Nursing and Midwifery Council

Annual Fitness to Practise Report

2018–2019

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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 2019

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

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

ISBN 978-1-5286-1432-0

CCS0619426192

Printed on paper containing 75% recycled fibre content minimum

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

Contents

Foreword

The year 2018–2019 was significant for fitness to practise in two respects.

In May 2018, the Professional Standards Authority published its review of the way we handled concerns about midwives' fitness to practise at Furness General Hospital. We know we did not get things right. As a result, we have taken important steps to become more compassionate and person-centred in our work.

In July 2018, we launched a new strategic direction for fitness to practise. After listening carefully to the views of members of the public, professionals, employers, and other partners, we are taking a new approach which is all about fostering a just culture in the health and care sector.

We are pleased to report on the significant progress we have made in these areas. Critically, we have established the Public Support Service which provides much needed, dedicated support to the people and their families affected by poor care who are involved in our fitness to practise process. We know from early feedback that this initiative has been welcomed. We are focused on sustaining these positive improvements in 2019–2020 and beyond.

Our relationships with employers and other partners are key to ensuring that risks to public protection and safety are effectively managed. We have worked closely with them to co-produce our new approach to fitness to practise and have significantly increased our engagement with them on issues of concern about people's practice. We have also improved how we share information about concerns with other regulators.

For the first time, in this report we are able to give information about the most common types of allegation that are found proved at our fitness to practise hearings. As we continue to develop our analytical capability, we will consider how to share this information more widely.

We are pleased to report that we have again met our two key performance indicators for fitness to practise, which measure how quickly we are able to take action to protect the public. Other key points to note from the statistical summary of our fitness to practise work are:

- The total number of new concerns we received represents around 8 referrals for every 1,000 people on our register – highlighting that the vast majority of people on our register practise safely and effectively.
- The number of new concerns raised with us has reduced slightly by 2.5 percent relative to last year - in particular, the number of concerns raised by employers has reduced. This may be as a result of our improved engagement with employers, helping to make sure that issues are dealt with effectively at a local level and only the right referrals are made to us.

- The proportion of new concerns we received broadly reflects the total distribution of registrants across England, Scotland, Wales, and Northern Ireland.
- The proportion of concerns we received broadly reflects the proportion of nurses and midwives on the register. We have not seen any material change in the proportion of midwives referred to us since statutory supervision was removed in March 2017.
- We have not received any fitness to practise concerns about nursing associates since we started to regulate them in England in January 2019.
- The number of cases we adjudicated at a hearing or meeting has reduced. This may be, in part, as a result of improvements we have made to our processes in previous years, for example, the introduction of additional powers for Case Examiners.

This year's report demonstrates the progress we are making to change our approach to how we regulate. We are very conscious of the impact of our work on people. Our priority for 2019–2020 and beyond is to make our proceedings more compassionate and people-centred for all those involved.

The progress we have made has only been possible through the efforts and commitment from the team in Fitness to Practise and across the organisation. We would like to thank them for what they have already done and will continue to do.

Philip Graf
Chair
4 July 2019

Andrea Sutcliffe
Chief Executive and Registrar
4 July 2019

Overview of how we protect the public

About us

We are the independent regulator for nurses, midwives and nursing associates. We hold the register of nurses and midwives who can practise in the UK, and nursing associates who can practise in England.

Better and safer care for people is at the heart of what we do, supporting the health and care professionals on our register to deliver the highest standards of care.

We make sure nurses, midwives and nursing associates have the skills they need to care for people safely, with integrity, expertise, respect and compassion, from the moment they step into their first job.

Learning does not stop the day nurses, midwives and nursing associates qualify. To promote safety and public trust, we require professionals to demonstrate throughout their career that they are committed to learning and developing to keep their skills up to date and improve as practitioners.

We want to encourage openness and learning among health and care professionals to improve care and keep the public safe. On the occasions when something goes wrong and people are at risk, we can step in to investigate and take action, giving the people affected, including those using services, patients, their carers and families, a voice as we do so.

Our regulatory responsibilities are to:

- maintain the register of nurses and midwives who meet the requirements for registration in the UK and nursing associates who meet the requirements for registration in England
- set standards for education, training, conduct and performance so nurses, midwives and nursing associates can deliver high-quality care consistently throughout their careers
- take action to deal with individuals whose integrity or ability to provide safe care is compromised, so that the public can have confidence in the quality and standards of care provided by nurses, midwives and nursing associates.

Our values

Our values underpin everything we do:

We value people: **we believe they matter.**
We value fairness: **we are consistent and act with integrity.**
We value transparency: **we are open and honest.**

At 31 March 2019 there were:

653,544
Nurses

36,916
Midwives

7,288
Nurses & Midwives

489
Nursing Associates

on our register.

A total of
698,237

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, midwives and nursing associates who meet our standards, and we have clear and transparent processes to investigate those who fall short of our standards.

If someone registered with us presents a risk to patients or the public, we can take action to restrict or remove their right to work as a nurse, midwife or nursing associate.

At the end of March 2019, there were 698,237 nurses, midwives and nursing associates on our register – around 8,000 more than at the end of March 2018.

Country	31/03/2019
England	551,438
Scotland	69,047
Wales	36,001
Northern Ireland	24,811
EU & Overseas	16,940

Registration type	31/03/2019
Nurse	653,544
Midwife	36,916
Nurse and midwife	7,288
Nursing associate	489
Total	**698,237**

What is fitness to practise?

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

The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates (NMC, 2018) sets out the standards that nurses, midwives and nursing associates 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, midwife and nursing associate 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, midwife or nursing associate, in the first instance they should raise their concerns with the employer to see if they can be resolved at a local level.

If the concerns cannot be resolved at a local level, or if someone believes them serious enough to require immediate regulatory action, they can raise their concerns with us. We will then 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 at the earliest opportunity.

How concerns get raised with us

Anyone can tell us at any time if they have concerns about a nurse, midwife or nursing associate's fitness to practise. We can also open cases ourselves if we consider it necessary.

Typically, we receive concerns from:

- a patient or person using the services of a nurse, midwife or nursing associate
- a member of the public
- the employer or manager of the nurse, midwife or nursing associate
- the police
- a nurse, midwife or nursing associate referring themselves
- other health and care regulators.

More information about how to tell us about concerns 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, midwife or nursing associate on our register. We cannot consider concerns if they are about other healthcare workers, or members of the public. We will however 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, midwife or nursing associate'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 may take to help us to assess concerns and decide whether any 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, midwife or nursing associate before
- asking their employer whether they have any other concerns about them
- taking statements from witnesses and gathering other evidence
- asking the nurse, midwife or nursing associate for their response to the concerns and to explain any steps they have taken to put things right.

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 consider making an interim order. There are two types of interim order:

- an interim conditions of practice order, which imposes conditions the nurse, midwife or nursing associate must comply with
- an interim suspension order, which temporarily suspends the nurse, midwife or nursing associate'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 concerns fully, our Case Examiners can:

- give advice to the nurse, midwife or nursing associate to remind them of the professional standards they are expected to uphold
- issue a warning to the nurse, midwife or nursing associate
- agree undertakings with the nurse, midwife or nursing associate, which are a series of agreed steps they must take in order to return to safe and effective practice
- refer the case for a hearing or meeting
- 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, midwife or nursing associate does not accept there are concerns about their practice, we will hold a hearing or meeting before an independent panel.

Hearings are normally held in public. We attend the hearing to explain what our regulatory concerns are and call witnesses to give evidence. The nurse, midwife, or nursing associate can attend and be represented. They, or their representative, explain what their response is to our concerns and call witnesses to give evidence.

Meetings are held in private. The panel carefully considers written evidence that we provide and any written evidence the nurse, midwife, or nursing associate gives us in advance.

At a hearing or meeting, an independent panel can:

- issue a caution order for up to five years
- impose conditions of practice which must be complied with for up to three years
- suspend from the register for up to one year
- strike 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 allow a nurse, midwife or nursing associate to voluntarily remove themselves from our register without the need for a hearing or a meeting.

Public information about our fitness to practise 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 someone's fitness to practise we explain our reasons to the person who raised the concerns with us and to the nurse, midwife or nursing associate involved.

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, midwife or nursing associate's entry on the register
- when the Case Examiners issue a warning or agree undertakings, an explanation and reasons are published with the nurse, midwife or nursing associate'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, midwife or nursing associate'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 do not 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.

Information about forthcoming hearings and recent panel decisions are on our website: **www.nmc.org.uk/concerns-nurses-midwives/hearings/hearings-sanctions/**

Fitness to Practise: Our work in 2018–2019

People at the heart of what we do

A key focus for us this year has been to make sure people are at the heart of our work.

In May 2018, the Professional Standards Authority (PSA) published a review into our handling of concerns about midwives' fitness to practise at Furness General Hospital. The concerns arose between 2004 and 2014. Tragically, during the period there were avoidable deaths of babies and mothers. The *Lessons Learned Review* identified that we need to support people using services, patients and families better so that we engage with their evidence, provide appropriate information, keep them informed, and are open with them throughout the process.

We have also worked with our stakeholders to understand what they think about us now and how we can improve our processes. Our surveys show reasonable levels of confidence in our current fitness to practise process.

- Average confidence score from members of the public: 7.2 out of 10
- Average confidence score from employers: 6.6 out of 10
- Average confidence score from registrants: 6.1 out of 10

We identified some key opportunities to help people better understand what we do and to provide better access to support for all those who are involved in our proceedings.

Support for patients, people using services and families

We established the Public Support Service (PSS) which supports people involved in our cases to ensure they are protected, valued, cared for, respected and held as important partners throughout the fitness to practise process. The PSS is responsible for driving a person centred approach to our work across all of our teams. Key achievements for the PSS this year include:

- establishing our Public Support Steering Group which brings together colleagues from across our organisation with people who have been affected by our processes, patient groups, representative bodies, employers and systems regulators. The group has been focusing on how we can humanise our process; looking at how fitness to practise processes can be used as a means to improve care; and developing a standards framework to help us handle complaints and concerns with a person-centred approach

- starting to offer meetings to people when a decision is made to investigate their concerns. A follow-up meeting is also offered after a final decision has been made on the case. These meetings help us fully understand someone's concerns, and also ensure that we have all the relevant information we need to help us carry out our investigation. We can also use the meetings to provide details of other organisations that may be able to offer further help. Finally, it is an important opportunity for us to explain the role and the remit of the NMC investigation
- delivering training to our caseworkers and members of the Public Support Network to help them better support individuals in vulnerable circumstances involved in our process. So far we have provided training in mental health awareness; learning disability awareness; learning from deaths; bereavement care; and handling conversations with vulnerable people
- reviewing how we correspond with people by revising our letter templates. We have made changes so that all of our letters are clear, use everyday language and set out plainly the reasons for our decisions with appropriate reference to our guidance
- providing useful and accessible information through a dedicated area of our public website for patients, families and the public. This includes details for help and support from us and signposting to other support organisations and a film to help witnesses at **www.nmc.org.uk/pss/**
- launching an independent emotional support helpline in partnership with the General Medical Council, which provides 24 hour assistance and support to people who have been affected by poor care
- working with independent and experienced advocates to identify individuals who may be vulnerable and require additional communication support to help them through our processes.

Feedback from people who have met with our Public Support Service:

"[She] set the expectations prior to the conference and wholly listened to all my questions and concerns and gave meaningful, useful replies. It was a great success"

"My concerns were acknowledged and taken on board. I feel heard and listened [to]. I hope that this allows the service to improve."

"The Public Support Officer was very attentive and it was clear she was trying to understand. [She] didn't pressure me if I didn't want to speak on certain things which made me feel safe."

Support for nurses, midwives and nursing associates

Our engagement with stakeholders also highlighted that we need to do more to support nurses, midwives, and nursing associates when they are involved in our proceedings. We identified three areas where we can do more:

- People told us they find it hard to understand our processes and some of our correspondence. In 2018–2019, we reviewed and improved all of our letter templates to make sure they are clear and easy to understand. In 2019–2020, we will do further work to improve the quality of information for nurses, midwives, and nursing associates involved in our proceedings.
- We know that being involved in fitness to practise proceedings can have a significant impact on nurses, midwives, and nursing associates. In response to what some people told us, we have started to record instances in which a nurse, midwife, or nursing associate dies during our proceedings. Since April 2018, we have recorded four instances in which a registrant has taken their own life while our proceedings are going on. In 2019–2020, we will introduce an emotional support telephone service for registrants involved in our proceedings.
- Many nurses, midwives, and nursing associates have access to excellent legal advice, often through membership of a representative body or trade union. However, some do not. In 2019–2020, we plan to work with an independent organisation to provide pro bono legal advice for them.

A new strategic direction

In July 2018, we set a new strategic direction for fitness to practise. As well as ensuring people are at the heart of what we do, we want our work to create an environment for people to experience better care. We do this by fostering a culture that encourages openness and honesty, responsibility and accountability, and learning from mistakes to prevent them happening again.

As part of developing our new strategic direction, we took careful account of the learning from the PSA's *Lessons Learned Review*. We held a public consultation asking people to comment on our plans. We received responses from nearly 900 people and organisations; this feedback and insight was invaluable in helping us shape our approach.

We asked an independent organisation to undertake qualitative research with patients, people who use services and their families, employers, and nurses and midwives, to understand what people expected from us and from the fitness to practise process.

We considered how we could best address the findings of research we commissioned from the University of Greenwich. The research, which was published in 2017, showed a disproportionate number of referrals about black and minority ethnic nurses and midwives from employers.

Strategic policy principles

Our new approach is based on 12 strategic policy principles.

1

Taking a person-centred approach to fitness to practise helps us to properly understand what happened, to make sure concerns raised by patients and families are properly listened to and addressed, and to explain to them what action we can take and why.

2

Fitness to practise is about managing the risk that a registrant poses to patients or members of the public in the future. It isn't about punishing people for past events.

3

We can best protect patients and members of the public by making final fitness to practise decisions swiftly and publishing the reasons openly.

4

Employers should act first to deal with concerns about a registrant's practice, unless the risk to patients or the public is so serious that we need to take immediate action.

5

We always take regulatory action when there is a risk to patient safety that is not being effectively managed by an employer.

6

We take account of the context in which the registrant was practising when deciding whether there is a risk to patient safety that requires us to take regulatory action.

7

We may not need to take regulatory action for a clinical mistake, even where there has been serious harm to a patient or service-user, if there is no longer a risk to patient safety and the registrant has been open about what went wrong and can demonstrate that they have learned from it.

8

Deliberately covering up when things go wrong seriously undermines patient safety and damages public trust in the professions. Restrictive regulatory action is likely to be required in such cases.

9

In cases about clinical practice, **taking action solely to maintain public confidence or uphold standards is only likely to be needed if the regulatory concern can't be remedied.**

10

In cases that aren't about clinical practice, **taking action to maintain public confidence and uphold standards is only likely to be needed if the concerns raise fundamental questions** about the trustworthiness of a registrant as a professional.

11

Some regulatory concerns, particularly if they raise **fundamental concerns about the registrant's professionalism, can't be remedied and require restrictive regulatory action.**

12

Hearings best protect patients and members of the public by resolving central aspects of a case that we and the registrant don't agree on.

We have updated all our guidance for decision-makers to reflect the new policy principles and embarked on extensive work with our stakeholders on how we can make the new approach work. Between September 2018 and March 2019 we piloted five operational changes to test the new ways of working.

1. Prioritising local action

In many cases, concerns can be investigated and resolved quicker by the nurse, midwife or nursing associate's employer. We worked with a number of employers across the health and care sector to produce guidance about what we require to investigate concerns. We also launched a new online referral system to improve the quality of information we receive and get employers to think more about local action.

2. Calls to people who raise concerns

When patients, people who use services or their family members raise concerns with us we phone them to ensure we fully understand what they want us to look into. We can also talk to them about our process and set expectations about what we can and cannot do.

3. Taking account of the context in which incidents occur

We know that the vast majority of nurses, midwives and nursing associates work hard to provide the very best standard of care to all of their patients. We also know that sometimes, mistakes happen and sometimes the complex issues and unique pressures in working environments are part of the reason for a mistake. We have been asking employers to tell us more about the context and environment when mistakes occur and building a more thorough and consistent approach to our assessment of context in our decision-making process.

4. Enabling remediation

To foster a just culture that encourages openness and honesty in health and social care, we want to work with nurses, midwives and nursing associates to encourage them to talk to us as early as possible about what happened and what they have done to put things right. We have been training our teams to help them encourage these discussions and give advice on how nurses and midwives can demonstrate they have learned from mistakes and ensure they will not be repeated.

5. Making the best use of hearings

As part of our work with nurses, midwives and nursing associates on remediating concerns about their practice, we want to work with them to agree where standards of care or professionalism have fallen short so that we only take cases to a full hearing when issues remain in dispute.

We have evaluated the outcomes from the pilots and identified a number of learning points. Implementing these outcomes is a priority for 2019–2020.

Employer Link and Regulatory Intelligence

The Employer Link Service (ELS) has continued to support the wider work of the organisation this year through engagement with employers of nurses, midwives and nursing associates, strategic oversight organisations, and other regulators.

ELS Regulation Advisers have continued to engage extensively with NHS health and social care trusts and boards to develop proactive working relationships with senior nursing and midwifery leaders. We have started to engage more with the independent sector and primary and social care; increasing our engagement in these sectors is a priority for 2019–2020.

ELS had 3,829 engagements with employers in 2018–2019 including:

- 217 meetings with directors of nursing or midwifery
- 208 attendances at group meetings, summits, speaking engagements and regional quality surveillance group meetings
- 1,428 phone calls with employers and other regulators.

This is a 16 percent increase on 2017–2018 activity when there were 3,312 engagements.

The work of our Regulatory Intelligence Unit (RIU) supports our objective of becoming an intelligence led regulator. This year we have:

- developed our tools to help us better understand risk factors and share lessons with others to enable safer patient care
- continued to share information each month with health and care regulators in England, Scotland, Northern Ireland and Wales linking the allegations in our cases to healthcare providers
- improved our collaborative relationships with other organisations this year in order to share and understand data, information and risk better. This allows us to take joint effective action where required
- worked with the Health and Social Care Regulators Forum to develop and implement a new *Emerging Concerns Protocol*. This allows us to share risk information quickly and take early and coordinated action to protect the public
- established 10 memoranda of understanding with other organisations.

We refer concerns to other regulatory bodies where we believe they may need to take action to protect the public. For example, if we identify concerns about doctors in our own investigations we share this with the General Medical Council. We use our allegations coding and reviews of fitness to practise panel decisions to identify referrals to the Disclosure Barring Service and Disclosure Scotland.

In 2018–2019, we made 354 referrals to other organisations:

- 154 to systems regulators
- 113 to professional regulators
- 87 to Disclosure Barring Service/Disclosure Scotland.

We shared intelligence 233 times in 2017–2018 and 131 times in 2016–2017. This steady increase reflects the increased capacity of RIU.

Sharing information case study

In November 2018, we triggered the *Emerging Concerns Protocol* when concerns began emerging from an organisation about a number of areas, including maternity services, student placements and the accident and emergency department.

We hosted a meeting of the General Medical Council, Care Quality Commission, Health Education England and local universities to share intelligence and actions. We were able to understand more about where we could work collaboratively to obtain information and provide training to staff at the organisation.

Regulatory Intelligence case study

We received concerns about a care setting which included nurses not following procedures, failing to uphold professional standards, failing to consider patient safety and poor record keeping.

We carried out an assessment of the intelligence and identified concerns about the placement of student nurses and midwives as well as fitness to practise concerns about a number of nurses and other healthcare professionals. We decided that there were wider systemic failings which needed to be investigated.

We opened fitness to practise cases against three nurses and these are currently progressing through our process.

We shared our intelligence with universities who placed their nursing students in the setting.

We also passed concerns on to the systems regulators and the General Medical Council.

In January 2017 we introduced a coding framework for allegations which allows us to understand the type of cases we hold.

This year we can publish information on the most common types of allegations found proved at our hearings. We have multiple levels of coding; level one is the headline allegation category and level two provides more detail about the allegation type.

The top three categories where the most allegations were found proved were patient care, record keeping and prescribing and medicines management. The most common allegations within each of these categories were:

Allegation category (Level 1) (% of total allegations)	Sub category allegation (Level 2)	Percentage of Level 1 allegation
Patient care (29%)	Diagnosis, observation or assessment	25%
	Inappropriate or delayed response to negative signs, deterioration or incidents	19%
	Handling patients	6%
Record keeping (13%)	Patient or clinical records	55%
	Drugs or medication records	28%
	Care plans	14%
Prescribing and medicines management (13%)	Not administering or refusing to administer medication	20%
	Inappropriate storage, transportation, preparation or disposal	12%
	Administering incorrect dosage	10%

2018–2019 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 84 percent (2017–2018: 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 86 percent (2017–2018: 81 percent).

Number of concerns

In 2018–2019 we received 5,373 new concerns, which is 2.5 percent fewer referrals than we received in 2017–18. The total number of concerns we received represents around 8 referrals for every 1,000 registrants.

	2018–19	2017–18	2016–17
Number of concerns received	5,373	5,509	5,476

In 2018–2019 we received

5,373

new concerns

2.5%

fewer than 2017–2018

8 referrals for every 1,000 registrants

Source of concerns

Table 1 shows the sources of concerns we received last year. The proportion of referrals from employers has reduced from 40 percent in 2017–2018 to 35 percent in 2018–2019. This reduction may reflect the improved engagement with employers through our Employer Link Service over the last three years.

Table 1: Source of concerns referred to us

	2018–19		2017–18	2016–17
Who referred concerns to us	Number of new concerns	Percentage of new concerns	Percentage of new concerns	Percentage of new concerns
Patient/public	1,566	29%	27%	28%
Self-referral	455	8%	10%	10%
Employer	1,906	35%	40%	39%
Opened by the NMC	197	4%	6%	6%
Another registrant	208	4%	3%	3%
Other regulator	47	1%	<1%	1%
Referrer unknown	361	7%	4%	3%
Any other informant	633	12%	10%	10%
Total	**5,373**	**100%**	**100%**	**100%**

Concerns by country of registered address

Sometimes we are not able to identify a nurse, midwife or nursing associate on our register when someone raises a concern with us. This could be because we do not have enough information to identify them or because they are not a nurse, midwife or nursing associate. In 2018–19, we were unable to identify someone on our register in 1,020 of the new cases raised with us.

The following section breaks down the 4,353 cases where we identified a registered nurse, midwife or nursing associate using their country of registered address. The proportion of concerns in each country broadly equates to the proportion of nurses, midwives and nursing associates on the register.

Country of registered address	Cases	Percentage of total concerns	Percentage of the register
Northern Ireland	139	3%	4%
Scotland	413	9%	10%
England	3,475	80%	79%
Wales	250	6%	5%
Outside UK	76	2%	2%

Concerns by registration type

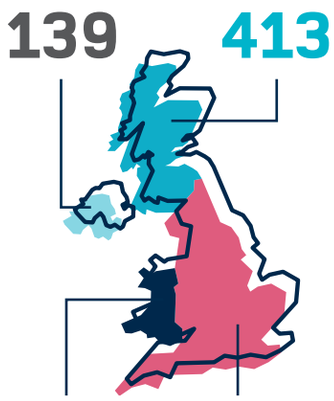
An individual can be registered with us as a nurse, as a midwife, or as both a nurse and midwife (known as dual registration) or, since January 2019, as a nursing associate.

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 2017–2018.

Table 2: New referrals by registration type

	2018–19		2017–18	2016–17
Registration type	Number of new referrals	Percentage of total referrals	Percentage of total referrals	Percentage of total referrals
Nurse	4,135	95%	95%	92%
Midwife	205	5%	5%	3%
Nursing associate	0	0%	N/A	N/A
Dual registration	13	<1%	0%	5%
Total	**4,353**	**100%**	**100%**	**100%**

Referrals in 2018–2019



76 were from outside the UK

There were...

4,135 about Nurses

205 about Midwives

0 about Nursing Associates

13 about individuals with dual registration

Initial assessment outcomes

In 2018–2019, after initial assessment we decided 1,990 cases required a full investigation (2017–2018: 2,420 and 2016–2017: 2,370).

We closed 3,389 cases in 2018–19 after initial assessment either because we were unable to identify a nurse, midwife or nursing associate on our register, or because, after initial assessment, we concluded the concerns did not require regulatory action (2017–2018: 3,081 and 2016–2017: 3,556).

Interim orders

In 2018–2019, our panels imposed interim orders to protect the public while our investigations continued in 506 cases (2017–2018: 580 and 2016–2017: 705). Table 3 shows the break down between the two types of interim order.

Table 3: Interim orders imposed

	2018–19		2017–18		2016–17	
Interim order decisions	Number	Percentage	Number	Percentage	Number	Percentage
Interim conditions of practice	268	53%	309	53%	326	46%
Interim suspension	238	47%	271	47%	379	54%
Total	**506**	**100%**	**580**	**100%**	**705**	**100%**

Table 4 breaks down the number of interim orders imposed by registration type. There has not been a material change in the proportion of interim orders imposed by registration type in 2018–2019 compared to 2017–2018.

Table 4: Interim orders imposed by registration type

	2018–19				2017–18			2016–17		
Interim order decisions	Nurse	Midwife	Nursing Associate	Dual	Nurse	Midwife	Dual	Nurse	Midwife	Dual
Interim conditions of practice	251 53%	16 58%	0	1 <1%	284 52%	25 71%	0	289 45%	20 59%	17 57%
Interim suspension	225 47%	12 42%	0	1 <1%	261 48%	10 29%	0	352 55%	14 41%	13 43%
Total	**476**	**28**	**0**	**2**	**545**	**35**	**0**	**641**	**34**	**30**

Case Examiner outcomes

In 2018–2019, our Case Examiners took 1,638 decisions (2017–2018: 2,234) at the end of an investigation. This reflects lower throughput than planned from our investigation teams to the Case Examiners. We worked to stabilise and improve performance in investigations by refocusing our teams and investing in additional external investigations.

Table 5 breaks down the total decisions by type. Powers to agree undertakings, issue warnings, and give advice were introduced in July 2017. The increase in the proportion of these outcomes in 2018–2019 reflects the fact that it is the first full year in which they have operated.

Table 5: Case Examiner outcomes 2018–2019

	2018–19		2017–18		2016–17	
Case Examiner decisions	Number	Percentage	Number	Percentage	Number	Percentage
Refer for hearing or meeting	520	32%	819	37%	1,539	57%
Advice	12	<1%	24	1%	-	-
Warning	102	6%	93	4%	-	-
Undertaking	41	3%	28	1%	-	-
No further action	963	59%	1,270	57%	1,170	43%
Total	**1,638**	**100%**	**2,234**	**100%**	**2,709**	**100%**

Table 6 breaks down the number of Case Examiner decisions by registration type.

As in 2017–2018, cases about midwives appear marginally less likely to be closed with no further action and marginally more likely to be closed with a warning or undertaking or referred to a hearing or meeting.

Table 6: Number of decisions by registration type

	2018–19				2017–18			2016–17		
Case Examiner decision	Nurse	Midwife	Nursing Associate	Dual	Nurse	Midwife	Dual	Nurse	Midwife	Dual
Refer for hearing or meeting	490 (32%)	30 (37%)	0	0	770 (37%)	49 (40%)	0	1,444 (57%)	56 (56%)	39 (71%)
Advice	12 (1%)	0	0	0	22 (1%)	2 (2%)	0	-	-	-
Warning	94 (6%)	7 (9%)	0	1 (20%)	87 (4%)	6 (5%)	0	-	-	-
Undertaking	37 (2%)	4 (5%)	0	0	22 (1%)	6 (5%)	0	-	-	-
No further action	919 (59%)	40 (49%)	0	4 (80%)	1,211 (57%)	59 (48%)	0	1,110 (43%)	44 (44%)	16 (29%)
Totals	**1,552**	**81**	**0**	**5**	**2,112**	**122**	**0**	**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 2018–2019 (2017–2018: 0 and 2016–2017: 0).

Hearing and meeting outcomes

In 2018–2019, our panels reached 661 final decisions on cases (2017–2018: 1,207 and 2016–2017: 1,513) through meetings and hearings. Table 7 breaks down the panel decisions by type.

The reduction in the number of hearing and meeting outcomes reflects:

- an overall reduction in caseload over the last three years as we have resolved the historical backlog
- uptake of Case Examiner powers to agree undertakings, issue warnings, and give advice that were introduced in July 2017
- lower output than planned from the investigation stage.

We continue to work with registrants and their representatives to encourage engagement, remediation, and insight at the earliest opportunity. The reduction in cautions (together with the corresponding increase in the number of warning issued by Case Examiners) and the reduction in findings of no impairment may be an indication of better early engagement and remediation. We continue to focus on this under our new strategic direction.

Table 7: Panel decisions

	2018–19		2017–18		2016–17	
Panel decision	Number	Percentage	Number	Percentage	Number	Percentage
Strike off	162	25%	257	21%	344	23%
Suspension	231	35%	372	31%	424	28%
Conditions of practice	99	15%	165	14%	267	18%
Caution	57	8%	129	11%	164	11%
FtP impaired – no sanction	0	0%	0	0%	5	<1%
Sub-total	**549**	**83%**	**923**	**77%**	**1,204**	**80%**
Facts not proved	17	3%	5	<1%	31	2%
FtP not impaired	95	14%	279	23%	278	18%
Total panel decisions	**661**	**100%**	**1,207**	**100%**	**1,513**	**100%**

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 previous years. There has been some change in distribution of outcomes for midwives. Given the small numbers, no firm conclusions should be drawn.

Table 8: Panel decisions by registration type

	2018–19			2017–18			2016–17		
Panel decision	Nurse	Midwife	Nursing Associate	Nurse	Midwife	Dual	Nurse	Midwife	Dual
Strike off	155 (25%)	7 (24%)	0	243 (21%)	14 (27%)	0	322 (23%)	6 (22%)	16 (18%)
Suspension	224 (35%)	7 (24%)	0	355 (31%)	17 (33%)	0	384 (27%)	4 (15%)	36 (44%)
Conditions of practice	92 (15%)	7 (24%)	0	157 (14%)	8 (16%)	0	246 (18%)	7 (26%)	14 (16%)
Caution	57 (9%)	0	0	127 (11%)	2 (4%)	0	153 (11%)	5 (19%)	6 (7%)
FtP impaired – no sanction	0	0	0	0 (0%)	0 (0%)	0	4 (<1%)	0 (0%)	1 (1%)
Sub-total	**528**	**21**	**0**	**882**	**41**	**0**	**1,109**	**22**	**73**
Facts not proved	16 (2%)	1 (4%)	0	5 (<1%)	0 (0%)	0	29 (2%)	5 (19%)	12 (14%)
FtP not impaired	88 (14%)	7 (24%)	0	269 (23%)	10 (20%)	0	261 (19%)	0 (0%)	2 (2%)
Totals	**632**	**29**	**0**	**1,156**	**51**	**0**	**1,399**	**27**	**87**

Fraudulent or incorrect register entries

As well as the fitness to practise panel decisions in tables 7 and 8, our panels also consider allegations that a nurse, midwife or nursing associate has been added to the register incorrectly or fraudulently. In these cases they do not consider whether someone's fitness to practise is impaired. If they find the allegation proved, the panel can direct the Registrar to remove or amend the entry on the register.

In 2018–2019, our panels directed the Registrar to remove a nurse or midwife from the register in 34 cases (2017–2018: 60 and 2016–2017: 36). There were no fraudulent or incorrect register entry cases involving nursing associates.

Voluntary removal

After a case has been referred for a hearing or meeting, nurses, midwives and nursing associates 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 decrease in the number of applications since last year broadly reflects the decrease in the number of cases referred for a hearing or meeting (Table 5).

Table 9: Voluntary removal applications

Voluntary removals	2018–19	2017–18	2016–17
Number of applications	101	136	165
Applications granted	60	66	77
Applications rejected	41	70	88

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

Table 10: Voluntary removal decisions by registration type

	2018–19		2017–18	
Voluntary removals	Nurse	Midwife	Nurse	Midwife
Applications granted	52	8	52	14
Applications rejected	38	3	60	10
Totals	**90**	**11**	**112**	**24**

Reviews and appeals

We have the power to review the Case Examiner's decisions, including advice, warnings and undertakings, and anyone can request that we do so.

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 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 three percent of all Case Examiner decisions.

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	2018–19	2017–18	2016–17
Total requests for review received	44	64	69
First stage: request closed	18	35	57
Second stage: fresh decision required	10	20	2
Second stage: original decision upheld	4	17	5

Of the 10 cases where the Registrar decided a fresh decision was required in 2018–2019, all were due to material flaws in the original decision. After these 10 cases were reconsidered:

- 8 cases were referred for a hearing
- 2 cases were closed with a warning by the Case Examiners.

A nurse, midwife or nursing associate can 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. We have not seen a material change in the proportion of appeals lodged against 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	2018–19	2017–18	2016–17
Total appeals lodged	28	32	54
Appeal upheld	18	12	22
Appeal dismissed	9	26	26

Learning from appeals case study

In May 2018 the High Court ordered a new hearing to be held in a case where a nurse had allegedly physically assaulted a patient with learning disabilities. The original panel decision to find no misconduct had prompted concerns from several learning disability organisations and the Professional Standards Authority appealed the decision. We agreed with the PSA that the decision did not protect the public or uphold confidence in the profession. A striking off order was imposed at the new hearing in December 2018.

We reviewed this case very carefully and found we could have improved our handling of the case by:

- providing regular updates to the patient's family
- being more sensitive to the family in our communications and in the panel's decision
- greater understanding of the challenges faced by patients with learning disabilities.

In 2018–2019 we worked with the Challenging Behaviour Foundation and Mencap to deliver bespoke training for our caseworkers to help them understand the needs of patients with learning disabilities or who may have behaviours that challenge others. We also delivered similar training to our panel members.

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

Table 13: Appeal of panel decisions by appeal type

	PSA	Registrant
Appeal upheld	5	13
Appeal dismissed	0	9

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 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 2018–2019. We have not identified any trends relating to the fluctuation in number of restoration applications over the last few years. Some applications for restoration do not progress to a panel because we do not receive all the necessary information from the registrant. We have identified some opportunities to streamline our processes which we will implement in 2019–2020.

Table 14: Restoration application outcomes

Outcome	2018–19	2017–18	2016–17
Total applications received	47	52	35
Application accepted	16	21	5
Application rejected	10	15	5

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

Table 15: Restoration decisions by registration type

	2018–19 total	Nurse	Midwife
Application accepted	16	16	0
Application rejected	10	10	0

Future focus: 2019–2020

Implementing our new strategic direction

In early 2019, we evaluated the pilots of our strategy to see what we need to do to fully implement our new ways of working. We will be continuing to engage with the professions and our stakeholders to build new ways of working, to ensure people are at the heart of our work, and to create a culture of openness, honesty and accountability where learning from mistakes prevents them happening again. We expect to begin implementation in the summer of 2019 and will report on the initial benefits of our new ways of working in our next annual report.

Person-centred approach

We plan to build on the steps we have taken this year to improve the way we engage with people involved in our fitness to practise process so they feel better supported. This includes making sure we treat everyone with respect, listening to what they have to say and being transparent and honest with people when things go wrong.

The Public Support Service will continue to deliver improvements to how we deal with people through the work of the steering group which will feed into our Strategy 2020–2025. We will be working with employers to ensure we know from the start of a case whether there are families or patients involved so we can provide them with the right information as soon as possible. We will also continue our work in ensuring all of our letters and communications to people are appropriate in tone and language. We will build upon the improvements we made to information provided on our website for patients, people who use services and family members.

We will also be improving ways we can support nurses, midwives and nursing associates who have had concerns raised about their fitness to practise. We will be launching a telephone advice line for people to provide emotional support and signposting to other support agencies.

For nurses, midwives and nursing associates who do not have representation we are working with an independent organisation to provide them with pro-bono legal advice.

Increasing our data capability

We have already started to make significant improvements to how we collect and analyse our data through investing in new systems and tools. Next year we will continue developing our data analysis to help us better understand our register and areas of risk in health and care settings. We will also continue to work across the organisation and with external stakeholders, using intelligence and learning the lessons when things go wrong.

Notes on the data

Comparability

We report using case numbers rather than nurses and midwives' personal identification numbers (PINs) as the identifier.

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).
- as a nursing associate.

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.

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.

Nursing & Midwifery Council

CCS0619426192
ISBN 978-1-5286-1432-0