NMC Nursing & Midwifery Council

Nursing and Midwifery Council: Annual Fitness to Practise Report 2011-2012

Nursing and Midwifery Council

Annual Fitness to Practise Report 2011-2012

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Foreword

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

This report describes how we have dealt with concerns raised with us about the fitness to practise of nurses and midwives during 2011-2012. It should be read alongside our Annual Report and Accounts 2011-2012 which covers all the work we do to safeguard the health and wellbeing of the public.

During 2011-2012, over 671,000 nurses and midwives were registered by us to practise in the UK. It is important to recognise that this report focuses on the very small number of those nurses and midwives – around 0.6 percent - who came to our attention because there was a concern about them. An even smaller number - less than 0.1 percent - received some sort of sanction following investigation by us. This means the vast majority of nurses and midwives practise safely and consistently meet the high standards which the public rightly expects.

The last year has been a challenging one for the Nursing and Midwifery Council, and our fitness to practise work has come under particular scrutiny. We have recognised the need to address weaknesses in the speed with which we progress cases, the customer service we provide and the quality of decision-making in fitness to practise cases. We have a clear action plan in place to tackle these issues supported by substantial investment. Progress against the plan is being closely monitored by Council to drive continued improvement in how we carry out our fitness to practise work. This, together with the major programme now underway to transform the NMC into a more efficient, effective and economic regulator, means that we have a clear and unwavering focus on delivering our fundamental duty – protecting the public.

Professor Judith Ellis MBE
Deputy Chair
NMC
4 September 2012

Jackie Smith
Acting Chief Executive and Registrar
NMC
4 September 2012

Introduction

This report explains the work which the Nursing and Midwifery Council does to protect the public from registered nurses and midwives whose fitness to practise is impaired. It tells you:

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

Who we are

We are the nursing and midwifery regulator for the UK.[1] We are independent from government, and are funded by the registration fees that we receive from the nurses and midwives on our register.

What we do

It is our job to safeguard the health and wellbeing of the public by making sure that all practising nurses and midwives have the skills, knowledge, good health and good character to do their job safely and effectively. To do this, we:

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

This report focuses on our fitness to practise work. You may also find it helpful to read our Annual Report and Accounts 2011-2012 which covers all the work we do to safeguard the health and wellbeing of the public.[2]

Oversight of our work

We are accountable to Parliament, through the Privy Council, for what we do. In 2011, the Health Committee exercised this role on behalf of Parliament by calling us to an accountability hearing.[3] We welcomed this opportunity to discuss our work and we are pleased that the Health Committee intends to hold these hearings every year.

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1 The Nursing and Midwifery Order 2001 SI 2002/253 (as amended)
2 www.nmc-uk.org/About-us/Annual-reports-and-statutory-accounts
3 www.publications.parliament.uk/pa/cm201012/cmselect/cmhealth/1699/169902.htm

Our work is also subject to oversight by the Council for Healthcare Regulatory Excellence (CHRE). Each year, the CHRE looks at a number of aspects of our work:

- It reviews our overall performance and reports on this to Parliament.[4]
- It can audit a sample of the fitness to practise cases we have closed at an early stage.[5]
- It reviews all final adjudication decisions in fitness to practise cases. If it thinks a decision is unduly lenient, it can ask the High Court to look at the case. It may also provide feedback on our adjudication processes and decisions by way of learning points.

Protecting the public

The NMC register

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

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

On 31 March 2012, there were 671,668 nurses and midwives on our register. Anyone can check whether a nurse or midwife is currently registered by visiting **www.nmc-uk.org/search-the-register.**

Fitness to practise

All qualified nurses and midwives must follow their professional code: *The code: Standards of conduct, performance and ethics for nurses and midwives*[6] and our standards, and be fit to practise, so that patients and the public can trust them with their health and wellbeing.

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

When someone considers that a nurse or midwife's fitness to practise is impaired they can bring these concerns to us. We investigate various allegations including:

- Misconduct.
- Lack of competence.

4 www.chre.org.uk/_img/pics/library/120620_CHRE_Performance_review_report_2011-12,_Vol_II_(Colour_for_web_-_PDF)_1.pdf
5 www.chre.org.uk/_img/pics/library/pdf_1321356841.pdf
6 www.nmc-uk.org/code

- Criminal behaviour.
- Serious ill health.

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

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

When we cannot investigate

We can only investigate complaints about:

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

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

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

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

Our work in 2011-2012 at a glance

4,407 referrals received in 2011-2012

- 0.6 percent approximately of 671,668 registered nurses and midwives.
- 48 percent increase since April 2009 (2010-2011: 4,211; 2009-2010: 2,986).

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

3,797 cases closed/concluded in 2011-2012

- 1,869 cases closed on initial assessment (screening).
- 1,175 cases closed by the Investigating Committee.
- 753 cases concluded at adjudication.

952 cases sent for adjudication by the Investigating Committee

- 866 sent to the Conduct and Competence Committee.
- 86 sent to the Health Committee.

753 cases concluded at adjudication in 2011-2012

- 103 cases: fitness to practise found not to be impaired.
- 650 cases: fitness to practise found to be impaired and sanction imposed.
  - 365 nurses or midwives struck off the register.
  - 136 nurses or midwives suspended from the register.
  - 51 nurses or midwives had conditions imposed on how they can practise.
  - 98 nurses or midwives received a caution order.

13 appeals against our decisions concluded

- 11 appeals by nurses or midwives against our decision.
- One judicial review by the originator of the concerns.
- One referral by CHRE because it considered a decision unduly lenient.

Five applications for restoration to the register

- Four applicants successful; One applicant unsuccessful.

One fraudulent or incorrect entry on the register

- One individual found to be on the register fraudulently and removed.

How do we know if there is a problem?

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

- Someone using the services of a nurse or midwife.
- A member of the public.
- The employer or manager of the nurse or midwife.
- Someone who works with the nurse or midwife.
- The police.
- Other organisations involved in regulating healthcare, such as the Care Quality Commission.

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

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

Making sure the right cases reach us

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

As the majority of our cases come from employers (42 percent last year), we work closely with those who employ nurses or midwives so that they know when to refer cases to us. In August 2011, we issued updated guidance to help employers understand our processes better.[7] We also undertook an extensive programme of visits and meetings throughout the four countries to discuss our work with them. In addition, directors of nursing, heads of midwifery, and local supervising authority midwifery officers can call our dedicated helpline to seek advice or information on possible cases and 101 did so during 2011-2012.

We also work with patient support groups so they can better understand what cases we can look at and improve the advice they give to patients and others. Our booklet *Complaints against nurses and midwives: Helping you support patients and the public* produced with help from our patient and public involvement group, aims to assist these groups to improve the help they can give to patients, service users and other members of the public.[8]

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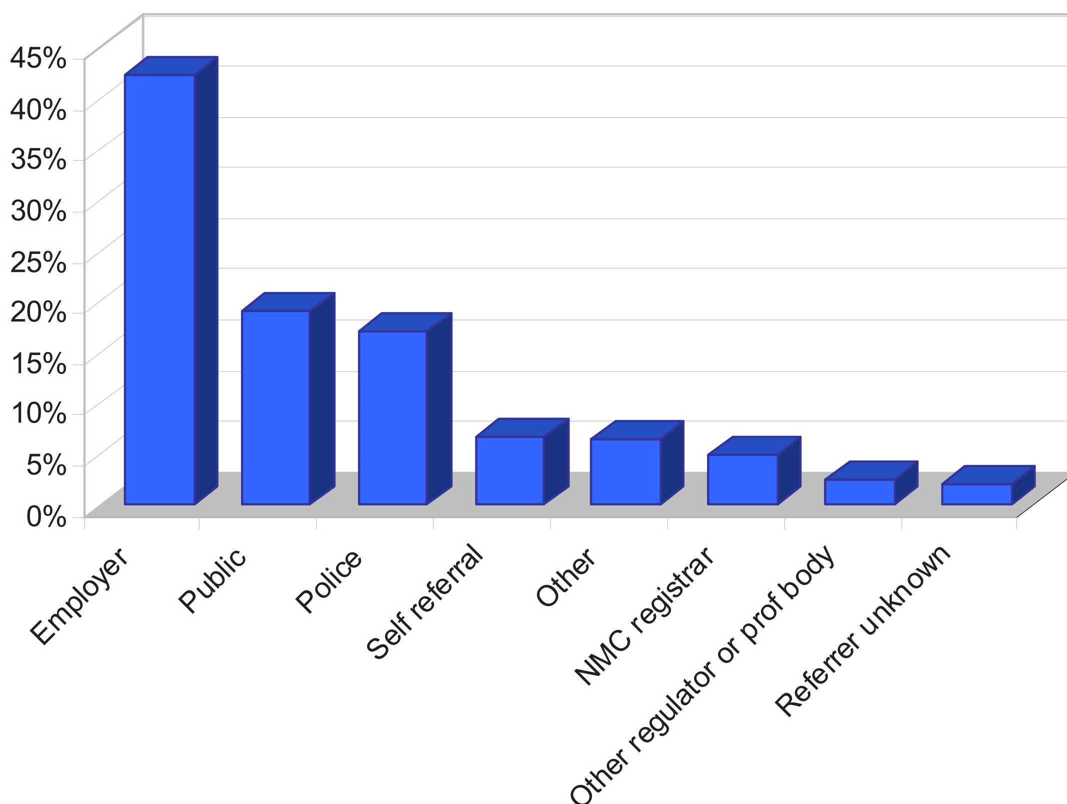
7 www.nmc-uk.org/Documents/FtP_Information/Advice-and-information-for-employers-of-nurses-and-midwives20110816.pdf
8 www.nmc-uk.org/supporting-patients

Table 1 – Who referred cases to us in 2011-2012?

Source of new referrals	Number of new referrals	Percentage
Employer	1,856	42%
Member of public, service user or patient	835	19%
Police	745	17%
Self referral	290	7%
Other (including lawyers and colleague referrals)	281	6%
NMC Registrar	211	5%
Other regulatory or professional body	103	2%
Referrer unknown	86	2%
Total	**4,407**	**100%**

Chart 1 – Who referred cases to us in 2011-2012?



How we deal with concerns raised with us

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

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

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

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

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

Our fitness to practise rules, which set out how we deal with cases, were amended in February 2012 to help us progress cases more quickly and efficiently.[9] The chart on page 12 shows what happens to cases after we receive them. Our aim is to begin the first day of the hearing or meeting stage of the adjudication process within 18 months of a concern being raised with us. However, we are not yet achieving this due to the high volume and complexity of cases we currently hold.

Practice committees

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

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

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

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

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

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

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9 www.nmc-uk.org/Documents/Legislation/NMC-Fitness-to-Practise-Rules-2004-consolidated-text-effective-from-06022012.pdf

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

On 31 March 2012, there were 416 panel members, including 119 panel chairs. 157 panel members are nurses or midwives.

More about how panels work can be found on our website.[10]

Ethnicity and diversity of panel members

We monitor the ethnicity and diversity of fitness to practise panel members and publish data on the make-up of our panel members, most recently in November 2011. This showed that in relation to most aspects of ethnicity and diversity panel members generally reflect the composition of the UK population as a whole.[11] We hope to publish updated information shortly.

More information about the NMC's work, including how we comply with our obligations under the Equality Act 2010 and how we use ethnicity and diversity data, is available in our Annual Report and Accounts 2011-2012.

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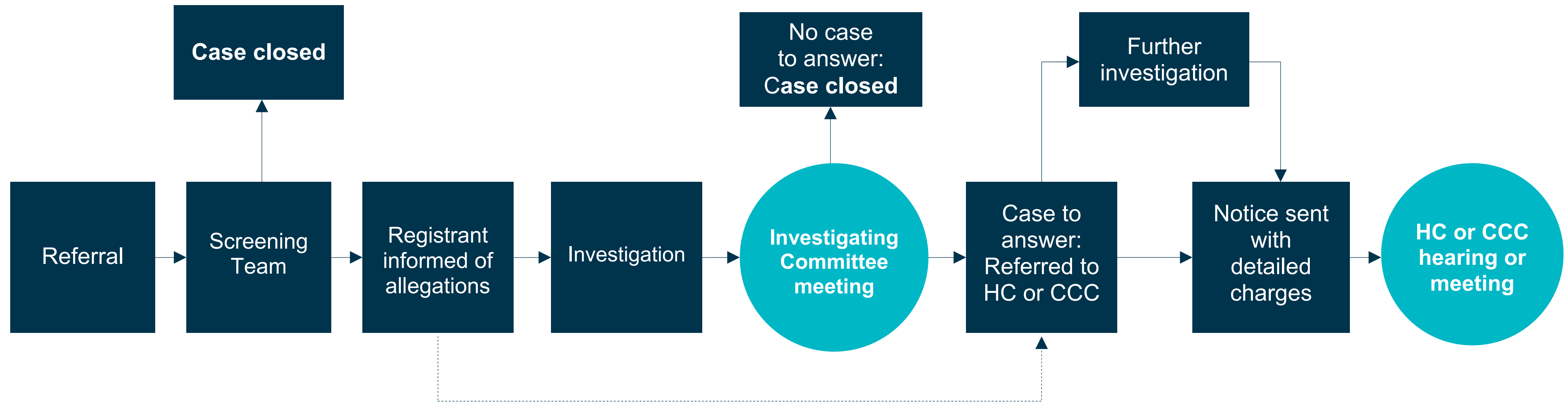
10 www.nmc-uk.org/Hearings/How-the-process-works.

11 www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council2011/NMC-Council-papers-November-2011.PDF

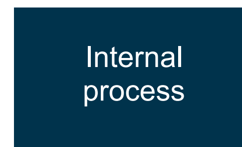
Fitness to practise process

This applies to all cases since 6 February 2012



Explanation of terms and chart styles

HC – Health Committee
CCC – Conduct and Competence Committee



Initial assessment

When we receive a new referral, we first investigate whether the individual complained about can be identified as a nurse or midwife who is on our register. If, after an initial assessment (screening), we cannot identify the individual as a registered nurse or midwife we have to close the case.

During 2011-2012 we received 4,407 new referrals. This represents a 48 percent increase since April 2009, as shown in the table below.

Table 2: New referrals received between 1 April 2009 and 31 March 2012

Month	2009-2010	2010-2011	2011-2012
April	233	393	294
May	181	331	342
June	249	337	390
July	231	352	403
August	239	278	383
September	186	394	377
October	242	302	378
November	244	333	419
December	279	291	356
January	266	365	378
February	262	473	315
March	374	362	372
Total	**2,986**	**4,211**	**4,407**

Chart 2: New referrals received between 1 April 2009 and 31 March 2012

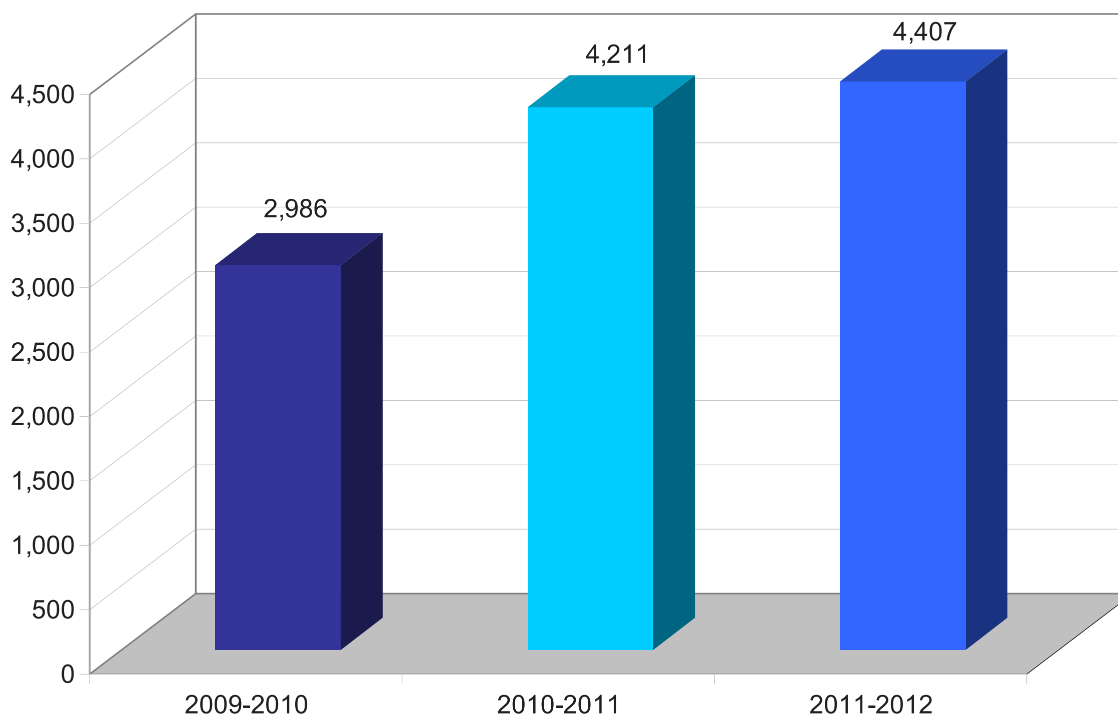
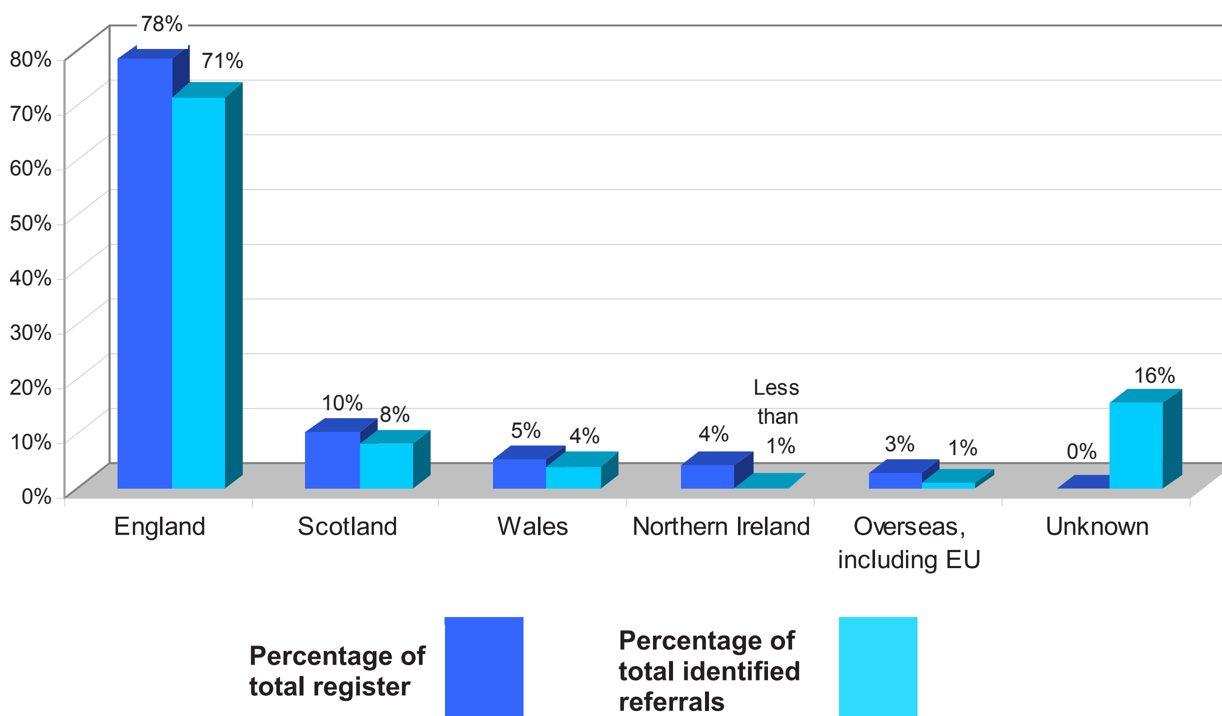


Table 3: New referrals by country compared to registration by country

It should be noted that at 31 March 2012, there were 1,217 cases (unidentified referrals) where we had not at that stage identified whether the individual complained about was a nurse or midwife on our register.

Country	Number on register	Percentage of register	Number of referrals	Percentage of referrals
England	526,568	78%	2,277	71%
Scotland	69,384	10%	253	8%
Wales	35,211	5%	127	4%
Northern Ireland	23,196	4%	2	Less than 1%
Overseas (including EU)	17,309	3%	33	1%
Unknown	-	-	498	16%
Total identified referrals	**671,668**	**100%**	**3,190**	**100%**
Unidentified referrals	-	-	1,217	-
Total referrals	**-**	**-**	**4,407**	**-**

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



What we know about the ethnicity and diversity of individuals referred to us

From our register we know the age and gender of any nurse or midwife who is referred to us. Since 2009, we have asked all the nurses and midwives registered with us to complete a diversity monitoring form. Provision of this information is entirely voluntary and we cannot require anyone to provide it to us. However, we strongly encourage nurses and midwives to complete the diversity monitoring form and have made it easier for them to do so by enabling returns to be made online.

At July 2011, 43 percent of registered nurses and midwives had returned a form to us and we used this information to publish a breakdown of the ethnicity and diversity of nurses and midwives on our register. This can be found on our website at **www.nmc-uk.org/equality-diversity-data**.

We have used the data we hold to produce an analysis of the ethnicity and diversity of the nurses and midwives who have been referred to us. However, considerable caution must be exercised in looking at this data because it cannot give the full picture. This is because at different stages of the fitness to practise process, we have different levels of diversity data available. For example, we have data in relation to 37 percent of some strands of diversity for all new cases referred to us, but at the adjudications stage, the data available for some diversity strands drops to 20 percent. This needs to be taken into account when considering this information. It would be inappropriate and potentially misleading to try to draw any conclusions from it or interpret it more generally.

We will be looking at the information we hold during 2012-2013 to see what, given these limitations, it can tell us about our work and whether this has any implications for, or impact on, groups with protected characteristics as defined in the Equality Act 2010.[12]

12 The protected characteristics are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Table 4: New referrals by gender

As at 31 March 2012, 90 percent of the register were female and 10 percent male.

Gender	Total referrals	Percentage
Male	711	22%
Female	2,479	78%
Total identified referrals	**3,190**	**100%**
Unidentified	1,217	-
Total of all referrals	**4,407**	**-**

Chart 4: New identified referrals by gender

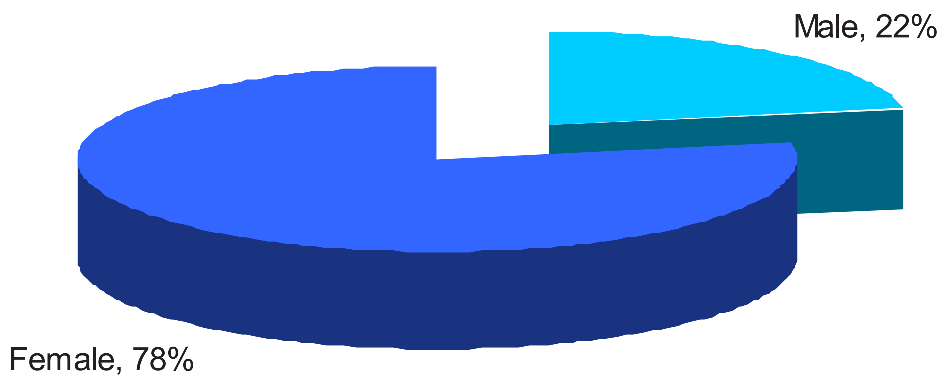


Table 5: New referrals by age

Age	Total referrals	Percentage
19 to 29 years	146	5%
30 to 39 years	650	20%
40 to 59 years	2,099	66%
60 years and over	295	9%
Total identified referrals	**3,190**	**100%**
Unidentified	1,217	-
Total of all referrals	**4,407**	**-**

Chart 5: New identified referrals by age

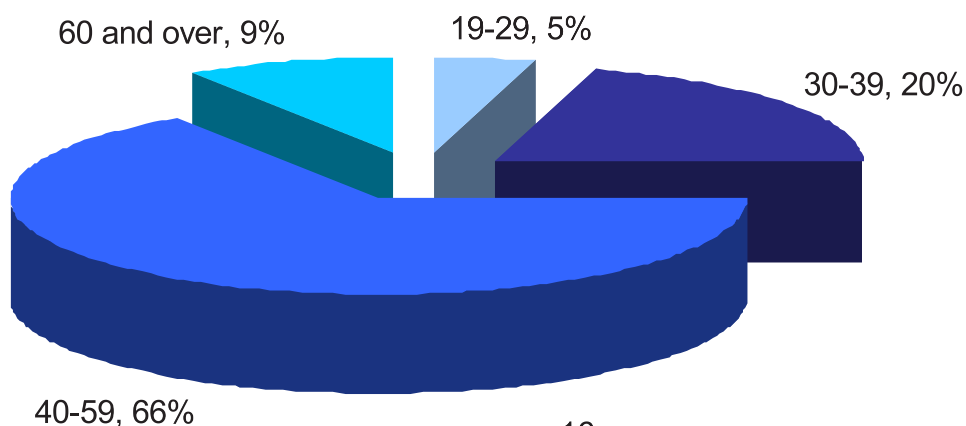


Table 6: New referrals by ethnicity

This is based on 37 percent of new identified referrals for which ethnicity data is available.

Ethnic group	Total referrals	Percentage
White	749	23%
Black	265	8%
Asian	119	4%
Mixed	30	1%
Other	18	1%
Prefer not to answer	28	1%
Unknown ethnicity	**1,981**	**62%**
Total identified referrals	**3,190**	**100%**
Unidentified referrals	1,217	-
Total of all referrals	**4,407**	**-**

Chart 6: New identified referrals by ethnicity

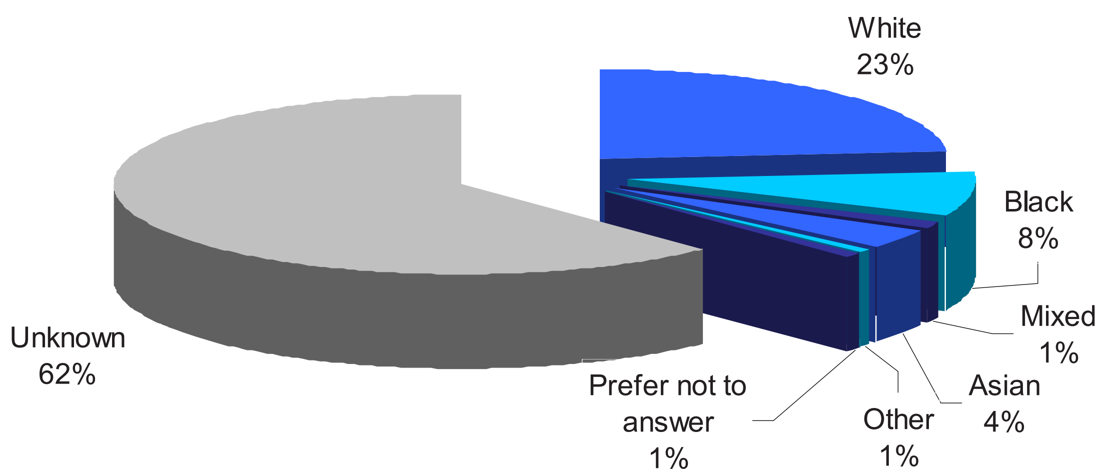


Table 7: New referrals by religion or belief

This is based on 34 percent of new identified referrals for which religion or belief data is available.

Religion or belief	Total referrals	Percentage
Christian	776	24%
No religion	155	5%
Prefer not to answer	102	3%
Other religion	56	2%
Muslim	25	Less than 1%
Buddhist	19	Less than 1%
Hindu	19	Less than 1%
Jewish	17	Less than 1%
Sikh	7	Less than 1%
Unknown	**2,014**	**63%**
Total identified referrals	**3,190**	**100%**
Unidentified	1,217	-
Total of all referrals	**4,407**	**-**

Chart 7: New identified referrals by religion or belief

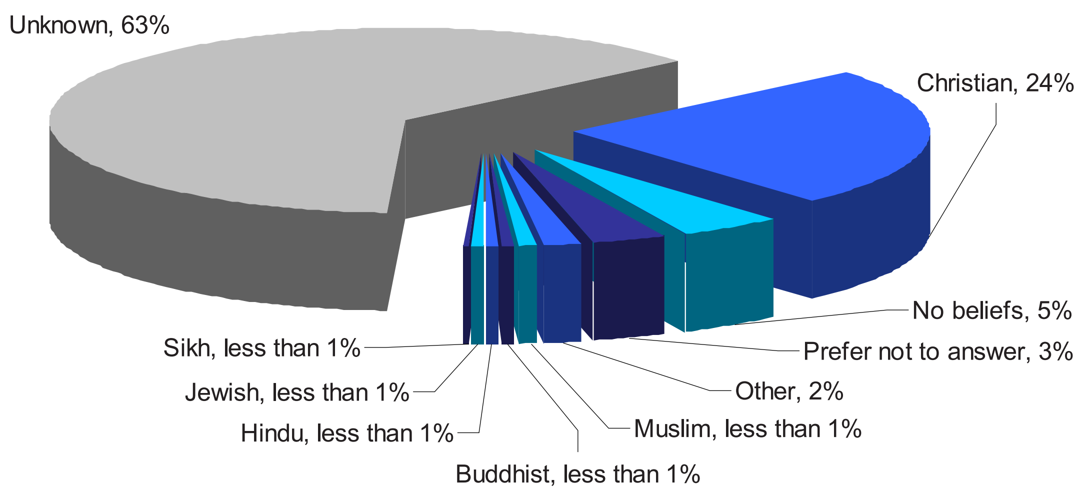


Table 8: New referrals by sexual orientation

This is based on 30 percent of new identified referrals for which sexual orientation data is available.

Sexual orientation	Total referrals	Percentage
Heterosexual	909	28%
Prefer not to answer	167	5%
Bisexual	29	1%
Gay or lesbian	38	1%
Unknown	**2,047**	**65%**
Total of identified referrals	**3,190**	**100%**
Unidentified	1,217	-
Total of all referrals	**4,407**	**-**

Chart 8: New identified referrals by sexual orientation

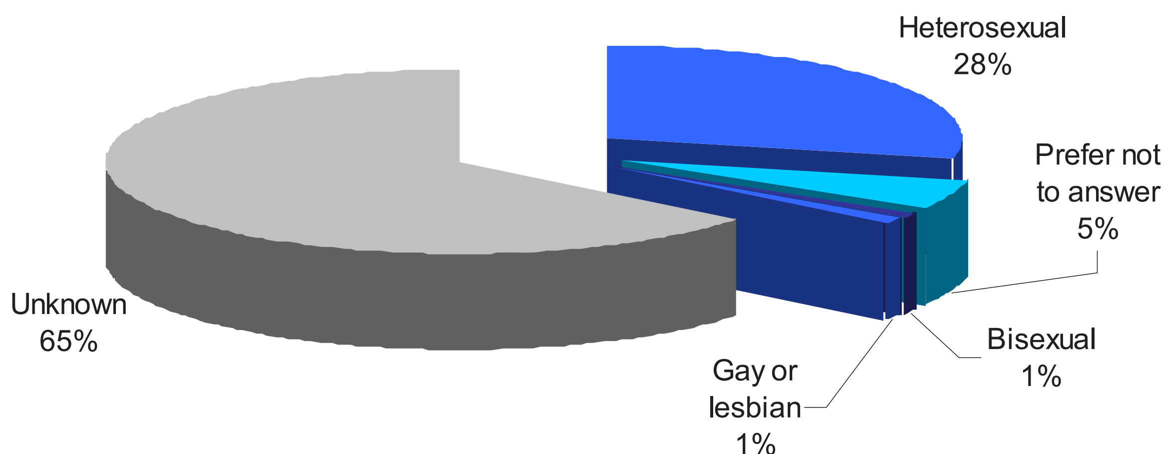
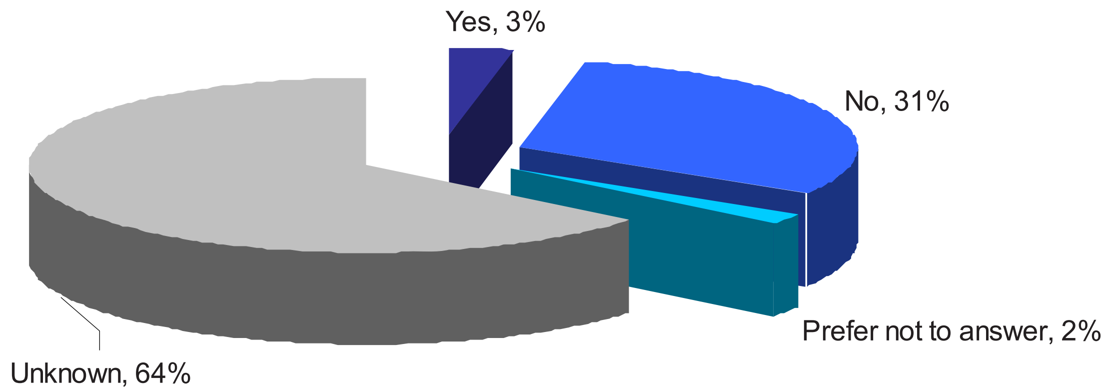


Table 9: New referrals by disability

This is based on 34 percent of new identified referrals for which disability data is available.

Disability	Total referrals	Percentage
Yes	98	3%
No	982	31%
Prefer not to answer	63	2%
Unknown	**2,047**	**64%**
Total identified referrals	**3,190**	**100%**
Unidentified	1,217	-
Total of all referrals	**4,407**	**-**

Chart 9: New identified referrals by disability



Nature of allegations referred to us

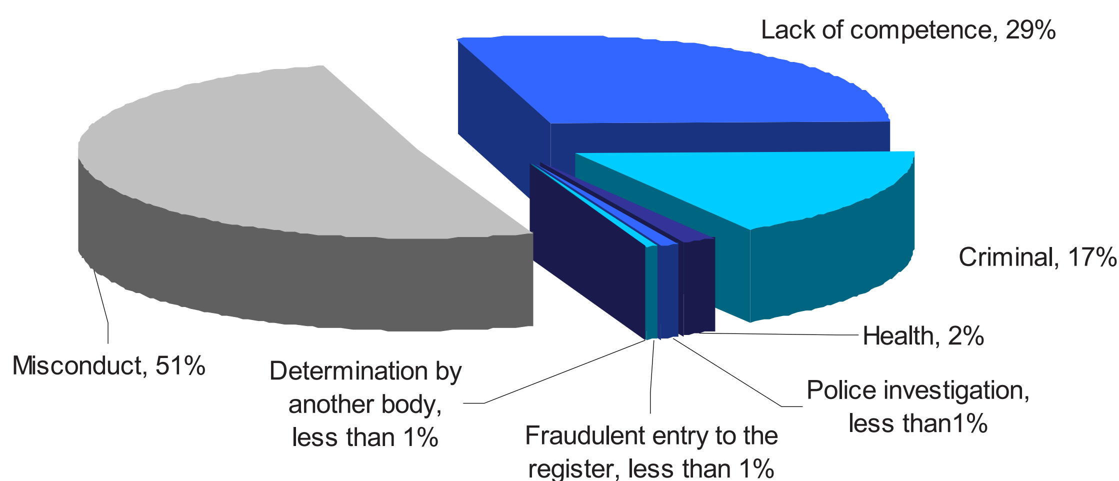
The table below shows the main types of allegations made in new referrals we received during 2011-2012. A more detailed breakdown of the numbers of allegations within each category is given in Appendix 1.

Many cases involve more than one type of allegation about a particular nurse or midwife which is why the total number of allegations at 8,300 is much higher than the number of new referrals (4,407).

Table 10: Types of allegations made in new referrals received in 2011-2012

Types of allegations	Total referrals	Percentage
Misconduct	4,250	51%
Lack of competence	2,412	29%
Criminal	1,385	17%
Health	145	2%
Police investigation	51	Less than 1%
Fraudulent entry	47	Less than 1%
Determination by another body (For example, Irish Nursing Board, Health and Care Professions Council)	10	Less than 1%
Total	**8,300**	**100%**

Chart 10: Types of allegations made in new referrals received in 2011-2012



Taking urgent action to protect the public

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

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

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

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

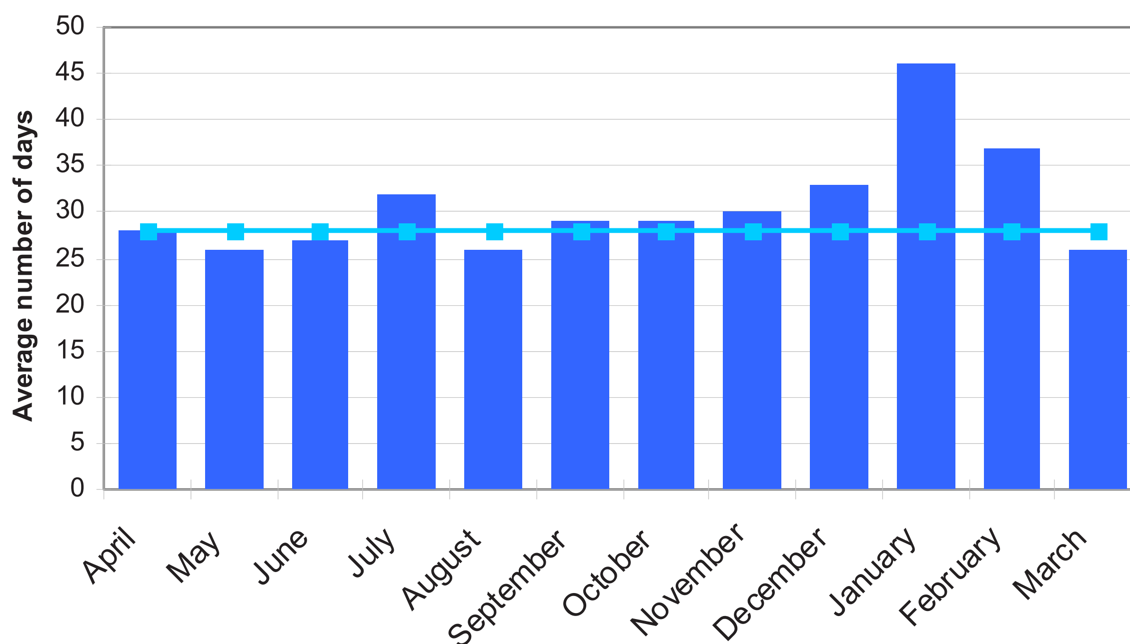
- Necessary to protect the public.
- In the public interest.
- In the nurse or midwife's interest.

Our performance in 2011-2012

We measure and monitor our performance using key performance indicators (KPIs). We have set a KPI for imposing interim orders within 28 days of receiving a case where we identify that urgent action to protect the public is needed. In 2011-2012, the median time taken was 28 days and the average time taken was 29.8 days as shown in the table below.

Average days to impose an interim order

KPI = 28 days



Interim order outcomes

Table 11: Interim orders imposed

Interim order decisions	Number of interim orders	Percentage
Interim conditions of practice order	259	28%
Interim suspension order	663	72%
Total interim orders imposed	**922**	**100%**

Chart 11: Interim orders imposed

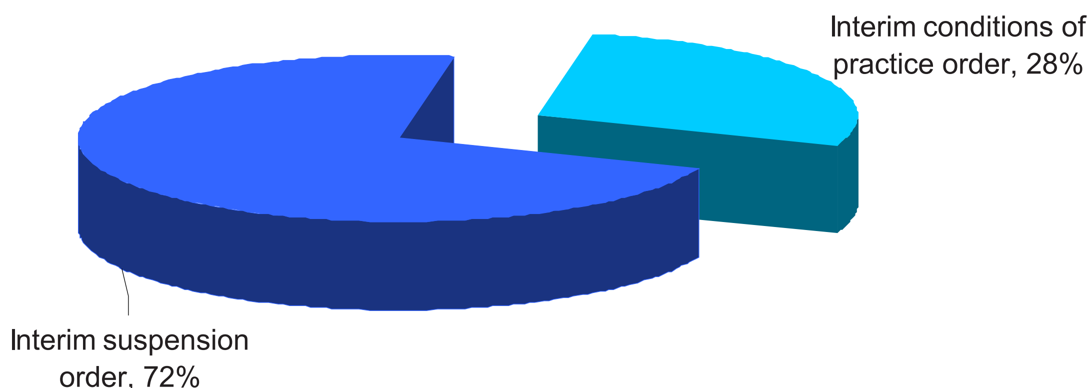


Table 12: Interim orders imposed by gender

Interim orders by gender	Interim order decisions	Number of interim orders	Percentage
Male	Interim conditions of practice order	57	6%
	Interim suspension order	191	21%
Total interim orders - male		**248**	**27%**
Female	Interim conditions of practice order	202	22%
	Interim suspension order	472	51%
Total interim orders - female		**674**	**73%**
Total interim orders made		**922**	**100%**

Chart 12: Interim orders imposed by gender

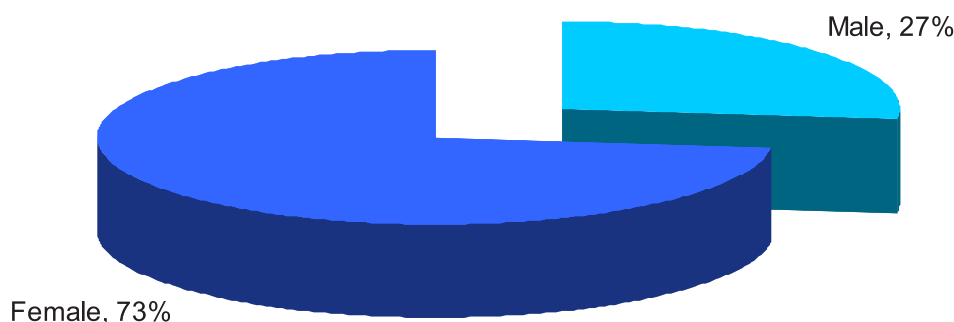


Table 13: Interim orders imposed by age

Age	Number of interim orders	Percentage
19 to 29 years	28	3%
30 to 39 years	180	20%
40 to 59 years	611	66%
60 years and over	103	11%
Total	**922**	**100%**

Chart 13: Interim orders imposed by age

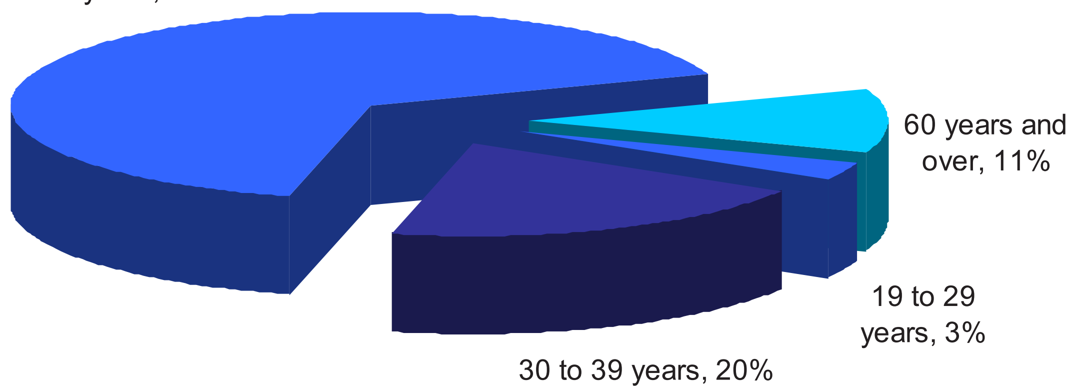


Table 14: Interim orders imposed by ethnicity

This is based on 35 percent of interim order cases for which ethnicity data is available.

Ethnic group	Interim suspension orders	Interim conditions of practice orders	Total interim orders	Percentage
White	135	57	192	21%
Black	49	29	78	9%
Asian	27	11	38	4%
Prefer not to answer	5	7	12	1%
Mixed	4	4	8	Less than 1%
Other	1	1	2	Less than 1%
Unknown	**442**	**150**	**592**	**64%**
Total	**663**	**259**	**922**	**100%**

Chart 14: Interim orders imposed by ethnicity

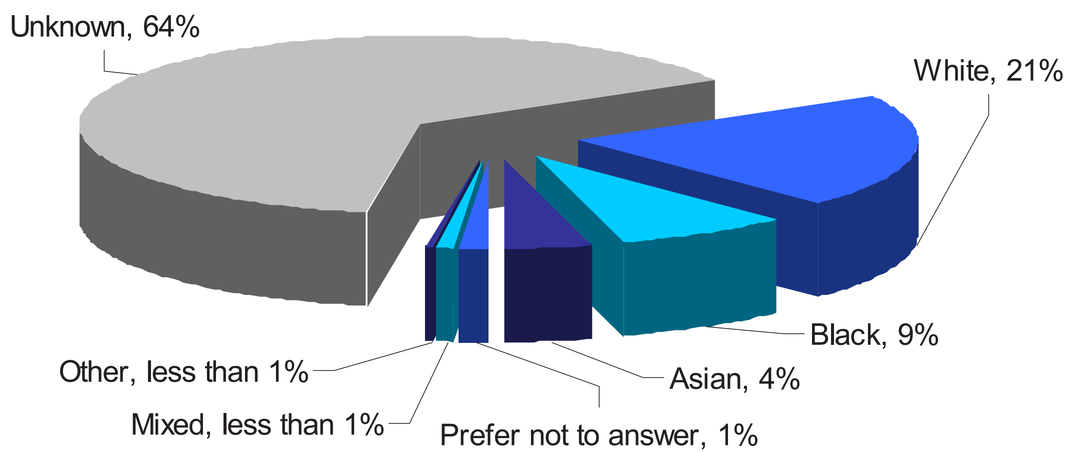


Table 15: Interim orders imposed by religion or belief

This is based on 32 percent of interim order cases for which religion or belief data is available.

Religion or belief	Interim suspension orders	Interim conditions of practice orders	Total interim orders	Percentage
Christian	148	75	223	24%
No religion	28	12	40	4%
Prefer not to answer	22	14	36	4%
Other religion	10	5	15	2%
Muslim	6	0	6	Less than 1%
Buddhist	4	1	5	Less than 1%
Hindu	2	2	4	Less than 1%
Jewish	2	1	3	Less than 1%
Sikh	0	0	0	0%
Unknown	**441**	**149**	**590**	**64%**
Total	**663**	**259**	**922**	**100%**

Chart 15: Interim orders imposed by religion or belief

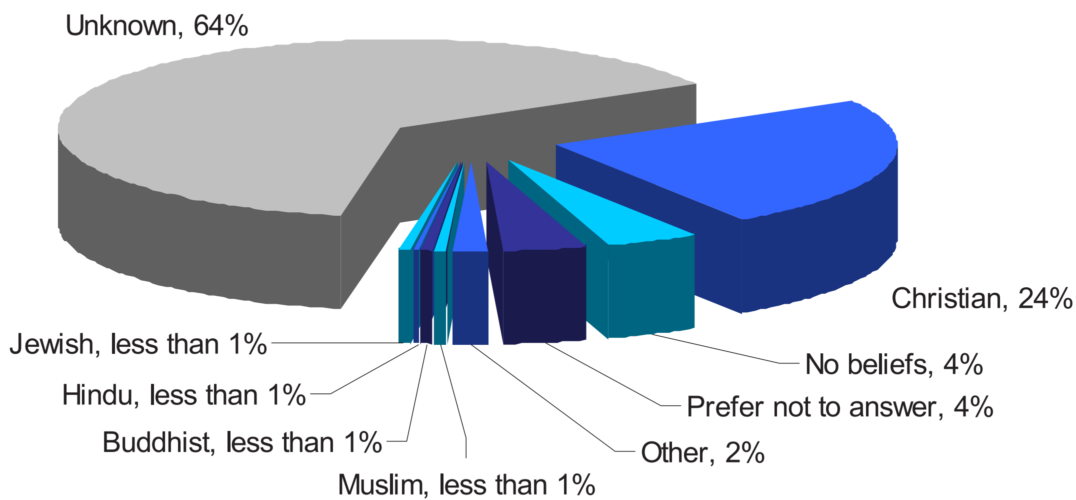


Table 16: Interim orders imposed by sexual orientation

This is based on 28 percent of interim order cases for which sexual orientation data is available.

Sexual orientation	Interim suspension orders	Interim conditions of practice orders	Total interim orders	Percentage
Heterosexual	161	78	239	26%
Prefer not to answer	45	24	69	8%
Gay or lesbian	8	4	12	1%
Bisexual	9	0	9	1%
Unknown	**440**	**153**	**593**	**64%**
Total	**663**	**259**	**922**	**100%**

Chart 16: Interim orders imposed by sexual orientation

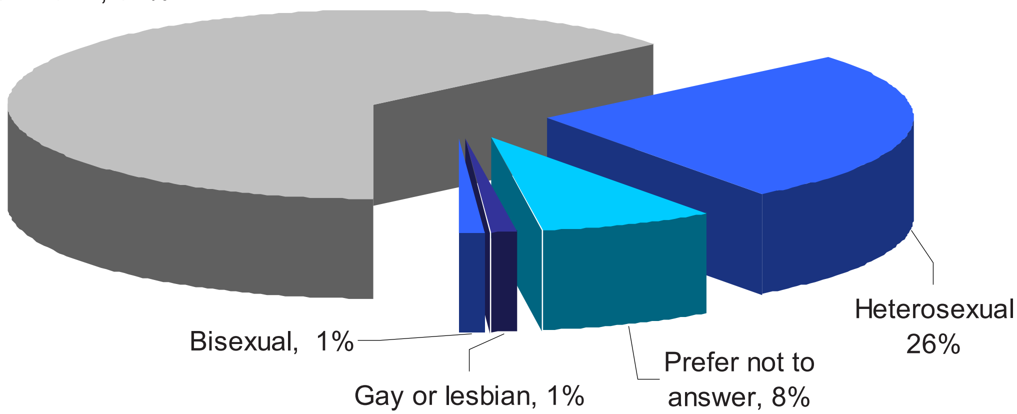
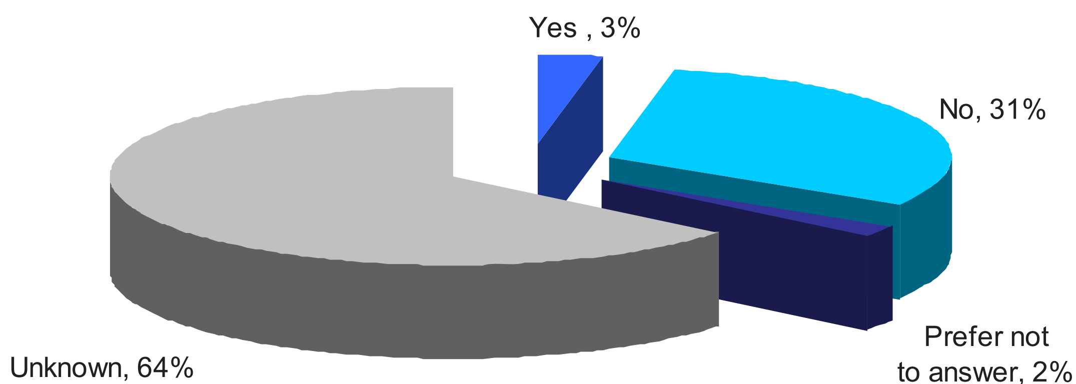


Table 17: Interim orders imposed by disability

This is based on 34 percent of interim order cases for which disability data is available.

Disability	Interim suspension orders	Interim conditions of practice orders	Total interim orders	Percentage
Yes	15	8	23	3%
No	191	95	286	31%
Prefer not to answer	13	6	19	2%
Unknown	**444**	**150**	**594**	**64%**
Total	**663**	**259**	**922**	**100%**

Chart 17: Interim orders imposed by disability



Investigations

Once we are satisfied that the case is one for us to deal with and we have carried out an investigation, the case is considered by a panel of the Investigating Committee. It is the role of the Investigating Committee panel to decide if there is a case to answer. This means that they must decide whether there is a real prospect that the allegation could be proved at the adjudication stage. Investigating Committee panels undertake their work in private.

If an Investigating Committee panel decides there is no case to answer, the matter is closed. However, the case can be reopened if another referral is made about the same nurse or midwife within three years. In 2011-2012, the Investigating Committee found no case to answer in 1,175 cases (55 percent of cases considered).

If a panel decides there is a case to answer, it sends the case to the Conduct and Competence Committee or the Health Committee depending on the nature of the allegations involved. In 2011-2012, 952 cases were sent for adjudication.

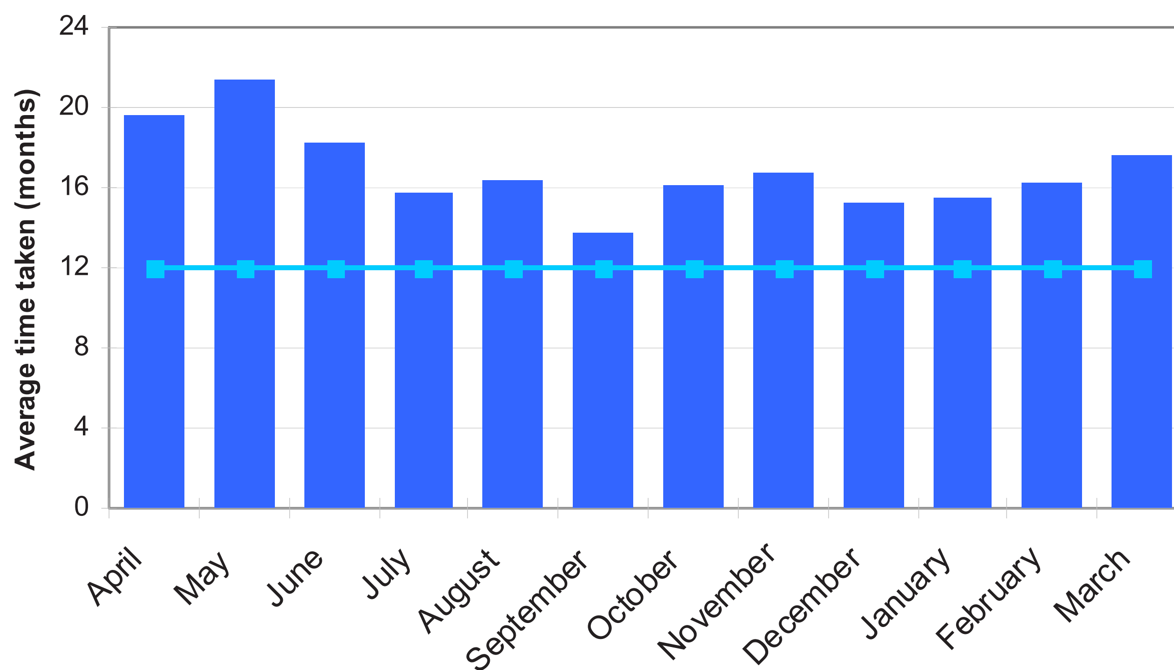
Our performance in 2011-2012

In 2011-2012, the Investigating Committee considered 3,596 cases on one or more occasions and reached a final conclusion on 2,127 cases.

We aim to complete our investigations in 12 months. During 2011-2012, we took on average 17.6 months to complete investigations as shown in the table below. However, as a result of the changes in our rules and other improvements being made, for cases received after January 2011, the average time taken in March 2012 was 10.38 months.

Average time (in months) to complete our investigations

KPI = 12 months



Investigating Committee outcomes

Table 18: Investigating Committee final outcomes

Investigating Committee final outcomes	Number of cases	Percentage
Refer to Conduct and Competence Committee (CCC)	866	41%
Refer to Health Committee (HC)	86	4%
Total sent for adjudication	**952**	**45%**
No case to answer	1,175	55%
Total Investigating Committee final outcomes	**2,127**	**100%**

Chart 18: Investigating Committee final outcomes

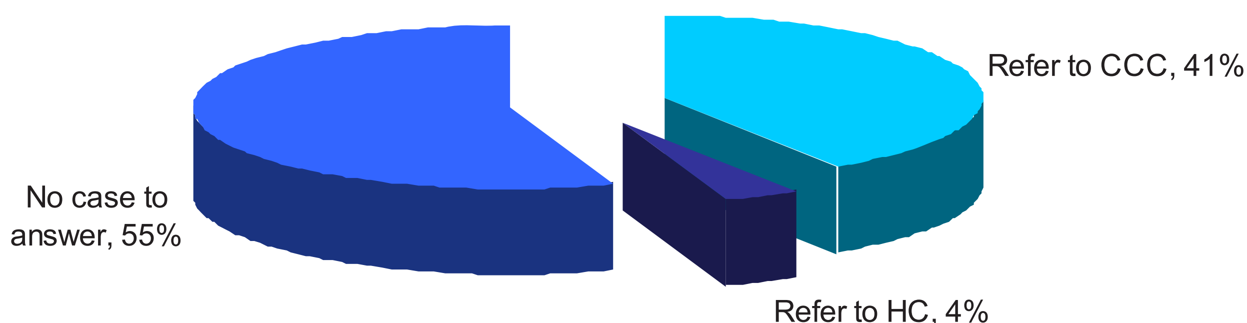


Table 19: Investigating Committee final outcomes by gender

Gender	No case to answer	Sent for adjudication	Total outcomes	Percentage
Male	256	275	531	25%
Female	919	677	1596	75%
Total Investigating Committee final outcomes	**1,175**	**952**	**2,127**	100%

Chart 19; Investigating Committee final outcomes by gender

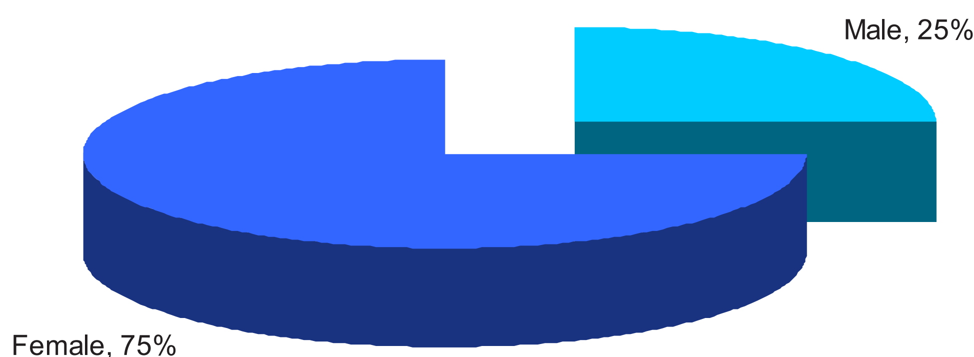


Table 20: Investigating Committee final outcomes by age

Age	No case to answer	Sent for adjudication	Total outcomes	Percentage
19 to 29 years	48	20	68	3%
30 to 39 years	229	166	395	18.5%
40 to 59 years	777	660	1,437	67.5%
60 years and over	121	106	227	11%
Total Investigating Committee final outcomes	**1,175**	**952**	**2,127**	**100%**

Chart 20: Investigating Committee final outcomes by age

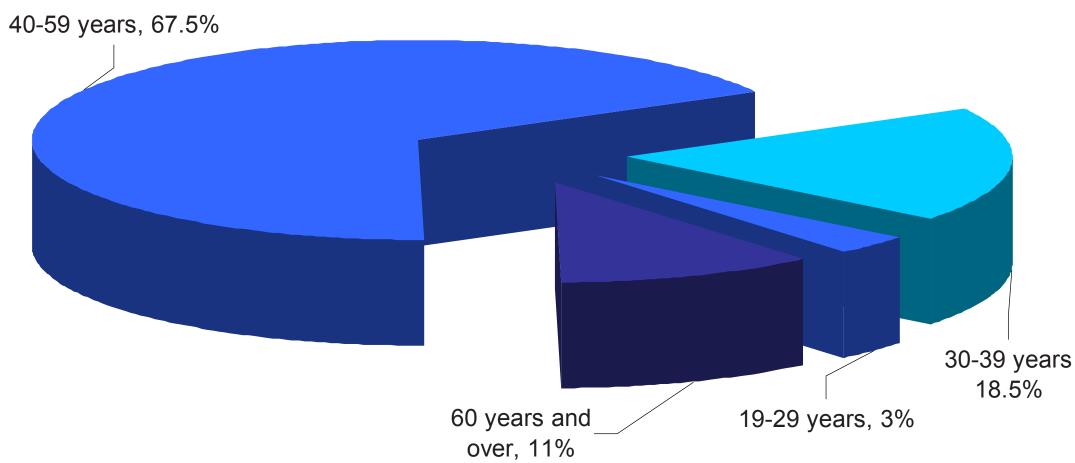


Table 21: Investigating Committee final outcomes by ethnicity

This is based on 34 percent of cases for which ethnicity data is available.

Ethnic group	No case to answer	Sent for adjudication	Total outcomes	Percentage
White	292	162	454	21%
Black	89	81	170	8%
Asian	33	37	70	3%
Prefer not to answer	10	11	21	1%
Mixed	7	11	18	Less than 1%
Other	4	13	17	Less than 1%
Unknown	**740**	**637**	**1377**	**65%**
Total Investigating Committee final outcomes	**1,175**	**952**	**2,127**	**100%**

Chart 21: Investigating Committee final outcomes by ethnicity

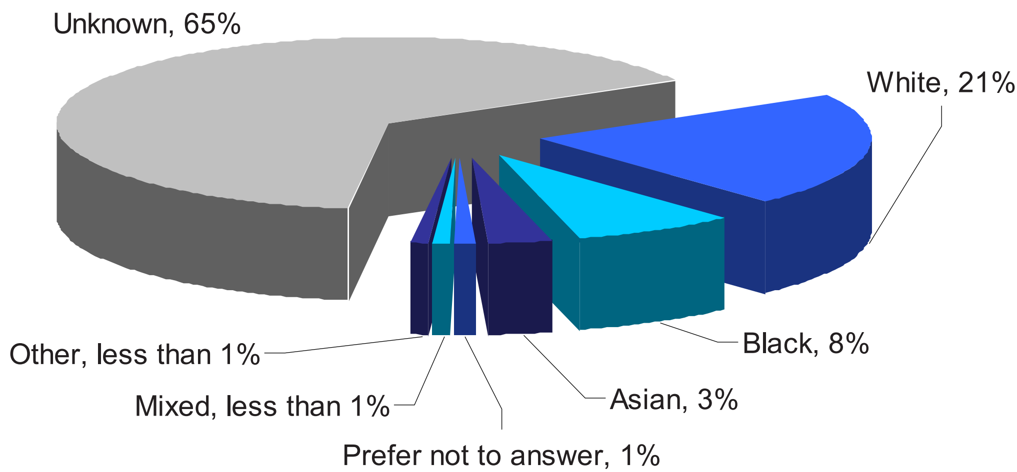


Table 22: Investigating Committee final outcomes by religion or belief

This is based on 32 percent of cases for which religion or belief data is available.

Religion or belief	No case to answer	Sent for adjudication	Total outcomes	Percentage
Christian	282	202	484	23%
No religion	66	29	95	4%
Prefer not to answer	40	34	74	3%
Other religion	22	12	34	2%
Muslim	10	7	17	1%
Buddhist	8	5	13	1%
Hindu	6	4	10	Less than 1%
Jewish	2	3	5	Less than 1%
Sikh	1	3	4	Less than 1%
Unknown	**738**	**653**	**1,391**	**65%**
Total Investigating Committee final outcomes	**1,175**	**952**	**2,127**	**100%**

Chart 22: Investigating Committee final outcomes by religion or belief

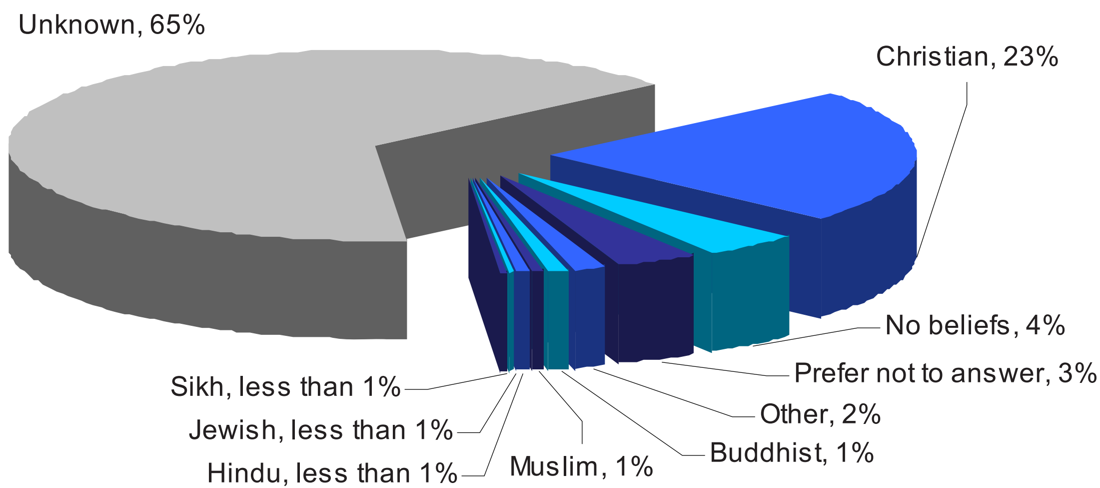


Table 23: Investigating Committee final outcomes by disability

This is based on 32 percent of cases for which disability data is available.

Disability	No case to answer	Sent for adjudication	Total outcomes	Percentage
Yes	28	14	42	2%
No	381	257	638	30%
Prefer not to answer	23	19	42	2%
Unknown	**743**	**662**	**1,405**	**66%**
Total Investigating Committee final outcomes	**1,175**	**952**	**2,127**	**100%**

Chart 23: Investigating Committee final outcomes by disability

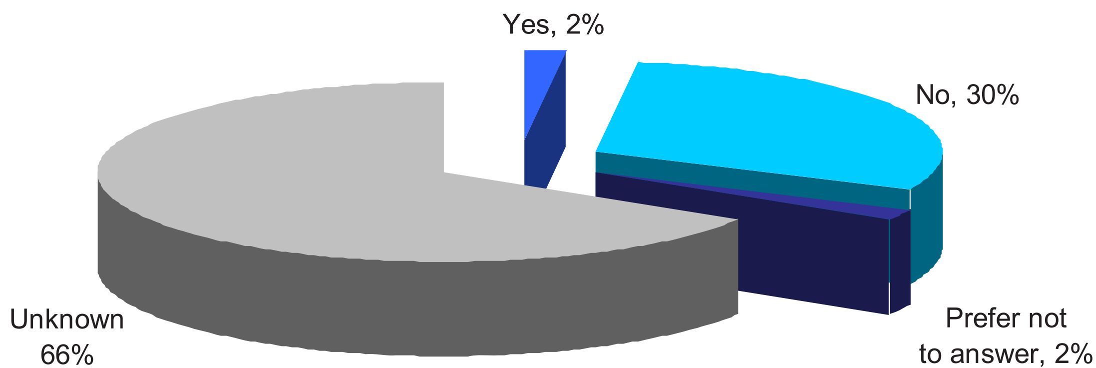
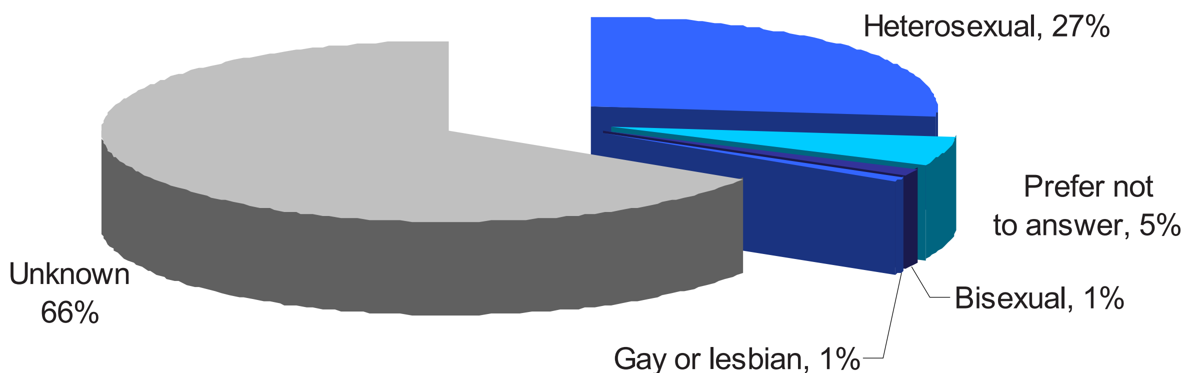


Table 24: Investigating Committee final outcomes by sexual orientation

This is based on 29 percent of cases for which sexual orientation data is available.

Sexual orientation	No case to answer	Sent for adjudication	Total outcomes	Percentage
Heterosexual	354	211	565	27%
Prefer not to answer	56	58	114	5%
Bisexual	8	15	23	1%
Gay or lesbian	8	9	17	1%
Unknown	**749**	**659**	**1,408**	**66%**
Total Investigating Committee final outcomes	**1,175**	**952**	**2,127**	**100%**

Chart 24: Investigating Committee final outcomes by sexual orientation



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

In 2011-2012 there was **one fraudulent entry case** where the person's name was **removed from the register**.

Adjudications

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

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

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

If a sanction is considered appropriate, using indicative sanctions guidance[13] the panel will consider in turn whether each of the available sanctions as set out on page 6 is the most appropriate to protect the health and wellbeing of the public.

Health cases are generally heard in private, due to the confidential nature of the medical evidence considered. Conduct and competence cases are usually heard in public. Anyone is welcome to observe public fitness to practise hearings. Information on how to attend can be found at **www.nmc-uk.org/hearings.**

We also publish all our final hearing decisions where a sanction has been imposed and the reasons for them at **www.nmc-uk.org/hearings**.

Our performance in 2011-2012

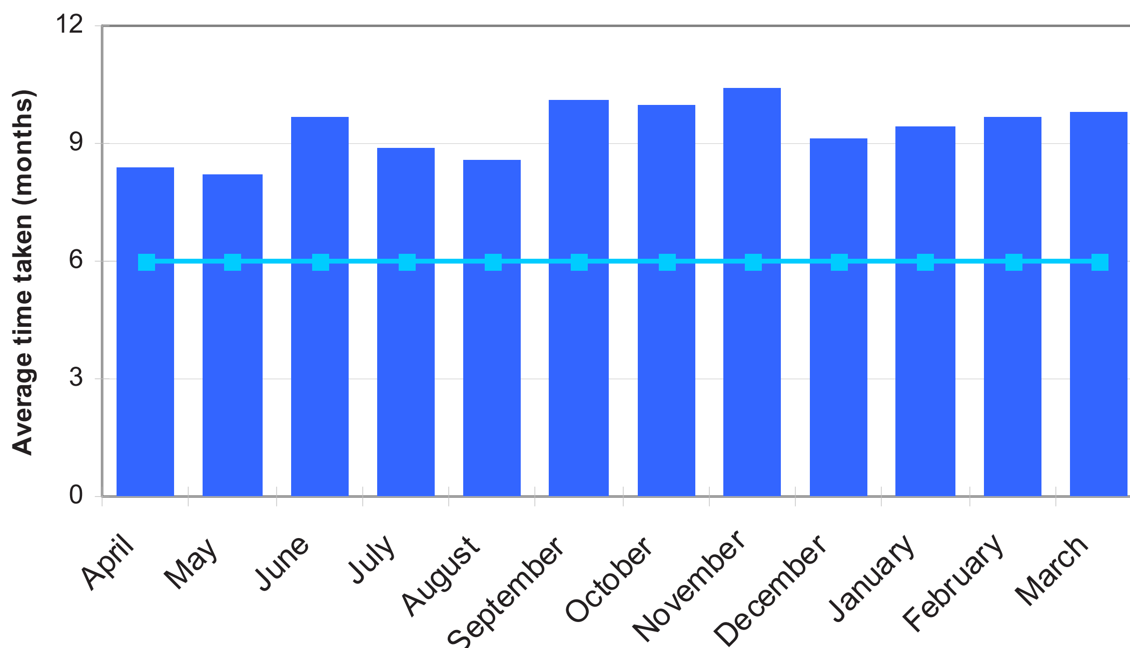
We set ourselves a target of commencing the adjudication stage hearing or meeting, within six months of the conclusion of the investigation. During 2011-2012, our average performance against this target was 9.8 months, as shown in the following chart.

However, as a result of the changes in our rules and other improvements being made, for cases we received after January 2011, the average time taken in March 2012 was 8 months.

13 www.nmc-uk.org/Documents/FtP_Information/Indicative-Sanctions-Guidance.May-12.pdf

Average time (in months) from completion of investigations to the start of a hearing or meeting

KPI = 6 months



Conduct and Competence Committee and Health Committee final outcomes

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

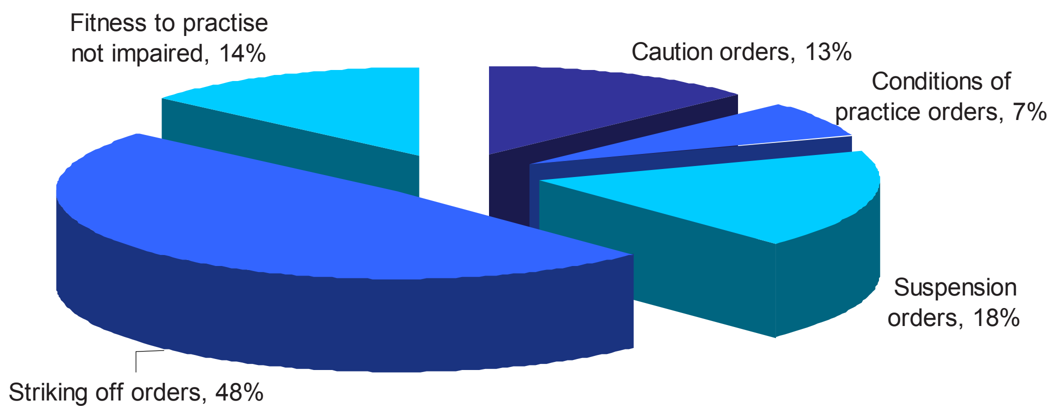
The Health Committee considers cases where a nurse or midwife's fitness to practise may be impaired due to physical or mental health issues. The Health Committee can only strike a nurse or midwife off the register if the nurse or midwife has been continuously suspended or under conditions of practice for the previous two years. It can send a case to the Conduct and Competence Committee for a decision if it considers that the concerns raised are more properly about a nurse or midwife's conduct or competence not relating to health issues.

Table 35 (Appendix 1) gives information about the types of allegations considered by Conduct and Competence Committee panels at the final adjudication stage.

Table 25: CCC and HC final adjudication outcomes

CCC and HC final adjudication outcomes	Number of cases	Percentage
Striking-off orders[14]	365	48%
Suspension orders	136	18%
Caution orders	98	13%
Conditions of practice orders	51	7%
Fitness to practise impaired – no sanction	0	-
Total	**650**	**86%**
Fitness to practise not impaired	103	14%
Total final outcomes	**753**	**100%**

Chart 25: CCC and HC final adjudication outcomes



14 These include decisions made on review of a substantive order imposed at an earlier stage

Table 26: Total final adjudication outcomes by gender

Gender	Striking - off	Suspension	Caution	Conditions of practice	Not impaired	Total final outcomes	Percentage
Male	121	38	31	9	20	219	29%
Female	244	98	67	42	83	534	71%
Total	**365**	**136**	**98**	**51**	**103**	**753**	**100%**

Chart 26: Total final adjudication by gender

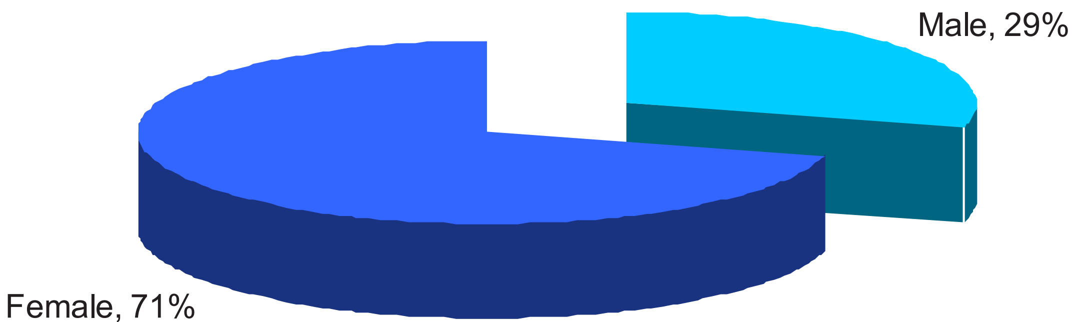


Table 27: CCC and HC final adjudication outcomes by age

Age	Striking - off	Suspension	Caution	Conditions of practice	Not impaired	Total final outcomes	Percentage
19-29	5	7	2	1	1	16	2%
30-39	57	22	14	8	19	120	16%
40-59	239	84	60	38	65	486	65%
Over 60	64	23	22	4	18	131	17%
Total	**365**	**136**	**98**	**51**	**103**	**753**	**100%**

Chart 27: CCC and HC final adjudication outcomes by age

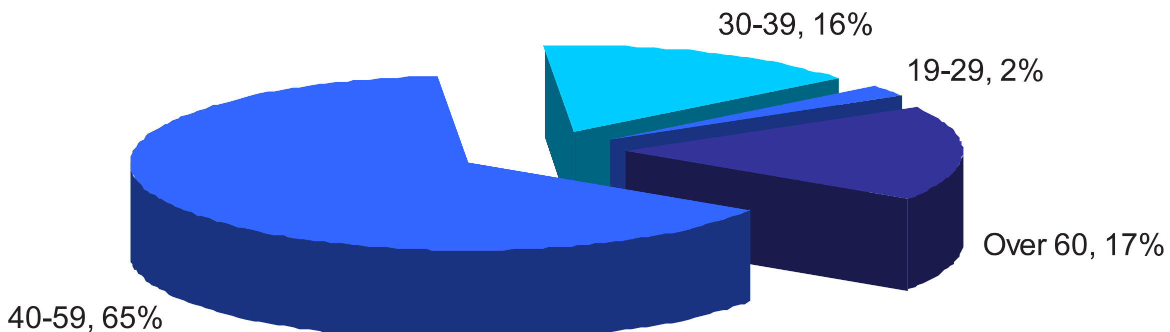


Table 28: CCC and HC final adjudication outcomes by ethnicity

This is based on 23 percent of adjudication outcomes for which ethnicity data is available.

Ethnic group	Striking-off	Suspension	Caution	Conditions of practice	Not impaired	Total final outcomes	Percentage
White	15	21	13	13	20	82	11%
Black	20	14	11	4	9	58	8%
Asian	5	6	4	9	2	26	3%
Prefer not to answer	3	2	1	0	1	7	1%
Mixed	1	1	0	0	0	2	Less than 1%
Other	0	2	0	1	0	3	Less than 1%
Unknown	**321**	**90**	**69**	**24**	**71**	**575**	**76%**
Total	**365**	**136**	**98**	**51**	**103**	**753**	**100%**

Chart 28: CCC and HC final adjudication outcomes by ethnicity

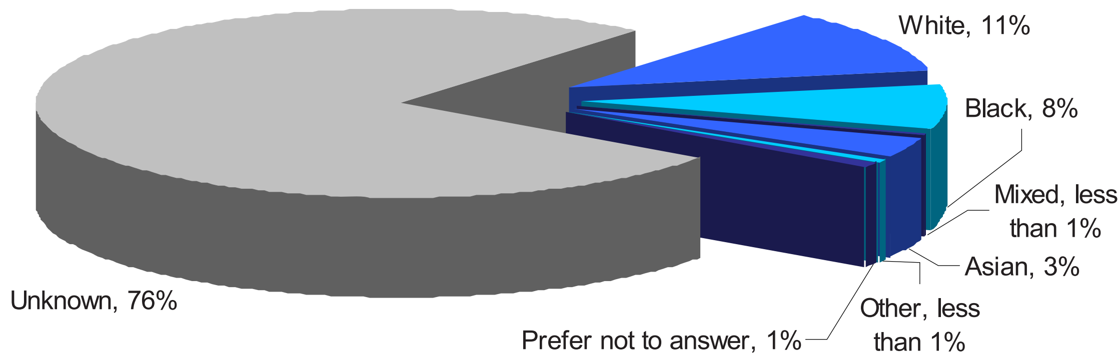


Table 29: CCC and HC final adjudication outcomes by religion or belief

This is based on 22 percent of adjudication outcomes for which ethnicity data is available.

Religion or belief	Striking - off	Suspension	Caution	Conditions of practice	Not impaired	Total final outcomes	Percentage
Christian	35	30	20	20	24	129	17%
No religion	3	3	2	3	5	16	2%
Prefer not to answer	3	4	4	0	3	14	2%
Other religion	1	5	0	0	0	6	1%
Muslim	1	1	2	1	0	5	1%
Buddhist	0	2	0	0	1	3	Less than 1%
Hindu	1	0	0	0	1	2	Less than 1%
Jewish	0	0	0	1	0	1	Less than 1%
Sikh	0	0	1	0	0	1	Less than 1%
Unknown	**321**	**91**	**69**	**26**	**69**	**576**	**76%**
Total	**365**	**136**	**98**	**51**	**103**	**753**	**100%**

Chart 29: CCC and HC final adjudication outcomes by religion or belief

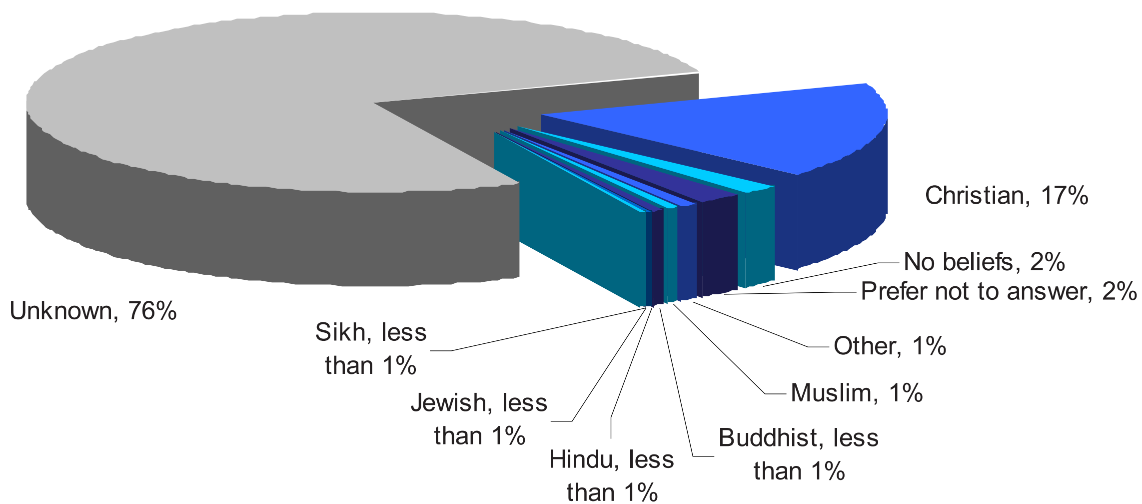


Table 30: CCC and HC final adjudication outcomes by disability

This is based on 25 percent of adjudication outcomes for which disability data is available.

Disability	Striking - off	Suspension	Caution	Conditions of practice	Not impaired	Total final outcomes	Percentage
Yes	2	3	3	4	9	21	3%
No	41	44	25	23	34	167	22%
Prefer not to answer	1	2	1	3	2	9	1%
Unknown	**321**	**87**	**69**	**21**	**58**	**556**	**74%**
Total	**365**	**136**	**98**	**51**	**103**	**753**	**100%**

Chart 30: CCC and HC final adjudication outcomes by disability

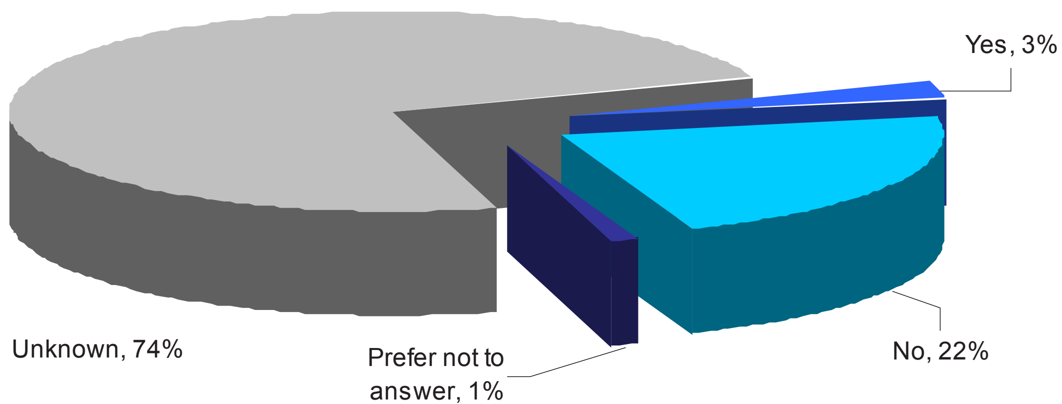
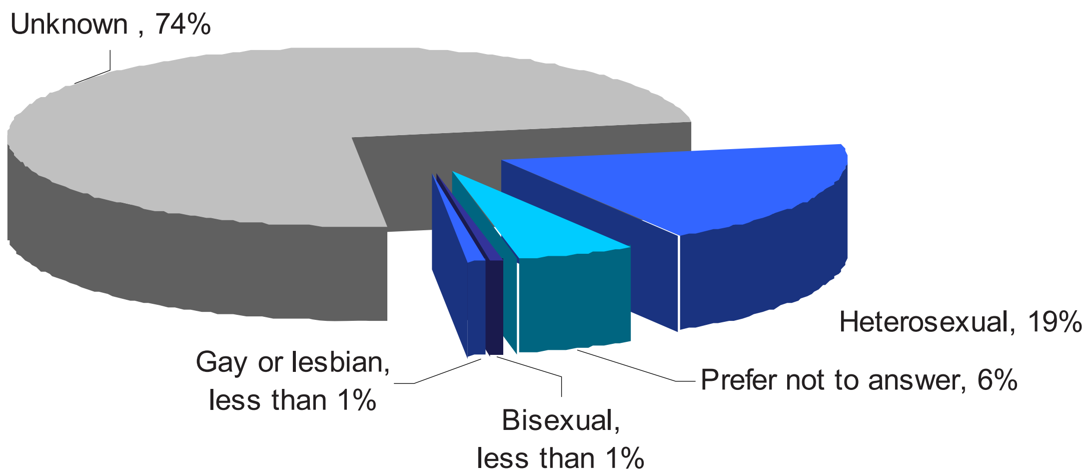


Table 31: CCC and HC final adjudication outcomes by sexual orientation

This is based on 20 percent of adjudication outcomes for which sexual orientation data is available.

Sexual orientation	Striking - off	Suspension	Caution	Conditions of practice	Not impaired	Total final outcomes	Percentage
Hetero-sexual	32	29	24	31	28	144	19%
Prefer not to answer	8	14	5	9	7	43	6%
Bisexual	1	2	0	1	0	4	Less than 1%
Gay or lesbian	3	1	0	1	0	5	Less than 1%
Unknown	**321**	**90**	**69**	**9**	**68**	**557**	**74%**
Total	**365**	**136**	**98**	**51**	**103**	**753**	**100%**

Chart 31: CCC and HC final adjudication outcomes by sexual orientation



Appeals against our decisions

A nurse or midwife can appeal against the sanction we imposed. The appeal has to be made within 28 days. Appeals are heard in the High Court of Justice in England and Wales, the Court of Session in Scotland or the High Court of Justice in Northern Ireland, depending on the country of the nurse or midwife's registered address. Twenty such appeals were lodged in 2011-2012 and seven of these remain ongoing.

The originator of the case cannot appeal against our decision but they can seek a judicial review if they are unhappy with the outcome.

In addition, if the CHRE considers that a decision in a case was unduly lenient it can refer our decision to the courts. One case was referred by the CHRE in 2011-2012.

Table 32: Appeals against our decisions

Appeal type	Number
Judicial review by the originator of the case	1
CHRE appeal	1
Appeal by registered nurse or midwife	11
Total appeals concluded	**13**

Appeal process followed	Number
Heard in court	8
Agreed by consent	5
Total appeals concluded	**13**

Outcomes of appeals	Number
Remitted back to practice committee to reconsider	4
Judgment pending	3
New sanction agreed	1
Upheld NMC decision	4
Other agreement	1
Total	**13**

Restoration to the register

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

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

Table 33: Restoration application outcomes

Restoration cases considered	Outcome
Application accepted	4
Application rejected	1
Total	**5**

Key developments in 2011-2012

Throughout 2011-2012, we have been taking forward the major programme we began in January 2011 to improve all aspects of our fitness to practise work.

We are investing substantial resources into our fitness to practise work. In 2011-2012 this amounted to £41.15m, approximately 67 percent of our budget. In September 2011, we set up an Efficiency Board to make sure that we identify and secure savings from the improvement programme. This has now been subsumed into a wider corporate Efficiency Board to drive improvements and efficiencies across all aspects of our work.

An important step forward was the changes we made, with Department of Health agreement, to the rules which say how we must deal with cases.[15] The amendments to the rules removed some unnecessary steps in our processes which caused delays, for example, by reducing the number of times a case has to be considered by the Investigating Committee. The changes came into effect on 6 February 2012 and should enable us to progress cases more quickly and efficiently.

We have consulted on other possible changes to our rules for example, to enable an individual to agree to be removed from the register in appropriate circumstances or which would result in an agreed way forward on a case. As part of this review we are looking at what the objectives of our case management process should be and considering the use of other case management tools. All the proposals are made with a view to ensuring that our processes are effective, fair, and in the public interest. If they go ahead we anticipate being able to make significant efficiency savings, for example, by minimising the number of unnecessary hearing days.

CHRE's performance review and audit reports in 2011 identified significant weaknesses in our fitness to practise work.[16] We developed an action plan, agreed with the Department of Health and the CHRE, to tackle these weaknesses, as outlined below. Progress against the plan is monitored monthly by the Council Fitness to Practise Action Plan Group, as well as being considered at full Council meetings. We recognise that we also need to do more to meet the CHRE's standards of good regulation relating to our fitness to practise work.[17]

Our action plan focuses our efforts to improve our work on three priority areas.

Progressing cases more quickly

- We have developed a plan to progress all cases we received before our improvement programme began in January 2011 – we call these historic cases. We aim to clear these historic cases by April 2013.

- We are increasing the number of hearings we hold each day, so we can conclude more cases more quickly. We procured new additional office accommodation to house our fitness to practise staff and converted our existing premises to provide more dedicated space for fitness to practise hearings.

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15 www.nmc-uk.org/rules

16 www.chre.org.uk/_img/pics/library/110623_Final_-_CHRE_Performance_Review_report_2010-11_(Colour_for_web_-_PDF_version).pdf and www.chre.org.uk/_img/pics/library/111018_NMC_audit_report_for_publication.pdf

17 https://www.chre.org.uk/_img/pics/library/100601_The_Performance_Review_Standards_1.pdf

- We aim to significantly increase our daily hearing event capacity. In order to achieve this and compensate for a high rate of adjournment, particularly where cases are adjourned part-heard, we have introduced a number of measures, including panellist training and an over-listing process to help make more effective use of our hearing capacity.

- We have changed our internal processes and strengthened the operating guidelines we give our staff to help improve how we work and eliminate delays in progressing cases.

- We have begun the process of undertaking our own investigations on cases rather than sending these to outside lawyers for investigation. This should help us to have more control over the progress of cases as well as improve our efficiency and effectiveness. We hope to continue to reduce the number of investigations where we need to use external lawyers over time.

- We started referring cases to employers where, after initial assessment, we consider that on its own the allegation is not sufficiently serious to require regulatory action. We contact the employer of the nurse or midwife and, where they confirm that they have no fitness to practise concerns, the case can generally be closed. We may also refer a case to an employer where we consider that the issue raised is more appropriately one for local resolution.

Improving customer service

- In August 2011, we published new customer care standards setting out what everyone involved in a case could expect from us. At the end of each case, we now send out a customer feedback form to all participants and, although the level of responses has so far been small, we analyse the causes of dissatisfaction to identify where we need to make further improvements.

- We have improved the quality of our communications through staff training and reference materials. We make sure the letters we send to all those involved in a case explain the reasons for our decisions as fully as possible, as well as giving information about our customer care standards and staff contact details.

- We set a target for sending out letters notifying the outcomes of a case within five days and achieved this in 88% of cases in March 2012.

- We implemented a more robust system for dealing with complaints about our work. We have set a target of responding to all complaints within 20 days of receiving them. During 2011-2012, we received 152 complaints and responded to 136 of these in 20 days (89 percent).

- We opened an office in Edinburgh, with dedicated space to hear cases involving nurses and midwives registered in Scotland. This has helped improve the customer care we can provide to all witnesses and others attending hearings in Scotland.

Improving the quality and consistency of the decisions we take

- Earlier this year, following an open recruitment process, we appointed 98 people to act as chairs of our fitness to practise panels against rigorous competencies, including the ability to manage hearings.
- We set up an internal group which reviews all decisions made by panels, including decisions made to adjourn cases after they have started. Learning identified from these reviews is fed back to panellists and fitness to practise staff and further support and guidance for panel members is provided where needed by our Panel Support Team.
- We have developed guidance tools to help panels ensure they address the key issues in reaching decisions, together with guidance on how to ensure that decisions are explained more fully. We are also in the process of revising our guidance to panels on the issues to consider in deciding the appropriate level of sanctions to be imposed.
- We have strengthened the support and advice our staff provide to panels and recruited some 132 new staff to these and a range of other fitness to practise roles.
- Our quality assurance team undertakes a structured programme of audits which provides a further mechanism for identifying areas for improvement in our work.

Conclusion

Ensuring that the public is protected from nurses and midwives whose fitness to practise is impaired is central to our statutory duty to safeguard the health and wellbeing of the public.

The large volume and increasing complexity of cases we have to manage are key factors affecting our performance. Our ability to improve the speed of our case progression and the quality of our work has been affected by the very high individual caseloads held by our staff and we have been taking steps to try to alleviate this. However, we recognise that we may see further increases in our workload following the report of the Public Inquiry into Mid-Staffordshire NHS Foundation Trust (Francis Inquiry) expected in late 2012.[18] We are taking steps to model our workflows to help us identify further scope for improvements and to build these assumptions into our planning and budgeting processes.

The steps we are taking in the three priority areas outlined above, together with continued significant investment, should help us to achieve the substantive performance improvements we are determined to see in our fitness to practise work.

18 www.midstaffspublicinquiry.com/

Appendix 1

Table 34 - Details of types of allegations contained in new referrals

This table gives a more detailed breakdown of the allegations summarised in Table 10. It shows in more detail than has previously been available the nature of the allegations we receive about nurses and midwives. Many cases involve more than one type of allegation about a particular nurse or midwife which is why the total number of allegations at 8,300 far exceeds the number of new referrals (4,407).

Allegation type – new referrals	Total
Misconduct – neglect of patients	618
Misconduct – other (non-clinical)	572
Misconduct – prescribing/drug administration	454
Misconduct – record keeping	382
Misconduct – other clinical treatment issues	346
Misconduct – dishonesty (non-clinical)	292
Misconduct – employment issues	193
Misconduct – dishonesty (clinical)	189
Misconduct – violence/behaviour towards colleagues	174
Misconduct – violence/physical abuse of patients	152
Misconduct – management/delegation issues	150
Misconduct – failing to maintain professional boundaries (other)	140
Misconduct – verbal abuse of patients	124
Misconduct – failing to maintain professional boundaries (sexual)	107
Misconduct – theft of drugs	105
Misconduct – breach of confidentiality	97
Misconduct – sleeping on duty	55
Misconduct – racism/discrimination	50
Misconduct – social networking	44
Misconduct – pornography	6
Total misconduct	**4,250**

Allegation type – new referrals (continued)	Total
Lack of competence – patient care	827
Lack of competence – lack of knowledge, skill and judgment	442
Lack of competence – drug administration	366
Lack of competence – record keeping	351
Lack of competence – communication issues	189
Lack of competence – other clinical issues	172
Lack of competence – other	65
Total lack of competence	**2,412**
Criminal – alcohol/drugs misuse	344
Criminal – other motor vehicle	283
Criminal – other violence	253
Criminal – other	155
Criminal – theft/other dishonesty	143
Criminal – fraud/forgery	138
Criminal – sexual offences	57
Criminal – child pornography	6
Criminal – murder/manslaughter	3
Criminal – racism	2
Criminal – child protection	1
Total criminal	**1,385**
Health – mental	118
Health – physical	27
Total health	**145**
Ongoing police investigation – not yet charged	27
Under police investigation	24
Total police	**51**
Fraudulent entry on to the register	**47**
Determination by another body	**10**
Grand total	**8,300**

Table 35 – Allegation types considered at final adjudications by the Conduct and Competence Committee

This table gives more detailed information on the types of allegations considered at the adjudications stage by the Conduct and Competence Committee.

Allegation types at final adjudications by conduct and competence committee	Percentage of cases
Criminal – alcohol/drugs misuse	2%
Criminal – theft/other dishonesty	2%
Criminal – other violence	1%
Criminal – other	1%
Criminal – fraud/forgery	1%
Criminal – other motor vehicle	1%
Criminal – sexual offences	Less than 1%
Criminal - child protection	Less than 1%
Criminal – child pornography	Less than 1%
Criminal – murder/manslaughter	Less than 1%
Total criminal	**11%**
Lack of competence – patient care	5%
Lack of competence – drug administration	3.5%
Lack of competence – lack of knowledge, skill and judgment	3%
Lack of competence – record keeping	3%
Lack of competence – other	2.5%
Lack of competence – communication issues	2%
Lack of competence – other clinical issues	2%
Total lack of competence	**21%**

Allegation types at final adjudications by conduct and competence committee (continued)	Percentage of cases
Misconduct – prescribing/drug administration	9%
Misconduct – record keeping	8.5%
Misconduct – other clinical treatment issues	8%
Misconduct – neglect of patients	6%
Misconduct – other (non-clinical)	5%
Misconduct – unknown	5%
Misconduct – dishonesty (non-clinical)	4.5%
Misconduct – dishonesty (clinical)	4%
Misconduct – violence/physical abuse of patients	3%
Misconduct – verbal abuse of patients	2.5%
Misconduct – violence/behaviour towards colleagues	2%
Misconduct – management/delegation issues	2%
Misconduct – failing to maintain professional boundaries (sexual)	2%
Misconduct – employment issues	1.5%
Misconduct – theft of drugs	1%
Misconduct – sleeping on duty	1%
Misconduct – failing to maintain professional boundaries (other)	1%
Misconduct – breach of confidentiality	1%
Misconduct – elder abuse	Less than 1%
Misconduct – racism/discrimination	Less than 1%
Misconduct – pornography	Less than 1%
Misconduct – social networking	Less than 1%
Total misconduct	**68%**

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