Council, 24 September 2015

Fitness to Practise Annual Report 2014-15

Executive summary and recommendations

Introduction

Article 44(1)(b) of the Health and Social Work Professions Order 2001 provides that the Council shall publish an annual report describing the range of fitness to practise activity undertaken in the previous year.

The text for the 2014-15 Fitness to Practise Annual Report is attached as appendix 1. The report includes a range of statistical information alongside explanatory narrative. In the main the report includes the same data sets, and follows a similar format, to previous reports. This short paper describes where the report differs in approach from previous years.

After consideration by Council, the report will undergo final proofing, will be edited and formatted in HCPC house style and will be sent for printing. The publication schedule should allow for receipt of printed copies by November 2015. The report will also be available on the HCPC website at the following page: http://www.hcpc-uk.org/publications/reports/

Decision

The Council is asked to approve the text for the 2014-15 Fitness to Practise Annual Report (subject to any necessary editorial or stylistic amendments).

Background information

As in previous years, a separate, shorter document, Fitness to Practise – key information 2015, will be published alongside the Fitness to Practise Annual Report 2014-15.

Resource implications

Production costs (design and printing).

Financial implications

The production costs have been accounted for in 2015-16 budget.

Appendices

Appendix 1 Fitness to Practise Annual Report 2014-15

Date of paper

10 August 2015

Fitness to Practise Annual Report 2014-15

1. Introduction

1.1 The Fitness to Practise Annual Report 2014-15 ('the report') includes a range of statistical information alongside explanatory narrative. In the main the report includes the same data sets, and follow a similar format, to previous reports. This short paper describes where the report differs in approach from previous years.

1.2 The text for the report can be found at Appendix 1.

2. General Social Care Council (GSCC)

2.1 The 2012-13 and 2013-14 reports both include a specific section about the progress of the cases transferred from the GSCC. Such a section has not been included in the 2014-15 report as the majority of these cases are now closed or are in the review cycle (i.e. there is a conditions of practice or a suspension order which has been imposed by and/or reviewed by a Panel of the Conduct and Competence Committee).

2.2 The approach taken with the 2014-15 report is to include statistical information about the number of transfer cases closed in the year together with the number which remain open, in the Executive Summary. Further, to include information about the transfer cases in the review cycle in the statistical information about suspension and condition of practise review hearings for all professions. This demonstrates that these are cases are now seen as business as usual.

3. Summary of decisions made by final hearing Panels

3.1 Previous reports contain a list of final hearing decisions setting out the date of the decision; the registrant's name and profession; the outcome; and a short statement describing the allegation. Such a list has not been included in the 2014-15 report.

3.2 The approach taken with the 2014-15 report is to illustrate the types of cases considered by final hearings Panels by including more examples of the type of allegation considered in the Misconduct and Lack of Competence sections. Further, to include a specific section about Convictions and Cautions setting out a list of examples of the type of offences considered by final hearing Panels together with a case study. The reader is also informed that more details of final hearing Panel decisions can be found on the website. This reminder is in three different places in the report and provides a directional link to the specific page.

3.3 The reasons for this change in approach are set out below:

- The Fitness to Practise Publication Policy ('the policy') states that when a caution or a conditions of practice order or a suspension order is imposed an annotation to the registrant's online register entry, with a link to the Panel's decision and order, will be made for as long as the sanction has effect. However, when the sanction no longer has effect, all information about the original decision and order and any review decisions will be removed from the website and the annotation and associated links will be removed from the online register. The policy also states when a striking off order is imposed, the published decision will remain on the website for a period of five years from the date the order takes effect. Consequently, to include a list of final hearing Panel decisions in the report, which once published will be available for time immemorial, will contravene this policy.

- The number of cases with an element of complexity (for example, lengthy allegations, more than one ground or part heard in private) is increasing. It is difficult to fairly and accurately describe these cases in one succinct statement. The statement may be misleading without an explanation of the full context of the case with information such as background information, aggravating and/or mitigating factors. Further, it may also be an information security risk.

- In 2013-14 the summary list spanned 22 pages of the report (21% of the total number of pages). Given the increase in final hearing decisions in 2014-15 (84 cases), the summary list will span many more pages in addition. This appears to be a disproportionate amount of the report, and of resources in producing the report, when the information is readily available on the website.

[front cover]

1 April 2014 to 31 March 2015 [strapline]

Fitness to practise annual report 2015 [title]

Contents

Further Information, including How to raise a concern

Appendix one (Historical Statistics).....

Executive Summary

Welcome to the twelfth fitness to practise annual report of the Health and Care Professions Council (HCPC) covering the period 1 April 2014 to 31 March 2015. This report provides information about the work we do in considering allegations about the fitness to practise of our registrants.

In 2014–15, the number of individuals on our Register increased by 2.7 per cent. The number of new fitness to practise concerns we received also increased from 2,069 to 2,170, a percentage rise of 4.8 from the year before. However, despite this increase, the proportion of the Register affected still remains low, with only 0.66 per cent of registrants (or 1 in 166) being subject to a new concern in 2014–15.

In terms of the cases we progressed through the fitness to practise process in 2014–15:

- 1,042 cases were closed without being considered by an Investigating Committee Panel (ICP);
- 849 cases were considered by an ICP;
- 351 final hearings were concluded; and
- 236 review hearings were held.

The number of cases considered by an ICP and the number of final hearings concluded increased significantly from 2013-14. 142 more cases were considered by an ICP, a 20 per cent increase, and 84 more final hearings were concluded, a 31 per cent increase. Further, the number of review hearings held increased by 47 per cent.

We had forecast these increases due to the high number of concerns we received in 2013–14 (25 per cent more than the previous year). We therefore planned our resources to allow for additional ICP and hearing days to ensure a higher number of cases could be considered in 2014–15. Given the further increases in concerns received in 2014–15, we have again planned our resources in 2015–16 to allow for additional ICP and hearing days if required.

In 2014–15, we also continued to progress the remaining open cases transferred from the General Social Care Council. Seven cases were considered by an ICP and 17 were considered at a final hearing. As of the 31 March 2015, there was one case under investigation prior to being considered by an ICP (this case is subject to a complex police investigation) and 14 cases were being prepared for final hearing.

Other activities in 2014–15 focussed on our commitment to improve the experience individuals have when they are involved in the fitness to practise process, be it a complainant, registrant, employer or witness. We continued our review of the ‘tone of voice’ of our correspondence. We undertook new initiatives, such as proactively seeking feedback from complainants and registrants at the conclusion of a case, and use of the Patients Association peer review model to assess how we handle fitness to practise concerns. Our

work with the Patients Association was driven by the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry which recommended the Patients Association peer review model be implemented across the NHS. We hugely benefitted from the Patients Association's expertise and external scrutiny.

We also continued our activities to enhance the information sources we have available to employers. In 2014–15, whilst the allegations received from employers represented the highest percentage of case to answer decisions, 28 per cent of the total number of concerns received from employers were closed without being considered by an ICP. Further, 68 per cent of the interim order applications made in 2014–15 were in cases received from employers. Our enhanced engagement with this complainant group is therefore important to ensure they understand what concerns to refer to us, at what time and what information to provide. In turn meaning we have the right information at the right time to assess risk and to ensure ongoing public protection.

As part of the ongoing development of our stakeholder relationships, alongside meetings with groups such as representative bodies, other regulators and larger employers, we signed new Memoranda of Understanding with the Care Quality Commission and the Data and Barring Service. These agreements set out how we will work together to achieve our separate statutory functions but also our joint objective of safeguarding the health and well-being of the public.

Other activities focussed on our commitment to building an evidence base for the field of professional regulation. We published 'Preventing small problems from becoming big problems in health and care'. A research report undertaken on our behalf by Professor Zubin Austin from the University of Toronto and the Picker Institute Europe. The report provides an insight into the triggers of disengagement from work for health and care professionals, and explores ways in which preventative action might be implemented.

In addition, as we are always looking at cost efficiency in the fitness to practise process, we commissioned research into the determinants of fitness to practise costs and the relative costs of the different stages of the process. We are working with colleagues at the Centre for Health Service Economic and Organisation on this research.

We continue to look at ways to improve and develop our processes. In 2015–16 this will include a review of our Standard of acceptance policy. The review will take into account the changing nature of the cases we receive, feedback from those involved in the process and feedback gathered from our audit and complaints data. We anticipate some key amendments to the Policy which will ensure it remains fit for purpose. We also plan to increase the accessibility of the Policy given that although the overall number of cases closed without being considered by an ICP (ie where the case has not met the Standard of acceptance) slightly decreased in 2014–15 from 2013–14, the percentage of those cases received from members of the public remained high (56 per cent).

We will also start work to further separate our investigation and adjudication functions to ensure enhanced independence in our fitness to practise process.

We were pleased the Professional Standards Authority recognised that we continue to meet all of the required standards in their 2014–15 performance review. We recognise they have raised timeliness in dealing with cases and timeliness in dealing with interim order applications as areas for improvement. These are areas we have previously concentrated on and have included in our 2015–16 workplan to focus on further to ensure we deal with all cases as quickly as possible.

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

John Barwick
Acting 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 2014 to 31 March 2015 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 visit 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, we will 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. Further information about how to tell us about a fitness to practise concern is in our brochure How to raise a concern, which is available 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 that means that 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);
- get involved in clinical or social care arrangements;
- reverse decisions of other organisations or bodies;
- 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 HCPC's 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.

In 2014–15 we reviewed six practice notes: Assessors and Expert Witnesses; Case Management and Directions; Disclosure of Unused Material; Cross Examination in Cases of a Sexual Nature; Health Allegations; and Requiring Production of Information and Documents and Summoning Witnesses.

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 2014–15

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 policy 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 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 regularly review this Policy in light of the changing nature and volumes of cases received and to ensure it continues to be a clear and understandable case management tool. A revised version of this Policy, following our latest review, will be available in 2015. 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 2014–15 compared to the total number of professionals registered by the HCPC (as of 31 March 2015).

Table 1 Total number of cases received in 2014–15

	Number of cases	Total number of registrants	% of registrants subject to complaints
2014–15	2,170	330,887	0.66

The proportion of HCPC registrants who have had a fitness to practise concern raised about them has increased slightly, from 0.64 per cent of all professionals on the Register in 2013–14 to 0.66 per cent in 2014–15. This means that only about one in 166 registrants were the subject of a new 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 2013–14 the number of cases received in 2014–15 increased by 4.8 per cent (in actual numbers, an increase of 101 cases). The number of professionals registered by the HCPC also increased over the same period by 2.7 per cent (in actual numbers, an increase of 8,866 registrants).

Graphs 1a and 1b shows the number of fitness to practise concerns received between 2010–11 and 2014–15 compared to the total number of HCPC registrants.

Table 2 Total numbers of cases and percentage of Register

Year	Number of cases	Number of registrants	% of Register
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
2014–15	2,170	330,887	0.66

Graph 1a Number of Fitness to Practise cases received by year 2010–11 to 2014–15

Year	Number of cases	% of register
2010–11	759	0.35
2011–12	925	0.42
2012–13	1653	0.52
2013–14	2069	0.64
2014–15	2170	0.66

Graph 1b Number of Registrants on HCPC Register by year from 2010–11 to 2014–15

Year	Number of registrants
2010–11	215,083
2011–12	219,162
2012–13	310,942
2013–14	322,021
2014–15	330,887

Cases by profession and complainant type

The following tables and graphs show information about who raised fitness to practise concerns in 2014–15 and how many cases were received for each of the professions the HCPC regulates. The total number of cases received in 2014–15 was 2,170.

Table 3 provides information about the source of the concerns which gave rise to these cases. Members of the public continue to be the largest complainant group, making up 46 per cent of the total number of concerns received. This has increased from 2013–14 when the proportion was 39 per cent.

Similarly employers continue to be the second largest source of concerns, comprising 26 per cent of the total. This is a slight decrease from 2013–14 when the proportion was 29 per cent.

Table 3 Who raised concerns in 2014–15?

Who raised a concern	Number	%
Article 22(6) / anon	65	3.0
Employer	554	25.5
Other	103	4.7
Other registrant / professional	71	3.3
Professional body	21	1.0
Police	15	0.7
Public	988	45.5
Self-referral	353	16.3
Total	**2,170**	**100**

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.

Table 4 Cases by profession and complainant type

Profession	Article 22(6) / Anon	%	Employer	%	Other	%	Other registrant	%	Police	%	Professional body	%	Public	%	Self referral	%	Total
Arts therapists	0	0	4	0.7	0	0.0	1	1.4	0	0.0	0	0.0	3	0.3	3	0.8	11
Biomedical scientists	1	1.5	22	4.0	0	0.0	5	7.0	0	0.0	1	6.7	3	0.3	4	1.1	36
Chiropodists / podiatrists	1	1.5	13	2.3	2	1.9	0	0.0	1	4.8	2	13.3	27	2.7	10	2.8	56
Clinical scientists	0	0.0	3	0.5	0	0.0	1	1.4	0	0.0	0	0.0	0	0.0	2	0.6	6
Dietitians	0	0.0	6	1.1	0	0.0	0	0.0	0	0.0	1	6.7	3	0.3	5	1.4	15
Hearing aid dispensers	0	0.0	2	0.4	0	0.0	0	0.0	0	0.0	2	13.3	9	0.9	5	1.4	18
Occupational therapists	6	9.2	33	6.0	4	3.9	2	2.8	2	9.5	1	6.7	29	2.9	20	5.7	97
Operating department practitioners	3	4.6	25	4.5	6	5.8	1	1.4	1	4.8	0	0.0	2	0.2	22	6.2	60
Orthoptists	0	0.0	0	0.0	0	0.0	1	1.4	0	0.0	0	0.0	0	0.0	1	0.3	2
Paramedics	16	24.6	52	9.4	9	8.7	10	14.1	0	0.0	2	13.3	42	4.3	100	28.3	231
Physiotherapists	3	4.6	37	6.7	6	5.8	4	5.6	7	33.3	0	0.0	58	5.9	18	5.1	133

Practitioner psychologists	2	3.1	17	3.1	14	13.6	14	19.7	1	4.8	1	6.7	99	10.0	9	2.5	157
Prosthetists / orthotists	0	0.0	2	0.4	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	2
Radiographers	1	1.5	35	6.3	3	2.9	4	5.6	4	19.0	2	13.3	13	1.3	18	5.1	80
Social workers in England	32	49.2	295	53.2	58	56.3	28	39.4	5	23.8	2	13.3	696	70.4	135	38.2	1251
Speech and language therapists	0	0.0	8	1.4	1	1.0	0	0.0	0	0.0	1	6.7	4	0.4	1	0.3	15
	65	**100**	**554**	**100**	**103**	**100**	**71**	**100**	**21**	**100**	**15**	**100**	**988**	**100**	**353**	**100**	**2170**

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.

Graph 2 Who raised concerns in 2014–15?

Who raised concern	Number	%
Article 22(6) / anon	65	3.0
Employer	554	25.5
Other	103	4.7
Other registrant / professional	71	3.3
Professional body	21	1.0
Police	15	0.7
Public	988	45.5
Self-referral	353	16.3

Total	**2,170**	**100**

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 42b Cases by profession

Profession	Number of cases	% of total cases	Number of registrants	% of the Register	% of registrants subject to concerns
Arts therapists	11	0.51	3,620	1.09	0.30
Biomedical scientists	36	1.66	22,640	6.84	0.16
Chiropodists / podiatrists	56	2.58	12,911	3.90	0.43
Clinical scientists	6	0.28	5,296	1.60	0.11
Dietitians	15	0.69	8,528	2.58	0.18
Hearing aid dispensers	18	0.83	2,151	0.65	0.84
Occupational therapists	97	4.47	36,128	10.92	0.27
Operating department practitioners	60	2.76	12,182	3.68	0.49
Orthoptists	2	0.09	1,379	0.42	0.15
Paramedics	231	10.65	21,185	6.40	1.09
Physiotherapists	133	6.13	49,685	15.02	0.27
Practitioner psychologists	157	7.24	20,996	6.35	0.75
Prosthetists / orthotists	2	0.09	1,011	0.31	0.20
Radiographers	80	3.69	29,786	9.00	0.27
Social workers in England	1,251	57.65	88,397	26.72	1.42
Speech and language therapists	15	0.69	14,992	4.53	0.10
Total	**2,170**	**100**	**330,887**	**100**	**0.66**

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. In 2014–15 no cases were received against ‘grandparented’ registrants and 3 per cent of cases received involved international registrants. This is similar to the previous year.

Graph 3 Cases by route to registration 2014–15

Route	% of cases	% of Register
Grandparenting	0	1
International	3	5
UK	97	94

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 2014–15, 1,042 cases were closed without being considered by a panel of the HCPC's Investigating Committee, a 3.5 per cent decrease compared to 2013–14 (where 1,080 cases were closed in this way). In 2014–15, 587 cases (56 per cent) that were closed in this way came from members of the public. This is the same percentage as 2013–14.

In 2014-15, 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 six months. The median average is the same as the previous year however the mean average has increased by one month. This may reflect the increase in the number of complaints received from the public and the requirement to request further information in order to ensure that cases are closed appropriately.

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	% of cases	Cumulative % of cases
0 to 4	504	504	48.4	48.4
5 to 8	315	819	30.2	78.6
9 to 12	144	963	13.8	92.4
13 to 16	43	1,006	4.1	96.5
17 to 20	21	1,027	2.0	98.6
over 20	15	1,042	1.4	100.0
Total	**1,042**		**100.0**	

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 in England, 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	14	1.3
Chiropodists / podiatrists	26	2.5
Clinical scientists	4	0.4
Dietitians	4	0.4
Hearing aid dispensers	12	1.2
Occupational therapists	43	4.1
Operating department practitioners	22	2.1
Orthoptists	0	0.0
Paramedics	115	11.0
Physiotherapists	67	6.4
Practitioner psychologists	80	7.7
Prosthetists / orthotists	0	0.0
Radiographers	27	2.6
Social workers in England	614	58.9
Speech and language therapists	10	1.0
Total	**1042**	**100.0**

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.'

An ICP 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 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 (ie misconduct, lack of competence, physical or mental health, caution or conviction or a decision made by another regulator responsible for health and social care); 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 whole. Examples of 'no case to answer' decisions can be found on page X.

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. 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.

In these 'no case to answer' decisions, if there are matters arising which the Panel considers should be brought to the attention of the registrant, it may include a learning point. Learning points are general in nature and are for guidance only. They assist with proportionality in the fitness to practise process as they allow ICPs to acknowledge that a registrant's conduct or

competence may not have been of the standard expected and that they should be advised on how they may learn from the event. While ensuring that only matters which meet all three elements of the 'realistic prospect' test are referred to a final hearing. In 2014–15 ICPs issued learning points in 50 cases. This is an increase from nine cases in 2013–14. This increase may in part be explained by a strengthened focus on learning points in the training provided to Panel members.

There were 849 cases considered by an ICP in 2014–15 (of these cases 39 were considered by an ICP twice as panels had requested further information). This is an increase of 20 per cent from 2013–14 when 707 cases were considered by an ICP. This is a notable increase, however it is one we had forecast due to the high number of concerns we received in 2013–14 (25% more than the previous year). We therefore planned our resources to allow for additional ICP hearing days to ensure a higher volume of cases could be considered in 2014–15.

Graph 4 shows the percentage of 'case to answer' decisions each year from 2010–11 to 2014–15. The 'case to answer' rate for 2014–15 is 53 per cent, the same as 2013–14.

Graph 4 Percentage of allegations with a case to answer decision

Year	% of cases with no case to answer
2010–11	57
2011–12	51
2012–13	58
2013–14	53
2014–15	53

Decisions by Investigating Committee Panels

Table 7 Examples of no case to answer decisions

This table shows a range of cases that were considered by an Investigating Committee Panel in 2014–15. The examples describe the allegation and a brief rationale of the Panel's decision of no case to answer.

Type of issue	Reason for no case to answer decision
It was alleged that a practitioner psychologist failed to effectively supervise an assessment of a prisoner undertaken by a trainee psychologist.	The Panel noted that most of the evidence presented in support of the assessment's findings was historical and that it was unclear whether up to date information had been considered. On this basis the Panel found that there was a realistic prospect of proving the facts of the allegation. Since the outcome of the assessment had serious consequences for the prisoner's rehabilitation, the Panel also found there was a realistic prospect of proving those facts amounted to misconduct and / or a lack of competence. However the Panel did not consider there was a realistic prospect of finding the registrant's fitness to practise to be impaired. In reaching its decision, the Panel noted that the alleged facts had occurred some five years earlier and in that time the registrant had made changes to her practice. In particular, how she reviews assessments. It also noted that there was no evidence that the lapse which gave rise to the allegation was part of a pattern of behaviour. Notwithstanding this, the Panel issued the registrant with a learning point to ensure that junior staff under her supervision observe the relevant guidance when undertaking formal assessments.
A paramedic self-referred an incident where he had allegedly	The Panel found sufficient evidence from the employer's investigation to

communicated poorly with a service user and their family during an emergency call and had completed the service user's records inadequately.	support the facts and that the facts amounted to misconduct and / or lack of competence. However, the Panel was not satisfied that there was a realistic prospect of finding fitness to practise impairment. In reaching its decision, the Panel noted the registrant had been required by his employer to address the identified failings through remedial action. This included completing reflective practice and attending customer care training. The Panel also noted that the registrant's response to the allegations demonstrated insight and that through a reflective approach he had learnt from the incident.
An operating department practitioner self-referred a conviction for a drink driving offence.	The conviction certificate satisfied the Panel that there was a realistic prospect of proving the facts and the ground. 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. In reaching its decision, the Panel noted that in his response to the allegation, the registrant had evidenced insight and that the lapse in his behaviour was an isolated incident. The Panel also took into account that the incident had occurred while the registrant was on leave and so had no direct link to his professional practice.
A practitioner psychologist self-referred that she had been the subject of a disciplinary investigation by her employer for behaving in an aggressive and threatening manner towards colleagues whom she managed.	The Panel was satisfied the realistic prospect test was met in relation to both the facts and the grounds. In reaching this conclusion the Panel noted that the registrant's behaviour had persisted over a prolonged period and had affected a number of people.

	In considering whether there was a realistic prospect of impairment being found, the Panel took account of the level of insight shown in the registrant's response to the allegations and the remedial action she had already taken, including a willing engagement with counselling, mediation with those affected and acceptance of a new post which did not carry management responsibilities. The registrant's manager had also provided a supportive reference demonstrating that the registrant was now well integrated into the team and was working alongside the individuals who had previously complained about her. For these reasons the Panel's conclusion was that there was not a realistic prospect of finding current impairment.
The allegations related to a physiotherapist using excessive pressure in treating a service user's back and communicating poorly with the service user during the treatment session.	In relation to the allegation of using excessive pressure during the treatment, the Panel noted that the technique used by the registrant is commonly practised and can cause bruising. In relation to the allegation about communication, the Panel noted that in her response, the registrant denied the allegation in part but acknowledged she could have communicated better with the service user. On this basis the Panel found there was a realistic prospect of proving some of the facts but that these would not amount to a lack of competence or misconduct. In reaching its decision, the Panel recognised this had been a one-off incident and the registrant had adjusted her practice both to ensure she communicates with service users throughout treatment sessions

	and that he thoroughly documents risk factors and post-treatment issues.
A chiropodist / podiatrist self-referred disciplinary action taken by his employer in relation to poor record keeping.	In his response to the allegations the registrant admitted the facts. The Panel noted that it was alleged the registrant had failed to complete records for 17 service users and to have completed records inadequately in three cases. Such persistent lapses persuaded the Panel that there was a realistic prospect of a future panel finding misconduct or a lack of competence. However the Panel recognised that the registrant had acknowledged and demonstrated insight into the shortcomings in his professional practice and had proactively taken steps to remedy these through additional training in record keeping. For these reasons the Panel's conclusion was that there was not a realistic prospect of finding current impairment.
A radiographer self-referred that she was the subject of an investigation by her employer for allowing her HCPC registration to lapse while continuing to practise.	The Panel was satisfied on the basis of information provided by the registrant's employer and by her own submissions that there was a realistic prospect of proving the facts. But the Panel was not persuaded that the facts, if proved, would amount to misconduct. It recognised the isolated nature of the incident in an otherwise unblemished 20 year career and noted that the registrant had shown insight by acting quickly to resolve the registration issue once her employer had alerted her to the matter.
It was alleged that a dietitian had demonstrated poor clinical skills by failing to undertake comprehensive consultations and by failing to	The Panel considered documents produced by the registrant's former employer within its capability

explain the rationale underpinning advice given to service users. In addition, that the registrant was unable to practise autonomously and required constant supervision.	process and also the registrant's response to the allegations. The Panel noted that the registrant had resigned however and that at the time of her resignation she was on course to address the shortcomings in her practice as identified by her by the capability process. It also took note of the contextual information provided by the registrant which helped explain why her practice had deteriorated. The registrant was also able to submit evidence that since her resignation she had undertaken a number of locum roles satisfactorily (she provided supportive references from her managers in these locum roles). The Panel was therefore of the view that, while there was a realistic prospect of proving the facts and grounds, there was not a realistic prospect of finding the registrant's fitness to practise currently impaired.
It was alleged that a social worker demonstrated multiple shortcomings in his professional practice, which in the main related to inadequate record keeping.	The Panel was satisfied that information provided by the registrant's employer was sufficient to indicate a realistic prospect of proving the facts. It was also satisfied that, if proven, the facts could amount to misconduct and / or lack of competence. The Panel noted that the registrant was a senior social work practitioner with a breadth of experience. It acknowledged that the allegations were serious and related to fundamental aspects of social work practice. Nonetheless, it noted, his employer was providing support to ensure he maintained the standards expected of an experienced practitioner. The Panel also considered that the registrant had shown significant insight and had engaged fully in the remediation

	process, including undertaking extensive further training. On this basis, the Panel concluded that there was not a realistic prospect of finding the registrant's fitness to practise currently impaired. In making this decision the Panel noted the shortcomings in the registrant's professional performance were rooted in difficulties he was experiencing in his personal life and these might have been dealt with better if addressed sooner. Accordingly, the Panel issued a learning point reminding the registrant to seek an appropriate support network at the earliest opportunity in the event of any further concerns which might affect his performance at work.

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 employers represent the highest percentage (68 per cent) of 'case to answer decisions' and are a large complainant group. However, allegations received from the police represent the second highest percentage (63 per cent) of 'case to answer decisions' and are a small complainant group.

Cases referred anonymously, or by article 22(6), have a case to answer rate of 53 per cent, and self-referrals a rate of 45 per cent. Allegations from members of the public have a case to answer rate of 24 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 2014–15, they raised 554 concerns. Of the 399 of these that were considered at ICP, 271 were judged to have a case to answer.

Members of the public are the largest complainant category but have the second lowest 'case to answer' rate. Of the 124 cases that were considered at ICP, 24 per cent were judged to have a 'case to answer' decision. This represents a 9 per cent increase in the number of 'case to answer' decisions made in respect of concerns raised by members of the public in 2013–14.

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	10	9	19	53
Employer	271	128	399	68
Other	8	13	21	38
Other registrant / professional	11	10	21	52
Police	12	7	19	63
Professional body	0	3	3	0
Public	30	94	124	24
Self-referral	91	113	204	45
Total	**433**	**377**	**810**	**53**

Case to answer decisions and route to registration

Table 9 shows that there is a 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	0	0	0	0	0	0
International	20	4.6	14	3.7	34	4.2
UK	413	95.4	363	96.3	776	95.8
Total	433	100	377	100	810	100

Time taken from point of meeting the Standard of acceptance to Investigating Committee Panel

Table 10 shows the length of time taken for allegations to be put before an ICP in 2014–15. The table shows that 88 per cent of allegations were considered by an ICP within eight months of the point of meeting the Standard of acceptance. This is a slight decrease from 2013–14 when 91 per cent of allegations were considered by an ICP within eight months of the point of meeting the Standard of acceptance.

The mean length of time taken for a matter to be considered by an ICP was five months from receipt of the allegation and the median length of time was three months. This is a decrease from 2013–14, when the mean and median were six and four months respectively.

Table 10 Length of time from point of meeting Standard of acceptance to Investigating Committee Panel

Number of months	Number of cases	Cumulative number of cases	% of cases	Cumulative % cases
1–4	523	523	64.57	64.57
5–8	186	709	22.96	87.53
9–12	58	767	7.16	94.69
13–16	24	791	2.96	97.65
17–20	8	799	0.99	98.64
21–24	7	806	0.86	99.51
25–28	1	807	0.12	99.63
29–32	1	808	0.12	99.75
33–36	1	809	0.12	99.88
Over 36	1	810	0.12	100.00
Total	**810**			

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 2014–15, representations were made to the ICP by either the registrant or their representative in 80 per cent of the cases considered. This was the same in 2013–14.

A total of 377 cases considered by an ICP resulted in a ‘no case to answer’ decision. Of this number, 93 per cent were cases where representations were provided. By contrast, only 7 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

Representation provided by	Case to answer	No Case to answer
Registrant	257	301
Representative	40	48
None	136	28
Total	433	377

Interim orders

In certain circumstances, panels of our practice committees may impose an 'interim suspension order' or an 'interim conditions of practice order' on registrants subject to a fitness to practise investigation. These interim orders prevent the registrant from practising or places limits on their practice, while the investigation is on-going. 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 will remain until the case is heard or the order is lifted on review. The duration of an interim order is set by the Panel however 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 2014–15 we applied to the High Court for an extension of an interim order in 15 cases. All applications were granted and extended for up to twelve months.

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 2014–15, 80 applications for interim orders were made, accounting for 3.6 per cent of the allegations being investigated. 71 (89%) of those applications were granted and nine (11%) were not. In 2013–14, 97 applications were made and 88 per cent of those applications were granted. Therefore, although there was an 18 per cent decrease in the number of applications made in 2014–15 compared the previous year, the proportion of applications granted remained the same.

Social workers in England and paramedics had the highest number of applications considered. These professions also had the highest number of applications considered in 2013–14.

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, or either order may be revoked. In 2014–15 there were eight cases where an interim order was revoked by a review panel.

We risk assess all complaints on receipt to help determine whether to apply for an interim order. In 2014–15, the median time from receipt of a complaint to a Panel considering whether an interim order was necessary was 20.4 weeks. In 2013–14, this was 15 weeks.

Not all interim order applications are made immediately on receipt of the complaint. It may be that we receive insufficient information with the initial complaint or that during the course of the investigation the circumstances of the case change. Specific examples of this from 2014–15 are new information received from the Police about ongoing investigations which changes the level of risk and information relating to the deterioration of registrants health conditions. As such, we also risk assess new material as it is received during the lifetime of a case to decide if it indicates that an interim order application in the case is necessary.

In 2014–15, the average time from the risk assessment of the relevant information indicating an interim order may be necessary, to a Panel hearing the application was 17 days. In 2013–14, this was 18 days.

Sixty eight per cent of the interim order applications made in 2014–15 were in cases where the complainant was the employer. The median time for these cases from receipt of complaint to a Panel considering whether an interim order was necessary was 17 weeks. We have been working on a number of

initiatives to enhance our engagement with employers, to ensure the timely provision of information and thereby enable us to make informed risk assessments. These initiatives will be rolled out in 2015–16 and we will monitor their impact in this area.

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	1	0	0	0
Biomedical scientists	3	2	1	28	0
Chiropodists / podiatrists	2	2	0	9	0
Clinical scientists	0	0	0	0	0
Dietitians	1	1	0	5	0
Hearing aid dispensers	0	0	0	4	0
Occupational therapists	2	2	0	9	1
Operating department practitioners	7	6	1	20	0
Orthoptists	0	0	0	0	0
Paramedics	13	12	1	41	1
Physiotherapists	10	10	0	22	1
Practitioner psychologists	1	1	0	3	0
Prosthetists / orthotists	0	0	0	1	0
Radiographers	5	4	1	5	0
Social workers in England	35	30	5	101	4
Speech and language therapists	0	0	0	1	1
Total	**80**	**71**	**9**	**249**	**8**

Public hearings

Three hundred and fifty one final hearing cases were concluded in 2014–15. This is an increase of 84 cases from the previous year.

Hearings where allegations were well founded concerned only 0.03 per cent of registrants on the HCPC Register.

Hearings can be adjourned in advance administratively by the Head of Adjudication if an application is made more than 14 days before 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. In 2014–15, 72 cases which were listed for a hearing were either adjourned or concluded part heard.

Panels have the power to hold preliminary hearings in private with the parties for the purpose of case management. Such hearings allow for substantive evidential or procedural issues, such as the use of expert evidence or the needs of a vulnerable witness, to be resolved (by a Panel direction) prior to the final hearing taking place. This assists in final hearings taking place as planned. In 2014–15, 48 cases had a preliminary hearing.

Cases transferred from the General Social Care Council are not included in this section. Please see the executive summary for further information about 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 2014–15, in addition to those in Belfast, Cardiff, Edinburgh and London, hearings took place in Bridgend, Cambridge, Glasgow, Inverness, Leeds, Liverpool and Middlesbrough.

Table 12 illustrates the number of public hearings that were held from 2010–11 to 2014–15. 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 a case was part heard 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
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	689
2014–15	337	351	236	5	0	916

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.

The length of time taken for cases that were referred for a hearing to conclude was a mean of 17 months and a median of 14 months from receipt of the allegation. This is the same as the previous year.

The length of time for a hearing to conclude 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 % of cases
0 to 4	0	0	0.0	0.0
5 to 8	19	19	5.4	5.4
9 to 12	122	141	34.8	40.2
13 to 16	80	221	22.8	63.0
17 to 20	62	283	17.7	80.6
21 to 24	24	307	6.8	87.5
25 to 28	21	328	6.0	93.4
29 to 32	8	336	2.3	95.7
33 to 36	5	341	1.4	97.2
Over 36	10	351	2.8	100

In last year's report we stated we had been analysing the length of time cases take to conclude. Using this analysis we have identified three main areas where delays may occur: at the initial stage of the investigation (when we are assessing if a concern meets the Standard of acceptance); during the further investigation conducted after a case to answer decision; and when the case is waiting to be scheduled for a final hearing. In 2014–15, to improve in these areas, we have:

- worked on a number of initiatives to improve our engagement with employers to help ensure the timely provision of information (we targeted employers for this work as they are the second largest complainant group and as they have the highest case to answer rate);
- re-modelled our communication methods with the external solicitors we instruct to undertake the post case to answer investigation so they are risk and exception based;
- started a pilot to trial the use of pre-hearing teleconferences to assist in identifying and resolving preliminary issues prior to a final hearing; and
- developed criteria to categorise cases (reception, standard and advancement) in order to inform the allocation of work and to potentially develop specialist teams or individuals to assist in the timely progression of cases.

We have also continued to use a risk-based reporting system to identify red, amber and green cases and a targeted approach to case-progression meetings.

Table 14 Time taken to conclude cases at final hearing from 2010–11 to 2014–15.

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
2014–15	351	16	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 2014–15, the total length of time for this combined group was a mean of nine months and a median average of seven months.

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 2014–15, there were 72 cases that took longer than 24 months to conclude. This accounted for four per cent of the total closures at all stages. This is similar to the percentage rate to the previous year.

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 cases	Cumulative number of cases	% of cases	Cumulative % of cases
0 to 4	569	569	32.1	32.1
5 to 8	497	1066	28.1	60.2
9 to 12	266	1332	15.0	75.3
13 to 16	174	1506	9.8	85.1
17 to 20	119	1625	6.7	91.8
21 to 24	73	1698	4.1	95.9
25 to 28	33	1731	1.9	97.8
29 to 32	17	1748	1.0	98.8
33 to 36	10	1758	0.6	99.3
Over 36	12	1770	0.7	100.0
Total	**1,770**			

Days of hearing activity

Panels of the Investigating Committee, Conduct and Competence Committee and Health Committee met on 1,672 days in 2014–15 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 2014–15.

Of these, 1,180 hearing days were held to consider final hearing cases. This includes where more than one hearing takes place on the same day. This number includes cases that were part heard or adjourned. This is a 24 per cent increase from 870 hearings days in 2013–14. This is a notable increase however is one we had forecast due to the high number of concerns we received in 2013–14 (25% more than the previous year). We therefore planned our resources to allow for more hearings days to ensure a higher volume of cases could be considered in 2014–15.

Panels of the Investigating Committee hear final hearing cases concerning fraudulent or incorrect entry to the Register only. There were two cases in 2014–15. One case concluded with no further action being taken whereas the other concluded with the registrant being removed from the Register.

Panels may hear more than one case on some days to make the best use of the time available. Of the 351 final hearing cases that concluded in 2014–15,

it took an average of 3.4 days to conclude cases. This is comparable to 3.6 days in 2013–14.

Table 16 Breakdown of public and private committee activity in 2014–15

Private meetings		Public hearings	
Activity	**Number of days**	**Activity**	**Number of days**
Investigating Committee	136	Final hearings	1,180
Preliminary meetings	36	Review of substantive sanctions	124
		Interim orders	196
Total	**172**		**1,500**

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.

These are the sanctions available to a Panel if the grounds of the allegation include misconduct.

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, this is known as voluntary removal agreement. 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 2014–15. 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:

- 22 per cent were not well found;
- 46 per cent had a sanction that prevented them from practising (including voluntary removal);
- 11 per cent had a sanction that restricted their practice; and
- 21 per cent had a sanction that did not restrict their practice (15% 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	Discontinued	Removed (incorrect/ fraudulent entry)	Struck off	Suspension	Voluntary removal	Total
Conduct and Competence Committee	0	52	38	6	74	15	0	62	66	28	341
Health Committee	0	0	1	0	2	0	0	0	3	2	8
Investigating Committee (fraudulent and incorrect entry)	0	0	0	1	0	0	1	0	0	0	2

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	Discontinued	Removed (fraudulent / incorrect)	Struck off	Suspended	Consent - removed	
Arts therapists	0	0	0	1	0	0	0	0	0	
Biomedical scientists	3	5	1	5	0	0	1	1	1	
Chiropodists / podiatrists	1	1	0	3	2	0	1	1	1	
Clinical scientists	0	0	0	0	0	0	0	0	0	
Dietitians	1	0	0	1	0	0	0	2	0	
Hearing aid dispensers	0	0	0	1	0	0	1	1	1	
Occupational therapists	4	2	0	4	2	0	4	3	2	
Operating department practitioners	4	2	1	4	0	0	4	4	0	
Orthoptists	0	0	0	0	0	0	0	0	0	
Paramedics	4	1	0	9	0	0	9	15	10	
Physiotherapists	4	7	1	5	0	0	9	3	0	
Practitioner psychologists	0	3	0	3	1	0	1	3	1	
Prosthetists / orthotists	2	0	0	0	0	0	0	0	0	
Radiographers	1	2	0	2	0	0	8	3	1	
Social workers in England	28	12	4	36	9	1	23	33	9	
Speech and language therapists	0	4	0	2	1	0	1	0	4	
Total	**52**	**39**	**7**	**76**	**15**	**1**	**62**	**69**	**30**	**351**

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. 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. 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 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 2014–15, 20 per cent of registrants represented themselves, with a further 31 per cent choosing to be represented by a professional. This combined figure of 49 per cent is a decrease from 2013–14, when registrants or representatives attended to represent in 60 per cent of cases. We are looking at why this may have happened and ways in which we can enhance registrants engagement with the fitness to practise process when they are subject to a concern. As part of this work, we will explore this issue with the registrants' representative bodies.

Graph 6 Representation at final hearings

Registrant	70	20%
Representative	109	31%
None	172	49%

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 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	11	25	16	52
Conditions	10	21	8	39
No further action	2	5	0	7
Not well found	27	40	9	76
Discontinued in full	4	4	7	15
Removed	0	0	1	1
Struck off	7	9	46	62
Suspended	10	9	50	69
Consent – removed	0	1	29	30
Total	**71**	**114**	**166**	**351**

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 96 per cent, which is higher than the 92 per cent in 2013–14.

Table 20 Outcome and route to registration

Route to registration	Other	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	0	0	0	0	0	1	1	0.3	2
International	0	1	4	0	4	0	3	2	1	15	4.3	7
UK	0	51	35	7	87	1	59	67	28	335	95.4	91
Total	**0**	**52**	**39**	**7**	**91**	**1**	**62**	**69**	**30**	**351**	**100.0**	**100**

Table 21 shows the source of the original complaint for cases that concluded at a final hearing in 2014–15. 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.

Nine of the 18 hearings (50 per cent) where the source of the original complaint was a member of the public were not well founded. This is compared to the 23 per cent where the source of the original complaint was an employer and 30 per cent where registrants had self-referred. This 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	2	0	3	0	4	16

Condition of practice	2	27	1	0	0	2	1	6
No further action	0	3	0	0	1	0	0	0
Not well founded / discontinued	2	50	5	1	2	1	9	19
Removed	1	0	1	0	0	0	0	0
Consent	4	18	0	0	1	0	0	6
Struck off	3	41	3	1	5	2	2	5
Suspension	2	49	2	2	0	1	2	11
Not impaired	0	2	0	0	0	0	0	0
Total	**18**	**213**	**14**	**4**	**15**	**6**	**18**	**63**

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 2014–15 there were 75 cases considered to be not well founded at final hearing. This is an increase of 15 cases (20%) compared to the previous year.

However, as a proportion of the total number of concluded hearings, the number that are not well founded is consistent with 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 XX are referred to a final hearing.

Table 22 sets out the number of not well founded cases between 2010–11 and 2014–15.

Table 22 Cases not well-founded

Year	Number of not well founded	Total number of concluded cases	% of cases not well founded
2010–11	85	315	27.0
2011–12	68	287	23.7
2012–13	54	228	23.7
2013–14	60	267	22.5
2014–15	75	351	21.4

In half of the cases (37 cases) which were not well founded, registrants demonstrated that their fitness to practise was not impaired. The test is that current 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 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. This 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 paramedic, did not provide an acceptable standard of care to a service user with chest pain. In particular, the registrant did not provide adequate pain relief, failed to diagnose a serious medical condition, did not transport the service user to the ambulance in an appropriate manner; and inappropriately left the service user in the care of an advanced technician while he drove the ambulance.

Having considered all of the evidence, including oral evidence from the registrant, the Panel found the facts proven in all but one of the allegations. It also found that the proven facts amounted to misconduct. For example, it determined that allowing the service user to walk to the ambulance was inappropriate as the registrant knew her symptoms possibly related to cardiac arrest and he should have dissuaded her from exerting herself. However, the Panel concluded that the registrant's fitness to practise was not impaired by his misconduct. In making this decision the Panel noted the registrant's previously unblemished career and that since the incident he had continued to practice with no other concerns arising. The Panel was therefore of the view that the incident was an isolated event. The Panel also took into account that the registrant had undertaken further training in the relevant areas since the incident and that he had demonstrated insight and remorse, including offering a genuine apology during his evidence. The Panel acknowledged that the registrant had seen the regulatory process as a positive stimulus to enhance his clinical knowledge and in doing so had remediated his practice.

In these circumstances, the Panel concluded that public confidence in the profession and the regulatory process would not be undermined if a finding of impairment was not made. It noted that the public, knowing that the registrant had altered and improved his clinical practice as a result of the incident and investigation, would be satisfied that the regulatory process had achieved its overriding aim of safeguarding the health and well-being of service users.

The Panel therefore determined that the allegation of fitness to practise impairment by reason of misconduct 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 2014–15, twenty nine cases were concluded via the HCPC's consent arrangements at final hearing. This is an increase of nine from the previous year.

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

Consent Case Study

Consent to a caution order for three years was granted in relation to a chiropodist / podiatrist who had breached confidentiality by accessing service user records without a professional reason for doing so. The records in question were those of a family member. The registrant was also found to have accessed her own records inappropriately and those of a third party by accident.

This matter had not previously been considered at a substantive hearing of a Panel of the Conduct and Competence Committee however the Panel was satisfied that granting the consent order rather than having a contested hearing would not be detrimental to public interest. In making this decision, the Panel noted that the registrant's misconduct had not had a serious adverse effect on service users and therefore concluding the matter by consent would not undermine public confidence in the profession or the regulator.

The registrant fully admitted the allegations and that they amounted to misconduct. In a reflective statement she outlined the circumstances from which the misconduct arose. This insight, together with the remedial action she had taken, indicated to the Panel that the registrant was unlikely to repeat her misconduct. It is also indicated that she did not pose a risk to the public.

The Panel considered the proposed sanction of a caution order was appropriate and proportionate to mark the seriousness of the registrant's admitted misconduct.

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 (ie discontinued in full) or part (ie discontinued in part) of the proceedings.

In 2014–15, following applications by the HCPC, allegations were discontinued in full in 15 separate cases by a panel. This is a decrease of seven cases from 2013–14 when allegations were discontinued in full in 22 separate cases.

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

Consistent with previous years, in 2014–15, the majority of cases heard at a final hearing related to allegations that the registrant's fitness to practise was impaired by reason of their misconduct. 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;
- breach of professional boundaries with service users or service user family members;
- breach of confidentiality;
- misrepresentation of qualifications and / or previous employment;
- failure to communicate properly and effectively with service users and / or colleagues;
- posting inappropriate comments on social media;
- acting outside scope of practise;
- falsifying service user records; and
- failure to provide adequate service user care.

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

More details about the decisions made by the Conduct and Competence Committee can be found on our website at www.hcpc-uk.org/complaints/hearings/

Misconduct case study 1

An occupational therapist was made the subject of a conditions of practice order for a period of one year after a Panel of the Conduct and Competence Committee found that he did not demonstrate adequate clinical reasoning, risk assessment or record keeping skills in relation to five elderly service users.

The registrant did not attend the hearing but submitted a written statement in which he admitted to the allegations. Based on his admissions, and its consideration of the evidence, the Panel found the facts of the allegations proven.

The Panel noted that there was some evidence to suggest the registrant's health was affected at the time of the allegations but he had failed to take up his employer's suggestion of assistance from their occupational health service. The Panel also noted that the allegations occurred during a period of a major restructuring at the registrant's employer and that this caused inconsistency in the level of supervision offered to employees. However, it was of the view the registrant could have raised this as a concern or could have taken proactive steps in seeking clinical supervision.

Taking the above into account, and as the allegations represented a significant departure from accepted practices; were not isolated single incidents; and fell below the standard accepted of a registered occupational therapist, the Panel concluded that the allegations amounted to misconduct rather than a lack of competence.

In considering whether the registrant's fitness to practise was currently impaired, the Panel recognised the registrant had demonstrated some insight through cooperating with his employer's investigation and his remorse in admitting to the allegations. However, as the registrant had not meaningfully engaged with the fitness to practise process and had not attended the hearing, the Panel did not have any up to date evidence to demonstrate that the registrant had remediated the concerns about his practice. The Panel determined that without such evidence the registrant may be a continuing risk to service users and accordingly found his current fitness to practise to be impaired.

In determining the appropriate sanction, the Panel considered the aggravating and mitigating factors of the case. The aggravating factors were the registrant was a senior occupational therapist and that at the time of the allegations, he had been on a final warning from his employers. Further, 45 service users had been at risk; the failures were repeated; there was an absence of full insight; and a risk of recurrence. The mitigating factors were the registrant's health issues and the uncertainty of the employer's supervision arrangements at the

time of the allegations. Further, the registrant had admitted the allegations and had shown remorse.

The Panel found that due to the risk of recurrence, a caution order would be insufficient however that a conditions of practice order would be the appropriate and proportionate sanction. The Panel was satisfied that the conditions, which included supervision requirements, a personal development plan and periodic submission of reflective work reports, allowed the registrant to continue to practise in his chosen profession but with sufficient safeguards for service users and public confidence in the profession and the regulatory process.

Misconduct case study 2

An operating department practitioner was suspended from the Register for a period of one year after a Panel of the Conduct and Competence Committee found that he had self-administered oxygen (from an anaesthetic machine) and tramadol (which he had misappropriated) in the workplace. After which, he collapsed and required medical assistance from a colleague, including a doctor who was required to leave an anesthetised service user.

The registrant was neither present nor represented at the hearing, however, in a written statement admitted to the allegations. Based on these admissions, and its consideration of the evidence, the Panel found the facts of the allegation proven.

The Panel noted from the registrant's statement that he cited pre-existing and continuing health issues as reasons for his actions. However, the Panel also noted that the registrant's conduct fell seriously below that expected of an operating department practitioner and breached the HCPC's Standards of conduct, performance and ethics. Further, that the registrant's actions not only endangered his own health but placed colleagues and service users at risk. The Panel therefore determined that allegation amounted to misconduct.

In considering whether the registrant's fitness to practise was currently impaired, the Panel noted he had admitted the allegations, had expressed regret and had insight into his behaviour and its impact on others. However, the Panel did not have any up to date evidence to suggest the registrant had taken steps to address and resolve the health issues he cited led to the misconduct. Nor was there any evidence to suggest the registrant had adopted coping strategies or put other appropriate measures in place to ensure there would be no repetition. The Panel was also of the view that the incident was so serious as to damage public confidence in the profession and the regulatory process. Accordingly, the Panel found the registrant's current fitness to practise to be impaired.

In determining the appropriate sanction the Panel considered the aggravating and mitigating factors. The aggravating factors were the incident took place while the registrant was on duty, posed a risk to the public and involved a breach of trust. The mitigating factors were that no actual harm was caused to

service users, the registrant had demonstrated remorse and insight and he had personal and health problems at the time of the incident.

Taking the above into account, the Panel determined that a failure to restrict the registrant's practice would not provide a satisfactory level of protection to service users and would not provide a sufficient deterrent message to other professionals. It also determined that a conditions of practice order was not appropriate as the registrant had not worked for 18 months and had given no indication that he had kept his skills and knowledge up to date. Further, such an order would not sufficiently address the dishonesty element of the registrant's conduct.

The Panel concluded that a one year period of suspension from the Register was the appropriate and proportionate sanction. It considered this would provide sufficient public protection until such a time when the registrant is able to demonstrate he has taken sufficient steps to ensure there would be no risk of repetition.

Lack of competence

In 2014–15, lack of competence allegations were most frequently cited as the reason for a registrant's fitness to practise being impaired after allegations of misconduct. This is consistent with previous years.

Some of the lack of competence allegations considered included:

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

The case studies below give an illustration of the types of issues that are considered where allegations relate to a lack of competence. They have been based on real cases that have been anonymised.

More details about the decisions made by the Conduct and Competence Committee can be found on our website at www.hcpc-uk.org/complaints/hearings/

Lack of competence case study 1

A social worker was cautioned for a period of three years after a Panel of the Conduct and Competence Committee found wide ranging failings in her record keeping and service user care. It was found that the registrant had failed to complete records on the electronic records system and had not conducted visits within the requirements specified by her employer.

The registrant attended the hearing and gave evidence. After considering all of the evidence, the Panel was satisfied that the registrant was unaware of the standards to which she should adhere to. It noted that the registrant had encountered severe workload pressures and that there were difficulties with

her induction. Taking these factors into account, the Panel was of the view that the registrant had not been wilful or reckless and that the facts proved amounted to a lack of competence and not misconduct.

In considering whether the registrant's fitness to practise was currently impaired, the Panel noted the registrant did no fully appreciate the seriousness of her deficiencies. It found insufficient evidence to suggest the registrant would be suitably assertive in requesting information about an employer's record keeping policies and procedures and supervision of her own records. Accordingly, the Panel found the registrant's current fitness to practise to be impaired.

The Panel went on to determine that the seriousness of the registrant's deficiencies were such public confidence in the profession and the regulator would be undermined if a sanction were not imposed. In determining the appropriate sanction, the Panel took into account that the allegation had occurred while the registrant was working for one particular employer among a series of placements she had undertaken in her chosen, and otherwise unblemished, career as an agency worker. It noted that in a subsequent placement the registrant had specifically requested weekly supervision. The Panel found this to be an indication of both remedial action and the registrant's growing insight into her deficiencies. The Panel was therefore of the view the likelihood of recurrence and risk to service users was low.

The Panel was satisfied that a caution order was the appropriate and proportionate sanction and that a period of three years was sufficient to reflect the seriousness of the case and the need to protect the public and its confidence in the profession.

Lack of competence case study 2

A physiotherapist was issued with a conditions of practice order for a period of 18 months after a Panel of the Conduct and Competence Committee found wide ranging failings in the registrant's clinical care of eight service users over a four month period.

The Panel heard evidence from two witnesses in management roles with the registrant's employer. The registrant also gave evidence and contested the allegations, suggesting that the assessments of his competence by his employer had been unfair.

Having considered all of the evidence, the Panel found the majority of allegations proven and that the allegations amounted to a lack of competence rather than misconduct. The Panel came to this conclusion as it took into account the registrant's own admissions that he lacked competence in two specific areas of practise relevant to the allegations, namely cardio-vascular and respiratory skills. Further as the evidence suggested there were broader concerns with his professional judgement, communication skills and ability to draw upon the appropriate knowledge base.

The Panel went on to determine that the registrant's fitness to practise was currently impaired. In making this decision, the Panel took into account that service users had been put at risk and the registrant had brought his profession into disrepute. Further, that since the time of the allegations the registrant had made no effort to remedy his failings.

In determining the appropriate sanction the Panel considered the aggravating and mitigating circumstances. The aggravating circumstances were that the allegations involved a range of clinical failings which were basic in nature and had the potential to put service users at risk. The registrant had also received a high degree of support from his employer throughout his employment and was on his second rotation in the cardio-vascular and respiratory department. Further, as the registrant had not remedied his failings there was a risk of repetition. The mitigating circumstances were the registrant was fairly new to the profession, had found the cardio-vascular and respiratory department rotation particularly stressful and had passed a number of other rotational placements with good references. He also fully engaged with the regulatory process.

Taking the above into account, the Panel determined that a caution order would not sufficiently protect the public or maintain the standards expected of the profession. It concluded that a conditions of practice order would be the appropriate and proportionate sanction as it would allow the registrant the opportunity to sufficiently address the identified deficiencies in his practice while safeguarding service users and the reputation of the profession. The conditions included a supervision requirement and the completion of a personal development plan.

Convictions / cautions

Criminal convictions or cautions were the third most frequent ground of allegation considered by Panels of the Conduct and Competence Committee in 2014–15. The allegation either solely related to the registrants conviction / s or caution / s or they also included other matters amounting to another ground, for example, misconduct.

Some of the criminal offences considered included:

- theft;
- fraud;
- shoplifting;
- possession of drugs and / or possession of drugs with the intent to supply;
- receiving a restraining order and breach of a restraining order;
- driving under the influence of alcohol;
- failure to provide a specimen;
- assault (common or by beating);
- possession of pornographic images; and
- sexual offences.

More details about the decisions made by the Conduct and Competence Committee can be found on our website at www.hcpc-uk.org/complaints/hearings/

Conviction case study

A biomedical scientist was suspended from the Register for a period of one year after a Panel of the Conduct and Competence Committee considered a two part allegation against him. First, that in May 2013 he was convicted of a drink drive offence and second, that he failed to declare his conviction to the HCPC during the renewal process.

The registrant was neither present nor represented at the hearing and had not engaged in the regulatory process.

The Panel was satisfied that the certified memorandum of conviction and the HCPC documentation were conclusive proof of the allegation and found the facts proven.

In respect to the second part of the allegation, the Panel noted the registrant had a number of opportunities to notify the HCPC of his conviction however he had not done so. In particular, it noted that there is a direct question about convictions and cautions on the renewal form and that when renewing between October / November 2013 the registrant had not indicated that he had received a conviction. The Panel concluded that the registrant had acted deliberately; that it was a serious issue; and a departure from the standards expected of a registrant which amounted to misconduct.

The Panel went on to consider if the registrant's fitness to practise is currently impaired by reason of his conviction and / or misconduct.

The Panel was seriously concerned about the circumstances of the registrant's conviction, in terms of the amount of alcohol he had consumed, the time of the day of the incident and that there was a potential risk to members of the public. It was also concerned that in not declaring his conviction, the registrant had breached two fundamental principles of being a professional, openness and integrity, by his deliberate failure to declare.

The Panel noted that as the registrant had not engaged with the regulatory process there was no evidence to demonstrate that he had insight in to, or had remedied, his behaviour (other than the remorse he expressed when being interviewed by the police). It was therefore of the view that risk of repetition was high. The Panel also considered that confidence in the biomedical scientist profession had been undermined by the registrant's behaviour. The Panel therefore concluded that the registrant's fitness to practise was currently impaired by reason of his conviction and also his misconduct.

In determining the appropriate sanction the Panel considered the aggravating and mitigating circumstances. The aggravating circumstances were that the

Panel had received no evidence of the registrant's insight, remediation or current remorse nor was it aware of the registrant's current professional status or intent. Further, his conviction was not minor in nature. The mitigating circumstances were that the registrant had expressed remorse to the police, prior to this matter the registrant had an unblemished criminal and professional career and there were no concerns about the registrant's competence as a biomedical scientist. Further the drink-drive offence occurred when he was off duty.

Taking the above into account, the Panel determined to take no further action or a caution order would not sufficiently protect the public or maintain the standards expected of the profession or confidence in the profession. As the registrant's impairment related to matters unconnected to his professional practice, the Panel considered a conditions of practice order was inappropriate as it would not be possible to formulate conditions to reflect the areas of concern.

The Panel concluded that as the registrant's conviction and misconduct had the potential to cause harm to service users and as there was no evidence of his insight, a suspension order for a period of one year was the proportionate and appropriate sanction. The Panel considered that the period of suspension would allow the registrant sufficient time to seek to address the issues of insight and remediation. Further, that the public would be adequately protected and that the case would have a deterrent effect on others, who find themselves in the same situation, from failing to declare criminal convictions and cautions to the HCPC.

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 eight cases in 2014–15, this is four cases less than in 2013–14. Of those cases one case resulted in a conditions of practice, two were not well founded, two resulted in voluntary removal by consent and three resulted in suspension.

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 2014–15, 236 review hearings were held. Table 23 shows the decisions that were made by review panels in 2014–15. Similar to the final hearing stage, the HCPC and the registrant concerned may seek to conclude a review case without the need for a contested review hearing. In 2014–15, two of the review cases (1%) were disposed of using voluntary removal agreements.

Table 23 Review hearing decisions

	Adjourned / part heard	Caution	Conditions of practice	Order revoked	Struck off	Suspension	Voluntary removal (consent)	Total
Arts therapists	0	0	0	1	0	0	0	1
Biomedical scientists	3	1	4	3	2	8	0	21
Chiropodists / podiatrists	0	0	1	2	4	2	0	9
Clinical scientists	0	0	0	0	0	0	0	0
Dietitians	0	0	1	0	0	1	0	2
Hearing aid dispensers	0	1	1	0	0	2	0	4
Occupational therapists	5	1	3	5	5	9	0	28
Operating department practitioners	0	0	1	3	2	11	0	17
Orthoptists	0	0	0	0	0	0	0	0
Paramedics	1	0	4	9	9	8	0	31
Physiotherapists	1	2	2	3	4	2	0	14
Practitioner psychologists	0	0	0	3	0	2	0	5
Prosthetists / orthotists	0	0	0	0	0	1	0	1
Radiographers	2	1	0	0	4	3	1	11
Social workers	8	0	12	12	13	35	1	81
Speech and language therapists	0	0	4	1	0	6	0	11

Total	**20**	**6**	**33**	**42**	**43**	**90**	**2**	**236**

Tables 24 and 25 set out the outcomes of the reviews of the suspension and conditions of practice orders in the period 2014–15

Table 24 Suspension orders

Review activity	Number	%
Suspension reviewed, suspension confirmed	85	51.8
Suspension reviewed, replaced with conditions of practice	14	8.5
Suspension reviewed, struck off	34	20.7
Suspension reviewed, caution imposed	6	3.7
Suspension reviewed, removed by consent	1	0.6
Suspension reviewed, no further action	24	14.6
Total	**164**	**100.0**

Table 25 Conditions of practice orders

Review activity	Number	%
Conditions reviewed, replaced with suspension	3	5.8
Conditions reviewed, struck off	9	17.3
Conditions reviewed, conditions confirmed	5	9.6
Conditions reviewed, conditions varied	12	23.1
Conditions reviewed, no further action	22	42.3
Conditions replaced, removed by consent	1	1.9
Total	**52**	**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 2014–15, five applications for restoration were heard, of which two were granted restoration to the Register.

The role of the Professional Standards Authority and High Court cases

The Professional Standards Authority (PSA) 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 2014–15, five HCPC cases were referred to the High Court by the PSA. One case was dismissed by the High Court however the PSA has appealed to the Court of Appeal. Two cases were allowed by the High Court and are being remitted back to a Panel for a decision on sanction. In another case, the registrant agreed to be removed from the Register by consent and in the final case, the HCPC conceded to the appeal and agreed to the making of a strike off order.

Five registrants appealed the decisions made by the Conduct and Competence Committee. One appeal was withdrawn, two appeals were dismissed and two appeals were allowed by the High Court to be remitted back to a Panel for a decision on sanction.

Five judicial review applications were also made. Permission was refused in one case, the appeals withdrawn in two cases and the appeals dismissed in two cases.

The information set out above in relation to the status of the cases was correct at the time of writing this report in September 2015.

Further Information

How to raise a concern

If you would like to raise a concern about a professional registered by the HCPC, please write to us at the following address.

Fitness to Practise Department
The Health 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 http://www.hcpc-uk.org/complaints

Appendix One

Historic statistics

Table 1: Total number of cases received 2002–03 to 2014–15

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
2014–15	2,170	330,887	0.66

Table 2: Who raised concerns 2005–06 to 2014–15

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
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
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
Employer	123	39	161	50	171	40.3	202	42	254	22.9	217	28.6	288	31.1	435	26.3
Other	15	5	1	0.3	5	1.2	16	3	30	3.9	21	2.7	46	5	87	5.3
Other registrant / professional	28	9	16	5	42	9.9	56	12	60	7.8	75	9.9	52	5.6	99	6
Police	24	8	31	9.6	35	8.3	36	7	39	5.1	25	3.3	27	3	27	1.6
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
Public	68	21	78	24.2	108	25.5	109	23	237	30.7	255	33.6	228	24.6	634	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

Total	**316**	**100**	**322**	**100**	**424**	**100**	**483**	**100**	**772**	**100**	**759**	**100**	**925**	**100**	**1653**	**100**

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

Table 3: Cases by profession 2005–06 to 2014–15

Profession	2005–06	2006–07	2007–08	2008–09	2009–10	2010-11	2011-12	2012-13	2013-14	2014-15
Arts therapists	2	4	16	8	5	4	4	7	4	11
Biomedical scientists	21	18	26	46	39	37	66	37	50	36
Chiropodists / podiatrists	62	38	40	62	76	78	55	53	71	56
Clinical scientists	3	2	6	8	4	10	9	9	3	6
Dietitians	7	6	14	1	12	9	12	12	21	15
Hearing aid dispensers	0	0	0	0	0	44	19	25	22	18
Occupational therapists	38	40	45	55	78	62	95	74	105	97
Operating department practitioners	19	22	38	55	38	39	63	45	63	60
Orthoptists	0	1	3	0	2	0	2	2	2	2
Paramedics	43	81	94	99	163	188	252	262	266	231
Physiotherapists	79	52	85	95	126	104	119	122	134	133
Practitioner psychologists	N/A	N/A	N/A	N/A	149	118	138	180	157	157
Prosthetists / orthotists	3	3	3	6	7	1	2	1	2	2

Radiographers	27	44	32	34	47	40	58	56	59	80
Social workers	N/A	N/A	N/A	N/A	N/A	N/A	N/A	734	1085	1251
Speech and language therapists	12	11	22	14	26	25	25	34	25	15
Total	**316**	**322**	**424**	**483**	**772**	**759**	**919**	**1,653**	**2,069**	**2,170**

Table 4: Cases by route to registration 2005–06 to 2014–15

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
Grandparenting	35	11	15	5	15	3.5	21	4.3	24	3	32	4	20	2	6
International	30	9.5	29	9	36	8.5	35	7.3	63	8	40	5	57	7	50
UK	242	77	278	86	373	88	425	88.4	685	89	687	91	848	91	1597
Not known	9	2.5	0	0	0	0	2	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**

Investigating Committee

Table 5: Allegations where a case to answer decision was reached 2004–05 to 2014–15

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
2014–15	53

Table 6: Percentage case to answer, comparison of 2005–06 to 2014–15

	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15
22(6)/Anon	58	86	61	49	69	72	50	76	64	53
BPS transfer cases*	0	0	0	0	7	0	0	0	0	0
Employer	81	84	84	81	80	82	69	73	68	68
Other	0	0	56	34	79	57	63	67	82	38

Other registrant / professional	60	46	77	67	62	29	50	29	31	45
Police	26	28	31	37	50	54	38	50	67	63
Public	18	33	29	22	22	22	17	19	46	24

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

Table 7: Representations provided to Investigating Committee Panel by profession 2006–07 to 2014–15

	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
2014–15	136	256	40	433	28	301	48	377	810

Interim orders

Table 8: Interim order hearings 2004–05 to 2014–15

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
2014–15	71	257	9	2170	3.3

Final hearings

Table 9: Number of hearings 2004–05 to 2014–15

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
2014–15	337	351	166	5	0	854

Table 10: Representation at final hearings 2006–07 to 2014–15

	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
2014-15	71	114	166

Suspension and conditions of practice review hearings

Table 11: Number of review hearings 2004–05 to 2014–15

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
2014–15	236