fitness to practise but we encourage early referral. This is because it can be difficult to trace witnesses and supporting evidence about events that occurred long ago.

Where there is an immediate risk to the public, we expect employers to refer a case to us immediately, so that we can consider whether an interim order should be made – for example, to remove a nurse or midwife or restrict their practice.

In cases where there appears to be no imminent risk to public safety, we recommend that employers refer cases to us when their internal procedures are completed. However, employers should refer a case to us straightaway if it becomes apparent during the course of their internal proceedings that the public is at risk. In addition, if an employer's internal procedures have to be suspended for a lengthy period, employers should refer the case to us as soon as they suspend the internal proceedings.

How are referrals made to Fitness to Practise?

We generally expect referrals to be made to us in writing but we accept referrals in other forms that we can transcribe if writing is difficult for the person asking us to look into the matter. We will arrange for translation of any referral not made in English.

We need the person making the allegation – we call this person 'the referrer' - to:

- clearly identify the nurse or midwife concerned
- give a clear account of the alleged incidents or behaviour leading to the referral
- give us any relevant documents or other evidence they may have that supports their allegation.

Leaflets for employers and members of the public are available on our website, as are the forms that can be used to make the referral. We introduced a new external liaison role in December 2010 to strengthen our relationships with employers on fitness to practise issues (we give more information about this work on pages 25 and 26).

What does the NMC do when it receives a referral?

First, our Screening team assesses the information provided to make sure it identifies a nurse or midwife on our register and that the allegation does concern the person's fitness to practise. Sometimes the Screening team will ask the referrer for more information so that we can deal with the case. The Screening team can close referrals that are not about people on our register or are not about fitness to practise.

If the nurse or midwife concerned has been convicted of a criminal offence and received a custodial sentence, the case may be sent direct to the Conduct and Competence Committee.

Prior to January 2011, all other cases were assigned to a named case officer who prepared the case to go to a panel of the Investigating Committee. The case officer would inform the nurse or midwife about the referral and invite them to send a written response to the committee.

Under our new system introduced early in 2011 to improve our processes, the Screening team now manages cases from receipt of the complaint until its first consideration by the Investigating Commitee. This has helped us progress cases more quickly.

Role of the Investigating Committee

Investigating Committee panels consider all the information sent in by both the referrer and the nurse or midwife. Their role is to decide whether there is a case to answer. The panels may ask for some investigations to be carried out to help them decide this question – for example, they may ask for a lawyer's investigation to collect statements and documentary evidence. In cases where a nurse or midwife's health may be impaired, a panel may ask the person to undergo medical testing or examination.

If an Investigating Committee panel decides there is no case to answer, the matter is closed. The panel may decide to keep a record of the case for three years so that it can be re-opened if another complaint is made about the same nurse or midwife.

If a panel decides there is a case to answer, it can mediate between the parties concerned or refer the case to the Conduct and Competence Committee or the Health Committee. In practice, panels have not used the option to mediate.

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.

Roles of the Conduct and Competence Committee and the Health Committee

Conduct and Competence Committee panels and Health Committee panels decide whether the allegations are proved and, if so, decide on the appropriate sanction. Panels can work in meetings – using just the paperwork collected in the case, or at hearings – when the NMC case presenter and the nurse or midwife and their representative can call witnesses and argue their points to the panel in person.

Hearings must take place in the UK country of the nurse or midwife's registered address (England if the address is outside the UK).

Nurses and midwives facing allegations of impaired fitness to practise are entitled to have their case decided at a hearing. Cases that go to a meeting are those where the person has not requested a hearing, the issues are straightforward and there is no public interest in dealing with them at a hearing. Most cases go to a hearing. Conduct and Competence Committee hearings take place in public; Health Committee hearings are held in private.

When a panel finds that a nurse or midwife's fitness to practise is impaired, the panel can decide to take no further action or apply one of the following sanctions:

- caution order (this can be applied for between one to five years)
- conditions of practice order (can be made for between one and three years and must be reviewed by a panel before expiry)
- suspension order (can be made for up to one year and must be reviewed by a panel before expiry)

- striking-off order (no application by a nurse or midwife for restoration to the register can be considered for five years)

The purpose of the sanction is to strike a proportionate balance between the nurse or midwife's interests and the public interest – by the public interest we mean: protecting members of the public; maintaining public confidence in the professions and the regulator; and declaring and upholding proper standards of conduct and performance. The NMC has issued indicative sanctions guidance to help panels decide on the appropriate sanction in each case. The guidance is available on our website (www.nmc-uk.org).

We publish details of all the orders that panels have made in the last three months together with the reasons on our website (www.nmc-uk.org).

Interim orders

All the committees can make interim orders to suspend registration or put in place conditions of practice while a case is being investigated and awaiting a final decision.

Before making an interim order, a panel must hold a hearing so that the nurse or midwife can attend – with their representatives – to explain their point of view about any interim order. Panels can make interim orders for up to 18 months. They must review interim orders after six months and then every three months. If a case is not concluded within the time specified, we can apply to the High Court (or equivalent court in the other countries of the UK) for an extension. The courts can extend an interim order for up to one year.

Panels can also make interim orders when they make final orders that affect the registration status of the person concerned. This is because final orders do not come into effect until the end of the appeal period or, if the person appeals, until the appeal has been decided by the court.

We publish on our website details of all the interim orders that panels have made in the last three months together with their reasons (www.nmc-uk.org).

Observing a hearing

People who wish to attend a hearing can go to our website (www.nmc-uk.org) where we publish details of all hearings open to the public, together with details about how to book a place.

Appeals against the sanction

A nurse or midwife can appeal against any sanction imposed by the NMC. 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 or midwife's registered address.

The role of the courts in examining the NMC's decisions and considering how the statutory provisions should be applied often provides useful guidance – even in cases where the NMC is unsuccessful.

In 2010-2011, there were 19 appeals lodged against sanctions imposed by the NMC: 17 of these were in England and Wales and there was one each in Scotland and Northern Ireland. Not all such appeals are heard in the same year as they are lodged. During 2010-11, negotiated settlements were reached in three cases. Ten cases went to a full hearing and, of those, the courts upheld the NMC's decisions in six cases and found in favour of the nurse or midwife in three cases, with one case being adjourned. One of the appeals in which the NMC's arguments were accepted by the High Court has led to significant developments in the way in which all healthcare regulators should approach the issue of impairment of fitness to practise.

Fitness to practise panel members

The members who sit on panels considering allegations of impaired fitness to practise are an essential component of the NMC's work to protect the public. We need to ensure that we have sufficient numbers of competent panel members to carry out that work efficiently, fairly and to a high standard. Panel members are a mix of registered nurses and midwives and lay members – that is, people who are not nurses or midwives. All panel members are independent of the NMC.

The Appointments Board, an arms-length committee of Council, is responsible for overseeing the recruitment, appointment, appraisal, training and performance management of fitness to practise panel members.

A complaints process was put in place in April 2010, to provide a means for dealing with complaints about the performance or behaviour of panel members when sitting on panels. A further process was developed in January 2011 to deal with allegations of impaired fitness to practise when made against any panel member who is a registered nurse or midwife.

During 2010-2011, we undertook a comprehensive appraisal of all our panel members for the first time. The process consists of 360-degree feedback from peers and officers, followed by an appraisal meeting with a member of the Appointments Board. The process has enabled us to identify any areas of individual weakness and provide the necessary support.

Training is provided each year for all panel members. During this year it has included topics such as the provision of good determinations and reasons; implementing conditions of practice; systems failure; and considering appeals against decisions of the Registrar.

During the coming year, the complete appraisal process will be reviewed and changes made where necessary. The competency framework for panel members will also be reviewed and updated. In addition, the terms of office of some panel members finish during 2011-2012 and an analysis will be undertaken of business needs to inform any new appointment and reappointment process.

Role of the Council for Healthcare Regulatory Excellence

The Council for Healthcare Regulatory Excellence (CHRE) is an independent body accountable to Parliament that oversees the work of the regulators of healthcare professionals, including the NMC.

We report all our final decisions to the CHRE. If the CHRE considers any adjudication outcome is unduly lenient and that action is necessary to protect the public, it can appeal to the courts as previously outlined on pages 8 and 9.

The CHRE also gives us feedback on the decisions made by Conduct and Competence and Health Committee panels. We use this information to improve our case presentation and develop panel members' skills in the giving of reasons. We also participate in the CHRE's Fitness to Practise Forum where we have the opportunity to learn from other regulators and understand issues of concern to the CHRE.

In 2010-2011, the CHRE began to audit those cases that we had been closed by us without being considered by the Conduct and Competence or Health Committees. The audit highlighted to us areas where we should strengthen our practice.

Challenges and improvements

Over the past year, the number of new referrals the NMC received increased by 41 percent.[3] While the NMC views this increase as a positive reflection of public confidence in our function, improved relationships with employers and more proactive regulation, it also presents a range of challenges for the FtP directorate.

We needed to ensure our directorate was adequately staffed to handle the significant increase in cases referred to us. Our newly appointed FtP director started in August 2010, bringing experienced fitness to practise leadership to the directorate. We also created a number of new positions to help improve our overall management of the fitness to practise function, including an assistant director of operations, assistant director (legal), assistant director (policy, strategy and legislation) a head of external liaison, a head of screening and administration and a head of adjudication.

We restructured the FtP directorate and reorganised how we manage our caseload. Two new case teams, the Screening team and the Escalation team, were created in early 2011. The Screening team manages cases from the receipt of a complaint until its first consideration by the Investigating Committee. The Escalation team will concentrate on progressing more complex cases and have more investigative responsibilities. We believe that these teams will help us continue to improve our ability to prioritise serious cases and meet our key performance indicators in overall case progression.

We have also recruited more case officers, case administrators, lawyers and council's officers to cope with the increased workload. The additional functions and capacity that these roles have provided have enabled FtP to monitor staff and the timeliness of case progression more robustly, improve our communication with our stakeholders, and implement new customer service standards.

[3] The period from 1 April 2010–31 March 2011 compared with 1 April 2009–31 March 2010.

The increase in our caseload brought other resource challenges to FtP this year. In order to meet our key performance indicators for case progression, we contracted additional legal services to assist with the preparation of cases for consideration by the Investigating Committee. We recently completed a full procurement exercise for new legal service providers, which we believe will help us continue to improve our performance with quality investigation work and eliminate unnecessary delays in the fitness to practise process going forward.

Performance

The FtP directorate's key objective, as set out in the NMC's corporate plan 2010-2013 is:

> "To bring about public confidence by taking swift and fair action to deal with individuals whose integrity or ability to provide safe care is questioned."

As previously indicated, the NMC saw a significant increase in the number of new cases referred to us in 2010-2011, adding considerable pressure to our caseload.

In January 2011, we improved and strengthened the range of measures we use to help monitor and manage our work, in particular to help us understand our performance at each stage of the process better, so that we can further identify scope for improvements. This data is produced monthly and monitored by our Corporate Leadership Board and quarterly by our Council as part of an organisation-wide suite of performance data.

Protecting the public by considering Interim Orders that prevent nurses or midwives from working whilst we investigate cases where the allegations are very serious is one such measure. This will be a key performance indicator which the Council will use to scrutinise performance in the forthcoming year. In these cases, we have to prepare evidence detailing the allegations to go before an Investigating Committee panel. We also need to give the nurse or midwife the opportunity to respond or arrange to attend the hearing. Our target is 28 days from the initial request to the hearing taking place. During 2010-2011, we redesigned our processes to ensure that new cases were scheduled for hearing within 48 hours of a panel's decision to consider an Interim Order and, at 31 March 2011, it took on average 27 days for interim order to be made.

Given the number of older cases still present in our caseload and our determination to bring these to a final resolution, the overall figures for the time taken to reach a final decision on cases still remains longer than we would like. We are continuing to work towards meeting our target of concluding 90 percent of cases within 15 months. However, the legislation and rules which govern our processes make this a very challenging target and one which we have yet to meet. We will continue to press for changes to be made to our legislative framework so that we can process our cases more efficiently and effectively.

We also measure other issues such as, the number of appeals against our decisions; the number of complaints we receive about how we conduct fitness to practise work; and how we support and develop our staff.

Despite the unparalleled increase in new referrals last year, we received complaints about only 2.65 percent of cases as a proportion of our caseload, a very creditable performance.

We were pleased that the CHRE recognised that significant improvements had been made to key aspects of our work including, for example, the introduction of an electronic case management system (CMS). The CMS has helped us monitor and manage our casework more effectively and progress cases more efficiently.

We have a major programme of work underway to build on the progress we have made so far, and whilst it will inevitably take time for the full impact and benefits of all these changes to bear fruit, we are determined to act to ensure the protection and safety of the public at all times.

Legacy cases

We have a small number of what we call ‘legacy cases’. These have either been inherited from our predecessor body or fall to be decided under rules which previously applied. There are five such cases involving six individuals. We continue to work on finding a final resolution to these cases, although this is not necessarily within our control.

Analysis of equality and diversity data

In 2009, we began collecting data with regard to six different strands of equality and diversity: that is, age, gender, religion or belief, ethnicity, sexual orientation and disability. We are about to commence a programme of analysis of this data in relation to the nurses and midwives on our register.

However, we cannot currently cross-refer this data to fitness to practise cases. We hope to begin collecting equality and diversity data for each of the six strands at each of the significant stages of our fitness to practise process in the near future. We will then be able to provide a much fuller breakdown for each of the six strands in future reports. In the meantime, we are currently only able to provide a breakdown of key stages of FtP processes by gender and these are detailed in the tables below. We aim to be in a position to provide a breakdown by age and possibly, in some respects, ethnicity in next year's report but areas such as sexual orientation and religion or belief will present a challenge.

Tables 1 to 7 provide an analysis of the available data we hold broken down by gender.

Table 1: New cases referred to us in 2010-2011

This table gives a breakdown of the number and percentage of male and female nurses and midwives on the register and the number and percentage of nurses and midwives referred to us.

Gender	Number on register	% on register	Total new cases referred to NMC in 2010-2011	New Cases as% of register	% of new cases by gender
Female	596,826	89%	3,012	0.5%	72%
Male	70,246	11%	986	0.17%	23%
Not identified by referrer*			213	N/A	5%
Total	**667,072**	**100%**	**4,211**		**100%**

* In some cases, a complaint may be closed before we are able to identify the gender of the individual nurse or midwife complained about: for example, the person complained about might be a health care worker and so not on our register. The NMC is only able to look at cases involving registered nurses or midwives.

Table 2: New interim orders made by the Investigating, Conduct and Competence and Health Committees during 2010-2011

This table shows the breakdown of male and female nurses and midwives who had new interim orders placed on them during 2010-2011.

Interim orders	Female %	Number of interim orders	Male %	Number of interim orders	Total
Interim conditions of practice order	23.51%	119	6.13%	31	150
Interim suspension order	43.68%	221	26.68%	135	356
Total	**67.19%**	**340**	**32.81%**	**166**	**506**

Table 3: Cautions, conditions of practice and suspension orders imposed during 2010-11

This table gives a breakdown by gender of nurses and midwives who received a caution; conditions of practice order; or a suspension order at a substantive meeting or hearing of the Conduct and Competence or Health Committees. It should be noted that this may include cases received before 1 April 2010.

Type of order imposed	Female	% of orders imposed	Male	% of orders imposed	Total
Caution	70	69%	31	31%	101
Conditions of practice	37	80%	9	20%	46
Suspension	84	77%	25	23%	109
Total	**191**	**75%**	**65**	**25%**	**256**

Table 4: Sanctions imposed (other than striking off) broken down by gender compared with numbers on the register during 2010-2011

	Number on register	% on register	Number sanctioned	% sanctioned
Male	70,246	11%	65	0.09%
Female	596,826	89%	191	0.03%

Table 5: Removals and striking off from the register during 2010-2011

This table gives a breakdown of males and females removed from, or struck off, the register as a result of a substantive meeting or hearing of the Conduct and Competence or Health Committees. It should be noted that this will include referrals received before 1 April 2010.

	Female	% of total removed/ struck off	Male	% of total removed/ struck off	Total removed/ struck Off
Removed/ Struck off	122	62%	76	38%	198

Table 6: Striking off orders by gender 2010-2011

	Number on register	% on register	Number removed/ struck off	% removed/ struck off
Male	70,246	11%	76	0.1%
Female	596,826	89%	122	0.02%

Restoration to the register

Nurses or midwives who have been struck off (or removed from the register under our previous legislation) can apply to be restored to the register. To do this, they must satisfy a panel of the Conduct and Competence Committee or the Health Committee that they are fit to practise. Nurses and midwives who have been struck off must wait five years before they can apply for restorations, whilst those removed from the register (under the previous legislation) can re-apply at any stage.

Restoration to the register requires careful consideration and is not granted lightly. As the nurse or midwife has not been able to work in the professions for at least five years, and they must also be able to satisfy a panel that they can re-establish their competence and practise safely, the number of applications for restoration to the register is low. We consider this stringent test a further aspect of our role in ensuring public protection.

In 2010-2011, we received 13 applications. The applications were heard by panels of the Conduct and Competence and Health Committees. In eight cases, the applicants were restored to the register and in two cases, the panels imposed a conditions of practice order on the nurse or midwife concerned. Nurses or midwives whose applications to be restored to the register are refused can appeal to the courts as explained on pages 8 to 9. None of those refused restoration to the register in 2010-2011 appealed against the NMC's decision.

Table 7: Applications to be restored to the register by gender 2010-2011

Committee	Outcome	Female	Male
Conduct and Competence Committee restoration hearings	Rejected	4	1
	Application accepted		5
	Application accepted and conditions of practice order imposed	1	
Health Committee restoration hearings	Application accepted	1	
	Application accepted and conditions of practice order imposed	1	
Total		**7**	**6**

Investigating Committee decisions on cases of fraudulent or incorrect entry on the register

A panel of the Investigating Committee has the power to direct the Registrar to amend the register or remove an entry completely if a nurse or midwife has applied using fraudulent or incorrect information or qualifications. Nurses or midwives may appeal against this decision within 28 days, to either the county court in England, Wales or Northern Ireland, or to the sheriff's court in Scotland. The decision does not take effect until the end of the appeal period, or until any considerations of appeal are completed.

In 2010-2011, the Investigating Committee considered two cases. Of those, one resulted in a removal from the register and the other resulted in an amendment to the register.

Table 8: Investigating Committee cases relating to fraudulent or incorrect entry details on the register 2010-2011

Investigating committee	Outcome	Female	Male	Total
Substantive meeting	Instruct Registrar to remove individual from register		**1**	**1**
Substantive hearing	Instruct Registrar to amend entry	**1**		**1**
Total		**1**	**1**	**2**

Analysis of fitness to practise cases dealt with between 1 April 2010 to 31 March 2011

This section provides statistical information about the work undertaken by the NMC on fitness to practise cases during 2010-2011.

Graph 1: New cases received by the NMC during 2010-2011

A total of 4,211 new referrals were received between 1 April 2010 and 31 March 2011, of these, 2,215 were sent for investigation (52.6 percent).

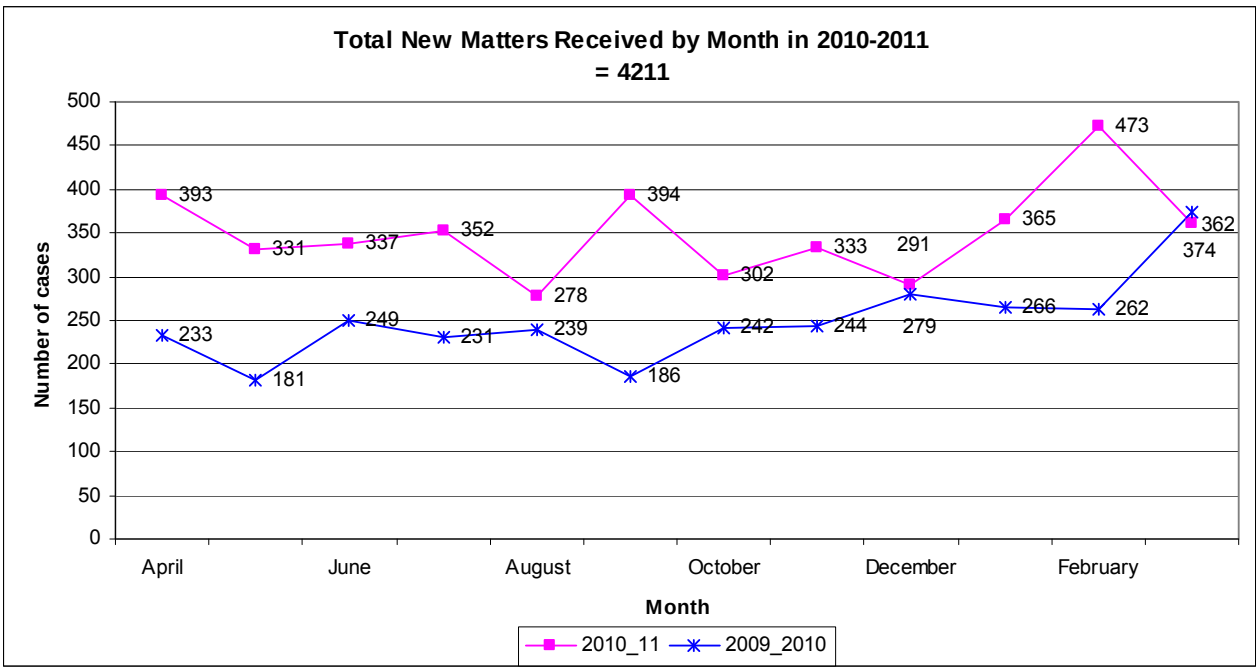

Table 9: Action taken on new cases received during 2010-2011

The following table shows the position on the new cases received during 2010-2011.

Cases can be closed at any stage of proceedings: that is at screening stage, Investigating Committee stage or by the Conduct and Competence or Health Committees. Open cases are those which are still under investigation or where a substantive final decision has not yet been reached and may include those where an interim order has been imposed.

Cases closed	1,996
Open cases	2,215
Total number of referrals received	**4,211**

Table 10: By country of origin of the registered nurse or midwife referred to us

This table gives a breakdown by country of the registered nurse or midwife referred to us. It should be noted that this is based on the registered address of the nurse or midwife concerned and does not necessarily reflect either the country in which the nurse or midwife works or where the incident complained about occurred.

Country where nurse or midwife complained about is registered	2010-2011	
	Number	%
England	3,596	≥85%
Scotland	224	≥5%
Wales	213	≥5%
Northern Ireland	114	≥2%
Outside the EU	7	≥2%
EU	0	0%
Cases where the country of registration is not identified	57	≥2%
Total	**4,211**	**100%**

Table 11: Who referred cases to us 2010-2011?

Source of referral	2010-2011	
	Number	%
Employer	1,743	≥41%
Police	909	≥23%
Public	915	≥23%
Other medical professionals	39	≥2%
Other*	495	≥13%
Anonymous	110	≥4%
Total	**4,211**	**100%**

* This category includes, for example, self-referrals, referrals by solicitors, referrals by educational institutions or by colleagues.

Table 12: Investigating Committee actions and decisions during 2010-2011

Investigating Committee panels sat for 269 days during 2010-2011 and considered 4,058 cases. Some of these cases will have been referred to us before 1 April 2010. Some cases will be closed before reaching the Investigation Committee stage and not all open cases received in 2010-2011 will have yet been considered by an Investigating Committee panel.

Action and decisions taken by Investigating Committee panels in 2010-2011*	
No case to answer	1,847
Further investigation requested	762
Case referred to an Investigating Committee to consider imposition of an interim order	47
No Interim order necessary	163
Interim suspension order imposed	147
Interim conditions of practice order imposed	57
Interim order continued	124
Interim order revoked	25
Medical examination requested	19
Referred to Health Committee	38
Referred to Conduct and Competence Committee	647
Withdrawn (for example, for rescheduling)	161
Adjourned to another date	19
Removed fraudulent entry on register	1
Registrar instructed to amend entry on register	1
Total	**4,058**

* This data reflects all the latest actions and decisions taken on a case by the Investigating Committee as at 31 March 2011.

Table 13: Consideration of Interim orders by Investigating Committee panels

Some of the cases considered in 2010-11 may have been referred to us before the 1 April 2010 and not all cases received in 2010-2011 will have posed such a threat to public safety that they merit the Investigating Committee considering whether to impose an interim order.

Investigating Committee		2010-2011	2009-2010
Interim order not necessary		**194**	**120**
New interim orders imposed	Interim conditions of practice order imposed	130	127
	Interim suspension order imposed	294	218
Total number of new interim orders		**424**	**345**
Reviews of existing interim orders	Interim order confirmed	610	458
	Interim order revoked	76	32
Total number of interim orders reviewed		**686**	**490**

Table 14: Cases by type of allegation considered by the Conduct and Competence Committee in 2010-2011

This table shows the nature of the allegations made in cases considered by panels of the Conduct and Competence Committee during 2010-2011. Some of these cases will have been referred to us before the 1 April 2010 and not all cases received in 2010-2011 will have been considered by a Conduct and Competence Committee panel.

Nature of allegations made*	%
Dishonesty (for example, theft or obtaining goods by deception)	≥25%
Competency issues (for example, maladministration of drugs or neglect of basic care)	≥24%
Patients (for example, verbal/physical/sexual abuse of a patient or inappropriate relationships with patient)	≥22%
Other practice related issues (for example, unsafe clinical practice)	≥7%
Other (for example, convictions)	≥5%
Record keeping (for example, failure to maintain adequate records)	≥4%
Drugs (for example, maladministration or theft of drugs)	≥2%
Management practices (for example, unsafe clinical practice or failure to collaborate with colleagues)	≥2%

Nature of allegations made*	%
Violence (for example, convictions or patient abuse)	≥4%
Serious motoring offences	≥2%
Pornography (for example, child pornography)	≥4%
Colleague (for example, failure to co-operate with colleagues, physical, verbal or sexual abuse or inappropriate relationships)	≥3%
Substance misuse	≥3%

* Many cases will involve more than one allegation

Table 15: Employer or workplace of the nurse or midwife complained about

Employer or workplace	%
Agency (for example, where the nurse or midwife is employed by an agency but may be working in an NHS, private or other facility)	1%
Residential or care home	9%
NHS	38%
Prisons	0%
Private hospital	4%
Other (for example, may be awaiting further information, or nurse or midwife might be employed in a community setting)	48%
Total	**100%**

Table 16: Conduct and Competence Committee consideration of interim orders 2010-2011

This table shows the outcomes of cases referred to the Conduct and Competence Committee during 2010-2011 to consider whether or not to impose an interim order in new cases, as well as the outcomes of cases where an existing interim order was reviewed by the Committee.

Conduct and Competence Committee consideration of interim orders		2010-2011
No interim order necessary		**31**
New interim orders imposed	Interim conditions of practice order imposed	17
	Interim suspension order imposed	58
Total number of new interim orders		**75**
Reviews of existing interim orders	Interim order confirmed	424
	Interim order revoked	5
Total number of interim orders reviewed		**429**

Table 17: Conduct and Competence Committee actions and outcomes in relation to cases considered during 2010-2011

This table gives details of the work undertaken by Conduct and Competence Committee panels during 2010-2011. Not all cases can be resolved at one panel meeting or hearing: for example, panels may have to adjourn or reschedule cases or may impose an interim order pending a full hearing or request further information.

Some of the cases in this table will have been referred to us before 1 April 2010 and not all cases received in 2010-2011 will be referred to a Conduct and Competence Committee panel.

Decision taken*	Number of cases
Order a meeting or hearing to be held	246
Fitness to practise not impaired	76
Interim order confirmed	116
Caution order imposed	100
Suspension order imposed	89
Striking off from register	187
Adjourned to another date	73
Conditions of practice order imposed (includes 1 restoration case)	39
Withdrawn (for example for rescheduling or further investigation)	20
Substantive order confirmed (includes 1 restoration case)	19

Decision taken*	Number of cases
Allow substantive order to expire	19
Interim suspension order imposed	16
Order interim order hearing	15
Interim order not necessary	11
Interim conditions of practice order imposed	9
Duration of the order varied	7
Directions given (for example, the panel might ask for the nurse or midwife to undergo a medical examination)	6
Refer to Health Committee for consideration	5
Restoration to register rejected	5
Substantive order revoked	5
Application to be restored to the register accepted	4
Referred to a formal hearing	4
Interim order revoked	2
Total	**1,073**

* The data in this table reflects the latest actions and outcomes on cases considered by the Conduct Competence Committee during 2010-2011 as at 31 March 2011.

Health Committee panels

Table 18: Health Committee cases by nature of issues raised 2010-2011

This table shows the type of issues raised in cases considered by Health Committee panels in 2010-2011.

Issues	%
Substance abuse	27%
Mental or physical health	39%
Other (for example, some cases may also raise issues around conduct or competency)	34%
Total	**100%**

Table 19: Health Committee consideration of interim orders 2010-2011

This table shows the outcomes of cases referred to the Health Committee during 2010-2011 to consider whether or not to impose an interim order in new cases, as well as the outcomes of cases where an existing interim order was reviewed by the Committee.

Health Committee consideration of interim orders		2010-2011
No interim order necessary		0
New interim orders imposed	Interim conditions of practice order	3
	Interim suspension order	40
Reviews of existing interim orders	Interim order confirmed	123
	Interim order revoked	2

Table 20: Health Committee actions and outcomes during 2010-2011

This table gives details of the work undertaken by Health Committee panels during 2010-2011. Not all cases can be resolved at one panel meeting or hearing: for example, panels may have to adjourn or reschedule cases; or may impose an interim order pending a full hearing; or request further information. Some of the cases included in this table will have been referred to us before 1 April 2010.

Outcome	Number
Suspension order imposed	49
Substantive order confirmed	32
Conditions of practice order imposed	24
Interim order confirmed	22
Order a hearing	16
Adjourned to another date	15
Interim suspension order imposed	8
Striking off order imposed	10
Time period of order varied	9
Cases referred to Conduct and Competence Committee	7
Substantive order allowed to expire	6
FtP not impaired	6

Outcome	Number
Directions given to obtain further information or evidence (for example, the panel might ask for the nurse or midwife to undergo a medical examination)	3
Substantive order revoked	3
Restorations application accepted	2
Interim conditions of practice order imposed	2
Refer for hearing to consider whether an interim order is needed	2
Withdrawn (for example, to await receipt of further information or for further investigation)	2
Caution order imposed	1
Medical examination requested	1
Interim order revoked	1
Total	**221**

* The data in this table reflects the latest actions and outcomes on cases considered by the Health Committee during 2010-2011 as at 31 March 2011.

External liaison

As a result of our programme of work to improve communication and engagement with external stakeholders, and feedback from the CHRE, we appointed to a newly created post of head of external liaison in December 2010. This role was introduced to build and maintain effective relationships with senior external stakeholder representatives, and in particular with employers, so that the NMC is able to safeguard the public through effectively administering its fitness to practise procedures.

The head of external liaison acts as a first point of contact for directors of nursing wishing to discuss fitness to practise issues, and in particular discussions around thresholds for referral of cases into the fitness to practise procedures. It was decided to roll this service out on a phased basis. A dedicated telephone number for this service became operational on 1 February 2011. The introduction of this role, and the dedicated telephone number, has received very positive feedback.

The ‘meet the NMC’ days and employers and managers road shows continue, and the head of external liaison is the fitness to practise lead for these events. He has also attended meetings and conferences to explain the fitness to practise process and engage on issues such as joint agency working around fitness to practise investigations.

An early objective for the head of external liaison was to develop a complaints process within FtP to facilitate the effective handling of complaints. This was launched in February 2011. The new process was designed to ensure that complaints are logged and allocated for an appropriate response within 20 working days. Logged complaints will be reported to the FtP senior management team quarterly, and to the Corporate Leadership Board and Council in liaison with the Chief Executive and Registrar's office. Moving forward, FtP will view complaints as an opportunity to improve our service and we will audit such improvements.

We continued to build on and strengthen relationships with other partners and stakeholders throughout the year, including through signing Memorandums of Understanding in 2010-2011 with the Care Quality Commission, Scottish Commission for Regulation of Care (the Care Commission) and the Health and Social Services department of the States of Jersey. Work is continuing on Memorandums with the Scottish Public Services Ombudsman and the Care Council for Wales and we hope to be in a position to sign these shortly.

Our considerable work to improve how we consult and engage with patient and public groups has been commended by the CHRE and is reported more fully in our annual report. Some aspects of this work may well have contributed to the dramatic increase in the number of referrals we received this year by making it easier for people to understand how to make a complaint. For example, simple changes such as using more accessible language for webpage titles has resulted in an increased profile when search engines are used. We have also increased our web profile and social media presence, for example, through facebook.

Our work on safeguarding and protecting the public has been heavily promoted with good uptake. For example, our work on developing guidance on raising and escalating concerns involved patient and public groups, such as Action on Elder Abuse and the National Childbirth Trust.

Our Chair hosts a Patient and Public Partners' Group which meets around five times a year and is proving an effective forum for consultation, engagement and information exchange. The meetings provide the Group with opportunities to raise questions about our role and work. The Group has received presentations about our work on FtP and had the opportunity to ask questions about our remit and how we approach out work. The Group is helping to raise our profile with the public and patients as well as helping increase the level of understanding of the NMC's work.

Looking forward

The coming year will be full of challenges and we hope to continue building on the progress made over the past year. One of the challenges we face will be bringing investigation of some fitness to practise cases in-house. We have established a continuous improvement project group to consider how we could do this. We will be running a pilot for this work in June 2011. We will assess the success of the pilot with a view to dealing with a proportion of our cases in house.

We hope to continue reducing the total caseload of fitness to practise cases by dealing with investigations and hearings as efficiently as possible, including by supporting our staff and equipping them with the necessary skills to progress cases effectively.

We have seen a dramatic reduction in our total caseload during the last three months of this fiscal year despite an increase in new referrals; we expect this to continue through the next fiscal period. We will achieve this reduction through the setting of standards and key performance indicators for investigations and the close monitoring of investigation timelines.

We have established a customer focused witness support team within our scheduling team, providing better support and assistance to witnesses who give evidence. We intend to build upon this work during the next year. We have begun work on establishing clear customer service standards for the directorate. Training on these standards will commence for all staff within the first few months of the next reporting period. To assist with this work we have recruited a new quality assurance manager, who will carry out a full review of our quality assurance processes.

We will continue working closely with the CHRE over the next year to ensure that we are able to continue to improve in the areas that they had previously identified as areas for improvement. We have set ourselves the ambitious goal of becoming a world leader in the regulation of healthcare professionals; we recognise that we can only achieve this through active collaboration with employers, CHRE, unions, other healthcare regulators and the public.

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