Council – 6 December 2011

CHRE Audit of the Initial Stages of the NMC's Fitness to Practise Process

Executive summary and recommendations

Introduction

In November 2011, the Council for Healthcare Regulatory Excellence (CHRE) published its report on its audit of the Nursing and Midwifery Council's (NMC) initial stage fitness to practise process. It has been HPC's practice to look at possible learning points from CHRE's audits of other health regulators as part of its commitment to continuous business improvement and internal quality assurance scrutiny. This paper looks at the recommendations made by the CHRE with regards to the work of the NMC and makes proposals as to how the HPC can ensure its fitness to practise processes remain robust, efficient, effective and fit for purpose.

Decision

The Council is asked to agree to the actions set out at paragraph 3 of the attached report and order the Executive to provide a report to the Fitness to Practise Committee in February 2012 to update on the progress made.

Background information

The paper does not provide detailed explanation of the HPC's processes in relation to each point as the processes operated by the Fitness to Practise Department have been explained in other papers, such as the CHRE performance review response considered by the FTP Committee in October 2011 (http://www.hpc-uk.org/assets/documents/10003718201110 13FTP05-CHREperformancereview.pdf) and the response to the CHRE initial audit report of all the regulators from the 2010 audit considered by the Committee in May 2011 (http://www.hpc-uk.org/assets/documents/100034F520110526FTP05-CHREFTPaudit.pdf).

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The CHRE also published its report on the initial stage audits of the General Pharmaceutical Council (GPhc) and the General Chiropractic Council (GCC). An The Executive will review those reports and submit a paper if necessary to a future meeting of the Council or the FTP Committee.

Resource implications

None

Financial implications

None

Appendices

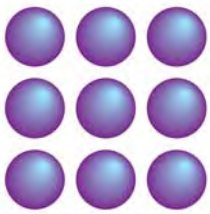
Appendix One – CHRE Audit Report
Appendix Two – HPC Report

Date of paper

28 November 2011

Audit of the Nursing and Midwifery Council's initial stages fitness to practise process

November 2011



council for healthcare regulatory excellence

About CHRE

The Council for Healthcare Regulatory Excellence promotes the health and well-being of patients and the public in the regulation of health professionals. We scrutinise and oversee the work of the nine regulatory bodies[1] that set standards for training and conduct of health professionals.

We share good practice and knowledge with the regulatory bodies, conduct research and introduce new ideas about regulation to the sector. We monitor policy in the UK and Europe and advise the four UK government health departments on issues relating to the regulation of health professionals. We are an independent body accountable to the UK Parliament.

Our aims

CHRE aims to promote the health, safety and well-being of patients and other members of the public and to be a strong, independent voice for patients in the regulation of health professionals throughout the UK.

Our values and principles

Our values and principles act as a framework for our decision making. They are at the heart of who we are and how we would like to be seen by our stakeholders.

Our values are:

- Patient and public centred
- Independent
- Fair
- Transparent
- Proportionate
- Outcome focused

Our principles are:

- Proportionality
- Accountability
- Consistency
- Targeting
- Transparency
- Agility

Right-touch regulation

Right-touch regulation means always asking what risk we are trying to regulate, being proportionate and targeted in regulating that risk or finding ways other than regulation to promote good practice and high-quality healthcare. It is the minimum regulatory force required to achieve the desired result.

1 General Chiropractic Council (GCC), General Dental Council (GDC), General Medical Council (GMC), General Optical Council (GOC), General Osteopathic Council (GOsC), General Pharmaceutical Council (GPhC), Health Professions Council (HPC), Nursing and Midwifery Council (NMC), Pharmaceutical Society of Northern Ireland (PSNI)

Contents

1. Overall assessment

Introduction

1.1 In July 2011 we audited 100 cases that the NMC had closed at the initial stages of its fitness to practise (FTP) processes during the previous five month period.

1.2 In the initial stages of their FTP processes the nine health professional regulatory bodies decide whether complaints which they have received should be referred to a hearing in front of a fitness to practise panel, or whether some other action should be taken, or whether they should be closed.

1.3 Our overriding aim in conducting audits is to seek assurance that the health professional regulators are protecting patients and the public, and maintaining the reputation of the professions and the system of regulation. We assessed whether the NMC achieved these aims in the particular cases we reviewed. We considered whether weaknesses in handling any of these cases might also suggest that the public might not be protected, or confidence not maintained, in future cases.

Summary of findings

1.4 In this year's audit of the NMC, we found continuing areas of significant weaknesses in its handling of cases at the initial stages of the fitness to practise process. Many of these weaknesses are ones that we identified in previous audits. These weaknesses create risks for public protection and public/professional confidence in the regulatory process.

1.5 We consider that there is some evidence of improvement in the quality and efficiency of the NMC's fitness to practise process in the last year resulting from the work being undertaken by the NMC to address weaknesses we have identified in previous audit reports, performance review reports and in our Progress Review report 2011. We also recognise that some of the weaknesses we identified during this audit occurred some time ago, in older cases. However, we remain concerned about the extent of the weaknesses that we identified during this audit, some of which occurred relatively recently (including since the NMC has initiated its current improvement programme).

1.6 Further details of our findings are below, but in summary, we found the following weaknesses:

- Delays in referring cases for interim orders and in informing registrants of the outcome of these referrals. We note that most of these delays occurred in cases the NMC opened prior to 2011. However, we identified one case where we consider that the information that was provided to the NMC in early 2011 should have resulted in consideration of a referral to an interim orders committee. These delays could have put the public at risk if the registrants concerned had continued to work in the interim period
- Inconsistencies in the retention of records detailing the outcome of the NMC's risk assessment of each case on initial receipt. This meant that it was unclear whether or not the potential need for an interim order application had been considered

- Inadequate risk assessment undertaken throughout the lifetime of each case. We identified a lack of evidence of risk assessment on initial receipt of a case in relation to cases that had been opened prior to 2011. We recognise that the NMC adopted a new approach to risk assessment in January 2011, and that in our audit we saw evidence that risk assessment on initial receipt of a case has improved since that date. However, we found an ongoing lack of consistency in the continuous risk assessment of cases throughout their lifetime in some cases that were opened both before or after January 2011. This meant that appropriate action was not necessarily taken once new information came to the attention of the NMC
- Inadequate information gathering in over 17 cases[2], which led to decisions to close cases being taken before sufficient information had been received to ensure that the decisions were robust
- Insufficient explanation or inaccurate details being provided in letters sent to complainants/registrants about the outcome of their cases. This meant that the recipients of some of the letters may not have fully understood the reasons for the decisions that had been taken
- Delays in the progression of cases, due to: ineffective case management by the NMC; human error by NMC staff, and/or inadequate oversight of investigations undertaken by NMC investigators. Some of the delays were of a significant length – those delays occurred in cases that were opened by the NMC prior to 2011. These delays caused potential unfairness to the complainants, witnesses, registrants and employers, and could impact on patient safety, and also potentially damage public confidence in the NMC as a regulator
- Inadequate record keeping together with the limitations of the electronic case management system meant that it could be difficult to identify an accurate and comprehensive audit trail in some cases
- Poor customer service and complaint handling which could lead to the perception that cases are not being handled properly and that the NMC is discourteous.

Method of auditing

1.7 We reviewed 100 cases that had been closed by the NMC between 1 January 2011 and 31 May 2011. We would usually review cases closed at the initial stages of the fitness to practise process during the previous six month period. However, due to the number of changes that had been instigated by the NMC during the latter part of 2010, we agreed with the NMC that we would review cases that had been closed between January and May 2011. We anticipated that focusing our audit on more recent cases would enable us to assess the evidence of the impact of the changes the NMC has made to the initial stages of its fitness to practise processes during 2010.

[2] The NMC disagree with CHRE on our findings in relation to two of these cases.

1.8 The 100 cases that we audited were selected from the 1,532 cases that the NMC closed during the period without a final determination by either the Competence and Conduct Committee (CCC) or the Health Committee (HC). We selected 50 cases at random, in proportion to the number of cases that had been closed by the NMC at each of the various closure points within the initial stages of its FTP processes. The other 50 cases were selected at random from categories of cases that we considered were likely to be 'higher risk'.

1.9 When auditing regulators, we base our assessment of the risk associated with cases on the information we have gathered during previous audits, on the information we are provided with during our annual performance review of the regulators, as well as on complaints we receive, and other relevant information that comes to our attention. In order to assess risk for the purposes of this audit we also considered the findings of our Progress Review (published in January 2011)[3].

1.10 In March 2010 CHRE led a meeting of representatives from all of the nine health professional regulators to agree a 'casework framework'. This was a description of the key elements that should be present in the different stages of a good fitness to practise process. A copy of this is at Annex 1. When auditing a regulator, we assess the handling of a case against the elements of the Casework Framework.

The NMC's FTP framework

1.11 The structure of the NMC's FTP process means that there are two points at which cases may be closed without referral to a formal hearing in front of a fitness to practise panel:

By NMC FTP staff without referral to the investigating committee

1.12 Rule 22 (5) of the NMC's statutory rules (The Nursing and Midwifery Order 2001 as amended) says that the NMC must refer to the relevant committee or person any allegation that is made to it 'in the form required'. The rules do not define what that phrase means. However, the NMC has defined it to mean that an allegation must be 'supported by appropriate evidence'. The NMC's processes permit staff in its fitness to practise department to close cases which are not 'in the form required'. Decisions to close cases on that basis are made by the screening team. The screening team caseworkers make a recommendation to close a case - which is then reviewed and agreed by the screening team manager and screening team lawyer.

[3] The Progress Review was undertaken at the request of the NMC. We were asked to consider the progress made by the NMC in improving its fitness to practise function since our Special Report to the Minister of State for Health Services in 2007/08. We found that whilst some significant improvements had been made, there was still room for considerable improvement to be made particularly in terms of decision-making, prioritisation of cases, case handing and the timely progression of cases.

By the investigating committee

1.13 The investigating committee's role is set out in legislation. The Nursing and Midwifery Order 2001 (section 26 (1) and (2)) explains that the committee's role is to:

'…consider in the light of the information which it has been able to obtain and any representations or other observations made to it under sub-paragraph (a) or (b) whether in its opinion in respect of an allegation of the kind mentioned in article 22(1)(a) [misconduct, lack of competence, conviction or a caution in the UK for a criminal offence, physical or mental health, or a determination by a body in the UK responsible under any enactment for the regulation of a health and social care profession to the effect that their fitness to practise is impaired, or a determination by a licensing body elsewhere to the same effect], there is a case to answer…'

1.14 The NMC's investigating committee's membership is made up of representatives from the nursing and midwifery professions and lay people.

1.15 In order to carry out its role, the investigating committee assesses whether or not there is a 'realistic prospect' of a fitness to practise panel deciding that the registrant's fitness to practise is impaired, should the matter be referred to a formal panel hearing. To help the investigating committee with this assessment, the committee can request that an investigation is conducted.

1.16 In the event that the investigating committee decides not to refer a case for a hearing by a fitness to practise panel, it may inform the registrant that the case may be taken into account in the consideration of any further allegation about them that is received by the NMC within three years of the decision not to refer the case for a hearing[4].

2. Detailed findings

Receipt of initial information stage

2.1 The first stage of any fitness to practise process will only work effectively if complainants are able to make complaints without encountering unnecessary tasks or obstacles, if cases are not discontinued for unjustifiable procedural reasons, and if clear information is given to and sought from complainants promptly.

2.2 During this audit we identified concerns arising in some cases about the timeliness of the information provided by the NMC to complainants after the NMC's receipt of the complaint, as well as the extent to which the NMC seeks appropriate clarification from complainants about information they have provided. We discuss these matters in more detail at paragraph 2.44 (timeliness of acknowledgement letters) and paragraph 2.17 (quality of investigation).

[4] NMC (Fitness to Practise) Rules Order of Council 2004 Rule (6)(1)

Risk assessment

2.3 Robust risk assessment both on receipt of a new case and on receipt of further information is necessary to enable the regulator to assess: what action should be taken; and the priority with which the case should be treated. In some circumstances the regulator may need to take immediate action on receipt of a case/further information. Such action could mean applying for an interim order to prevent the registrant from practising unrestricted while the matter is under investigation, or it could mean the regulator sending information to another interested body (e.g. the registrant's employer).

2.4 In January 2011 the NMC introduced a formalised and consistent approach to recording risk assessments. We saw evidence of this new process being used in some of the cases we reviewed during our audit. However, in ten cases that we audited (which we recognise were opened by the NMC before the introduction of its new process) there was no clear evidence that a risk assessment had been undertaken when the NMC first received the case. The NMC says that, at the time it received these cases; initial risk assessment was carried out by individual case managers, and was not formally recorded.

2.5 In one case (which the NMC received before its change of process in January 2011) in which a risk assessment had been undertaken and formally recorded, the record that was made did not explain the reasons for the NMC's decision not to alert the investigating committee to the need to consider referring the case to an interim order hearing. The NMC informs us that the appropriate form (the screening assessment form) has been updated since this risk assessment took place and that staff are now required to record the reasons for their decision to alert/not to alert the investigating committee to the need to consider a case for referral to an interim order hearing.

2.6 In one case that we audited we saw that the NMC had strived to bring forward the date of an interim order review hearing where new evidence had come to light. We thought that this was an appropriate step to take in the circumstances. However, we found that there had been delays in referring another twelve cases that we audited to an interim orders committee (we note that these twelve cases were all received prior to 11 January 2011). In our view the delays in referring these matters to an interim orders committee created risks for both public protection and public confidence in the regulatory process.

2.7 In three of these cases (which we note were received by the NMC in 2009, 2008 and 2006), the delay in referring the cases to an interim order committee following receipt of the complaint were lengthy - 16, 17 and 27 months respectively. In two of these cases, despite the delay, the interim orders committee decided to impose an interim order on the registrant. This indicates that the registrants were considered to pose a risk to public protection/public confidence. We are concerned that these registrants had been able to practise unrestricted for significant periods of time before the interim orders were imposed, as the result of the NMC's failure to apply for interim orders promptly after receiving the complaints.

2.8 In the other nine cases we found delays in referring cases to an interim orders committee of up to 10 months following receipt of each complaint. In one case (which the NMC received in 2010) involving allegations of sexual assault (which were being investigated by the police) the NMC took six months to apply for an interim order. In our view the delay in making that application raised risks for both public protection and public confidence in the NMC. The registrant's employer had suspended them from work pending the outcome of the police investigation, and we consider that the public would expect the regulator to have taken (or at least considered taking) similar action promptly.

2.9 It is essential that registrants are informed promptly about the outcome of any interim order hearing. Delays in notification of an interim order being imposed could result in potentially dangerous registrants continuing to work while unaware of the regulatory action. We identified that prompt notification of interim order hearing outcomes did not occur in four cases that we audited. In the first case the hearing before the interim order committee was held on 18 August 2010 at which an 18 month interim order was imposed. The registrant was not informed about the interim order until 6 December 2010. The NMC agrees that this notification was sent to the registrant unacceptably late. In a second case there was a delay of three months in informing the registrant that their interim suspension order had been continued (the interim order hearing took place in May 2010 and the registrant was not notified of the result until August 2010). In the other two cases there were delays of two months and three weeks respectively in the registrant being notified that the committee had decided not to impose an interim order. The NMC recognises that failing to notify registrants promptly about the outcome of interim order hearings is a serious issue and has said that it now has a key performance indicator for all decision letters to be sent within five days of the hearing.

2.10 It is important that regulators carry out adequate risk assessments throughout the lifetime of each case so that they are able to take action when any new risks are identified. We saw evidence of the NMC undertaking risk assessments throughout the lifetime of one case during our audit. However, in five further cases that we audited we were concerned that the NMC had not undertaken ongoing risk assessment, which had led, in our view, to potential risks to public protection, as described below:

- In one case the NMC were notified by the police of a criminal investigation into the care provided by the registrant. In early 2011 the NMC received additional information from the police which indicated that there might be other registrants who were also involved. We did not see any evidence that the NMC gathered further information from the police about these two registrants, in response to that additional information
- In another case the NMC received additional information from an employer (on 1 July 2011) which stated that 'the registrant referred to by the NMC was not the registrant involved in the incident, it was the 'unregistered nurse on duty'. Following receipt of this information, the NMC did not carry out any further checks to establish whether the individual involved in the incident was a former NMC registrant or someone who was unlawfully holding themselves out to be a registered nurse. The NMC disagree with our view that further checks should have been carried out

- In a third case, concerns were raised about the complainant's involvement in a safeguarding incident (which was the subject of her complaint to the NMC in relation to another registrant) and the fact that the complainant had used the care home's letterheaded paper to make the referral to the NMC whilst she was on sick leave. Given that the complainant indicated she was a 'first level nurse' and that her name appeared to be listed on the NMC's register, (we checked this during our audit in July 2011) in our view the NMC should have considered whether it was necessary to open an investigation into her conduct. However the NMC did not do so
- We audited one case where the registrant involved died while the NMC's investigation was ongoing. The police had considered whether the actions of two registrants (who had taken care of the deceased registrant in the 36 hours before their death) might have contributed to her death. We saw no evidence that the NMC had taken any steps to consider investigating those registrants in response to the notification received from the police of their action (in 2011). The NMC has told us that the decision to take no further action was informed by notification from the police that they did not expect there to be any criminal charges arising out of their investigation. However, we consider that the NMC should have obtained further information about the nature of the concerns being considered against the registrants, to ensure there were no wider fitness to practise concerns that it should consider
- In one case which we audited we were concerned that a letter on file from the registrant's current line manager (a senior midwifery manager) addressed to the investigating committee (dated 23 May 2011) stated that they had received written concerns from women about the registrant's communication and professional behaviour and attitude, and that the manager's predecessor had started an investigation which had not been completed as a result of the registrant being absent from work (first on long term sick leave and then on maternity leave). The letter stated that the investigation would be completed once the registrant returned to work. We considered that in these circumstances it would have been appropriate for the NMC to ask the employer to inform them if there was anything further to report once the registrant returned to work.

2.11 As noted above, in January 2011 the NMC introduced a new screening process to be applied to all complaints on receipt. The new process means that each case is reviewed by a case administrator and a screening manager within forty eight hours of receipt. Where those staff consider that an interim order application is appropriate, they refer the case for consideration by an in-house lawyer (the screening lawyer).

2.12 We saw that this new screening process had been followed in the majority of the cases that we audited. However, we identified five cases in which it was not clear that the screening process had been followed. In relation to two of those cases the NMC acknowledges that its risk assessment was not formally recorded on the file. However, the NMC states that risk assessments are now always carried out and in fact the electronic case management system's workflow does not permit assignment of a case to a case officer until a screening manager has considered whether an interim order committee referral is necessary. We would emphasise the importance of ensuring that all risk assessments are recorded.

2.13 In two further cases that we audited the screening assessment forms did not record a full risk assessment. The NMC's explanation for this was that the process was adapted by a temporary member of staff (who only recorded her risk assessment in the 'alerts' section of the electronic case management system) while the screening lawyer was away on leave. In our view inconsistencies in the methods used to record decisions could lead to problems in identifying/retrieving that data later in the lifetime of the case. In another case that we audited the screening manager had recommended that an interim order be applied for (22 December 2010), however we could find no formal document on the file indicating that an interim order committee had been asked to consider the case. The NMC have told us that a note of the committee's decision was in fact recorded in the 'case notes' section of the electronic case management system. In our view it is essential that there are clear, formalised records of decisions made in individual cases, and that those records are filed consistently so that staff know where to look for them.

2.14 We were concerned that the NMC had not referred one case that we audited to an interim orders committee (this occurred in early 2011). Given the seriousness of the allegations and the potential risk to patients in this case, we considered that an interim order should have been applied for by the NMC, despite the lapse of time since the alleged events took place (in 2004 and 2005). As the police were still investigating the case, there remained a risk that the registrant would be charged with a criminal offence. We considered that until the Crown Prosecution Service had decided whether or not to charge the registrant, there was a possibility that an interim order might need to be imposed to protect the public or otherwise in the public interest. We drew this case to the attention of the NMC during our audit.

Gathering information

2.15 Gathering the right information early enough in the FTP process is essential to enabling the regulator to assess the risks that a registrant may pose to patient safety, and to ensuring that appropriate action can be taken promptly to protect the public (including, where necessary, applying for an interim order).

2.16 In our audit we found some cases that demonstrated a pro-active approach being taken by NMC staff to opening new cases and gathering information. For example, the NMC opened one investigation following the publication of a news article stating that a care worker had been suspended after an elderly resident was injured when they had wandered away from the home. The NMC made enquiries of the chief executive of the care home asking: whether the person referred to in the article was a registered nurse; for the name of the nurse in charge of the home; and for details of the investigation that had been undertaken. The NMC also wrote to the city Council asking for information on the matter.

2.17 However, we also found several cases where we considered that the NMC's approach to information gathering had been inadequate. Our concerns about this are set out below.

Over-reliance of other organisation's investigations

- The NMC did not carry out an investigation into allegations of verbal and physical abuse relating to six vulnerable patients. Instead the investigating committee closed the case (in March 2011). We considered that this was inappropriate and that the NMC should instead have taken steps to obtain additional evidence (e.g. from the patients involved) before reaching a decision to close the case
- The investigating committee closed another case (in which a registrant had been arrested on suspicion of conspiring to pervert the course of justice) in March 2011, following confirmation that the police would not be instituting criminal proceedings against the registrant. We thought that before reaching any decision to close the case, the investigating committee should first have sought further information from the police, so that it could reach an informed view as to whether or not there was a realistic prospect of a panel finding on the balance of probabilities that the registrant's fitness to practise was impaired (which is a different issue from that considered by the police). The NMC do not agree with our view that further investigation should have been conducted before this case was closed.

Failing to obtain all the relevant information necessary to make a robust evidence based decision

- In one case that we audited the caseworker had not followed the investigating committee's instructions in terms of the information to be obtained. Whilst we did not consider that this failure had impacted on the investigating committee's ultimate decision in this particular case, departing from the committee's instructions could have a significant impact in other cases
- In another case that we audited we considered that the NMC should have obtained the CCTV evidence, which was key to the employer's investigation. The NMC say that if it were handling this case under its current processes, it is likely that this information would be obtained – as staff now interpret the NMC's investigation powers as widely as possible
- In a further case that we audited we noted that the NMC failed to check the Police National Computer ('PNC') to see whether or not the registrant had any previous criminal convictions. This was despite the fact the investigating committee had expressed concerns about a possible pattern of offending by the registrant. The NMC informs us that this case was considered before it had introduced undertaking routine PNC checks in all cases where the registrant has been convicted of a criminal offence (as part of its new screening process, introduced in January 2011). The NMC says that such cases are now not treated as being 'in the form required' (and therefore are not progressed) until the outcome of the PNC check has been received.

- In one case, that we audited there was reference to an earlier employer disciplinary hearing concerning similar allegations. However, we did not see any evidence that the NMC had sought further information about these earlier similar allegations and we were concerned that the NMC had failed to investigate whether or not there was a pattern of misconduct. Furthermore, in the same case there was an allegation that the registrant had walked off her shift, which similarly was not investigated by the NMC.
- In another case that we audited we concluded that the investigating committee's decision would have been more robust if the NMC had obtained evidence from the registrant's current employer about any recent concerns or incidents. (Although we note that the registrant had not provided her employment details to the NMC following their request as part of the original notice of referral.) We were also concerned that a potential issue relating to the registrant's health had not been the subject of any inquiries by the NMC.
- In one case we thought that further information should have been obtained from the complainant including specific details of the allegations she was making e.g. dates, names of other potential witnesses to the alleged facts, copies of the records she refers to as containing forged signatures, as well as the name of the individuals within 'management' to whom she allegedly repeatedly reported her concerns (as the only person the NMC appeared to ask about this was the Chief Executive). Once those details had been obtained, it might have been possible to seek corroborating evidence from other people. We considered that a view about the credibility of the complainant's evidence (and therefore the weight to be placed on it in the absence of any corroboration) should have been taken by the investigating committee, not by NMC staff. The NMC disagrees that further investigations should have been carried out.

Failing to consider each aspect of the complaint made

2.18 In addition to the cases summarised above, we identified other examples of cases where we considered that the NMC had not fully investigated individual complaints.

- In relation to one case that we audited we had concerns that the NMC's investigators did not appear to have considered the impact of the registrant's inclusion on the protection of vulnerable adults (POVA) and protection of the children act (POCA) lists on their fitness to practise. Given that the registrant's name was retained on the POVA/POCA (now Safeguarding Vulnerable Adults) lists in 2009 due to deficiencies in her medication administration, we consider that the NMC's failure to consider restricting the registrant's practice would give rise to public concern. We consider that the public would find it difficult to reconcile how the registrant can be barred from working with vulnerable adults and children by one organisation at the same time as their regulator taking no action to consider the matter at all

- In a second case that we audited we were concerned that the NMC's investigators had not considered including an allegation relating to a breach of confidentiality. The issue was only identified by the investigating committee. This failure to identify a potential allegation at an early stage led to unnecessary delay and the need for an additional investigating committee to be held before the case could be concluded
- In another case we were concerned that the NMC only focused on one aspect of a breach of confidentiality, although two separate matters had been raised. There were no clear reasons recorded to explain why this had happened.

Failing to clarify details contained either within the complaint made or the evidence received

- In two cases that we audited we identified that the NMC should have taken further steps to clarify details either of the original complaint or of evidence the NMC had received. In one of those cases the NMC's failure to clarify the evidence it had been provided with (that the Crown Prosecution Service intended not to take criminal action against the registrant) before the first investigating committee meeting took place meant that a second committee meeting had to be arranged (to feedback to the committee the clarification obtained).
- In relation to five of the cases we have referred to in this section and above the NMC says that it did not seek further information/clarification either because the cases were closed without the investigating committee asking for an investigation by lawyers, or because the cases were closed by the screening team (which has no powers to carry out detailed investigations). We note that the NMC disagree with CHRE's views in relation to one of the five cases that we identified. In relation to another of the cases we audited the investigating committee decided that an information sharing error appeared to have been isolated and was capable of remedy, and that because the registrant had provided positive testimonials and shown insight it considered that there was no real prospect of a finding of current impairment of fitness to practise. However, given that there was evidence that this was not an isolated incident, and that a patient's death may have been prevented if this error had not occurred, we consider it may have been best if this case was referred onto a conduct and competence committee. We consider that the decisions to close these five cases were taken prematurely. Therefore, there will be an inherent risk to public protection and public confidence in the regulator if the NMC continues to close cases without having information that is sufficiently clear to ensure that a robust decision can be made.
- During the audit we alerted the NMC to our concerns about one case (involving serious allegations about a substandard level of care allegedly provided at a care home) that had been closed. We were seriously concerned that the public had been put at risk as a result of that decision to close this particular case. The investigating police force had also raised concerns about the NMC's decision to close this case. Whilst it appeared that some initial legal advice had been requested by the NMC following contact from the police because of concerns about the decision, this was some time before we

had audited the case and no subsequent action had been taken. The NMC had been provided with an extensive list of documents from the police about the ongoing criminal investigation - but instead of asking the police for that information, the NMC's investigating committee decided to close the case. In our view that decision was inappropriate.

- In four cases that we audited we considered that the decisions made might have been more robust if the NMC had shared the registrants' responses to the complaints with the relevant complainants. At the time that these cases were considered (late 2010/early 2011), the NMC did not as a matter of policy share the registrant's response with the complainant. However, we are pleased to note that the NMC has changed its practice recently, and now in cases where there are factual disputes between the accounts provided by the registrant and the complainant, the registrant's response will be shared with the complainant.
- In two cases that we audited we thought that the NMC should have checked or validated the evidence provided by the registrant. In one case (where the allegations related to the production of a factually incorrect report regarding an incident at a residential home) the investigating committee did not request any further information before deciding to close the case. The registrant denied any involvement in the case, including denying that he had ever been employed as a nurse at the care home (despite the referral originating from the employer) denying that he had written the report, and denying that he had any involvement with the company that produced the report. We considered that the NMC should have sought further evidence in order to validate/challenge the registrant's account of his involvement in the case.

2.19 We were concerned that the NMC could not reasonably have assured itself of the level of risk posed by the registrants concerned before it made the decision to close the above cases.

Links between the NMC's fitness to practise and registration databases

2.20 We were concerned about the effectiveness of the safeguards in place in relation to the interaction between the NMC's two main computer systems, and the implications this has for ensuring that the NMC can deal adequately with all allegations.

2.21 The NMC only has power to investigate fitness to practise complaints against its registrants. WISER is the computer system that stores information about the registration status of each registrant. If a nurse/midwife has left the NMC's register by the time the NMC is informed of an allegation, the NMC has no power to take action against them (unless they apply to rejoin the register). In those circumstances, the NMC's procedure is for an 'under investigation' flag to be added to the individual's WISER record. This is in order to ensure that the individual is not permitted to rejoin the NMC's register until the allegation has been investigated.

2.22 In several cases that we audited we found clear records of the checks that had been undertaken to ascertain if the person who was the subject of the complaint was an NMC registrant, as well as checks to establish whether or not they had any history of previous fitness to practise allegations being proved against them. However, the following cases caused us concern:

- One individual's name had been flagged as being 'under investigation' on WISER. However, it appeared that individual had been able to rejoin the NMC's register in 2008 without the previous allegations against her being investigated. This suggests that the system referred to in paragraph 2.21 above was not working consistently. The NMC says that its Screening team is now much more robustly managed than in 2008, and that updating WISER is now routinely done in all cases.
- In three cases that we audited it was not clear from the NMC's case electronic management system whether or not a flag had been placed against the individuals' names on WISER after allegations had been received about them. The NMC says that these individuals had been flagged as being 'under investigation' on WISER, but that this is not routinely recorded on the electronic case management system.

2.23 We are concerned that this exposes an area of administrative weakness which creates risks that fitness to practise issues may not be investigated before an individual rejoins the register if, due to human error, WISER is not updated with all outstanding allegations against an individual. We consider that consistently recording on the case management system that WISER has been updated would provide a safeguard in those circumstances.

2.24 In two of the cases noted above (which the NMC opened prior to January 2011) we identified that there had been a delay in identifying that an individual was no longer on the NMC's register (delays of one month and almost 12 months respectively). This meant that in the interim, the NMC continued to expend its limited resources on handling and investigating the allegations, even though the NMC had no powers in relation to the individuals concerned (at least until such time as they seek to rejoin the NMC's register). The NMC has assured us that more robust screening procedures are now in place to avoid such errors recurring.

Evaluation and giving reasons for decisions

Quality of decision reasoning

2.25 Providing detailed reasons for the decisions that are taken either by NMC staff or by the investigating committee, and ensuring that those reasons clearly demonstrate that all the relevant issues have been addressed, is essential to maintaining public confidence in the regulatory process. Requiring decision-makers to provide detailed reasons also acts as a check to ensure that the decisions themselves are robust.

2.26 We identified a number of weaknesses in the explanations provided for decisions to close cases that we audited. These weaknesses occurred both in cases that were closed by the investigating committee, and those that were closed by NMC staff without referral to the investigating committee:

- In eight of the cases closed by the NMC's investigating committee and in one of the cases closed by the NMC's screening team that we audited we were concerned that the reasons provided by the NMC were inadequate to explain why the cases had been closed. For example, in one case the investigating committee's reasons for closing the case (as set out in a letter dated 10 March 2011) were that 'the panel had carefully considered the information before it, noting the report from the legal team. The conclusion of this report is that there is no case to answer and the panel has decided to close the case.' In our view this wording did not adequately explain why the committee had concluded that there was 'no case to answer'.
- In five of the cases that we audited, while we agreed that closure would have been a reasonable outcome, we considered that the reasons given (by the investigating committee in four cases, and by the screening team in the other case) for the closures were inaccurate/inadequate.
    - For example in one of the cases (which was closed in April 2011) the letter sent to explain the committee's decision to close the case stated that the registrant had apologised and was remorseful. In fact the registrant's submission said that she refuted the allegation, and there was no indication that she had demonstrated any remorse.
    - In another case a decision not to impose an interim order was based on the interim orders committee's conclusion that the registrant had shown some insight, alongside the fact that the registrant's employer had not investigated the matter. On auditing the case, we did not see any evidence of insight on the registrant's part (in fact it seemed that the registrant did not accept he had acted inappropriately, despite having undergone relevant training that should have improved his understanding of the situation). We also noted that the employer had not investigated the matter further specifically because they had referred it to the NMC to deal with.
- In one case that we audited we concluded that the NMC should have obtained further information before taking the decision to close the case. We think that the investigating committee should have deferred that decision pending receipt of disclosure of the evidence gathered by the police, as at the date of the committee decision the NMC did not know the reasons why the police had offered no evidence at the criminal trial, nor did it have any knowledge of the evidence gathered by the police during their investigation (including any forensic evidence). We think that deferring the decision pending receipt of that evidence would have been more appropriate in order to maintain public confidence in the regulatory process.While it is not clear that additional information would have materially affected the decision, we considered that it would have been better practice in order to minimise the risk of the wrong decision being made.

- In five cases that we audited we identified concerns about the content of the standard letters used by the NMC. In three of the cases we found letters that had not been appropriately tailored for their intended recipients. For example, in one case a decision letter to the registrant referred initially to 'you' and 'your case' and then reverted to 'the registrant'. In two of the letters (sent in May 2011) standard phraseology had been used which we did not consider was appropriate. In one case the letter said 'this case is not in the form required' without explaining what this meant. We consider that 'in the form required is a legalistic term that holds no meaning to anyone outside of the NMC. In the second case the letter said 'I appreciate the matters that you wrote to us about caused you concern but they do not raise any potential issues of fitness to practise that would require a full investigation'. This wording did not reflect the actual reasons for closing the case. We were also concerned that this wording could damage confidence in the regulator, as the case did involve serious allegations. The NMC says that it is now reviewing its standard letters. We would also recommend that staff receive training about the importance of adapting standard letters to the circumstances of the individual cases that they are dealing with.
- In three cases we considered that it would have been helpful if the NMC's letters notifying registrants of the investigating committee outcomes in their cases had reminded the registrants of their obligations under the NMC Code of Conduct and Competence ('the Code'). For example, in one case the registrant had said in his response to the investigating committee that the police had indicated that they would not disclose his caution to the NMC. We thought that it would have been helpful if the NMC had reminded the registrant that he has an obligation under the NMC's Code to disclose police cautions and convictions to the NMC, regardless of whether or not the police separately notify the NMC about them.
- In one case that we audited the decision letter contained basic errors about the case. In our view this could damage confidence in the NMC as it could lead to a perception that the NMC had not handled the case properly.
- In another case we audited the interim orders committee had not received up to date information about the case. The NMC said that it has now introduced timeframes within which its investigators must provided progress reports on cases, which may prevent such errors recurring.

2.27 We consider that in the following eight cases (some of which are referred to above) serious failings in gathering information and analysis led to decisions which would either not protect the public or which would not maintain public confidence in the nursing profession and/or the regulatory process:

- The investigating committee decided to close another case (which involved allegations of verbal and physical abuse relating to six vulnerable patients) without referring it for an investigation by the NMC's solicitors. We thought that it would have been more appropriate for the NMC to seek witness evidence from the potential witnesses before taking a decision to close the case

- The investigating committee decided to close a case concerning a registrant who had been arrested on suspicion of conspiring to pervert the course of justice. The committee decided to close the case (on 29 March 2011) on the basis that the police had confirmed that they would not be taking any action against the registrant. We considered that it would have been more appropriate for the NMC to obtain further information from the police about the reasons for that decision, in order to judge whether there was a realistic prospect that the registrant's fitness to practise might be found to be impaired. This is because any decision by the police not to prosecute would be based on an assessment of whether criminal allegations could be proved 'beyond a reasonable doubt'. By contrast, fitness to practise proceedings may look at allegations that do not directly correspond with a criminal offence, and apply the civil standard rather than the criminal standard of proof. Therefore, we consider that it is not appropriate simply to rely upon a criminal prosecuting authority's decision not to prosecute a case when reaching a decision about fitness to practise allegations. As noted above, the NMC disagrees with our views on this case
- The investigating committee decided (on 18 January 2011) to close a case involving allegations of dishonesty, because the employer had dismissed the registrant, and the registrant had indicated that he had retired and wished to come off the NMC's register. Allegations of dishonesty are regarded as serious and, if proved at a fitness to practise panel hearing, usually result in a significant sanction being imposed. We were concerned about the investigating committee's decision in this case and the committee's apparent failure to appreciate that the regulator has a wider remit than that of an employer in terms of public protection. Our concerns about this decision increased when we discovered that the registrant had not in fact retired from the NMC's register, as indicated (as at July 2011)
- In one case involving a registrant who had been arrested for the offence of assault/neglect of a young child, the decision to close the case appeared to have been taken because the police were taking no action against the registrant. However, the NMC had not (in our view) gathered sufficient information from the police about their investigation in order to assess whether or not there was evidence to support an allegation of impaired fitness to practise before deciding to close the case
- We identified one case where we thought that the public would struggle to understand how the NMC had reached the decision to take no action against a nurse who had been banned from working with vulnerable children/adults by virtue of inclusion on the POVA, POCA and ISA lists (and whose challenge of her inclusion on those lists had failed) as a result of the same allegations. We considered that this lack of action by the NMC in response to allegations that had, separately, resulted in the registrant being banned from working with vulnerable children or adults could damage confidence in the NMC as the regulator

- In one case that was closed by the NMC in February 2011, the NMC's letter to the complainant said that the registrant had shown remorse and insight for his actions. However, we considered that there is no evidence of remorse or insight. The registrant had in fact denied some of the allegations, and had offered a rationale for his behaviour. In our view, he had not shown remorse and it was clear that he did not accept that his behaviour was inappropriate (in his statement he said that he should be commended rather than condemned for his role in the events)
- We considered that the investigating committee's decision to close the case that we specifically brought to the NMC's attention during the course of the audit was premature and inappropriate. At the date of the decision to close the case, the police investigation had not concluded, and the NMC had not obtained all the relevant information from the police regarding the alleged offence. We also noted that the NMC had only asked the investigating committee to consider allegations relating to one of the patients involved. We consider that it would have been advisable for the case to have been referred to the interim orders committee and for the NMC's investigation to have remained open until the Crown Prosecution Service had reached a decision about criminal proceedings and the NMC had gathered appropriate evidence (including from the police). We were also concerned about the impact on public confidence in the nursing profession of the reasoning within the investigating committee's letter closing the case. The reasoning implied that the registrant's fitness to practise could not be impaired because other registrants had also provided 'severely sub-standard general nursing care'
- We did not think that it was reasonable for the investigating committee to close one case that we reviewed which concerned allegations about the administration of Botox. We considered that the NMC had not fully investigated the professional/legal issues around the registrant's apparent administration of the treatment "off-label". Furthermore, there was evidence (in the complainant's letter) that the complainant may not have given valid consent to the administration of the treatment. We were concerned that this issue did not appear to have been considered by the NMC

2.28 In one other case which we audited we were not concerned about the public protection impact of the decision made by the investigating committee, but about the implications of the decision on the NMC's ability to manage its fitness to practise cases efficiently. This case was eventually closed by a 'pre-meeting' of a conduct and competence committee. The investigating committee had had exactly the same information as the 'pre-meeting' of the conduct and competence committee and could have closed the case several months earlier. We consider that expenditure of resources to progress cases which do not meet the 'realistic prospect' test impacts upon the NMC's ability to progress other cases efficiently.

Case management

2.29 Effective case management is the third element of a good fitness to practise process. We consider that this includes having processes in place to ensure:

- The timely progression of cases
- That there is comprehensive and accurate record keeping
- The provision of good customer service.

Timeliness

2.30 Delays in the progression of cases are not in the interests of complainants, registrants, employers or the public. Whilst we recognise that in some cases some delays are unavoidable (e.g. because of ongoing criminal investigations or difficulties in obtaining evidence) we consider that much of the delay in the NMC cases we audited could have been avoided by better case management.

2.31 We identified significant delays in over a third of the cases which we audited. We recognise that these occurred in cases that had been opened by the NMC before the introduction of its new screening process in January 2011 (and that several of the cases were opened several years ago). These delays came to our attention in this audit as a result of the NMC's focus on clearing the 'backlog' of cases that had previously been inactive and severely delayed. This recent initiative may have resulted in a disproportionate number of the cases that we audited having been affected by delays at some stage in their lifetime. Nevertheless, our findings give cause for concern about the NMC's case management and we are pleased to note that the NMC is already taking action to improve its performance.

2.32 The delays we found appeared to be caused by:

- The lack of effective management and oversight by the NMC of investigations. This meant that progress on concluding cases became prolonged as a result of delays by the investigators in completing investigations. In cases that we audited we saw lengthy delays of between nine months to three years in six cases, and a delay of two months in a seventh case. We note that the NMC has introduced closer monitoring of external investigations since April 2011
- In 26 cases that we audited we saw delays that had been caused by a lack of effective case management by NMC staff. In some cases no activity had been undertaken for significant periods. In other cases there had been unnecessary delays between different stages of the fitness to practise process. In nine of these cases the delays ranged from 12 months to in excess of 24 months. Delays of this length are unacceptable in terms of public protection and maintaining public confidence in the regulator, as well as being potentially unfair to the individuals involved. In two of these cases, it is clear that the NMC's delay in progressing the case was a factor that had to be taken into account by the investigating committee in its decision-making. In the other 14 cases there were delays of 12 months or less. The NMC has told us that its current case audit process should prevent such significant delays occurring, as it ensures that all cases are reviewed and progressed

- In three cases (two of which were opened by the NMC in 2010, and one in 2011) we audited we identified that administrative errors by NMC staff had led to avoidable delays in the progression of cases. The resulting delays ranged in length from one to nine months. The errors related to incorrect composition of the investigating committee, or listing/allocation of the cases
- In two cases we audited we identified that there had been some delay (four and six months) between receipt of the police referral and the NMC opening an investigation. The NMC says that this happened because the referrals were being sent erroneously to a defunct inbox and action was taken to put this right once it was identified (in January 2011)
- We identified that there had been significant delay in the progression of another two cases that we audited. It appeared that this was due to communication problems relating to the transfer of cases between NMC case officers

2.33 We have been told by the NMC that it now has more robust case management processes in place. Since November 2010 NMC fitness to practise management have carried out full case audits every two to four weeks, as well as monthly reviews of the oldest open cases. Staff are encouraged to run live reports from the case management system and reconcile these with their own spreadsheets prior to each audit, in order to ensure that any cases transferred to case officers are not overlooked. We have also been told by the NMC that any case that does not proceed to a scheduled event (e.g. an investigation committee meeting) or does not proceed as expected, will be reviewed by the Head of Case Management and, if appropriate, referred as a critical incident for a cause and effect analysis to be undertaken. The NMC believes that these processes would identify cases that have been overlooked or inactive for any period of time.

2.34 The NMC has told us that it has also changed its procedure for management and oversight of the work undertaken by its investigators. The NMC has new timeframes in place that the solicitors must comply with when investigating cases. The NMC has a legal services liaison officer (since May 2011) who is responsible for monitoring all internal and external legal investigations.

Record keeping

2.35 Maintenance of a single comprehensive record of all actions and information on a case is essential for proper management of cases and for good quality decision making.

2.36 Although we noticed some improvement in the NMC's record keeping compared to the findings at our previous audits we remain concerned about the general quality of the case records. We identified record keeping deficiencies in several cases that we audited:

- Discrepancies between the paper and electronic case files. By this we mean that one or more documents could only be found in either the paper/electronic case file, but not in the other. This error occurred in relation to clinical and legal advice provided to case officers, in relation to correspondence between the NMC and the registrant/complainant and in relation to referral documents. In one of the cases in which we found discrepancies, the NMC have told us

that to print and save a copy of the documentation onto the paper file would have been cumbersome and not a good use of resources. We would suggest where decisions have been made not to replicate documents onto either the paper or electronic file, that they are recorded on the relevant file

- Documents which were missing from both the electronic and paper case files. We note that the bulk of the work on two of these cases was carried out prior to the recent introduction of the NMC's post-scanning process (which ensures that records are saved and scanned to the electronic file) and that a third case that we audited had been managed under an older (and now defunct) case management system. However, we still found that documents were missing from some of the more recent cases
- Documents relating to the wrong registrant being filed on the case files. We found that documents about a different registrant had been wrongly filed in four of the cases that we audited
- Failure to file all relevant documentation on case files where the case was linked to another case(s). This meant that there was no clear audit trail of the actions taken on each case. Instead, auditors (or anyone reviewing the file) had to look at the files relating to other registrants in order to identify the activities that had taken place on the case. The NMC says that it does not agree that all documentation needs to be copied onto each file, because the electronic case management system clearly indicates where cases are linked – which means that the information can easily be found from the linked case files. However, we consider that this approach exposes the NMC to the risk of human error, and we note that during our audit we identified one case where we could not access the linked cases (and therefore it would be difficult in such cases to retrieve all the necessary information)
- Basic administrative errors, such as original complaint letters not being clearly marked with the date they were received, failures to obtain and use the correct address and duplicate cases being opened in circumstances where the same complaint had been submitted by the same complainant at different times
- Unclear or incomplete screening assessment forms. We found cases in which it was not clear what the complaint/allegation was or what the NMC's reasons were for closing the case. In relation to the clarity of decisions, we consider that it would be helpful if the decision recorded on the screening assessment form clearly set out which closure sub category was being used by the NMC. For example, when a decision has been made to close a case because a registrant is no longer on the register, we consider the NMC should record whether this is because the individual has never been on the register or because they have lapsed from the register. We note that the NMC does not accept our views about amending its approach to recording which closure sub-category is relevant
- Failure to obtain consent from the complainant prior to the disclosure of their complaint to the registrant. This occurred in three cases that we audited which had been opened in 2010/2011. The NMC says that it has changed its process, and that the screening team now routinely requests the consent of complainants to disclose their complaints

- Provision of inaccurate information. We audited one case where the registrant was informed (in January 2011) that all her convictions would be considered at an investigating committee. The registrant contacted the NMC to inform them that seven of the convictions had already been considered. After some initial internal uncertainty, the NMC agreed with the registrant and offered its apologies. The NMC says that this error occurred due to difficulties in searching the NMC's (and its predecessor, the UKCC) records that pre-dated the introduction of the electronic case management system
- Failure to maintain a complete audit trail. We audited one case where it was unclear whether or not an interim order hearing had been held. There was paperwork on the file to indicate that interim order hearings had been scheduled, but it was unclear whether or not any of these scheduled hearings had actually taken place. These errors occurred before the NMC introduced its current electronic case management system (in December 2009) and the NMC have told us that since the introduction of that system, all reasons and decisions have been recorded, in order to ensure that there is a clear audit trail
- Inconsistencies in the dates recorded on the electronic case management system and the paper records. In more than 15 cases that we audited we found inconsistencies between: the date the case was opened on the electronic case management system (CMS) and the date on which the complaint was actually received by the NMC; and/or inconsistencies between the date the case was shown as being closed on the CMS and the date the complainant and registrant were informed of the closure decision. We were concerned that these inconsistencies could impact on the integrity and accuracy of the NMC's performance data - which we understand is based on data retrieved from the NMC's case management system. We note that in some cases the inconsistencies were relatively minor (amounting to discrepancies of between one to five days) but in other cases they were more significant (over four months). The NMC does not consider that a delay of one to two days will impact significantly on its performance data, but it does recognise that in some cases there was a delay in opening the case after receipt of a complaint although this was not reflected in the date recorded on the case management system as the date of receipt.

2.37 The NMC introduced a new centralised filing system in November 2010. The NMC informs us that any documents that are received outside of the usual system (i.e where incoming mail is scanned and electronically filed) are date-stamped and marked to show where they should be placed within the case file before the administrative team file (or scan and file) them. The NMC have put in place a standard operating procedure for staff to follow when undertaking this filing activity. Additionally, the NMC tell us that staff are encouraged to file items whenever they are using the file, and to save onto the case management system any documents received electronically. Each case is allocated a 'case owner' who is responsible at the conclusion of the case for reconciling the paper and electronic copies of the file. While these procedures should result in good file management, it is clear from the findings from our audit that they are not yet working consistently. Furthermore, from our audit we found that it was often difficult to locate case records if they had been scanned and added to a large

bundle near the end of a case's lifetime. While we acknowledge the potential impact on resources of scanning documents which were received prior to the introduction of the NMC's electronic mail process, we consider it important that documents are scanned onto the case management system when they are received during the lifetime of a case.

2.38 Whilst some of the errors that we identified in the NMC's record keeping arose in cases which had been under investigation for some time (and which therefore pre-dated the initiatives that the NMC has taken in the last 12 months to improve its performance) many of the errors occurred more recently in late 2010 or in 2011. We recommend that the NMC takes steps to expand its quality assurance of records management, in order to ensure that performance in this area improves.

Case management system

2.39 An effective case management system is key to the maintenance of an efficient fitness to practise process. We are concerned about the impact of the limitations of the NMC's current electronic case management system on the accuracy of the NMC's case records. During our audit we found the following issues in relation to entries on the case management system:

- Four cases where the recorded 'case closure stage' was inaccurate. This occurred in cases where a decision had been made (for various reasons) to refer the case back to a previous stage within the fitness to practise process, at which point the decision was taken to close the case. The NMC inform us that these inaccuracies have occurred because the case management system is not able to accommodate a case being moved backwards within the process. We recommend that the NMC looks at adjusting the case management system to permit certain staff (with the appropriate authorisation) to move cases between stages within the process, so that accurate records can be maintained by the NMC
- One case where an 'alert' (the purpose of which was to show that the case was linked with another case) had accidently been generated. We have been told by the NMC that once 'alerts' have been created, they cannot be removed.
- One case where the case management system indicated that there was an interim order in place against the registrant when in fact that was not correct and no interim order was in place. The NMC say that this is the result of an error in the case management system

2.40 We would suggest to the NMC that it seeks to identify a remedy to the issues identified in the second and third bullet points above in order to avoid any confusion for staff handling fitness to practise cases.

2.41 We identified some additional issues with the case management system, which the NMC informs us have been resolved since our audit. These issues are:

- Improving the accuracy of the audit trail on each file by requiring all staff (since February 2011) to record the stage that the case reached at the point that it was closed, rather than just recording the fact that it has been closed. We found several cases, closed before this date, where this had not happened

- Ensuring that letters retained on the system show the correct date. Since mid 2010 an error in the system has been fixed so all letters permanently now retain the date the letter was created, rather than updating the date shown to the date that the document is opened
- Clearly indicating which versions of documents were sent. In some cases we found it difficult to distinguish between final and draft documents. The NMC says that the case management system does not allow caseworkers to delete draft documents from the file once created. This is in order to preserve a complete audit trail. Staff are now encouraged to clearly indicate any letters that have not been sent, for example by changing their title or writing a note in the document itself to indicate this. We consider that it would also be helpful if a scanned copy of each sent document is kept on the electronic case file.

Other case management issues

2.42 During our audit we identified some further case management issues that relate to three separate areas.

- The first concerns errors in documenting the complaints/allegations made to the NMC. In one case we audited we saw that the case officer's instructions to the previous external solicitors did not refer to both sets of allegations that were to be investigated. In two cases we saw that the NMC had inaccurately compiled the allegations to be considered by the investigating committee. In another case, the NMC only asked the investigating committee to consider the most recent allegations, and had overlooked an earlier set of allegations. We considered that had the allegations to the panel been drafted to include the earlier allegations, the outcome might have been different – as the two sets of allegations, if considered together, might have indicated a pattern of poor practice
- The second issue concerned problems with handling mail efficiently. In one case we found that the registrant's response to the allegations had been returned to the registrant undelivered in 2009, although it had been received at the NMC's office. This led to a delay in the progression of the case. We note that the NMC has now changed its processes for handling mail, and it has not received any recent complaints about similar issues.
- The third issue concerns the impact that the advice that the NMC gives to employers on referring fitness to practise cases to the NMC could have on public protection. The NMC's previous advice to employers strongly implied that employers must demonstrate that local action has been completed before they made a referral to the NMC. We were concerned that this was inappropriate in terms of public protection - as circumstances might require the NMC to consider whether or not an interim order is necessary at a much earlier date than at the end of the local employment disciplinary procedures. We had raised our concerns about this in previous performance review reports[5].

[5] Paragraph 15.24 of the Performance Review 2009/2010

During this audit we found one case (involving serious allegations of patient harm) that had not been referred to the NMC by the employer until 18 months after the events occurred, and we were concerned that this demonstrated the potentially harmful impact of the NMC's advice to employers. However, we are pleased that the NMC has now revised and clarified its advice to employers, so that it is clear that employers must refer a case before the conclusion of local investigations, where it considers that the public may be at risk.

Customer service

2.43 Good customer service is important to maintaining professional and public confidence in a regulator. The NMC acknowledges that its customer service has not always been of the highest standard in the past, and says that it has now made it a high priority to improve the service it provides. We saw some evidence of improved customer service during the audit, including: timely acknowledgement letters, clear and informative standard letters, some oversight and quality-checking of letters, and appropriate tailoring of letters to the circumstances of the recipient. However, we also identified a number of concerns with the NMC's customer service which we consider could result in a perception that the NMC is not handling cases properly, and/or in a perception of discourtesy by the NMC. We are also concerned that the weaknesses we identified could indicate that there is insufficient oversight of caseworkers' output.

2.44 We identified 17 cases where there was delay by the NMC in sharing information with either a complainant or a registrant.

- In four of these cases the delays related to informing the registrant/complainant about the outcome of an investigating committee's consideration of a case. The delays ranged from five days to 17 months. In two of these cases the NMC apologised for the delays.
- In two cases (which were opened by the NMC in 2006 and 2007), there were very lengthy delays between correspondence sent to the registrant by the NMC (delays of 2 years 10 months and 3 years 10 months respectively). The letters began 'In my last letter I told you that …' but there was no reference to the lapse of time since the previous letters, nor was any apology or explanation for the delay offered
- In ten cases the delays were in acknowledging correspondence from either a complainant or an employer, or providing an update on the progress of cases. In four of the cases, the individual had to contact the NMC to ask for further information (which was then provided). In another case no response was provided between the initial acknowledgment being sent on 27 January 2009 and 15 April 2011 - during which time there had been two investigating committee meeting outcomes. In two other cases, the NMC only contacted individuals 9 and 13 months after the date of the previous correspondence
- In one case a registrant wrote to the NMC on 1 October 2010 to ask whether they were under investigation. The registrant was not informed until 4 January 2011 that they were in fact under investigation.

2.45 We identified two cases where there had been a breach of confidentiality by the NMC. In one of the cases this was due to confidential papers being sent in envelopes which were not strong enough for the weight of the papers. The envelopes therefore split open, revealing their contents. This occurred twice in relation to the same case. The NMC says that it has stopped using these envelopes following several complaints about their suitability.

2.46 In the second case, a caseworker erroneously sent a copy of a notification of an interim order hearing and a bundle of supporting papers to the Royal College of Nursing (RCN) although the RCN was not representing the registrant concerned. These papers were returned to the NMC by the RCN. The error was not acknowledged by the NMC, nor was the registrant informed of this incident, nor does it appear the NMC considered whether or not it should report the breach to the Office of the Information Commissioner. The NMC says that it now has a policy of recording all breaches of confidentiality as critical incidents, so that they can be reviewed. Advice is also sought from the data and information governance manager.

2.47 We identified a number of cases where basic errors were made in correspondence that was sent to either the registrant or the complainant:

- We found two cases where letters were not tailored to the circumstances of the complainant
- There were six cases where correspondence contained errors (such as the incorrect address being used, spelling errors, incorrect dates relating to case events) as well as incorrect allegations being recorded on the notice of referral. In three of these cases the errors were brought to the attention of the NMC by the recipient of the letter (rather than being identified as the result of internal file audits/quality checking). The NMC then apologised for the errors.

2.48 The NMC has informed us previously that it introduced customer service standards in April 2011, and that all staff would be trained on these standards and general customer service during April and May 2011. We were informed by the NMC during this audit that the staff were actually trained in June and July 2011 on customer service, and that the NMC's customer service pledge was implemented on 1 August 2011. The NMC has told us that it has sent out its customer service pledge to registrants and complainants and that this explains the level of service they should expect. The NMC has said that it will also be seeking feedback from registrants and complainants on its performance against the customer service standards.

2.49 As a result of this audit we have identified some concerns about the NMC's standard letters and processes. The NMC does not routinely disclose to the registrant that their case is being referred to an investigating committee meeting until the meeting has been scheduled. We are concerned that this is unfair, as this information is generally shared with the complainant at an earlier stage of the process. The NMC say that this process is under review and is likely to change in autumn 2011 when it will begin a process of referring cases back to employers for consideration. The NMC is also carrying out a review of its standard letters, and has agreed to consider changing its standard letters to:

- Remove the reference to the investigating committee being independent of the NMC

- Include the date of the referral when acknowledging the referral letter (currently the letter just says ‘thank you for your recent referral’) and
- Combine standard letters where possible to avoid more than one letter being sent on the same day providing different information.

Complaint handling

2.50 Effective and efficient complaint handling is important to the maintenance of public and professional confidence in a regulator. We note that the NMC has a corporate complaints process and that it also has a separate process used for complaints about its fitness to practise process. We note that in relation to the fitness to practise process, the standard letters that the NMC sends out notifying individuals of the decisions made by the screening team state how to make a complaint about any decision they are dissatisfied with. However, we have concerns about the consistency of the application of these processes.

2.51 We audited four cases where complaints about decisions made by the fitness to practise department were filed in the case management system, but there was no indication that any action was being taken to respond to the complaints. In three of the four cases, action has now been taken by the NMC

2.52 In another three cases, we saw that there were delays in responding to complaints. This appeared to have resulted from a miscommunication in one case (the complainant believed they had raised a complaint over the telephone, but the caseworker was waiting for a written complaint before taking action). In the other two cases the delays occurred as a result of NMC staff failing to follow up requests for legal advice. Action was only taken by the NMC once it was contacted by the complainant in one case, and following CHRE bringing the other case to its attention.

2.53 In another two cases we identified that the complainants had raised concerns about the decisions, following which the cases had been reviewed, reopened and subsequently closed. In one of these cases it appears that the complainant was only informed that the case had been reopened, and was never informed that it had been closed for a second time. In another case, it appears that the complainant was not told anything about the case being re-opened, reviewed and closed again.

2.54 In one complaint that was initially handled by the Chief Executive’s office, it appears that information was not shared with the fitness to practise department, which meant that an email from a complainant received no response. In the same case it appears that the NMC reopened a complaint, despite the practitioner involved no longer being on the NMC’s register (their registration had lapsed in 1988). It appears that the Chief Executive’s office did not check the practitioner’s status with the fitness to practise or registrations department before informing the complainant that this case would be re-opened. This does not reflect good customer service, and we would suggest that the NMC should consider how to improve communications between the Chief Executive’s office and other departments (including registrations and fitness to practise) in order to avoid a similar error occurring again.

3. Recommendations

3.1 We are aware that the NMC is taking action to address many of the concerns addressed in the report. We recognise the improvements that it has begun to make, particularly in identifying and prioritising serious cases. However, we recommend that the NMC urgently reviews all the issues raised in this report to ensure that its current action plans will address the weaknesses and the risks we have identified. By way of example only, we would expect the NMC to consider:

- Improving the timeliness of the information that it provides to complainants after initial receipt of their complaints and throughout the lifetime of each case
- Improving the robustness of its approach to information gathering and analysis
- Implementing checks to ensure:
  - that all risk assessments are consistently undertaken and recorded
  - the consistency and quality of its record keeping
  - the consistency of its complaint handling
  - that staff are appropriately tailoring standard letters to the circumstances of the case they are managing
  - improving the quality of its decision letters
  - improving internal case management to prevent delays in the progression of cases.
- We recommend that the NMC continues to provide quarterly updates to CHRE on the progress it is making to improve its fitness to practise processes.
- We also recommend that the NMC promptly rolls out a wider programme of internal quality assurance, so that it has information on which to benchmark its performance outside of CHRE's reviews.

4. Annex 1: Fitness to practise casework framework – a CHRE audit tool

4.1 The purpose of this document is to provide CHRE with a standard framework as an aid in reviewing the quality of regulators' casework and related processes. The framework will be adapted and reviewed on an ongoing basis.

Stage specific principles

Stage	Essential elements
Receipt of information	• There are no unnecessary tasks or hurdles for complainants/informants • Complaints/concerns are not screened out for unjustifiable procedural reasons • Provide clear information • Give a timely response, including acknowledgements • Seek clarification where necessary.
Risk assessment	*Documents/tools* • Guidance for caseworkers/decision makers • Clear indication of the nature of decisions that can be made by caseworkers and managers, including clear guidance and criteria describing categories of cases that can be closed by caseworkers, if this applies • Tools available for identifying interim orders/risk. *Actions* • Make appropriate and timely referral to Interim Order panel or equivalent • Make appropriate prioritisation • Consider any other previous information on registrant as far as powers permit • Record decisions and reasons for actions or for no action • Clear record of who decided to take action/no action.

Stage	Essential elements
Gathering information/ evidence	*Documents/tools* • Guidance for caseworkers/decision makers • Tools for investigation planning. *Actions* • Plan investigation/prioritise time frames • Gather sufficient, proportionate information to judge public interest • Give staff and decision makers access to appropriate expert advice where necessary • Liaise with parties (registrant/complainant/key witnesses/employers/other stakeholders) to gather/share/validate information as appropriate.
Evaluation/decision	*Documents/tools* • Guidance for decision makers, appropriately applied. *Actions* • Apply appropriate test to information, including when evaluating third party decisions and reports • Consider need for further information/advice. • Record and give sufficient reasons • Address all allegations and identified issues • Use clear plain English • Communicate decision to parties and other stakeholders as appropriate • Take any appropriate follow-up action (eg warnings/advice/link to registration record).

Overarching principles

Stage	Essential elements
Protecting the public	• Every stage should be focused on protecting the public and maintaining confidence in the profession and system of regulation.
Customer care	• Explain what the regulator can do and how, and what it means for each person • Create realistic expectations. • Treat all parties with courtesy and respect • Assist complainants who have language, literacy and health difficulties. • Inform parties of progress at appropriate stages.
Risk assessment	• Systems, timeframes and guidance exist to ensure ongoing risk assessment during life of case • Take appropriate action in response to risk.
Guidance	• Comprehensive and appropriate guidance and tools exist for caseworkers and decision makers, to cover the whole process • Evidence of use by decision makers resulting in appropriate judgements.
Record keeping	• All information on a case is accessible in a single place. • There is a comprehensive, clear and coherent case record • There are links to the registration process to prevent inappropriate registration action • Previous history on registrant is easily accessible.
Timeliness and monitoring of progress	• Timely completion of casework at all stages • Systems for, and evidence of, active case management, including systems to track case progress and to address any delays or backlogs.

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1 Introduction

1.1 In November 2011, the Council for Healthcare Regulatory Excellence (CHRE) published its report on its audit of the Nursing and Midwifery Council's (NMC) initial stage fitness to practise process.

1.2 It has been HPC's practice to look at possible learning points from CHRE's audits of other health regulators as part of its commitment to continuous business improvement and internal quality assurance scrutiny. This paper looks at the recommendations made by the CHRE with regards to the work of the NMC and makes proposals as to how the HPC can ensure its fitness to practise processes remain robust, efficient, effective and fit for purpose.

2 Detailed findings

2.1 CHRE's detailed findings are set out from section 2 of its report. A detailed analysis of the issues that relates to the HPC, are set out below.

2.2 Receipt of initial information stage

2.2.1 At point 2.1of their report, CHRE reference complainants encountering unnecessary tasks or obstacles in making a compliant. A summary of the mechanisms already in place at HPC to reduce any obstacles and to make the fitness to practise process as accessible as possible are as follows:

- Clear publications setting out the process
- Clear information on the HPC website about how to contact HPC and the types of cases we can consider
- Publication of an Easy Read brochure
- Ability for someone to make a complaint over the phone or in person where they are unable to put this in writing
- A 'raising a concern' form which sets out the information needed in order for an allegation to be made
- A clear policy document setting out the standard of acceptance for allegations (due to be considered by the Council at its meeting in December 2011)

2.2.1 The Executive will undertake the following work in the coming months to ensure that processes and training remain up to date:

- Review the advice given by Case Managers to complainants on the phone and the feasibility of a script for responses to some common questions or FAQ's
- Review the operating guidance for Case Managers on taking complaints over the phone and in person and incorporate this into the programme of workshops. A review of all operating guidance is underway in any event to ensure their compatibility with the new case management system
- Provide customer service training to the whole department in 2012-13. This has been incorporated into the draft budget for the next financial year

2.2.2 In addition to measures above, the Executive are also reviewing how to ensure cases that require an additional level of time or effort to progress are appropriately managed. This also includes providing support to those complainants who require an additional level of support in setting out their concerns.

2.2.3 At paragraph 2.2 of their report, CHRE make reference to the timeliness of the information provided by the NMC to complainants after the NMC's receipt of the complaint. Further concern has been raised about the extent to which the NMC seeks appropriate clarification from complainants about information they have provided. Detail is provided on this later in this report.

2.3 Risk assessment

2.3.1 At paragraphs 2.3 to 2.14 of their report, CHRE highlight concerns with regards to the NMC's risk assessment processes. HPC's risk assessment processes provide that a risk assessment is undertaken on initial receipt of a case and then on receipt of new material to determine whether it is appropriate to apply for an interim order. Copies of all risk assessments are retained on the individual case file. The completion of risk assessments forms part of the internal case file audit that is undertaken.

2.3.2 The Executive propose that the existing process of risk assessment continues. The Executive also suggest that as well as continuing with the case audit process already in place, a sample of cases are reviewed to specifically assess the quality of the information provided by the Case Managers on the forms to ensure consistency and quality.

2.3.3 With the introduction of the new case management system, all cases will have an automatic action attached on creation requiring the Case Manager to conduct a risk assessment. It is anticipated that it will be possible to produce reports on the number of risk assessment actions have been applied to each case in order to monitor its use.

2.3.4 Paragraph 2.10 of the CHRE report references a number of cases that were closed by the NMC without following up on information. When closing any case without a panel decision, the HPC process provide that there are two signatures on the closure form (one of which must be a manager) and legal advice sought where necessary. In light of criticism by CHRE of the NMC decision making in this instance, the Executive plan to review the content of the operating guidance in this area to ensure it is sufficiently detailed.

2.3.5 At paragraph 2.13 of the CHRE report, there is reference to a temporary employee adapting the risk assessment process. The Executive has considered the need for consistency and to ensure that all employees follow guidance and policy. This will be a particular challenge in the coming year with what is expected to be an increase in the number of employees within the department to manage the social worker transfer and also the introduction of the new case management system. Mechanisms are in place to ensure appropriate induction and training of new employees. Each role has an induction programme and list of training requirements. Specific sign off is required of certain competencies before the employee can work autonomously. The induction and training programme will be reviewed in light of the new case management system.

2.3.6 At paragraph 2.14 of their report, CHRE refer to a case where the NMC had not applied for an interim order in a case under investigation by the police where there was not yet a conviction. The HPC consider any such allegation under the misconduct ground of the Health Professions Order 2001 to allow an application for an interim order to be made while the police conclude their investigation. The seriousness of the issues under investigation is always considered in the initial and on-going risk assessment and consideration given to the need to make an interim order application.

2.4 Gathering information

2.4.1 Between paragraphs 2.15 and 2.24 of their report, CHRE set out their findings in relation to the approach the NMC takes towards gathering the right information in the course of a fitness to practise investigation. This

section highlights a number of potential areas of development for the HPC. The reports breaks this section down into separate headings, referred to below. As a general area of further improvement that the Executive proposes to review, is the use of registrant assessors to provide clinical advice at the early stages of the investigation. There is already a provision for this in our processes, however, this is one area in which the Executive consider further guidance and training for Case Managers could assist in ensuring a robust and effective investigation.

2.5 Over-reliance of other organisation's investigations

2.5.1 Reference is made to the closure of cases where the police have not pursued criminal charges. As referred to in paragraph 2.3.4 above, the HPC closure process requires two signatures and management approval. In cases where a police investigation has been undertaken, the Case Manager will undertake an assessment of viability of evidence provided by the police and determine whether HPC should pursue a fitness to practise allegation.

2.6 Failing to obtain all the relevant information necessary to make a robust evidence based decision

2.6.1 The report makes reference to the NMC's new approach of undertaking routine Police National Computer (PNC) checks in all cases where the registrant has been convicted of a criminal offence. In the particular case CHRE reference, there were concerns of a pattern of behaviour by the registrant. HPC does not routinely request a PNC check for other convictions where we are made aware of a conviction. The Executive propose to review this approach. A proportionate approach needs to be taken in such cases and the review will take this into account.

2.6.2 A further reference is made to a case where the NMC failed to contact a current employer to determine whether there were any on-going concerns. The nature of the allegation is not clear from the report, or what information the current employer may have been able to provide. The majority of cases that HPC considers are misconduct allegations where the registrant's current conduct may not impact on the investigation, but may form part of any mitigation they wish to present. Equally there are occasions where current information about the registrant's performance or conduct would be relevant, particularly if the Investigating Committee were minded to close the case.

2.6.3 The HPC, as a matter of routine, asks the registrant to provide the contact details of any employer or anyone they provide services to. They are required to provide this information under the Health Professions Order 2001, however where no information is provided it can be difficult to

confirm whether there is an employer HPC has not been made aware of. The standard letter in this area will be reviewed to ensure it is sufficiently clear to the registrant that they must provide this information, and also that we may need to use the information to contact their current employer.

2.7 Failing to consider each aspect of the complaint made

2.7.1 At paragraph 2.18, the report refers to cases in which the NMC failed to properly investigate or particularise allegations. It is important that enough time is allocated to Case Managers to review information thoroughly to ensure that all issues are identified and followed up. The forecasting model currently in use by HPC provides for each case manager to handle 38 pre Investigating Committee cases at any one time.. The Executive will continue to review this ratio when preparing forecasts and planning workloads.

2.7.2 The Investigating Panel also has a role in reviewing the documentation gathered and determining whether any amendments should be made to the allegation, or any further lines of enquiry pursued. This is incorporated into the training provided to new and existing panel members. The case to answer practice note, has also been amended to further highlight to the panel, their role in amending allegations and ensuring that all relevant points are covered.

2.8 Failing to clarify details contained either within the complaint or the evidence

2.8.1 The CHRE report raises concern about the premature closure of cases. It appears that cases are closed prior to being considered as an allegation, as the NMC does not have the powers to undertake a thorough investigation. This differs from the way in which HPC undertakes the management of cases. Each case is managed by a Case Manager and additional information is sought, even where on receipt the case does not meet the standard of acceptance. Although the Case Manager cannot utilise Article 25 of the Health Professions Order 2001 (ability to demand information), it is possible to obtain enough information to either decide that the case does not meet the standard of acceptance, or that it is a fitness to practise allegation.

2.8.2 If a case is received where the issues raised are not matters that can be considered by HPC, Case Managers are expected to consider referring the case to an alternative body. Operating guidance is available on signposting giving details of appropriate organisations. The Executive propose to review the case closure form completed by case managers to ensure consideration is given to need (or not) to refer the case to another body.

2.8.3 The Executive also undertakes an internal audit of closed cases. The Executive are also in the process of further developing quality assurance processes.

2.8.4 The CHRE report also refers to sharing the registrant's response to the allegation with the complainant. On receipt of the registrant's response, Case Managers are required to thoroughly review the response to determine whether any further information is required. This is always an area in which further training and guidance can be provided and this will be incorporated as an on-going area of training for the Case Managers.

2.9 Links between fitness to practise and registration databases

2.9.1 At paragraph 2.22 of their report, CHRE highlight concerns that an individual was allowed to re-join the NMC register without previous allegations being investigated. The HPC's Net Regulate system has functionality to flag up applicants where potential concerns about fitness to practise have been raised prior to their entry to the register, or while their registration has lapsed.

2.9.2 The Executive undertakes monthly audits of closed miscellaneous enquiries to the HPC which includes checks to ensure that individuals have been added to the watch-list where appropriate. In the course of reviewing the quality assurance framework, the Executive will look to enhance the current auditing procedures in place to ensure that there are no areas of weakness.

2.9.3 In addition, the new case management system will have the functionality to prevent a new case being logged unless the individual has a fitness to practise status on Net Regulate. Currently a monthly audit of all individuals with fitness to practise statuses on Net Regulate is undertaken to ensure the accuracy of those statuses and to assist in reconciling any discrepancies.

2.10 Evaluation and giving reasons for decisions

2.10.1 Between paragraphs 2.25 and 2.28 of the report, CHRE focus on decision making and reasoning and the way in which this is documented and explained.

2.10.1 At paragraph 2.25 of the report CHRE highlight the importance of providing detailed reasons for decisions reached by employees or by the Investigating Committee. The importance of providing reasons remains a focus at all panel training sessions where recent case studies are used to highlight any areas of weakness. A workshop was held for Case

Managers in September 2011 on audit learning which included the importance of file notes and documenting reasons for decisions made. In addition, case closure forms must be completed with detailed reasons before a case is closed prior to consideration by the Investigating Committee. Improvements have been made in the drafting of panel decisions at final hearings in recent years and it is important to ensure that administrative decisions are also well explained. The Executive intends to continue to review this area and include this specifically within the quality assurance framework.

2.10.2 At paragraph 2.26 of their report, CHRE identified weaknesses in the explanations provided for decisions to close cases by both the investigating committee and NMC staff without referral to the Investigating Committee. The Executive undertook a comprehensive review of all the fitness to practise standard in the autumn of 2010. Additional optional paragraphs were added to a number of letters to assist in tailoring and adapting letters appropriately depending on the circumstances of the case. Audits of closed cases that did not proceed to investigating committee and a sample of no case to answer decisions are undertaken on a monthly basis. The Executive intends to continue to review this area as part of its quality assurance process.

2.10.3 A further review of all letters is due to be undertaken in any event to coincide with the HPC's name change. As part of that project the HPC will be developing a glossary of common terms across the organisation which will help to ensure consistency not only in FTP letters but across the organisation.

2.10.4 At paragraph 2.28 of their report, CHRE raise concerns about the public protection impact of the failure of the NMC's Investigating Committee to close a case that was subsequently closed by a 'pre-meeting' of a Conduct and Competence committee who had exactly the same information as the Investigating Committee. There is always a risk that panels may come to different conclusions based on the same information.

2.10.5 The Council has approved the use of the discontinuance process that allows allegations to be discontinued where there is no realistic prospect of the HPC being able to prove its case. All discontinuance hearings are held in public and cases should ordinarily be identified at an early stage following referral by the Investigating Committee and always following further investigations. Regular refresher training, the use of practice notes and partner newsletters assists with ensuring consistency in decision-making.

2.11 Case Management

2.11.1 Paragraph 2.29 to 2.42 of the CHRE report discusses a number of elements of case management.

2.12 Timeliness

2.12.1 At paragraph 2.30 of their report, CHRE highlight that delays in the progression of cases are not in the interests of any parties involved in a case. The HPC already has various measures in place to ensure cases are progressed expeditiously such as regular case review meetings between Case Managers and their Lead, monthly audits of case files at pre Investigating Committee stage and statistical reporting on the length of time cases take to progress through the process.

2.12.2 Case progression conferences are scheduled to begin in January 2012. At these conferences there where there will be a review of the investigation to date, discussions about any reasons for delay and recommendations about the future progression of the case. The Executive is also reviewing the practice note on concurrent proceedings and recent case law to assist in this area and prevent unnecessary delays where appropriate.

2.12.3 At paragraph 2.32 of their report, CHRE highlight concerns regarding external and internal management and oversight of investigations. The Executive is also in the progress of reviewing its service level agreement with HPC's legal services providers to ensure there is robust management and oversight the work undertaken. Furthermore, with an increasing number of employees the Executive will ensure that there are good case handover processes and documentation in place.

2.13 Record Keeping

2.13.1 At paragraph 2.36 of their report, CHRE raise concerns about the general quality of the NMC's case records, including discrepancies between paper and electronic records, missing documentation, documents being filed to the wrong case and basic administrative errors. HPC has operating guidance on the subject of file maintenance. The current audit process undertaken by HPC also includes checks to ensure that documentation on paper and electronic files matches, checks are also undertaken at any manager sign off stage.

2.13.2 The introduction of the new case management system will see a move to an entirely paperless process with a more structured process in place with

regards to the receipt and scanning of documentation to include basic actions such as ensuring date stamping of documents

2.14 Customer Service

2.14.1 Paragraphs 2.43 to 2.49 of the CHRE report addresses concerns around the quality of customer service provided to those involved in FTP proceedings. There are concerns that weakness in this area could indicate a lack of oversight of the output from caseworkers at the NMC.

2.14.2 The report references a number of cases at paragraph 2.44 where significant delay has occurred. The way in which HPC addresses and ensures delay does not occur in cases is set out previously in this report

2.14.3 CHRE raise concerns about confidentiality in paragraphs 2.45 and 2.46 of the report. The FTP Department implemented operating guidance in relation to confidentiality and information security in August 2011. The team are aware of the consequences of errors and that any issues must be referred to a manager within the department. Where issues have arisen they have been thoroughly investigated and on where it was necessary referred to relevant bodies such as CHRE and the Information Commissioner were informed.

2.14.4 At paragraph 2.48 of the CHRE report, reference is made to the service standards in place at the NMC and the training that has been provided to employees in relation to these. The HPC is currently reviewing the service standards relevant to the FTP function as part of the 2011-12 work- plan.

2.15 Complaint handling

2.15.1 Specific reference is made within the report to the way in which the NMC handle complaints about the FTP process and the inconsistency in this area. The HPC has a process for managing complaints about process and customer service issues. This is managed through the Operations Directorate. It can sometimes be difficult to disentangle complaints about process as they are often included in the course of a letter that contains other information relevant to the investigation or are not obviously about the way the HPC has managed the case rather than general dissatisfaction about the outcome of a case. The Executive is looking at better ways such issues can be managed, logged and monitored and will be reviewed as part of the quality assurance programme.

3 Action for the HPC

3.1 Highlighted throughout this report is a list of activity that the Executive proposes to undertake to improve HPC's fitness to practise processes. That activity is repeated here for ease of reference:

- Review the operating guidance for Case Managers on taking complaints over the phone and in person and incorporate this into the programme of workshops
- Complete the review of all operating guidance to ensure compatibility with the new case management system
- Provide bespoke customer service training to the whole department in 2012-13
- Review a sample of cases to specifically assess the quality of the information provided by Case Managers on risk assessment forms to ensure consistency and quality
- Review the content of the operating guidance provided to case managers on closing cases ensure it is sufficiently detailed
- Review guidance and training provided to Case Managers on the use of Registrant Assessors
- Review the induction and training programme in light of the new introduction of the new case management system and the anticipated increase in headcount
- Review the current policy of not routinely requesting a PNC check for other convictions
- Review the standard letter requesting that the registrant provides detail of their current employer
- Keep under review the ratio of cases per case manager when planning forecasts and preparing workloads
- Review the case closure form completed by Case Manager
- Provide further training and guidance to Case Managers on requesting further information on receipt of a registrant's response to the Investigating Committee Panel
- Review and enhance the current quality assurance frameworks to improve existing audit processes

- Review the practice note on concurrent proceedings
- Complete the review of service level agreement with legal services providers
- Review and enhance case handover documentation

4 Decisions

4.1 The Council is asked to agree to the actions set out at paragraph 3 and order the Executive to the Fitness to Practise Committee in February 2012 to update on the progress made.