hcpc health & care professions council

1 April 2013 to 31 March 2014

# Fitness to practise annual report 2014

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# Executive summary

Welcome to the eleventh fitness to practise annual report of the Health and Care Professions Council (HCPC) covering the period 1 April 2013 to 31 March 2014. This report provides information about the HCPC's work in considering allegations about the fitness to practise of HCPC registrants.

In the last twelve months, there has been a further increase in the number of fitness to practise complaints compared to previous years. 2,069 new concerns were raised, an increase of 25 per cent on the previous year.

The number of individuals on our Register also increased in the last year by four per cent. Despite this increase, the number of fitness to practise cases remains low, with only 0.64 per cent of registrants (or 1 in 160) being the subject of a new concern in 2013–14. This compares to 0.53 per cent in 2012–13.

This year saw an increase in the number of complaints that were made by members of the public. We also saw an increase (in percentage and volume) in the number of complaints that were closed without referral to a final hearing. We are looking at why this is the case and at ways in which we can develop understanding of the regulatory process for those who interact with it. We are also developing our guidance for employers on how to raise a concern with us.

Concluded case numbers also increased this year, with 25 per cent more cases concluded at our Investigating Committee when compared with 2012–13. For these cases, the case to answer rate decreased from 58 to 53 per cent.

The 'case to answer' rate for 2013–14 does not include cases where further information was requested by the panel, or where the case was closed because it did not meet the Standard of acceptance. If those cases were taken into account, the percentage of 'case to answer' decisions would reduce in relation to the total number of cases that were considered at Investigating Committee Panels (ICP) during 2013–14. The case to answer rate is therefore 22 per cent, when taking into account all cases closed at, or prior to, ICP stage.

We held 267 final hearings in 2013–14, an increase of 17 per cent on the previous year. Our rate of 'not well founded' cases was 22 per cent, which is similar to the previous year. 74 per cent of final hearings were well founded, with 25 per cent having a caution or condition imposed, 41 per cent having a suspension or striking off order, and eight per cent having removal by consent.

We have continued to progress the cases that were transferred from the General Social Care Council. We have concluded most of the investigations, with only four cases still under investigation as of 31 March 2014. For those considered by our Investigating Committee to have a case to answer, we aim to conclude the remaining 19 scheduled hearings before autumn 2014. We have included a section in this report on the outcomes of the transferred cases.

We continue to look at ways to improve and develop our processes. In 2014–15 this will include looking at how we can improve the experience that individuals (be they complainant, registrant or witness) have with the fitness to practise process. We are working with Professor Zubin Austin, from the University of Toronto, and with colleagues at Picker Europe, into the possible causes behind disengagement in health and care professionals from their work.

As part of our continuing work engaging with stakeholders, we have started a review of the 'tone of voice' of our correspondence, as well as meeting regularly with registrants' representative bodies to discuss our ongoing process and guidance development work, and how they can contribute to this.

We were pleased that the Professional Standards Authority recognised that we met all of the required standards in their 2013–14 performance review, and continue to be an efficient and effective regulator. We will continue to address the issues associated with meeting the increasing challenges of managing cases in a timely manner.

I hope you find this report of interest. If you have any feedback or comments, please email me at ftpnoncaserelated@hcpc-uk.org

**Kelly Holder**
**Director of Fitness to Practise**

# Introduction

## About us (the Health and Care Professions Council)

We are the Health and Care Professions Council (HCPC), a regulator set up to protect the public. To do this, we keep a register of those who meet our standards for their training, professional skills and behaviour. We can take action if someone on our Register falls below our standards.

In the year 1 April 2013 to 31 March 2014 we regulated the following 16 professions.

— Arts therapists
— Biomedical scientists
— Chiropodists / podiatrists
— Clinical scientists
— Dietitians
— Hearing aid dispensers
— Occupational therapists
— Operating department practitioners
— Orthoptists
— Paramedics
— Physiotherapists
— Practitioner psychologists
— Prosthetists / orthotists
— Radiographers
— Social workers in England
— Speech and language therapists

Each of the professions we regulate has one or more 'protected titles' (protected titles include titles like 'physiotherapist' and 'operating department practitioner').

Anyone who uses a protected title and is not registered with us is breaking the law, and could be prosecuted. It is also an offence for a person who is not a registered hearing aid dispenser to perform the functions of a dispenser of hearing aids.

For a full list of protected titles and for further information about the protected function of hearing aid dispensers, please go to our website at www.hcpc-uk.org. Registration can be checked either by logging on to www.hcpc-uk.org/check or calling +44(0)845 300 6184.

## Our main functions

To protect the public, we:

— set standards for the education and training, professional skills, conduct, performance, ethics and health of registrants (the professionals who are on our Register);
— keep a register of professionals who meet those standards;
— approve programmes which professionals must complete before they can register with us; and
— take action when professionals on our Register do not meet our standards.

For an up-to-date list of the professions we regulate, or to learn more about the role of a particular profession, see www.hcpc-uk.org

## What is 'fitness to practise'?

When we say that a professional is 'fit to practise' we mean that they have the skills, knowledge and character to practise their profession safely and effectively. However, fitness to practise is not just about professional performance. It also includes acts by a professional which may affect public protection or confidence in the profession. This may include matters not directly related to professional practice.

## What is the purpose of the fitness to practise process?

Our fitness to practise process is designed to protect the public from those who are not fit to practise. If a professional's fitness to practise is 'impaired,' it means that there are concerns about their ability to practise safely and effectively. This may mean that they should not practise at all, or that they should be limited in what they are allowed to do. We will take appropriate actions to make this happen.

Sometimes professionals make mistakes that are unlikely to be repeated. This means that the person's overall fitness to practise is unlikely to be 'impaired.' People sometimes make mistakes or have a one-off instance of unprofessional conduct or behaviour. Our processes do not mean that we will pursue every isolated or minor mistake. However, if a professional is found to fall below our standards, we will take action.

## What to expect

If a concern about a professional is raised with us, you can expect us to treat everyone involved in the case fairly and explain what will happen at each stage of the process. Our processes are designed to protect members of the public from those who are not fit to practise, but they are also designed to ensure that we balance the rights of the registrant during any investigation or hearing. We will keep everyone involved in the case up-to-date with the progress of our investigation. We allocate a case manager to each case. They are neutral and do not take the side of either the registrant or the person who makes us aware of concerns.

Their role is to manage the case throughout the process and to gather relevant information. They act as a contact for everyone involved in the case. They cannot give legal advice. However, they can explain how the process works and what panels consider when making decisions.

## Raising a fitness to practise concern

Anyone can contact us and raise a concern about a registered professional. This includes members of the public, employers, the police and other professionals. You can find information about how to tell us about a fitness to practise concern in our brochure How to raise a concern, which can be found on our website at www.hcpc-uk.org/publications/brochures

## What types of case can the HCPC consider?

We consider every case individually. However, a professional's fitness to practise is likely to be impaired if the evidence shows that they:

- were dishonest, committed fraud or abused someone's trust;
- exploited a vulnerable person;
- failed to respect service users' rights to make choices about their own care;
- have health problems which they have not dealt with, and which may affect the safety of service users;
- hid mistakes or tried to block our investigation;
- had an improper relationship with a service user;
- carried out reckless or deliberately harmful acts;
- seriously or persistently failed to meet standards;
- were involved in sexual misconduct or indecency (including any involvement in child pornography);
- have a substance abuse or misuse problem;
- have been violent or displayed threatening behaviour; or
- carried out other, equally serious, activities which affect public confidence in the profession.

We can also consider concerns about whether an entry to the HCPC Register has been made fraudulently or incorrectly. For example, the person may have provided false information when they applied to be registered or other information may have come to light since, which means they were not eligible for registration.

## What can’t the HCPC do?

We are not able to:

- consider cases about professionals who are not registered with us;
- consider cases about organisations (we only deal with cases about individual professionals);
- deal with customer-service issues;
- arrange refunds or compensation;
- fine a professional;
- give legal advice; or
- make a professional apologise.

## Practice notes

The HCPC has a number of practice notes in place for the various stages of the fitness to practise process. Practice notes are issued by the Council for the guidance of Practice Committee Panels and to assist those appearing before them. New practice notes are issued on a regular basis and all current notes are reviewed to ensure that they are fit for purpose. All of the HCPC’s practice notes are publicly available on our website at www.hcpc-uk.org/publications/practicenotes

## Partners and panels

The HCPC uses the profession-specific knowledge of HCPC ‘partners’ to help carry out its work. Partners are drawn from a wide variety of backgrounds – including professional practice, education and management. We also use lay partners to sit on our panels.

Lay panel members are individuals who are not, and have never been, eligible to be on the HCPC Register. At least one registrant partner and one lay partner sit on our panels to ensure that we have appropriate public input and professional expertise in the decision-making process.

At every public hearing there is also a legal assessor. The legal assessor does not take part in the decision-making process, but gives the panel and the others involved advice on law and legal procedure, ensuring that all parties are treated fairly. Any advice given to panels is stated in the public element of the hearing. At HCPC hearings, the legal assessor does not sit with the panel. This step has been taken to signify their independence from the panel and their role in giving advice to all those who are in attendance at the hearing.

The HCPC’s Council members do not sit on our Fitness to Practise Panels. This is to maintain separation between those who set Council policy and those who make decisions in relation to individual fitness to practise cases. This contributes to ensuring that our hearings are fair, independent and impartial. Furthermore, employees of the HCPC are not involved in the decision-making process. This ensures decisions are made independently and are free from any bias.

# Cases received in 2013–14

This section contains information about the number and type of fitness to practise concerns received about registrants. It also provides information about who raised these concerns. A concern is only classed as an 'allegation' when it meets our Standard of acceptance for allegations.

The Standard of acceptance sets out the information we must have for a case to be treated as an allegation. As a minimum this information:

- must be in writing (fitness to practise concerns may also be taken over the telephone if a complainant has any accessibility difficulties);
- must include the professional's name; and
- must give enough detail about the concerns to enable the professional to understand those concerns and to respond to them.

The policy also recognises that, while concerns are raised about only a small minority of HCPC registrants, investigating them takes a great deal of time and effort. So it is important that HCPC's resources are used effectively to protect the public and are not diverted into investigating matters which do not give cause for concern. Where cases are closed we will, wherever we can, signpost complainants to other organisations that may be able to help with the issues they have raised.

Any case which does not yet meet the standard of acceptance is classed as an 'enquiry'. In these circumstances we will always seek further information. Many enquiries then become allegations once we have this additional information. The HCPC's Standard of acceptance for allegations policy explains our approach more fully. If additional information is not found to meet the Standard of acceptance, we have an authorisation process to close the case.

We continue to review this policy in light of the changing nature and volumes of our cases, and to ensure that it continues to provide a clear and understandable mechanism for progressing cases, with the resources required and the impact of parties involved in the complaint. For further information, please see the Standards of acceptance for allegations policy on our website at www.hcpc-uk.org/publications/policy

Table 1 shows the number of cases received in 2013–14 compared to the total number of professionals registered by the HCPC (as of 31 March 2014).

**Table 1 Total number of cases received in 2013–14**

| | Number of cases | Total number of registrants | % of registrants subject to complaints |
|---|---|---|---|
| 2013–14 | 2,069 | 322,021 | 0.64 |

The proportion of HCPC registrants who have had a fitness to practise concern raised about them has also increased slightly, from 0.53 per cent of all professionals on the Register in 2012–13 to 0.64 per cent in 2013–14. This still means that only about one in 160 registrants were the subject of a concern about their fitness to practise. It should be noted that in a few instances a registrant will be the subject of more than one case.

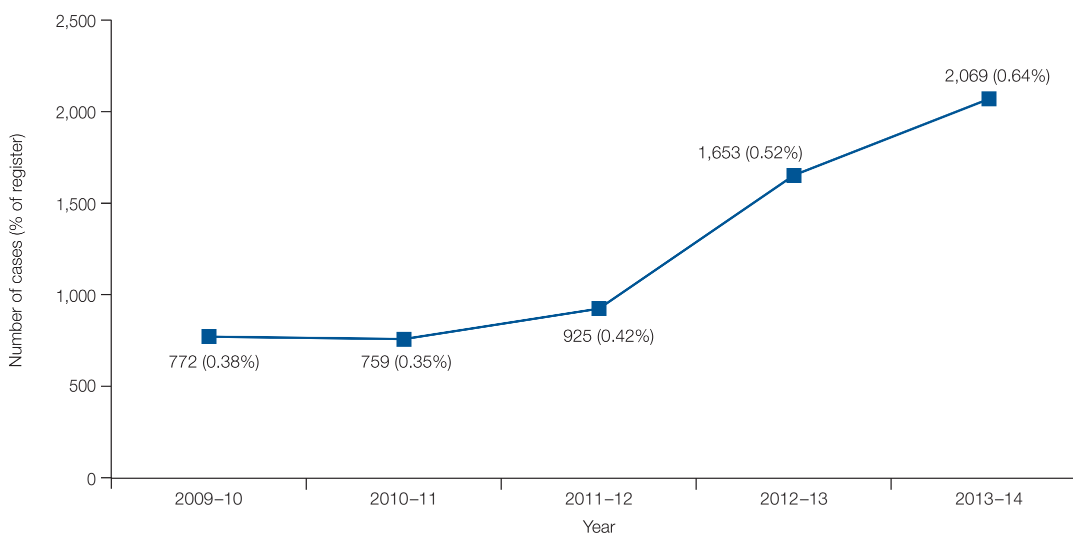
Compared to 2012–13 the number of cases received in 2013–14 increased by 25 per cent (in actual numbers, an increase of 416 cases). The number of professionals registered by the HCPC also increased over the same period, by around 4 per cent. However, we started regulating Social Workers in England on 1 August 2012, and so the increased number of registrants was in effect for only eight months in that year.

**Table 2 Total numbers of cases and percentage of Register**

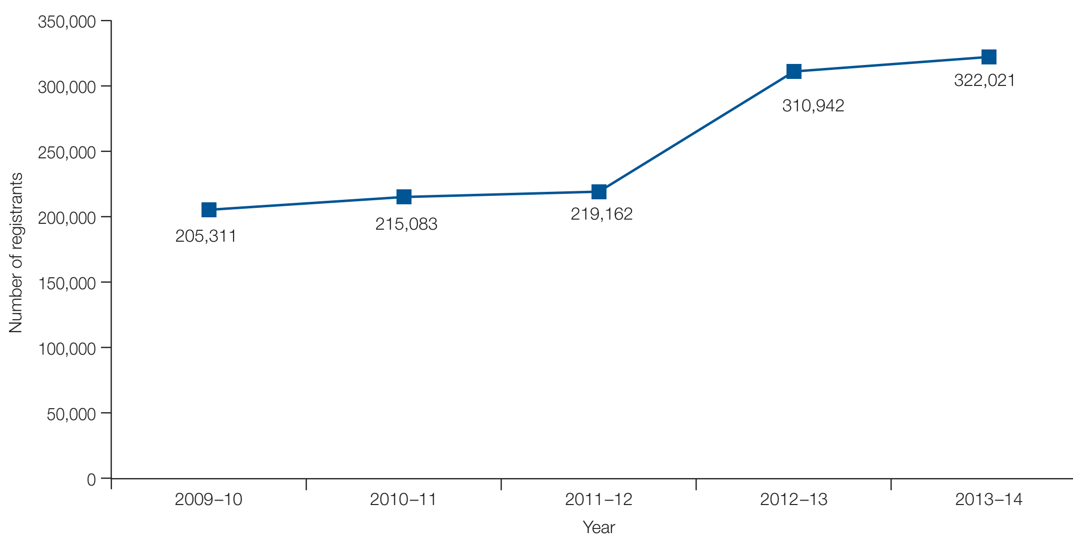
| Year | Number of cases | Number of registrants | % of register |
|---|---|---|---|
| 2009–10 | 772 | 205,311 | 0.38 |
| 2010–11 | 759 | 215,083 | 0.35 |
| 2011–12 | 925 | 219,162 | 0.42 |
| 2012–13 | 1,653 | 310,942 | 0.52 |
| 2013–14 | 2,069 | 322,021 | 0.64 |

Graphs 1a and 1b shows the number of fitness to practise concerns received between 2009–10 and 2013–14 compared to the total number of HCPC registrants.

**Graph 1a Number of fitness to practise cases received by year 2009–10 to 2013–14**




**Graph 1b Number of registrants on HCPC Register by year from 2009–10 to 2013–14**



## Cases by profession and complainant type

The following tables and graphs show information about who raised fitness to practise concerns in 2013–14 and how many cases were received for each of the professions the HCPC regulates. The total number of cases received in 2013–14 was 2,069.

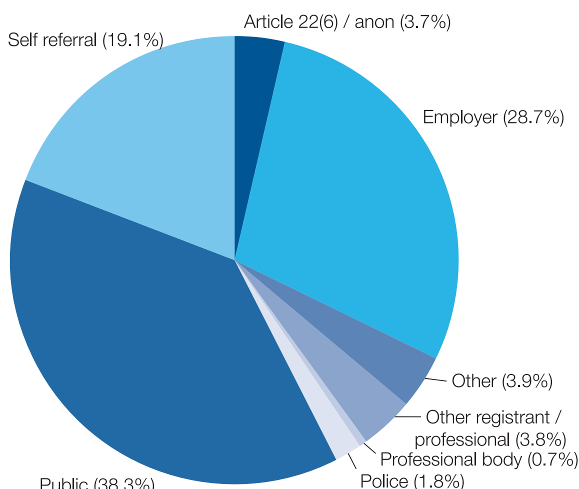
Table 3 provides information about the source of the concerns which gave rise to these cases. In 2013–14, as in 2012–13, members of the public were the largest complainant group, making up just over 38 per cent of cases.

In 2013–14 employers were the second largest source of concerns, comprising 29 per cent of the total. This has increased from the previous year when the proportion was 26 per cent.

**Table 3 Who raised concerns in 2013–14?**

| Who raised a concern | Number | % |
|---|---|---|
| Article 22(6) / anon | 77 | 3.7 |
| Employer | 593 | 28.7 |
| Other | 81 | 3.9 |
| Other registrant / professional | 78 | 3.8 |
| Professional body | 14 | 0.7 |
| Police | 37 | 1.8 |
| Public | 793 | 38.3 |
| Self referral | 396 | 19.1 |
| **Total** | **2,069** | **100** |

**Graph 2 Who raised concerns in 2013–14?**




## Article 22(6) of the Health and Social Work Professions Order 2001

Article 22(6) of the Health and Social Work Professions Order 2001 enables the HCPC to investigate a matter even where a concern has not been raised with us in the normal way (for example, in response to a media report or where information has been provided by someone who does not want to raise a concern formally). This is an important way we can use our legal powers to protect the public.

Article 22(6) is important in 'self-referral' cases. We encourage all professionals on the HCPC Register to self-refer any issue which may affect their fitness to practise. Standard 4 of the HCPC's Standards of conduct, performance and ethics states that 'You must provide (to us and any other relevant regulators) any important information about your conduct and competence'. All self-referrals are assessed to determine if the information provided suggests the registrant's fitness to practise may be impaired and whether it may be appropriate for us to investigate the matter further using the Article 22(6) provision.

### Table 4a Cases by profession and complainant type

| Profession | Article 22(6) / Anon | % | Employer | % | Other | % | Other registrant | % | Police | % | Professional body | % | Public | % | Self referral | % | Total cases per profession |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Arts therapists | 0 | 0 | 1 | 0.2 | 1 | 1.2 | 0 | 0.0 | 0 | 0 | 0 | 0 | 1 | 0.1 | 1 | 0.3 | 4 |
| Biomedical scientists | 2 | 2.6 | 20 | 3.4 | 2 | 2.4 | 3 | 3.8 | 0 | 0 | 1 | 7.1 | 4 | 0.5 | 18 | 4.5 | 50 |
| Chiropodists / podiatrists | 8 | 10.4 | 17 | 2.9 | 2 | 2.4 | 3 | 3.8 | 2 | 5.4 | 3 | 21.4 | 26 | 3.3 | 10 | 2.5 | 71 |
| Clinical scientists | 0 | 0 | 10 | 1.7 | 0 | 0 | 1 | 1.3 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0.5 | 13 |
| Dietitians | 2 | 2.6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 0.8 | 3 | 0.8 | 11 |
| Hearing aid dispensers | 1 | 1.3 | 2 | 0.3 | 1 | 1.2 | 1 | 1.3 | 0 | 0 | 1 | 7.1 | 15 | 1.9 | 1 | 0.3 | 22 |
| Occupational therapists | 2 | 2.6 | 41 | 6.9 | 5 | 6.1 | 2 | 2.6 | 3 | 8.1 | 1 | 7.1 | 23 | 2.9 | 28 | 7.1 | 105 |
| Operating department practitioners | 6 | 7.8 | 19 | 3.2 | 2 | 2.4 | 3 | 3.8 | 1 | 2.7 | 1 | 7.1 | 3 | 0.4 | 28 | 7.1 | 63 |
| Orthoptists | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2.7 | 0 | 0 | 0 | 0 | 1 | 0.3 | 2 |
| Paramedics | 13 | 16.9 | 62 | 10.5 | 4 | 5 | 13 | 16.7 | 6 | 16.2 | 1 | 7.1 | 32 | 4 | 134 | 33.8 | 265 |
| Physiotherapists | 2 | 2.6 | 33 | 5.6 | 7 | 8.5 | 8 | 10.3 | 8 | 21.6 | 0 | 0 | 58 | 7.3 | 18 | 4.5 | 134 |
| Practitioner psychologists | 3 | 3.9 | 18 | 3 | 9 | 11 | 10 | 12.8 | 1 | 2.7 | 2 | 14.3 | 100 | 12.6 | 14 | 3.5 | 157 |
| Prosthetists / orthotists | 0 | 0 | 1 | 0.2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0.1 | 0 | 0 | 2 |
| Radiographers | 2 | 2.6 | 27 | 4.5 | 3 | 3.7 | 0 | 0 | 3 | 8.1 | 0 | 0 | 9 | 1.1 | 15 | 3.8 | 59 |
| Social workers in England | 36 | 46.7 | 328 | 55.4 | 46 | 56.1 | 34 | 43.6 | 12 | 32.5 | 4 | 28.7 | 508 | 64.2 | 118 | 29.5 | 1,086 |
| Speech and language therapists | 0 | 0 | 13 | 2.2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 0.8 | 6 | 1.5 | 25 |
| **Total** | **77** | **100** | **592** | **100** | **82** | **100** | **78** | **100** | **37** | **100** | **14** | **100** | **792** | **100** | **397** | **100** | **2,069** |

The category ‘Other’ in Table 4a and Graph 2 includes solicitors acting on behalf of complainants, hospitals / clinics (when not acting in the capacity of employer), colleagues who are not registrants and the Disclosure and Barring Service, which notifies us of individuals who have been barred from working with vulnerable adults and / or children.

Table 4b provides information on the breakdown of cases received by profession and gives a comparison to the Register as a whole.

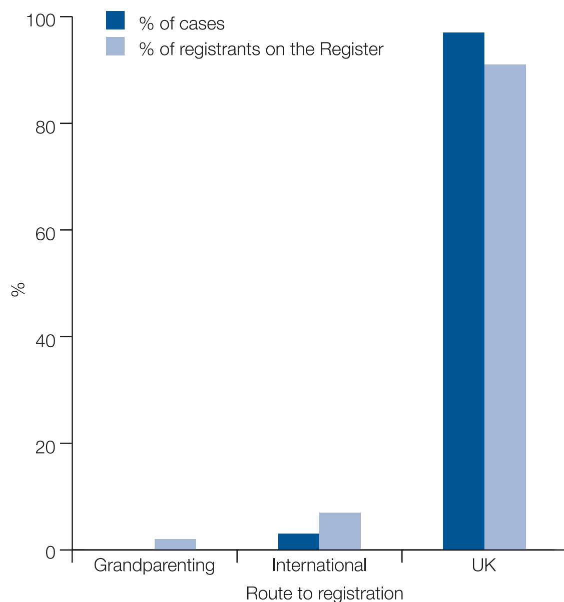
**Table 4b Cases by profession**

| Profession | Number of cases | % of total cases | Number of registrants | % of the Register | % of registrants subject to concerns |
|---|---|---|---|---|---|
| Arts therapists | 4 | 0.19 | 3,450 | 1.07 | 0.12 |
| Biomedical scientists | 50 | 2.42 | 21,904 | 6.8 | 0.23 |
| Chiropodists / podiatrists | 71 | 3.43 | 13,017 | 4.04 | 0.55 |
| Clinical scientists | 3 | 0.14 | 4,942 | 1.53 | 0.06 |
| Dietitians | 21 | 1.01 | 8,381 | 2.6 | 0.25 |
| Hearing aid dispensers | 22 | 1.06 | 2,010 | 0.62 | 1.09 |
| Occupational therapists | 105 | 5.07 | 34,154 | 10.61 | 0.31 |
| Operating department practitioners | 63 | 3.04 | 11,880 | 3.69 | 0.53 |
| Orthoptists | 2 | 0.10 | 1,316 | 0.41 | 0.15 |
| Paramedics | 266 | 12.86 | 20,097 | 6.24 | 1.32 |
| Physiotherapists | 134 | 6.48 | 48,868 | 15.18 | 0.27 |
| Practitioner psychologists | 157 | 7.59 | 19,919 | 6.19 | 0.79 |
| Prosthetists / orthotists | 2 | 0.10 | 948 | 0.29 | 0.21 |
| Radiographers | 59 | 2.85 | 28,060 | 8.71 | 0.21 |
| Social workers in England | 1085 | 52.45 | 88,946 | 27.63 | 1.22 |
| Speech and language therapists | 25 | 1.21 | 14,129 | 4.39 | 0.18 |
| **Total** | **2,069** | **100** | **322,021** | **100** | **0.64** |

## Cases by route to registration

Graph 3 shows the number of cases by route to registration and demonstrates a close correlation between the proportion of registrants who entered the HCPC Register by a particular route and the percentage of fitness to practise cases. Only three cases against 'grandparented' registrants were received in 2013–14, and the number of cases involving international registrants also fell from the previous year.

**Graph 3 Cases by route to registration 2013–14**




## Case closure

Where a case does not meet the Standard of acceptance, even after we have sought further information, or the concerns that have been raised do not relate to fitness to practise, the case is closed.

In 2013–14, 1,080 cases were closed without being considered by a panel of the HCPC's Investigating Committee, a 47 per cent increase compared to 2012–13 (where we closed 736 cases). In 2013–14, 607 cases (56%) that were closed in this way came from members of the public. In 2012–13, 347 of these cases (47%) were from the public.

In 2013–14, the average length of time for cases to be closed at this first closure point was a median average of four months and a mean average of five months.

This has increased by one month since the previous year and reflects the number of cases received from the public and the requirement to request further information in order to ensure that cases are closed appropriately.

These changes relate to the variation in the sources of complaints and the requirements of the Standard of acceptance, and the fact that we have received more complaints overall. For the cases where the source of the complaint was a member of the public, the mean and median closure time was four and three months respectively. For the same category of cases closed in 2013–14, the mean and median closure times had increased to five and four months respectively.

**Table 5 Length of time from receipt to closure of cases that are not considered by Investigating Committee**

| Number of months | Number of cases | Cumulative number of cases | % number of cases | Cumulative % of cases |
|---|---|---|---|---|
| 0 to 4 | 601 | 601 | 56 | 56 |
| 5 to 8 | 359 | 960 | 33 | 89 |
| 9 to 12 | 89 | 1,049 | 8 | 97 |
| 13 to 16 | 17 | 1,066 | 2 | 99 |
| 17 to 20 | 7 | 1,073 | 0.5 | 99.5 |
| over 20 | 7 | 1,080 | 0.5 | 100 |
| **Total** | **1,080** | **1,080** | **100** | **100** |

Table 6 provides information about the variation across the professions for cases that are closed without consideration by an Investigating Committee Panel.

There is a wide range of variation in these patterns of referral. For instance, social workers are the largest profession on the Register, and have the most concerns raised. This profession also has the largest number of cases that are closed because the concerns did not meet the Standard of acceptance.

Paramedics are the profession with the second largest number of concerns raised. Concerns about this group are the second largest to be closed, because they do not reach the Standard of acceptance.

Physiotherapists are the second largest profession, yet have a much lower rate of concerns raised than paramedics or social workers, and also have a lower rate of closure due to not meeting the Standard of acceptance.

**Table 6 Cases closed by profession before consideration at Investigating Committee**

| Profession | Number of cases | % of total cases |
|---|---|---|
| Arts therapists | 4 | 0.4 |
| Biomedical scientists | 11 | 1 |
| Chiropodists / podiatrists | 31 | 2.9 |
| Clinical scientists | 4 | 0.4 |
| Dietitians | 5 | 0.5 |
| Hearing aid dispensers | 15 | 1.4 |
| Occupational therapists | 42 | 3.9 |
| Operating department practitioners | 20 | 1.9 |
| Orthoptists | 1 | 0.1 |
| Paramedics | 156 | 14.4 |
| Physiotherapists | 46 | 4.3 |
| Practitioner psychologists | 110 | 10 |
| Prosthetists / orthotists | 1 | 0.1 |
| Radiographers | 28 | 2.6 |
| Social workers in England | 597 | 55.3 |
| Speech and language therapists | 9 | 0.8 |
| **Total** | **1,080** | **100** |

# Investigating Committee panels

The role of an Investigating Committee Panel (ICP) is to consider allegations made against registrants and to decide whether there is a 'case to answer'.

The Investigating Committee can decide that:

— more information is needed;

— there is a 'case to answer' (which means the matter will proceed to a final hearing); or

— there is 'no case to answer' (which means that the case does not meet the 'realistic prospect' test).

An ICP meets in private to conduct a paper-based consideration of the allegation. Neither the registrant nor the complainant appears before the ICP. The panel must decide whether or not there is a 'case to answer' based on the documents before it. The test that the panel applies when making its decision is the 'realistic prospect' test. The panel must decide whether there is a 'realistic prospect' that the HCPC will be able to establish that the registrant's fitness to practise is impaired.

The panel must be satisfied that there is a realistic or genuine possibility that the HCPC, which has the burden of proof, will be able to prove the facts alleged and, based upon those facts, that the panel hearing the case would conclude that:

— those facts amount to the statutory ground (eg misconduct); and

— the registrant's fitness to practise is impaired.

Only cases that meet all three elements of the 'realistic prospect' test can be referred for consideration at a final hearing. Panels must consider the allegation as a whole. Examples of 'no case to answer' decisions can be found on page 19.

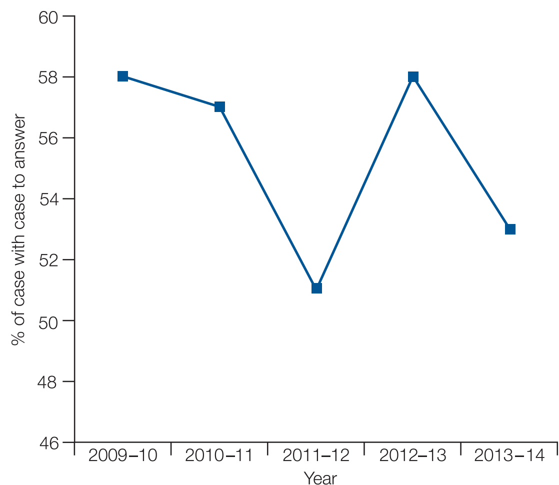
In some cases there may be information which proves the facts of a case. However, the panel may consider that there is no realistic prospect of establishing that the facts amount to the ground(s) of the allegation (eg misconduct, lack of competence etc). Likewise, panels may consider that there is sufficient information to provide a realistic prospect of proving the facts and establishing the ground(s) of the allegation but there is no realistic prospect of establishing that the registrant's fitness to practise is impaired. This could be because the incident that gave rise to the concern was an isolated lapse that is unlikely to recur, or there is evidence to show the registrant has taken action to correct the behaviour that led to the allegation being made. Such cases would result in a 'no case to answer' decision and the case would not proceed.

We continue to monitor the number of cases receiving a 'case to answer' decision at ICP stage and to refine the ICP decision-making process. In 2010–11, we introduced the use of 'learning points' as an additional tool available to ICPs. Learning points can only be used by ICPs in cases where the panel concludes that there is a realistic prospect of proving the facts and statutory ground of the allegation, but not fitness to practise impairment. The panel may include learning points or comments on other matters arising from the statutory ground of the allegation, which the panel considers should be brought to the attention of the registrant. Learning points must be general in nature and are designed to act as guidance only. The introduction of learning points is considered to help ensure that the fitness to practise process is proportionate and that matters are referred for consideration at a final hearing only when the 'realistic prospect' test is fully met. In 2013–14 ICPs issued learning points in nine cases.

There were 707 cases considered by an ICP in 2013–14. Of those cases, 25 were considered at ICP twice as panels had requested further information. This is an increase of 25 per cent from the 563 cases that went to an ICP in 2012–13.

Graph 4 shows the percentage of 'case to answer' decisions each year from 2009–10 to 2013–14. The 'case to answer' rate for 2013–14 is 53 per cent. This is down five per cent from 2012–13. This may in part be explained by the higher number of cases that were closed prior to being considered by an Investigating Committee in 2013–14, on the basis that they did not meet the HCPC's Standard of acceptance for allegations.

**Graph 4 Percentage of allegations with a case to answer decision**



## Decisions by Investigating Committee panels

### Table 7 Examples of no case to answer decisions

This table shows a range of professions that were considered at Investigating Committee. The examples describe the case as considered, and the decision of the panel with a brief rationale.

| Type of issue | Reason for no case to answer decision |
|---|---|
| It was alleged that a biomedical scientist's fitness to practise was impaired by reason of their health in that they had mental health issues. | The panel found that there was a realistic prospect of proving the facts and that the facts amounted to the statutory ground. However, the panel was not satisfied that there was a realistic prospect of a future panel finding current impairment because there was insufficient evidence to establish a connection between the registrant's health and his occasional employment issues. The registrant provided submissions to the panel to demonstrate that they had insight into their health issues, that they were seeking appropriate treatment and that they were engaging with occupational health in order to manage the condition. |
| It was alleged that a practitioner psychologist had produced an expert report based on only one assessment meeting with the family of a child. It was also alleged that the report made implicit criticisms of the family, and that the report was not impartial and that the registrant did not display empathy and rapport with the child's family. | The panel found that the registrant did only meet once with the family, but that this was not in itself sufficient to provide a realistic prospect of establishing ongoing impairment of fitness to practise.<br><br>The panel reviewed the information provided, including that provided by the registrant and the employer, and considered that the report produced was in fact competent and measured, and outlined the issues in an appropriate manner to assist the tribunal in its assessment. |
| The allegations related to a clinical scientist who did not maintain adequate records in relation to the storage of specimens and ensuring consistency between paper and electronic records. | The panel found that there was evidence to support the facts alleged. The panel benefitted from the registrant's comprehensive response to the allegation, from which the panel was satisfied that the failings noted were either not the registrant's responsibility or were matters the registrant was trying to address. The panel noted the information provided by the registrant's employer, which confirmed that although there were some general management failings, these cannot be said to be specifically the fault of the registrant.<br><br>The panel also noted that there was no detriment to the public as a result of any of the issues raised. |

| Type of issue | Reason for no case to answer decision |
|---|---|
| The allegations related to a number of failings around a dietitian's clinical reasoning, inaccurate assessment of the risk of re-feeding syndrome, poor record keeping and inaccurate calculation of nutritional requirements.<br><br>The registrant provided a submission in response to the allegation. | The panel found that there was a realistic prospect of proving the facts. However, the panel was not satisfied that there was a realistic prospect of establishing that the facts amounted to misconduct and / or lack of competence. In reaching its decision, the panel noted that the majority of the issues were relatively minor in nature and related to a two-month period in an otherwise unblemished clinical career. The panel noted that during the relevant time period the registrant was under strict supervision and dealing with difficult personal circumstances, which required them to seek medical assistance regarding stress. The panel took account of the registrant's work situation, in the time leading to the events in question, when they were working in an isolated environment as a lone practitioner. This was in a newly created dietetic post during which the registrant's supervisor was only available by telephone for advice and guidance.<br><br>The panel noted the registrant's detailed and considered response to the allegations, and in particular that they acknowledged some of their mistakes and expressed insight into their actions. The panel noted the positive reference provided by the registrant's current employer and found that there was not a realistic prospect of finding their current fitness to practise impaired. |
| It was alleged that a social worker had breached confidentiality by divulging details of a child that was protected by a Court Order, and that they had allowed the parent of the child to have access. | The panel were satisfied that the facts alleged were sufficient to provide a realistic prospect of establishing misconduct / lack of competence.<br><br>However, the panel did not consider that there was a realistic prospect that the registrant's fitness to practise was impaired by reason of this misconduct / lack of competence.<br><br>The panel noted that the issues related to a complex case, and that the registrant had offered significant mitigation for their actions. This included demonstrating how they had no knowledge of the contents of the Court Order, despite having requested access to the details.<br><br>The mitigation also included details of how the access to the child had been arranged with the grandparents of the child also present to assure safety.<br><br>The registrant had provided evidence of insight into the situation, and how they had reflected on their approach, as well as how they would behave in similar future situations.<br><br>The panel therefore found that there was no prospect of finding the registrant's fitness to practise currently impaired. |

| Type of issue | Reason for no case to answer decision |
| --- | --- |
| An occupational therapist self-referred a conviction for a drink driving offence. The registrant provided submissions in response to the allegation. | There was a realistic prospect of establishing the facts and grounds by virtue of the conviction certificate. However, the panel did not consider that there was a realistic prospect of finding that the registrant's fitness to practise was impaired by reason of the conviction.<br><br>In reaching its decision, the panel noted that this matter was a one off lapse in behaviour and that the incident did not occur during working hours. The panel was of the view that the registrant displayed insight and remorse in relation to the conviction via her submission. |
| It was alleged that an operating department practitioner did not complete a safety checklist upon receiving a patient, which resulted in the patient being wrongly anaesthetised. | The panel was satisfied that the realistic prospect test was met in relation to facts and grounds. However, it was not satisfied that there was a realistic prospect of a future panel finding that the registrant's fitness to practise was impaired.<br><br>In reaching its decision, the panel was assisted by submissions made by the registrant. The panel considered that the errors occurred as a result of systemic failings, which provided mitigating circumstances for the registrant's actions. The panel was also satisfied that the registrant had shown insight into his failings as demonstrated by the further learning undertaken since the incident giving rise to the allegations occurred. |
| A paramedic self-referred a fraud conviction for which they received a two-year conditional discharge. As per the HCPC's Practice note on convictions and cautions, any matter for which a registrant receives a conditional discharge must be alleged as misconduct. | The panel was satisfied that there was a realistic prospect of establishing the facts and that the facts, if proven, would amount to misconduct. However, the panel was not satisfied that there was a realistic prospect of finding impairment.<br><br>In reaching its decision, the panel noted that although this was a serious matter that had the potential to damage the reputation of, and public confidence in, the profession, the allegation related to an isolated incident regarding a personal / domestic setting and did not impact on the registrant's professional practice.<br><br>The panel issued a learning point reminding the registrant of the need to uphold professional standards in both their public and private life and to engage fully with the regulatory process. |

| Type of issue | Reason for no case to answer decision |
|---|---|
| It was alleged that a radiographer, during the course of x-raying a patient, did not communicate effectively (both prior to and during the x-ray) and did not offer the patient a chaperone. The facts were alleged in the alternative as misconduct and / or lack of competence. | The panel found that there was a realistic prospect of finding the facts and grounds.<br><br>However, the panel was not satisfied that the facts provided a realistic prospect of establishing the registrant's current fitness to practise was impaired<br><br>The panel was of the view that this was an isolated incident and noted that the registrant apologised to the patient.<br><br>The panel also noted that the registrant had undertaken 'lone worker' training and provided several positive references as to their competence and conduct.<br><br>The panel issued a learning point, reminding the registrant of the need to communicate clearly with patients, particularly when explaining each step of a procedure. |

## Case to answer decisions by complainant type

Table 8 shows the number of 'case to answer' decisions by complainant type. There continue to be differences in the case to answer rate, depending on the source of the complaint. Fitness to practise allegations received from professional bodies represent the highest percentage of 'case to answer' decisions, but are a small group. However, when combined, allegations raised by employers, professional groups (including the police), or from other registrants, have a case to answer rate of 67 per cent.

Cases referred anonymously, or by article 22(6), have a case to answer rate of 63 per cent, and self-referrals a rate of 46 per cent. Allegations from members of the public have a case to answer rate of 16 per cent. It should be noted that cases may not be considered in the same year in which they are received.

Employers are the second highest source of complaints. In 2013–14, they made 593 allegations against registrants. Of the 307 that were considered at ICP, 210 received a case to answer decision. This represents 68 per cent of those cases considered. In 2012–13, the figure from this complainant source was slightly higher at 73 per cent.

Members of the public are the largest complainant category but have the lowest case to answer rate. Of the 128 cases considered at ICP, 15 per cent received a 'case to answer' decision. This represents a four per cent decrease in the number of 'case to answer' decisions made in respect of concerns raised by members of the public since 2012–13.

**Table 8 Case to answer by complainant**

| Complainant | Number of case to answer | Number of no case to answer | Total | % case to answer |
|---|---|---|---|---|
| Article 22(6) / anon | 14 | 8 | 22 | 63.6 |
| Employer | 210 | 97 | 307 | 68.4 |
| Other | 14 | 3 | 17 | 82.4 |
| Other registrant / professional | 5 | 11 | 16 | 31.3 |
| Police | 14 | 7 | 21 | 66.7 |
| Professional body | 8 | 1 | 9 | 88.9 |
| Public | 20 | 108 | 128 | 15.6 |
| Self referral | 75 | 87 | 162 | 46.3 |
| **Total** | **360** | **322** | **682** | **52.8** |

## Case to answer decisions and route to registration

Table 9 shows that there is no difference in the proportions of cases that are considered case to answer, irrespective of the route to registration.

**Table 9 Case to answer and route to registration**

| Route to registration | Number of case to answer | % of allegations | Number of no case to answer | % of allegations | Total allegations | % of allegations |
|---|---|---|---|---|---|---|
| Grandparenting | 1 | 0.28 | 0 | 0.00 | 1 | 0.15 |
| International | 19 | 5.28 | 12 | 3.73 | 31 | 4.55 |
| UK | 340 | 94.44 | 310 | 96.27 | 650 | 95.3 |
| **Total** | **360** | **100** | **322** | **100** | **682** | **100** |

## Time taken from receipt of allegation to Investigating Panel

Table 10 shows the length of time taken for allegations to be put before an ICP in 2013–14. The table shows that 91 per cent of allegations were considered by a panel within eight months of receipt, from the point of meeting the Standard of acceptance. This is up from 2012–13, when 83 per cent of allegations were considered by an ICP within eight months of receipt. The mean length of time taken for a matter to be considered by an ICP is six months from receipt of the allegation and the median length of time is four months. This has improved by one month since 2012–13.

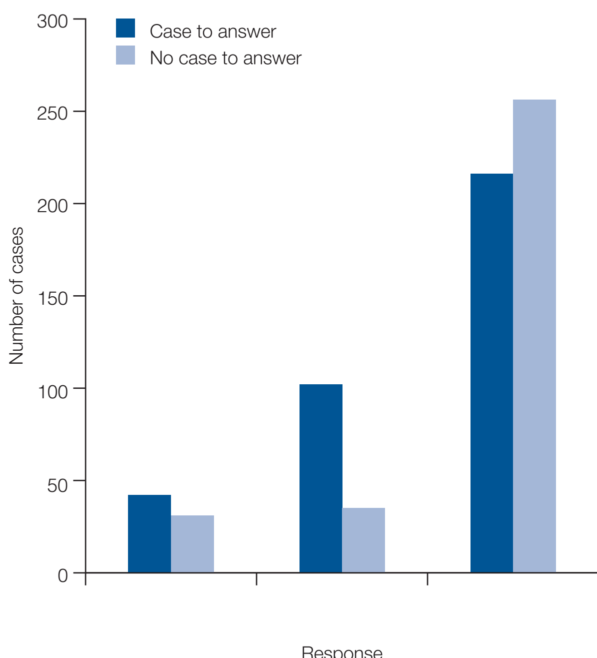
**Table 10 Length of time from receipt of allegation to Investigating Panel**

| Number of months | Number of cases | Cumulative number of cases | % of cases | Cumulative % cases |
|---|---|---|---|---|
| 1-4 | 475 | 475 | 69.6 | 69.6 |
| 5-8 | 142 | 617 | 20.8 | 90.4 |
| 9-12 | 34 | 651 | 5 | 95.4 |
| 13-16 | 12 | 663 | 8 | 97.2 |
| 17-20 | 8 | 671 | 2 | 98.4 |
| 21-24 | 6 | 677 | 9 | 99.3 |
| 25-28 | 3 | 680 | 5 | 99.8 |
| 29-32 | 0 | 680 | 0 | 99.8 |
| 33-36 | 1 | 681 | 0.1 | 99.9 |
| Over 36 | 1 | 682 | 0.1 | 100 |
| **Total** | **682** | **682** | **100** | **100** |

## Case to answer decisions and representations

Graph 5 provides information on 'case to answer' and 'no case to answer' decisions and representations received in response to allegations. In 2013–14, representations were made to the ICP by either the registrant or their representative in 80 per cent of the cases where a decision was made by a panel of the Investigating Committee. A total of 322 cases considered by an ICP resulted in a 'no case to answer' decision. Of this number, 89 per cent were cases where representations were provided. By contrast, only eleven per cent resulted in a 'no case to answer' decision being made where no representations were provided by the registrant or their representative.

**Graph 5 Representations provided to Investigating Panel**



# Interim orders

In certain circumstances, panels of our practice committees may impose an 'interim conditions of practice order' or an 'interim suspension order' on registrants, subject to a fitness to practise investigation. This power is used when the nature and severity of the allegation is such that, if the registrant remains free to practise without restraint, they may pose a risk to the public or to themselves. Panels will only impose an interim order if they are satisfied that the public or the registrant involved require immediate protection. Panels will also consider the potential impact on public confidence in the regulatory process, should a registrant be allowed to continue to practise without restriction whilst subject to an allegation. An interim order takes effect immediately and its duration is set out in the Health and Social Work Professions Order 2001. It cannot last for more than 18 months. If a case has not concluded before the expiry of the interim order, the HCPC must apply to the relevant court to have the order extended.

In 2013–14 we applied to the High Court for an extension of an interim order in five cases. All applications were granted and extended for up to twelve months.

An interim order prevents a registrant from practising, or places limits on their practice, whilst the investigation is ongoing and will remain until the case is heard or is lifted on review.

A practice committee panel may make an interim order to take effect either before a final decision is made in relation to an allegation, or pending an appeal against such a final decision. Case managers from the Fitness to Practise Department, acting in their capacity of presenting officers, present the majority of applications for interim orders and reviews of interim orders. This is to ensure resources are used to their best effect.

Table 11 shows the number of interim orders by profession and the number of cases where an interim order has been granted, reviewed or revoked. These interim orders are those sought by the HCPC during the management of the case processing. It does not include interim orders that are imposed at final hearings to cover the registrant's appeal period.

In 2013–14, 97 applications for interim orders were made. These 97 applications account for 4.6 per cent of the allegations being investigated. In 2012–13, the percentage was 2.4 per cent, with 2012–13 being the only other year since 2007–08 where the percentage was less than five.

Eighty five of those orders were granted and sixteen were not granted. Social workers in England and paramedics had the highest number of applications considered.

The number of interim order applications has increased each year, but the proportion of cases where an interim order is sought has remained steady. A breakdown since 2004–05 can be found in the historical statistics appendix.

The legislation we are governed by provides that we have to review an interim order six months after it is first imposed, and every three months thereafter. The regular review mechanism is particularly important given that an interim order will restrict or prevent a registrant from practising pending a final hearing decision. Applications for interim orders are usually made at the initial stage of the investigation; but a registrant may ask for an order to be reviewed at any time if, for example, their circumstances change or new evidence becomes available. In some cases an interim suspension order may be replaced with an interim conditions of practice order if the panel consider this will adequately protect the public. In 2013–14 there were three cases where an interim order was revoked by a review panel.

In 2013–14, the median time from receipt of a fitness to practise complaint to a panel considering whether an interim order was necessary was 15 weeks.

Where interim order applications are not made immediately on receipt of the complaint, the time difference between receipt and the panel consideration demonstrates that we do not always receive the total information about a registrant's practice at the initial stages, or that circumstances change during the investigation that warrant a later consideration.

We risk assess cases on receipt to help determine whether to apply for an Interim order. A further risk assessment is undertaken when new material is received during the lifetime of the case.

The average time from initial risk assessment to consideration of an interim order application by a panel is 18 days. In 2012–13, it was 19 days.

**Table 11 Number of interim orders by profession**

| Profession | Applications considered | Applications granted | Applications not granted | Orders reviewed | Orders revoked on review |
|---|---|---|---|---|---|
| Arts therapists | 1 | 0 | 1 | 0 | 0 |
| Biomedical scientists | 8 | 8 | 0 | 6 | 0 |
| Chiropodists / podiatrists | 2 | 2 | 0 | 6 | 0 |
| Clinical scientists | 0 | 0 | 0 | 0 | 0 |
| Dietitians | 1 | 1 | 0 | 2 | 0 |
| Hearing aid dispensers | 1 | 1 | 0 | 7 | 0 |
| Occupational therapists | 2 | 2 | 0 | 7 | 0 |
| Operating department practitioners | 8 | 8 | 0 | 18 | 0 |
| Orthoptists | 0 | 0 | 0 | 0 | 0 |
| Paramedics | 14 | 13 | 1 | 28 | 0 |
| Physiotherapists | 8 | 7 | 1 | 19 | 1 |
| Practitioner psychologists | 1 | 1 | 0 | 15 | 0 |
| Prosthetists / orthotists | 1 | 1 | 0 | 2 | 0 |
| Radiographers | 5 | 4 | 1 | 7 | 1 |
| Social workers in England | 43 | 36 | 7 | 43 | 1 |
| Speech and language therapists | 2 | 1 | 1 | 6 | 0 |
| **Total** | **97** | **85** | **12** | **166** | **3** |

# Public hearings

Two hundred and sixty seven final hearing cases were concluded in 2013–14, involving 265 registrants (two registrants had more than one allegation considered at their hearing). Hearings where allegations were well founded concerned only 0.06 per cent of registrants on the HCPC Register. A further 40 cases were listed for a hearing, but were adjourned or concluded part heard.

Hearings can be adjourned in advance administratively by the Head of Adjudication if an application is made more than 14 days in advance of the hearing. If the application is made less than 14 days before the hearing, the decision on adjournment is made by a panel. Hearings that commence but do not conclude in the time allocated are classed as part heard. 34 cases also had an additional preliminary hearing in order to seek a panel direction on a matter related to the case progression.

Cases that transferred from the General Social Care Council are not included in this section. Please see the separate section of the report for analysis of these cases.

Most hearings are held in public, as required by our governing legislation, the Health and Social Work Professions Order 2001.

Occasionally a hearing, or part of it, may be heard in private in certain circumstances.

The HCPC is obliged to hold hearings in the UK country of the registrant concerned. The majority of hearings take place in London at the HCPC's offices. Where appropriate, proceedings are held in locations other than capitals or regional centres, for example, to accommodate attendees with restricted mobility. In 2013–14, in addition to those in Belfast, Cardiff, Edinburgh and London, hearings took place in Aberdeen, Durham, Dundee, Glasgow, Manchester, Newcastle and Nottingham.

Table 12 illustrates the number of public hearings that were held from 2009–10 to 2013–14. It details the number of public hearings heard in relation to interim orders, final hearings and reviews of substantive decisions. Some cases will have been considered at more than one hearing in the same year, for example, if proceedings ran out of time and a new date had to be arranged.

**Table 12 Number of concluded public hearings**

| Year | Interim order and review | Final hearing | Review hearing | Restoration hearing | Article 30(7) hearing | Total |
|---|---|---|---|---|---|---|
| 2009–10 | 141 | 331 | 95 | 0 | 0 | 567 |
| 2010–11 | 171 | 404 | 99 | 2 | 1 | 677 |
| 2011–12 | 197 | 405 | 126 | 3 | 1 | 732 |
| 2012–13 | 194 | 228 | 141 | 1 | 1 | 565 |
| 2013–14 | 265 | 267 | 160 | 4 | 1 | 697 |

## Time taken from receipt of allegation to final hearing

Table 13 shows the length of time it took for cases to conclude, measured from the date of receipt of the allegation. The table also shows the number and percentage of allegations cumulatively as the length of time increases. These cases do not include those that were transferred from the General Social Care Council, but do include social worker cases that were referred directly to the HCPC after 1 August 2012. Details of these cases can be found in the General Social Care Council transfer cases section of this report.

The length of time taken for cases that were referred for a hearing to conclude was a mean of 17 and a median of 14 months from receipt of the allegation. In 2012–13 the mean average length of time was 16 months and the median average length of time was 14 months.

The length of hearings can be extended for a number of reasons. These include protracted investigations, legal argument, availability of parties and requests for adjournments, which can all delay proceedings. Where criminal investigations have begun, the HCPC will usually wait for the conclusion of any related court proceedings. Criminal cases are often lengthy in nature and can extend the time it takes for a case to reach a hearing.

**Table 13 Length of time from receipt of allegation to final hearing**

| Number of months | Number of cases | Cumulative number of cases | % of cases | Cumulative % cases |
|---|---|---|---|---|
| 0 to 4 | 1 | 1 | 0.37 | 0.37 |
| 5 to 8 | 21 | 22 | 7.87 | 8.24 |
| 9 to 12 | 95 | 117 | 35.58 | 43.82 |
| 13 to 16 | 49 | 166 | 18.35 | 62.17 |
| 17 to 20 | 26 | 192 | 9.74 | 71.91 |
| 21 to 24 | 26 | 218 | 9.74 | 81.65 |
| 25 to 28 | 16 | 234 | 5.99 | 87.64 |
| 29 to 32 | 12 | 246 | 4.49 | 92.13 |
| 33 to 36 | 10 | 256 | 3.75 | 95.88 |
| Over 36 | 11 | 267 | 4.12 | 100 |

In the last year, we have been further analysing the length of time cases take to conclude. We have:

- developed a risk-based reporting system to identify red, amber and green cases (where red cases require immediate, high level action; amber cases have an acceptable action plan, but fall outside of our service standards; and green cases are progressing without concern);
- assigned case escalation actions and dedicated owners for these cases, to ensure that they continue to progress through the process;
- weekly reporting and monitoring of trends in these cases;
- redirected existing case progression meetings to review and manage cases that are not progressing; and
- commissioned external review and analysis of our oldest cases, to identify any learning that can be applied to future cases.

We can now identify a number of triggers early in the stages of the case that can be used to predict the impact on the lifetime of the single case, and also the overall system. We have modelled a number of scenarios based on this data, and are currently looking at how this can be developed further.

**Table 14 Time taken to conclude cases at final hearing from 2010–11 to 2013–14**

| Year | Number of concluded cases | Mean time from allegation to conclusion (months) | Median time from allegation to conclusion (months) |
|---|---|---|---|
| 2010–11 | 315 | 15 | 14 |
| 2011–12 | 287 | 17 | 15 |
| 2012–13 | 228 | 16 | 14 |
| 2013–14 | 267 | 17 | 14 |

Table 15 sets out the total length of time to close all cases from the point the concern was received to case closure at different points in the fitness to practise process. In 2013–14, the total length of time for this combined group was a mean of eight months and a median average of five months.

In 2012–13, the total length of time for this combined group was a mean of nine months and a median average of six months.

This reduction in the overall mean and median values is related to the increase in the number of cases that are closed earlier in the process, due to not meeting the Standard of acceptance.

In 2013–14, there were 70 cases that took longer than 24 months to conclude. This accounted for four per cent of the total closures at all stages. In 2012–13, there were 28 cases that took over 24 months to conclude, or 2.3 per cent of all closures.

**Table 15 Length of time to close all cases from receipt of complaint, including those closed pre-ICP, those where no case to answer is found and those concluded at final hearing**

| Number of months | Number of cases | Cumulative number of cases | % of cases | Cumulative % of cases |
|---|---|---|---|---|
| 0 to 4 | 678 | 678 | 40.4 | 40.4 |
| 5 to 8 | 525 | 1,203 | 31.3 | 71.7 |
| 9 to 12 | 221 | 1,424 | 13.2 | 84.9 |
| 13 to 16 | 100 | 1,524 | 6 | 90.9 |
| 17 to 20 | 48 | 1,572 | 2.9 | 93.8 |
| 21 to 24 | 36 | 1,608 | 2.1 | 95.9 |
| 25 to 28 | 23 | 1,631 | 1.4 | 97.3 |
| 29 to 32 | 15 | 1,646 | 0.9 | 98.2 |
| 33 to 36 | 13 | 1,659 | 0.8 | 99 |
| Over 36 | 19 | 1,678 | 1 | 100 |
| **Total** | **1,678** | **1,678** | **100** | **100** |

## Days of hearing activity

Panels of the Investigating Committee, Conduct and Competence Committee and Health Committee met on 1,261 days in 2013–14 across the range of public and private decision making activities. Final hearings are usually held in public and are open to members of the public and other interested parties, including the press. In certain circumstances, such as to protect confidential health issues of either the registrant or witnesses, an application can be made to hold some or all of the hearing in private. Table 16 sets out the types of hearing activity in 2013–14.

Of these, 870 hearing days were held to consider final hearing cases. This includes where more than one hearing takes place on the same day. The number also includes cases that were part heard or adjourned.

Panels of the Investigating Committee hear final hearing cases concerning fraudulent or incorrect entry to the Register only. There was one case in 2013–14.

Panels may hear more than one case on some days to make the best use of time available. Of the 267 final hearing cases that concluded in 2013–14, it took an average of 3.6 days to conclude cases. This has increased slightly from 2012–13, when the average was 2.5 days and reflects the increasing complexity of cases, as well as the impact of cases that adjourned or went part heard and therefore had to resume at a later date.

**Table 16 Breakdown of public and private committee activity in 2013–14**

| Private meetings | | Public hearings | |
|---|---|---|---|
| **Activity** | **Number of days** | **Activity** | **Number of days** |
| Investigating Committee | 108 | Final hearings | 870 |
| Interim orders | 124 | Review of substantive sanctions | 101 |
| Registration appeals | 24 | | |
| Preliminary meetings | 34 | | |
| **Total** | **290** | **Total** | **971** |

## What powers do panels have?

The purpose of fitness to practise proceedings is to protect the public, not to punish registrants. Panels carefully consider all the individual circumstances of each case and take into account what has been said by all parties involved before making any decision.

Panels must first consider whether the facts of any allegations against a registrant are proven. They then have to decide whether, based upon the proven facts, the 'ground' set out in the allegation (for example misconduct or lack of competence) has been established and if, as a result, the registrant's fitness to practise is currently impaired. If the panel decide a registrant's fitness to practise is impaired they will then go on to consider whether to impose a sanction.

In cases where the ground of the allegations solely concerns health or lack of competence, the panel hearing the case does not have the option to make a striking off order in the first instance. It is recognised that in cases where ill health has impaired fitness to practise or where competence has fallen below expected standards, that it may be possible for the registrant to remedy the situation over time. The registrant may be provided the opportunity to seek treatment or training and may be able to return to practice if a panel is satisfied that it is a safe option.

If a panel decides there are still concerns about the registrant being fit to practise, they can:

— take no further action or order mediation (a process where an independent person helps the registrant and the other people involved agree on a solution to issues);

— caution the registrant (place a warning on their registration details for between one to five years);

— make conditions of practice that the registrant must work under;

— suspend the registrant from practising; or

— strike the registrant's name from the Register, which means they cannot practise.

In cases of incorrect or fraudulent entry to the Register, the options available to the panel are to take no action, to amend the entry on the Register or to remove the person from the Register.

In certain circumstances, the HCPC may enter into an agreement allowing a registrant to remove their name from the Register. The registrant must fully admit the allegation and, by signing, they agree to cease practising their profession. The agreement also provides that, if the person applies for restoration to the Register, their application will be considered as if they had been struck off. Agreements are approved by a panel at a public, but not contested, hearing.

Suspension or conditions of practice orders must be reviewed before they expire. At the review a panel can continue or vary the original order. For health and competency cases, registration must have been suspended, or had conditions, or a combination of both, for at least two years before the panel can make a striking off order. Registrants can also request early reviews of any order if circumstances have changed and they are able to demonstrate this to the panel.

## Outcomes at final hearings

Table 17 is a summary of the outcomes of hearings that concluded in 2013–14. It does not include cases that were adjourned or part heard. Decisions from all public hearings where fitness to practise is considered to be impaired are published on our website at www.hcpc-uk.org. Details of cases that are considered to be not well founded are not published on the HCPC website, unless specifically requested by the registrant concerned. A list of cases that were well founded is included in Appendix one of this report.

An analysis of the impact on the registrant's registration status shows that:

— 26 per cent were not well found;

— 48 per cent had a sanction that prevented them from practising (including voluntary removal);

— 10 per cent had a sanction that restricted their practice; and

— 16 per cent had a sanction that did not restrict their practice (10% had a caution entry on the Register).

**Table 17 Outcome by type of committee**

| Committee | *Amended* | *Caution* | *Conditions of practice* | *No further action* | *Not well founded* | *Removed (incorrect / fraudulent entry)* | *Struck off* | *Suspension* | *Voluntary removal* | *Total* |
|---|---|---|---|---|---|---|---|---|---|---|
| Conduct and Competence Committee | 0 | 36 | 25 | 5 | 67 | 0 | 52 | 50 | 19 | 254 |
| Health Committee | 0 | 0 | 1 | 1 | 2 | 0 | 0 | 7 | 1 | 12 |
| Investigating Committee (fraudulent and incorrect entry) | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 |

## Outcome by profession

Table 18 shows what sanctions were made in relation to the different professions the HCPC regulates. In some cases there was more than one allegation against the same registrant. The table sets out the sanctions imposed per case, rather than by registrant.

**Table 18 Sanctions imposed by profession**

| Profession | Caution | Conditions of practice | No further action | Not well founded | Removed (incorrect / fraudulent) | Struck off | Suspension | Discontinued | Voluntary removal (consent) | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Arts therapists | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| Biomedical scientists | 0 | 2 | 0 | 4 | 0 | 2 | 7 | 0 | 2 | 17 |
| Chiropodists / podiatrists | 1 | 2 | 1 | 2 | 0 | 3 | 3 | 0 | 0 | 12 |
| Clinical scientists | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Dietitians | 0 | 2 | 1 | 0 | 0 | 1 | 1 | 0 | 1 | 6 |
| Hearing aid dispensers | 1 | 0 | 0 | 0 | 0 | 2 | 3 | 0 | 0 | 6 |
| Occupational therapists | 1 | 2 | 1 | 1 | 0 | 4 | 9 | 0 | 4 | 22 |
| Operating department practitioners | 5 | 1 | 1 | 2 | 0 | 3 | 8 | 0 | 2 | 22 |
| Orthoptists | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 2 |
| Paramedics | 9 | 4 | 1 | 22 | 0 | 15 | 9 | 0 | 2 | 62 |
| Physiotherapists | 2 | 3 | 1 | 7 | 0 | 5 | 1 | 1 | 1 | 21 |
| Practitioner psychologists | 1 | 2 | 0 | 5 | 1 | 1 | 3 | 5 | 0 | 18 |
| Prosthetists / orthotists | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Radiographers | 6 | 1 | 0 | 4 | 0 | 5 | 2 | 1 | 0 | 19 |
| Social workers in England | 9 | 5 | 0 | 10 | 0 | 8 | 9 | 1 | 4 | 46 |
| Speech and language therapists | 1 | 2 | 0 | 2 | 0 | 1 | 2 | 1 | 3 | 12 |
| **Total** | **36** | **26** | **6** | **60** | **1** | **52** | **57** | **9** | **20** | **267** |

## Outcome and representation of registrants

All registrants have the right to attend their final hearing. Some attend and represent themselves, whilst others bring a union or professional body representative or have professional representation, for example a solicitor or counsel. Some registrants choose not to attend, but they can submit written representations for the panel to consider in their absence.

The HCPC encourages registrants to participate in their hearings where possible. To do this, we make information about hearings and our procedures accessible and transparent in order to maximise participation, and to ensure any issues that may affect the organisation, timing or adjustments can be identified as early as possible. We do this in a number of ways. Our correspondence sets out the relevant parts of our process and includes guidance. We also produce Practice notes, which are available on our website, detailing the process and how the HCPC or the panels make decisions. This allows all parties to understand what is possible at each stage of the process.

Panels may proceed in a registrant's absence if they are satisfied that the HCPC has properly served notice of the hearing and that it is just to do so. Panels cannot draw any adverse inferences from the fact that a registrant has failed to attend the hearing. They will receive independent legal advice from the legal assessor in relation to choosing whether or not to proceed in the absence of the registrant.

The panel must be satisfied that in all the circumstances, it would be appropriate to proceed in the registrant's absence. The HCPC's Practice note, Proceeding in the absence of the registrant provides further information on this.

In 2013–14, 15 per cent of registrants represented themselves, with a further 45 per cent choosing to be represented by a professional. This combined figure of 60 per cent is similar to 2012–13, when registrants or representatives attended in 59 per cent of cases.

**Graph 6 Representation at final hearings**

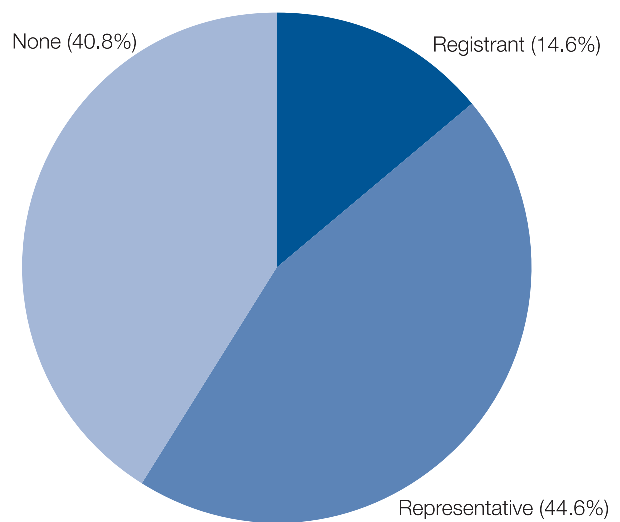


Table 19 details outcomes of final hearings and whether the registrant attended alone, with a representative or was absent from proceedings. In cases where there is representation (either by self or by a representative), sanctions that prevent the registrant from working are less frequently applied. This also applies to removal by consent, but for a different reason, as registrants have signed a legal agreement with the HCPC to be removed from the Register, and so rarely attend the hearing.

**Table 19 Outcome and representation at final hearings**

| | Represented self | Represented | No representation | Total |
|---|---|---|---|---|
| Caution | 9 | 18 | 9 | 36 |
| Conditions | 3 | 19 | 4 | 26 |
| No further action | 3 | 2 | 1 | 6 |
| Not well found | 9 | 42 | 9 | 60 |
| Discontinued | 0 | 5 | 4 | 9 |
| Register entry amended | 0 | 0 | 0 | 0 |
| Removed | 0 | 0 | 1 | 1 |
| Restored | 0 | 0 | 0 | 0 |
| Struck off | 7 | 9 | 36 | 52 |
| Suspended | 8 | 20 | 29 | 57 |
| Consent – removed | 0 | 4 | 16 | 20 |
| Consent – caution | 0 | 0 | 0 | 0 |
| Consent – conditions | 0 | 0 | 0 | 0 |
| **Total** | **39** | **119** | **109** | **267** |

## Outcome and route to registration

Table 20 shows the correlation between routes to registration and the outcomes of final hearings. As with case to answer decisions at ICP, the percentage of hearings where fitness to practise is found to be impaired broadly correlates with the percentage of registrants on the Register and their route to registration. The number of hearings concerning registrants who entered the Register via the UK approved route was 92 per cent, which is higher than the 87 per cent in 2012–13.

**Table 20 Outcome and route to registration**

| Route to registration | Caution | Conditions of practice | No further action | Not well founded | Removed | Struck off | Suspension | Voluntary removal | Total cases | % of cases | % of registrants on the Register |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Grandparenting | 0 | 0 | 0 | 1 | 0 | 0 | 2 | 0 | 3 | 1.1 | 2 |
| International | 0 | 6 | 1 | 4 | 0 | 5 | 2 | 1 | 19 | 7.1 | 7 |
| UK | 36 | 20 | 5 | 64 | 2 | 47 | 53 | 19 | 246 | 91.8 | 91 |
| **Total** | **36** | **26** | **6** | **69** | **2** | **52** | **57** | **20** | **268** | **100** | **100** |

Table 21 shows the source of the original complaint for cases that concluded at a final hearing in 2013–14. The table shows the sanction applied at that final hearing.

There is variation in the types of sanction imposed depending on the source of the complaint. In general, complaints from employers resulted in more restrictive sanctions, such as striking off and suspension, in addition to conditions being imposed. This may be because of the support mechanisms available to registrants to fulfil the requirements of any conditions.

The table demonstrates that cases that are not well founded are more likely to result from hearings where the complaint was made by a member of the public.

**Table 21 Outcome and source of complaint**

| Outcome | Article 22(6) / Anon | Employer | Other | Other registrant | Police | Professional body | Public | Self |
|---|---|---|---|---|---|---|---|---|
| Caution | 4 | 23 | 0 | 0 | 1 | 0 | 1 | 7 |
| Conditions of practice | 1 | 22 | 0 | 0 | 0 | 0 | 1 | 2 |
| No further action | 0 | 1 | 0 | 0 | 0 | 0 | 2 | 2 |
| Not well founded | 15 | 30 | 5 | 0 | 1 | 0 | 11 | 7 |
| Removed | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 |
| Consent | 2 | 15 | 0 | 1 | 0 | 0 | 0 | 2 |
| Struck off | 6 | 35 | 0 | 1 | 3 | 2 | 3 | 2 |
| Suspension | 12 | 36 | 2 | 2 | 1 | 0 | 1 | 3 |
| **Total** | **40** | **162** | **7** | **6** | **6** | **2** | **19** | **25** |

## Not well founded

Once a panel of the Investigating Committee has determined there is a case to answer in relation to the allegation made, the HCPC is obliged to proceed with the case. Final hearings that are 'not well founded' involve cases where, at the hearing, the panel does not find the facts have been proved to the required standard or concludes that, even if those facts are proved they do not amount to the statutory ground (eg misconduct) or show that fitness to practise is impaired. In that event, the hearing concludes and no further action is taken. In 2013–14 there were 60 cases considered to be not well founded at final hearing. This is an increase of six cases (11%) compared to last year.

The proportion of cases not well founded is overall lower than in previous years. We continue to monitor these cases to ensure we maintain the quality of allegations and investigations. The Fitness to Practise Department has continued to ensure that Investigating Panels receive regular refresher training on the 'case to answer' stage in order to ensure that only cases that meet the realistic prospect test as outlined on page 17 are referred to a final hearing.

Table 22 sets out the number of not well founded cases between 2009–10 and 2013–14.

**Table 22 Cases not well-founded**

| Year | Number of not well founded | Total number of concluded cases | % of cases not well founded |
|---|---|---|---|
| 2009–10 | 76 | 256 | 29.7 |
| 2010–11 | 85 | 315 | 27.0 |
| 2011–12 | 68 | 287 | 23.7 |
| 2012–13 | 54 | 228 | 23.7 |
| 2013–14 | 60 | 267 | 22.5 |

In half of the cases (27 cases) which were not well founded, registrants demonstrated that their fitness to practise was not impaired. The test is that fitness to practise is impaired and so is based on a registrant's circumstances at the time of the hearing. If registrants are able to demonstrate insight and can show that any shortcomings have been remedied, panels may not find fitness to practise currently impaired.

In some cases, even though the facts may be judged to amount to the ground of the allegation (eg misconduct, lack of competence), a panel may determine that the ground does not amount to an impairment of current fitness to practise. For example, if an allegation was minor in nature or an isolated incident, and where reoccurrence is unlikely. In 2012–13 this occurred in nine cases (17%).

In other cases the facts of an allegation may not be proved to the required standard (the balance of probabilities). This may be due to the standard or nature of the evidence before the panel. We review any cases that are not well founded on facts to explore if an alternative form of disposal would have been appropriate, and links to our work on discontinuance of allegations where there is insufficient evidence to prove the case, or where a registrant can enter an agreement to voluntarily be removed from the Register. We are monitoring the levels of not well founded cases to ensure that we are utilising our resources appropriately, and that we minimise the impact of public hearings on the parties involved.

### Not well founded case study

A panel of the Conduct and Competence Committee considered an allegation that the registrant, a speech and language therapist, had not demonstrated an adequate level of clinical competence. In particular, the registrant was unable to consistently formulate and implement suitable clinical recommendations, had not maintained accurate and clear written records and did not communicate appropriately with a number of patients.

The panel heard evidence from the registrant, who admitted the facts of the allegation and accepted that those facts amounted to a lack of competence when judged against the standard applicable to the post in which she was working at the time. The registrant had accepted several promotions within her first two years of employment, culminating in appointment to a band 7 post in which she was responsible for the support of both adults and children with a range of speech and language disorders.

The criticisms of the registrant's practice all related to her duties whilst working in the Band 7 post with adult service users. After encountering a number of difficulties at this level, the registrant sought redeployment at lower banding working with paediatric cases alone.

The registrant provided a number of positive testimonials and letters to the panel to demonstrate that she had been working at an acceptable level in this role since the events in question.

The panel concluded that the registrant's acceptance of a lack of competence was correct, judged by the standard she had identified.

Whilst noting that it was the registrant's responsibility to ensure that she did not accept a role that was beyond her current skills and experience, the panel was satisfied that she had developed full insight into this error, had demonstrated self-awareness in removing herself from the Band 7 post and would be highly unlikely to make a similar mistake in the future.

The panel therefore determined that the registrant was able to act safely without restriction in her current role and found that the allegation of impairment by virtue of a lack of competence was not well founded.

## Disposal of cases by consent

The HCPC's consent process is a means by which the HCPC and the registrant concerned may seek to conclude a case without the need for a contested hearing. In such cases, the HCPC and the registrant consent to conclude the case by agreeing an order of the nature of which the panel would have been likely to make had the matter proceeded to a fully contested hearing. The HCPC and the registrant may also agree to enter into a Voluntary Removal Agreement, whereby the HCPC allows the registrant to remove themselves from the HCPC Register on the basis that they no longer wish to practise their profession and fully admit the allegation that has been made against them. Voluntary Removal Agreements have the effect of treating the registrant as if they were subject to a striking off order.

Cases can only be disposed of in this manner with the authorisation of a panel of a Practice Committee.

In order to ensure the HCPC fulfils its obligation to protect the public, neither the HCPC nor a panel would agree to resolve a case by consent unless they are satisfied that:

- the appropriate level of public protection is being secured; and
- doing so would not be detrimental to the wider public interest.

The HCPC will only consider resolving a case by consent:

- after an Investigating Committee Panel has found that there is a 'case to answer', so that a proper assessment has been made of the nature, extent and viability of the allegation;
- where the registrant is willing to admit the allegation in full (a registrant's insight into, and willingness to address, failings are key elements in the fitness to practise process and it would be inappropriate to dispose of a case by consent where the registrant denies liability); and
- where any remedial action agreed between the registrant and the HCPC is consistent with the expected outcome if the case was to proceed to a contested hearing.

The process may also be used when existing conditions of practice orders or suspension orders are reviewed. This enables orders to be varied, replaced or revoked without the need for a contested hearing.

In 2013–14, 20 cases were concluded via the HCPC's consent arrangements at final hearing.

Further information on the process can be found in the Practice note Disposal of cases by consent at www.hcpc-uk.org/publications/practicenotes

### Consent case study

Consent to a Voluntary Removal Agreement was granted in relation to a social worker who showed poor professional judgement. In this case, the social worker delayed escalating concerns arising from a statement made to her by a service user for two days, failed to conduct a risk assessment and did not report the concerns she had about the service user.

This matter had not previously been considered by a substantive final hearing before the Conduct and Competence Committee; however, the panel considering the case was satisfied that the granting of the consent order would not be detrimental to the public interest. The registrant fully admitted the allegation. Furthermore, the facts of the case arose from a lack of competence rather than misconduct and in the judgment of the panel, no direct harm to service users had been alleged.

The panel decided that the wider public interest would not be compromised by consenting to conclude the matter without a fully contested hearing. The application was granted by the Conduct and Competence Committee.

## Discontinuance

Occasionally, after the Investigating Committee has determined that there is a 'case to answer' in respect of an allegation, further and objective appraisal of the detailed evidence which has been gathered since that decision was made may reveal that it is insufficient to sustain a realistic prospect of all or part of the allegation being 'well founded' at a final hearing.

Where such a situation arises, the HCPC may apply to a panel to discontinue all or part of the proceedings.

In 2013–14, following applications by the HCPC, allegations were discontinued in 22 separate cases by a panel.

## Conduct and Competence Committee panels

Panels of the Conduct and Competence Committee consider allegations that a registrant's fitness to practise is impaired by reason of misconduct, lack of competence, a conviction or caution for a criminal offence, or a determination by another regulator responsible for health or social care. Some cases may have a combination of these reasons for impairment in their allegations.

## Misconduct

In 2013–14 the majority of cases heard at a final hearing, 76 per cent, related to allegations that the registrant's fitness to practise was impaired by reason of their misconduct. In 2012–13, the proportion of misconduct cases was 72 per cent. Some cases also concerned other types of allegations concerning lack of competence or a conviction. Some of the misconduct allegations that were considered included:

- attending work under the influence of alcohol;
- bullying and harassment of colleagues;
- engaging in sexual relationships with a service user;
- failing to provide adequate care;
- false claims to qualifications; and
- self-administration of medication.

The case studies below give an illustration of the types of issue that are considered where allegations relate to matters of misconduct. They have been based on real cases that have been anonymised.

**Misconduct case study 1**

A hearing aid dispenser was suspended from the Register for twelve months after a panel of the Conduct and Competence Committee found that his record-keeping had been deficient in a number of respects amounting to poor clinical practice.

The panel heard oral evidence from three witnesses in management roles with the registrant's employer. Their evidence revealed that a clinical audit of the registrant's service user records over a one month period had disclosed a number of discrepancies and omissions in relation to completion of record cards, including not recording answers to medical questions and failing to document relevant tests carried out on service users – for example, otoscopy results and bone conduction tests. Whether the registrant had simply failed to record test results or had not in fact carried out the tests was unclear. The registrant's records also showed no evidence of service users being referred to a doctor where test results warranted such a referral. The panel concluded that all of these failings could potentially have an impact on the well-being of service users.

In the panel's judgement the registrant's actions amounted to misconduct rather than to a lack of competence. As an experienced practitioner the registrant would have known how to conduct the relevant tests, how to keep proper records and how to practise to the expected standard, but he did not do so. His reasons for not doing so were unclear as he had not engaged with the fitness to practise proceedings.

The panel determined that the registrant's fitness to practise was impaired by his misconduct. The panel was of the view that the registrant lacked insight since he had failed to acknowledge that his behaviour fell below the standards expected.

He had not engaged with the HCPC during the fitness to practise proceedings and there was no evidence of insight. Nor, while the registrant's failings were capable of remediation, was there any evidence they had been remediated. In the panel's assessment this meant that the registrant's misconduct might be repeated and he therefore continued to present a risk to the public.

In determining the appropriate sanction to ensure adequate public protection the panel considered a Caution Order but concluded this would be insufficient because the risk of recurrence was too high. The panel then considered a Conditions of Practice Order but judged this unworkable given that the registrant had disengaged from the regulatory process. In all the circumstances the panel concluded that the appropriate sanction was a Suspension Order. There was a possibility that the registrant could remediate his clinical practice and he should be afforded the opportunity to do this. The panel commented that any panel reviewing the Suspension Order could be assisted by the registrant's presence at the review hearing and demonstration of remediation and insight into the identified failings.

### Misconduct case study 2

A social worker received a two-year Caution Order after a panel found he had asked a student nurse to give a service user medication, namely diazepam, which the service user had not been prescribed. The registrant was also found to have dishonestly made misleading entries in his employer's patient record system to disguise his actions.

The panel heard evidence from the student nurse involved, from the employer's investigating officer and from the social work team doctor as well as from the registrant himself. In giving his evidence the registrant admitted that he had asked the student nurse to give the medication and that he had subsequently not fully documented this action and the reasons he had taken it. He denied, however, that he had been dishonest.

The panel learned that the incident took place during a home visit made by the registrant and student nurse to the service user. The service user had been prescribed lorazepam to take as and when she needed it but had exhausted her supply. She was very anxious about an important health assessment due the next day and felt she needed her medication. The registrant had with him a bag of "stock" medication issued to him by his employer that morning. This did not include lorazepam so he decided to give her two 2mg tablets of diazepam instead. The registrant told the panel that this decision was his alone and he had acted in what he believed to be the service user's best interests.

In relation to the allegation of subsequently making misleading record entries the panel heard evidence from the witnesses that the initial record of the home visit made no mention of the diazepam although less significant aspects of the visit had been recorded in considerable detail. A subsequent entry, purporting to be contemporaneous but in fact added later, did mention it but implied that the medication had not been given until the registrant had obtained a prescription from the team doctor, whereas in reality the prescription was only obtained after the event.

The panel determined that the registrant's actions amounted to misconduct. It was abundantly clear that the registrant did not lack competence. By his own admission he had known at the time that he should not issue medication from "stock", that he should have recorded the matter in his record of the home visit and that in making his subsequent record entry he should have made clear that this was not contemporaneous.

This was an isolated incident in the registrant's career. There had been no pattern of failures or omissions. Nonetheless the panel considered that issuing prescription medication to a service user who had not been prescribed that medication fell seriously short of the standards of conduct expected of a registered social worker. The panel noted that in giving the service user diazepam the registrant had not only put the service user at risk but had also involved the student nurse and team doctor in compromising situations which could have had serious consequences for their own professional registrations.

In considering whether the registrant's fitness to practise was impaired by his misconduct the panel first considered whether he was likely to repeat misconduct of this kind. It had careful regard to whether the registrant's misconduct was easily remediable, whether it had been remedied and whether it was likely to be repeated. The panel noted the registrant's early acceptance of the facts of the allegation and that when challenged by his employer he had disclosed the details of what he had done and taken full responsibility for his actions. On the basis of the oral evidence he gave, the panel was satisfied that the registrant had demonstrated substantial insight into his misconduct and had made efforts to remediate his failings through additional training and reflection in discussion with colleagues.

Nonetheless the registrant had been dishonest, had issued medication when not authorised to do so and had potentially compromised fellow professionals. Taking account of these circumstances the panel concluded that the need to uphold standards and maintain public confidence in the profession would be undermined if it did not make a finding of impaired fitness to practise.

In determining the appropriate sanction the panel had uppermost in its mind that the registrant had overstepped professional boundaries, had exposed a service user to risk and had been dishonest. In relation to the dishonesty the panel considered that this was at the lower end of the range of seriousness since the registrant had derived no personal benefit from his actions and the dishonesty was confined to a single incident. The panel judged that a Caution Order was the appropriate and proportionate sanction and that this should be for two years, which would be long enough to mark the seriousness of the case and reflect the need to protect the public interest.

### Misconduct case study 3

A paramedic was struck off the Register after a finding that he did not respond to an emergency call but instead returned to the ambulance station to hand over to another crew. The panel also found that the registrant, despite his dishonest claim to have done so, did not contact the Emergency Operations Centre (EOC) to seek permission for a change of crew and then subsequently attempted to influence witnesses to provide false information to mislead his employer's investigation of the matter.

The registrant did not attend the hearing. In oral evidence from the employer's investigating officer and a paramedic colleague, the panel heard that during the

employer's investigation the registrant had explained his decision not to respond to the call as being the result of severe tiredness following his return to work after several months' sick absence, and to a request from his female crewmate that she wished to return to the ambulance station for personal reasons, which may have been embarrassing for her to disclose. He also said there was another crew ready to take over the ambulance.

The panel heard evidence too that, while suspended by his employer, the registrant had contacted witnesses and attempted to influence their evidence to the investigation to support his, false, claim that he had sent a message to the EOC about the emergency call.

Having found the facts of the allegation proven, the panel went on to consider whether the registrant's behaviour amounted to misconduct. In the panel's assessment the factual particulars of the case were sufficiently serious to constitute behaviours which fell short of what would have been proper in the circumstances. These behaviours arose from a wilful failure by the registrant to comply with the expected standards of conduct in performing his professional duties. The registrant had clearly put patient safety at risk and had compounded this by his subsequent dishonesty.

In the panel's determination the registrant's misconduct was so serious that it would damage public confidence in the profession and the regulatory process if the panel were not to conclude that his fitness to practise was impaired by his misconduct.

In making this determination the panel noted in particular that the registrant had literally driven past the road that would have taken him to the patient and carried on to the ambulance station for his own purposes.

In considering the appropriate sanction to ensure adequate public protection the panel kept in mind both the mitigating and aggravating factors. The former included the registrant's length of service and the fatigue associated with his ill-health. The aggravating factors were that the registrant had not engaged with the fitness to practise process and had not addressed, or displayed adequate insight into, his misconduct. Failure by an experienced paramedic to attend to a patient for whom an emergency call had been made is a serious breach of trust and in consequence the panel regarded the aggravating factors as significantly outweighing the mitigating factors.

The panel considered imposing a caution, conditions of practice or a suspension order but concluded that the nature and gravity of the misconduct was such that a striking off order was the appropriate and proportionate sanction. Any lesser sanction would not have a suitable deterrent effect given the seriousness of the misconduct found. Only the sanction of last resort would maintain public confidence in the paramedic profession.

## Lack of competence

There were 125 allegations heard at final hearing that concerned issues of lack of competence in 2013–14. These included:

- failure to provide adequate service user care;
- inadequate professional knowledge; and
- poor record-keeping.

Lack of competence allegations were most frequently cited as a reason of impairment of fitness to practise after allegations of misconduct in 2013–14. Of the 125 allegations concerning competence, only 33 related solely to lack of competence, rather than being alleged in the alternative (ie misconduct and / or lack of competence). In 2012–13, there were similar proportions of these cases, with 110 allegations relating to lack of competence, with only 25 having no misconduct or other aspects.

The case studies below provide examples from hearings that considered allegations that related solely to lack of competence.

**Lack of competence case study 1**

An occupational therapist was suspended from the Register for a period of twelve months after a panel of the Conduct and Competence Committee found wide-ranging failings in the registrant's performance which demonstrated significant deficiencies over an extended period of time. These failings included an inability to work independently, a lack of professional knowledge and understanding, not keeping accurate records and a failure to provide timely treatment to service users. The evidence emanated from the registrant's work in several different settings.

The panel noted that the registrant had difficulty in making autonomous decisions and lacked confidence in his own decision making ability. He often appeared to need reassurance from colleagues on what were basic occupational therapy tasks or practices. There were also a number of examples of his failing to demonstrate adequate clinical reasoning or progressing treatment for service users in a timely manner. The panel heard evidence, for example, that following a visit to a service user's home the registrant did not progress an identified need for a back door ramp, with the result that the case had to be reallocated to another occupational therapist.

The panel determined that the facts proved amounted to a lack of competence and not misconduct. This was because the panel was satisfied that the registrant's failings resulted from an inability to achieve proper standards rather than through any wilful or reckless conduct.

The panel acknowledged that the registrant had shown some insight into his failings. Given the broad and persistent nature of these failings, however, and the fact that he had provided little real evidence of correcting or remedying his deficiencies, the panel found the registrant's fitness to practise to be impaired.

In considering whether a sanction was needed to protect the public the panel noted among other factors that over a period of four years the registrant had been made the subject of a capability procedure by his employer on three separate occasions. On two of these occasions he had managed to regain an acceptable standard of practice, but when the intensive supervision and support provided through the capability procedure was withdrawn the standard of his practice again began to decline. The panel accepted that the registrant was highly motivated in his desire to help the vulnerable and disadvantaged but there was evidence that the deficiencies in the registrant's practice had put vulnerable service users at risk. Despite evidence from the registrant that he had learned from his mistakes, the panel noted that these mistakes had nonetheless been repeated.

Having concluded that taking no action would manifestly fail to provide adequate protection to the public, the panel considered whether a Conditions of Practice Order would be an appropriate sanction. The registrant suggested that he would be more than willing to comply with suitable conditions of practice and that such an order would demonstrate whether or not he could raise himself to the required level of competence. It was argued by the registrant that his

practice could be restricted to non-complex cases. The panel carefully considered this proposal as it accepted the registrant's assertion that he was genuinely passionate about the profession of occupational therapy. The panel's conclusion though, was that a Conditions of Practice Order would be unworkable because it is not possible to ensure that any area of occupational therapy practice could be restricted to simple cases. The complexity of a case becomes apparent only after a competent occupational therapy assessment. Furthermore, because of the broad range of the failings in the registrant's practice, conditions sufficient to protect the public would have had to be so tightly drawn as to prevent his working other than under the close and detailed direction of an experienced practitioner. Such conditions would effectively amount to a suspension in all but name. Accordingly, the panel concluded that a Suspension Order was the only sanction available to it which could provide an adequate level of public protection.

**Lack of competence case study 2**

A biomedical scientist was made the subject of conditions of practice after a panel found that her performance over a prolonged period and in different settings had been akin to a pre-registration trainee, rather than an experienced Band 6 specialist practitioner.

The panel heard evidence from her former employer to the effect that the registrant had worked in the hospital's Microbiology Department on the Faeces Bench, the Wound Bench and the Blood Culture Bench. Concerns had been raised about her capability almost from the outset of her employment at the hospital. As she did not make sufficient progress during a review period, the employer implemented a formal capability process, but this was not concluded as the registrant subsequently resigned.

Oral evidence was given to the panel by three senior biomedical scientists from the hospital. Written evidence only was also provided by a fourth. This evidence pointed to the registrant being unable to practise independently while working on the Faeces Bench because of an inability to understand basic identification techniques. In addition, the registrant did not communicate the results of Clostridium Difficile testing, used to prevent hospital-based infection, to consultant microbiologists. The panel was also given evidence that while placed on the Wound Bench the registrant was unable to recognise salmonella in a sample. Salmonella is associated with serious potential health risks.

On the basis of the evidence presented to it, the panel was satisfied that the registrant lacked competence. It concluded that the registrant's proficiency in professional practice was consistently below the minimum acceptable level and that this was apparent in a significant proportion of her work over a period of time.

The panel then went on to consider whether the registrant's lack of competence meant her fitness to practise as a biomedical scientist was impaired. In doing this it noted that the evidence of lack of competence related to events some time previously and that a finding of impairment must relate to current impairment.

In the panel's judgement, as the registrant had resigned from her employment before the conclusion of the capability process and had not engaged with the HCPC during the fitness to practise process, it could not be satisfied the competence issues had been addressed. Accordingly, it concluded that the registrant's fitness to practise was currently impaired.

In considering the question of what sanction should be imposed to provide adequate protection for the public, the panel concluded that the registrant's deficiencies were capable of being remedied and that therefore a

Conditions of Practice Order for a period of two years would protect the public. The conditions included a requirement for the registrant to notify any future employer of the Order and to be supervised in her practice by another biomedical scientist.

## Health Committee panels

Panels of the Health Committee consider allegations that registrants' fitness to practise is impaired by reason of their physical and / or mental health. Many registrants manage a health condition effectively and work within any limitations their condition may present. However, the HCPC can take action when the health of a registrant is considered to be affecting their ability to practise safely and effectively.

The HCPC presenting officer at a Health Committee hearing will often make an application for proceedings to be heard in private. Often sensitive matters regarding registrants' ill-health are discussed and it may not be appropriate for that information to be discussed in public session.

The Health Committee considered twelve cases in 2013–14. Of those cases one case resulted in a conditions of practice, three were not well founded, one was removal by consent and seven were suspended.

# Suspension and conditions of practice review hearings

All suspension and conditions of practice orders must be reviewed by a panel before they expire. A review may also take place at any time at the request of the registrant concerned or the HCPC. Registrants may request reviews if, for example, they are experiencing difficulties complying with conditions imposed or if new evidence relating to the original order comes to light.

The HCPC can also request a review of an order if, for example, it has evidence that the registrant concerned has breached any condition imposed by a panel.

In reviewing a suspension order, the panel will look for evidence to satisfy it that the issues that led to the original order have been addressed and that the registrant concerned no longer poses a risk to the public.

If a review panel is not satisfied that the registrant concerned is fit to practise, it may:

- extend the existing order; or
- replace it with another order.

In 2013–14, 160 review hearings were held. Table 23 shows the decisions that were made by review panels in 2013–14. Five of the review cases (3%) were disposed of using voluntary removal. We are currently monitoring the requests for disposal by consent for cases in the review cycle, as well as the final hearing disposal.

**Table 23 Review hearing decisions**

| Profession | Adjourned / part heard | Caution | Conditions of practice | Order revoked | Struck off | Suspension | Voluntary removal (consent) | Total |
|---|---|---|---|---|---|---|---|---|
| Arts therapists | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 2 |
| Biomedical scientists | 1 | 0 | 7 | 2 | 5 | 2 | 0 | 17 |
| Chiropodists / podiatrists | 0 | 0 | 5 | 0 | 3 | 5 | 0 | 13 |
| Clinical scientists | 1 | 0 | 1 | 1 | 1 | 1 | 0 | 5 |
| Dietitians | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 3 |
| Hearing aid dispensers | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 2 |
| Occupational therapists | 0 | 0 | 3 | 3 | 4 | 9 | 0 | 19 |
| Operating department practitioners | 0 | 0 | 1 | 1 | 2 | 6 | 1 | 11 |
| Orthoptists | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| Paramedics | 2 | 3 | 4 | 9 | 8 | 12 | 1 | 39 |
| Physiotherapists | 1 | 0 | 3 | 4 | 3 | 7 | 1 | 19 |
| Practitioner psychologists | 0 | 0 | 0 | 2 | 2 | 1 | 0 | 5 |
| Prosthetists / orthotists | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Radiographers | 0 | 0 | 2 | 1 | 1 | 6 | 0 | 10 |
| Social workers in England | 0 | 0 | 0 | 1 | 0 | 3 | 1 | 5 |
| Speech and language therapists | 0 | 0 | 0 | 0 | 1 | 7 | 1 | 9 |
| **Total** | **5** | **3** | **26** | **27** | **32** | **62** | **5** | **160** |

Tables 24 and 25 set out the outcomes of the reviews of the suspension and conditions of practice orders in the period 2013–14

**Table 24 Suspension orders**

| Review activity | Number | % |
|---|---|---|
| Suspension reviewed, suspension confirmed | 57 | 46 |
| Suspension reviewed, replaced with conditions of practice | 10 | 8 |
| Suspension reviewed, struck off | 33 | 27 |
| Suspension reviewed, caution imposed | 3 | 2 |
| Suspension reviewed, removed by consent | 5 | 4 |
| Suspension reviewed, no further action | 16 | 13 |
| **Total** | **124** | **100** |

**Table 25 Conditions of practice order**

| Review activity | Number | % |
|---|---|---|
| Conditions reviewed, replaced with suspension | 8 | 22 |
| Conditions reviewed, struck off | 1 | 3 |
| Conditions reviewed, conditions confirmed | 4 | 11 |
| Conditions reviewed, conditions varied | 12 | 33 |
| Conditions reviewed, no further action | 11 | 31 |
| **Total** | **36** | **100** |

# Restoration hearings

A person who has been struck off the HCPC Register and wishes to be restored to the Register, can apply for restoration under Article 33(1) of the Health and Social Work Professions Order 2001.

A restoration application cannot be made until five years have elapsed since the striking off order came into force. In cases where the striking off decision was made by the General Social Care Council, that period is reduced to three years. In addition, if a restoration application is refused, a person may not make more than one application for restoration in any twelve-month period.

In applying for restoration, the burden of proof is upon the applicant. This means it is for the applicant to prove that he or she should be restored to the Register and not for the HCPC to prove the contrary. The procedure is generally the same as other fitness to practise proceedings, however in accordance with the relevant procedural rules, the applicant presents his or her case first and then it is for the HCPC presenting officer to make submissions after that.

If a panel grants an application for restoration, it may do so unconditionally or subject to the applicant:

- meeting the HCPC's 'return to practice' requirements; or
- complying with a conditions of practice order imposed by the panel.

In 2013–14, four applications for restoration were heard, of which one was granted restoration to the Register.

# The role of the Professional Standards Authority and High Court cases

The Professional Standards Authority (PSA), formerly known as the Council for Healthcare Regulatory Excellence (CHRE), is the body that promotes best-practice and consistency in regulation by the UK's nine health and care regulatory bodies.

The PSA can refer a regulator's final decision in a fitness to practise case to the High Court (or in Scotland, the Court of Session). They can do this if it is felt that the decision is unduly lenient and that such a referral is in the public interest.

In 2013–14, three HCPC cases were referred to the High Court by the PSA. At the time of writing this report in July 2014, in two cases the registrant agreed to be removed from the Register by consent, and one case the registrant received a six month suspension order in place of the not well found decision reached by the original hearing panel.

In 2013–14 seven registrants appealed the decisions made by the Conduct and Competence Committee. At the time of writing this report in July 2014, two appeals had been dismissed, three had been refused, one had been remitted back to the conduct and competence committee (where a new panel reached the same decision as that at the original hearing), and one was still ongoing.

# General Social Care Council transfer cases

## Introduction to the transfer

Following the closure of the General Social Care Council (GSCC) on 31 July 2012, all open misconduct cases were transferred to the HCPC for continued investigation, hearing or review.

## Managing the transferred cases

The General Social Care Council (Transfer of Register and Abolition – Transitional and Saving Provision) Order of Council 2012 provided that, in relation to outstanding cases which were transferred to it from the GSCC, the HCPC should make "such arrangements as it considers just for the disposal of the matter". The HCPC therefore established 'just disposal criteria' which were applied to all cases on transfer. All transferred cases were reviewed on an individual basis and assessed to determine the most appropriate course of action.

## Investigating Committee

Two hundred and seventeen cases were transferred. Of these cases, 120 (55%) were considered by the Investigating Committee between 1 August 2012 and 31 March 2013. Between 1 April 2013 and 31 March 2014 a further 48 cases (22%) were considered by the Investigating Committee. The case to answer rate for these cases is 80 per cent, which is higher than the non-transfer cases (53% in 2013–14 and 58% in 2012–13).

At 31 March 2014, four cases remain at the enquiry or pre-Investigating Committee stage. Two of these cases are awaiting the conclusion of criminal investigations by the police, one has been referred to the conduct and competence committee, and one is being considered for closure due to information not being available to support the allegation.

The remaining 45 cases that were transferred (20%) have been closed as they do not meet the standard of acceptance for allegations.

## Final hearings

One hundred and thirty three final hearings were held in the period 1 August 2012 to 31 March 2014. 28 of these cases (20%) were adjourned, and a further eight (6%) were part heard.

**Table 26 Outcomes of final hearings in 2012–14**

| Outcome | Number | % |
|---|---|---|
| Caution | 17 | 13 |
| Conditions of practice | 8 | 6 |
| Not well founded | 20 | 15 |
| No further action | 1 | 1 |
| Removed by consent | 11 | 8 |
| Struck off | 43 | 32 |
| Suspended | 33 | 25 |
| **Total** | **133** | **100** |

There are also 20 cases that have been referred to a conduct and competence or health committee final hearing. These cases are in various stages of investigation, or awaiting the hearing to commence. Several of the cases have been delayed due to ongoing local investigations, or criminal trial matters. They should all be concluded by autumn 2014.

## Reviews of substantive orders

Cases where suspension or condition of practice were imposed by the General Social Care Council had to be reviewed by the HCPC. By 31 March 2014, there were 51 cases (24%) that had an existing reviewable order from the GSCC, or that had a sanction imposed by an HCPC final hearing panel.

Twenty eight (53%) of those with a reviewable sanction had a review hearing in the period 1 August 2012 to 31 March 2014. Table 28 provides a breakdown of these reviews.

**Table 27 Outcomes of substantive review hearings**

| Outcome | Number | % |
|---|---|---|
| Caution continued | 1 | 3.6 |
| Conditions continued | 6 | 21.4 |
| Conditions revoked | 2 | 7.1 |
| Conditions revoked and replaced with a Caution | 1 | 3.6 |
| Suspension continued | 10 | 35.7 |
| Suspension revoked | 1 | 3.6 |
| Suspension revoked and replaced with a Caution | 1 | 3.6 |
| Suspension revoked and replaced with Conditions | 2 | 7.1 |
| Struck off | 4 | 14.3 |
| **Total** | **28** | **100** |

## Interim orders

As part of the initial review of cases at the point of transfer, an assessment was made as to whether an interim order application should be made. Thirty six interim orders were sought. This relates to 17 per cent of the transferred cases. This figure is slightly higher than the proportion of cases with an interim order in other HCPC registered professions, which is around ten per cent.

Thirty two of the interim order applications (89%) were made within six months of the transfer of the cases. The remaining four applications were made on receipt of new information. In three cases, the application was not granted.

There were 70 reviews of interim orders in the period 1 August 2012 to 31 March 2014.

**Table 28 Outcome by source of complaint (GSCC cases concluded at final hearing)**

| Outcome | Article 22(6) / Anon | Employer | Other | Other registrant | Police | Professional body | Public | Self |
|---|---|---|---|---|---|---|---|---|
| Caution | 0 | 12 | 1 | 0 | 0 | 0 | 0 | 3 |
| Conditions of practice | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 3 |
| No further action | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Not impaired | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Not well founded | 0 | 11 | 1 | 0 | 1 | 0 | 0 | 1 |
| Removed | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Consent | 0 | 8 | 0 | 0 | 0 | 0 | 0 | 1 |
| Struck off | 1 | 23 | 1 | 0 | 1 | 0 | 0 | 4 |
| Suspension | 0 | 32 | 1 | 0 | 1 | 0 | 0 | 2 |
| **Total** | **1** | **90** | **4** | **0** | **3** | **0** | **0** | **15** |

# How to raise a concern

If you would like to raise a concern about a professional registered by the HCPC, please write to our Director of Fitness to Practise at the following address.

**Fitness to Practise Department**
**The Health and Care Professions Council**
**Park House**
**184 Kennington Park Road**
**London SE11 4BU**

If you need advice, or feel your concerns should be taken over the telephone, you can also contact a member of the Fitness to Practise Department on:

**tel +44 (0)20 7840 9814**
**freephone 0800 328 4218 (UK only)**
**fax +44 (0)20 7582 4874**

You may also find our 'Reporting a concern' form useful, available at www.hcpc-uk.org/complaints

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# Appendix one – Historical statistics

## Cases received

**Number of cases received 2002–03 to 2013–14**

| Year | Number of cases | Total number of registrants | % of registrants subject to complaints |
|---|---|---|---|
| 2002–03 | 70 | 144,141 | 0.05 |
| 2003–04 | 134 | 144,834 | 0.09 |
| 2004–05 | 172 | 160,513 | 0.11 |
| 2005–06 | 316 | 169,366 | 0.19 |
| 2006–07 | 322 | 177,230 | 0.18 |
| 2007–08 | 424 | 178,289 | 0.24 |
| 2008–09 | 483 | 185,554 | 0.26 |
| 2009–10 | 772 | 205,311 | 0.38 |
| 2010–11 | 759 | 215,083 | 0.35 |
| 2011–12 | 925 | 219,162 | 0.42 |
| 2012–13 | 1,653 | 310,942 | 0.52 |
| 2013–14 | 2,069 | 322,021 | 0.64 |

**Who raised concerns 2005–06 to 2013–14**

| Type of complaint | 2005–06 | % of cases | 2006–07 | % of cases | 2007–08 | % of cases | 2008–09 | % of cases | 2009–10 | % of cases | 2010–11 | % of cases | 2011–12 | % of cases | 2012–13 | % of cases | 2013–14 | % of cases |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Article 22(6) / Anonymous | 58 | 18 | 35 | 10.9 | 63 | 14.8 | 64 | 13 | 108 | 13.9 | 166 | 21.9 | 284 | 30.7 | 58 | 3.5 | 77 | 3.7 |
| BPS / AEP transfer* | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 44 | 5.7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Employer | 123 | 39 | 161 | 50.0 | 171 | 40.3 | 202 | 42 | 254 | 32.9 | 217 | 28.6 | 288 | 31.1 | 435 | 26.3 | 593 | 28.7 |
| Other | 15 | 5 | 1 | 0.3 | 5 | 1.2 | 16 | 3 | 30 | 3.9 | 21 | 2.7 | 46 | 5 | 87 | 5.3 | 81 | 3.9 |
| Other registrant / professional | 28 | 9 | 16 | 5.0 | 42 | 9.9 | 56 | 12 | 60 | 7.8 | 75 | 9.9 | 52 | 5.6 | 99 | 6 | 78 | 3.8 |
| Police | 24 | 8 | 31 | 9.6 | 35 | 8.3 | 36 | 7 | 39 | 5.1 | 25 | 3.3 | 27 | 3 | 27 | 1.6 | 37 | 1.8 |
| Professional body | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 21 | 1.3 | 14 | 0.7 |
| Public | 68 | 21 | 78 | 24.2 | 108 | 25.5 | 109 | 23 | 237 | 30.7 | 255 | 33.6 | 228 | 24.6 | 634 | 38.3 | 793 | 38.3 |
| Self referral | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 292 | 17.7 | 396 | 19.1 |
| **Total** | **316** | **100** | **322** | **100** | **424** | **100** | **483** | **100** | **772** | **100** | **759** | **100** | **925** | **100** | **1,653** | **100** | **2,069** | **100** |

*These are cases that were transferred from the British Psychological Society to the HPC

**Cases by profession 2005–06 to 2013–14**

| Profession | 2005–06 | 2006–07 | 2007–08 | 2008–09 | 2009–10 | 2010–11 | 2011–12 | 2012–13 | 2013–14 |
|---|---|---|---|---|---|---|---|---|---|
| Arts therapists | 2 | 4 | 16 | 8 | 5 | 4 | 4 | 7 | 4 |
| Biomedical scientists | 21 | 18 | 26 | 46 | 39 | 37 | 66 | 37 | 50 |
| Chiropodists / podiatrists | 62 | 38 | 40 | 62 | 76 | 78 | 55 | 53 | 71 |
| Clinical scientists | 3 | 2 | 6 | 8 | 4 | 10 | 9 | 9 | 3 |
| Dietitians | 7 | 6 | 14 | 1 | 12 | 9 | 12 | 12 | 21 |
| Hearing aid dispensers | 0 | 0 | 0 | 0 | 0 | 44 | 19 | 25 | 22 |
| Occupational therapists | 38 | 40 | 45 | 55 | 78 | 62 | 95 | 74 | 105 |
| Operating department practitioners | 19 | 22 | 38 | 55 | 38 | 39 | 63 | 45 | 63 |
| Orthoptists | 0 | 1 | 3 | 0 | 2 | 0 | 2 | 2 | 2 |
| Paramedics | 43 | 81 | 94 | 99 | 163 | 188 | 252 | 262 | 266 |
| Physiotherapists | 79 | 52 | 85 | 95 | 126 | 104 | 119 | 122 | 134 |
| Practitioner psychologists | N/A | N/A | N/A | N/A | 149 | 118 | 138 | 180 | 157 |
| Prosthetists / orthotists | 3 | 3 | 3 | 6 | 7 | 1 | 2 | 1 | 2 |
| Radiographers | 27 | 44 | 32 | 34 | 47 | 40 | 58 | 56 | 59 |
| Social workers | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 734 | 1,085 |
| Speech and language therapists | 12 | 11 | 22 | 14 | 26 | 25 | 25 | 34 | 25 |
| **Total** | **316** | **322** | **424** | **483** | **772** | **759** | **919** | **1,653** | **2,069** |

**Cases by route to registration 2005–06 to 2013–14**

| Route to registration | 2005–06 | % of cases | 2006–07 | % of cases | 2007–08 | % of cases | 2008–09 | % of cases | 2009–10 | % of cases | 2010–11 | % of cases | 2011–12 | % of cases | 2012–13 | % of cases | 2013–14 | % of cases |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Grandparenting | 35 | 11 | 15 | 5 | 15 | 3.5 | 21 | 4.3 | 24 | 3 | 32 | 4 | 20 | 2 | 6 | 0.4 | 0 | 0 |
| International | 30 | 9.5 | 29 | 9 | 36 | 8.5 | 35 | 7.3 | 63 | 8 | 40 | 5 | 57 | 7 | 50 | 3 | 62 | 3 |
| UK | 242 | 77 | 278 | 86 | 373 | 88 | 425 | 88.4 | 685 | 89 | 687 | 91 | 848 | 91 | 1,597 | 96.6 | 2,007 | 97 |
| Not known | 9 | 2.5 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **316** | **100** | **322** | **100** | **424** | **100** | **483** | **100** | **772** | **100** | **759** | **100** | **925** | **100** | **1,653** | **100** | **2,069** | **100** |

## Investigating Committee

**Allegations where a case to answer decision was reached 2004–05 to 2013–14**

| Year | % of allegations with case to answer decision |
|---|---|
| 2004–05 | 44 |
| 2005–06 | 58 |
| 2006–07 | 65 |
| 2007–08 | 62 |
| 2008–09 | 57 |
| 2009–10 | 58 |
| 2010–11 | 57 |
| 2011–12 | 51 |
| 2012–13 | 58 |
| 2013–14 | 53 |

**Percentage case to answer, comparison of 2005–06, 2006–07, 2007–08, 2008–09, 2009–10, 2011–12, 2012–13 and 2013–14**

| | 2005–06 | 2006–07 | 2007–08 | 2008–09 | 2009–10 | 2010–11 | 2011–12 | 2012–13 | 2013–14 |
|---|---|---|---|---|---|---|---|---|---|
| 22(6) / Anon | 58 | 86 | 61 | 49 | 69 | 72 | 50 | 76 | 64 |
| BPS transfer cases* | 0 | 0 | 0 | 0 | 7 | 0 | 0 | 0 | 0 |
| Employer | 81 | 84 | 84 | 81 | 80 | 82 | 69 | 73 | 68 |
| Other | 0 | 0 | 56 | 34 | 79 | 57 | 63 | 67 | 82 |
| Other registrant / professional | 60 | 46 | 77 | 67 | 62 | 29 | 50 | 29 | 31 |
| Police | 26 | 28 | 31 | 37 | 50 | 54 | 38 | 50 | 67 |
| Public | 18 | 33 | 29 | 22 | 22 | 22 | 17 | 19 | 16 |

*These are cases that were transferred from the British Psychological Society and the Association of Educational Psychologists to the HPC.

**Representations provided to Investigating Panel by profession 2006–07 to 2013–14**

| | Case to answer | | | | No case to answer | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Year | No response | Response from registrant | Response from representative | Total case to answer | No response | Response from registrant | Response from representative | Total No case to answer | Total cases |
| 2006–07 | 40 | 79 | 28 | 147 | 3 | 66 | 4 | 73 | 220 |
| 2007–08 | 59 | 85 | 9 | 153 | 17 | 68 | 6 | 91 | 244 |
| 2008–09 | 61 | 131 | 14 | 206 | 21 | 115 | 13 | 149 | 355 |
| 2009–10 | 70 | 200 | 21 | 291 | 14 | 177 | 7 | 198 | 489 |
| 2010–11 | 84 | 185 | 25 | 294 | 10 | 195 | 13 | 218 | 512 |
| 2011–12 | 49 | 182 | 21 | 252 | 28 | 197 | 21 | 246 | 498 |
| 2012–13 | 86 | 186 | 29 | 301 | 18 | 176 | 28 | 222 | 523 |
| 2013–14 | 99 | 218 | 43 | 360 | 35 | 256 | 31 | 322 | 682 |

## Interim orders

### Interim order hearings 2004–05 to 2013–14

| Year | Applications granted | Orders reviewed | Orders revoked on review | Number of cases | % of allegations where interim order was imposed |
|---|---|---|---|---|---|
| 2004–05 | 15 | 0 | 0 | 172 | 8.7 |
| 2005–06 | 15 | 12 | 1 | 316 | 4.7 |
| 2006–07 | 17 | 38 | 1 | 322 | 5.3 |
| 2007–08 | 19 | 52 | 3 | 424 | 4.5 |
| 2008–09 | 27 | 55 | 1 | 483 | 5.6 |
| 2009–10 | 49 | 86 | 6 | 772 | 6.3 |
| 2010–11 | 44 | 123 | 6 | 759 | 5.8 |
| 2011–12 | 49 | 142 | 4 | 925 | 5.3 |
| 2012–13 | 39 | 151 | 8 | 1653 | 2.4 |
| 2013–14 | 85 | 166 | 3 | 2069 | 4.6 |

## Final hearings

### Number of hearings 2004–05 to 2013–14

| Year | Interim order and review | Final hearing | Review hearing | Restoration hearing | Article 30(7) | Total |
|---|---|---|---|---|---|---|
| 2004–05 | 25 | 66 | 11 | 1 | 0 | 103 |
| 2005–06 | 28 | 86 | 26 | 0 | 0 | 140 |
| 2006–07 | 55 | 125 | 42 | 0 | 0 | 222 |
| 2007–08 | 71 | 187 | 66 | 0 | 0 | 324 |
| 2008–09 | 85 | 219 | 92 | 0 | 0 | 396 |
| 2009–10 | 141 | 331 | 95 | 0 | 0 | 567 |
| 2010–11 | 171 | 404 | 99 | 2 | 1 | 677 |
| 2011–12 | 197 | 405 | 126 | 3 | 1 | 732 |
| 2012–13 | 194 | 228 | 141 | 1 | 1 | 565 |
| 2013–14 | 265 | 267 | 160 | 4 | 1 | 697 |

**Representation at final hearings 2006–07 to 2013–14**

| | Type of representation | | |
|---|---|---|---|
| **Year** | **Registrant** | **Representative** | **None** |
| 2006–07 | 13 | 46 | 43 |
| 2007–08 | 17 | 80 | 59 |
| 2008–09 | 21 | 74 | 80 |
| 2009–10 | 44 | 114 | 98 |
| 2010–11 | 41 | 160 | 113 |
| 2011–12 | 38 | 155 | 94 |
| 2012–13 | 31 | 102 | 95 |
| 2013–14 | 39 | 119 | 109 |

## Suspension and conditions of practice review hearings

**Number of review hearings 2004–05 to 2013–14**

| Year | Number of review hearings |
|---|---|
| 2004–05 | 11 |
| 2005–06 | 26 |
| 2006–07 | 42 |
| 2007–08 | 66 |
| 2008–09 | 92 |
| 2009–10 | 95 |
| 2010–11 | 99 |
| 2011–12 | 126 |
| 2012–13 | 141 |
| 2013–14 | 160 |

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