



Learning points

Digest January-July 2018



1,754
Determinations received



89
Learning points fed back



77
Detailed case reviews



11
Case meetings

Most common sanctions we have fed back on:

▶ Case closed/not impaired/ no misconduct	31
▶ Suspension	23
▶ Conditions	11
▶ Caution	11
▶ No further sanction	11
▶ Further conditions/ suspension	1
▶ Other	1



In this digest we will concentrate on three themes that we have noticed from the volume of learning points identified between January and July 2018:

- health cases;
- failing to seek expert evidence; and
- failing to bring full allegations.

You can read through our previous two digests. The **first digest** concentrated on the quality and level of detail in determinations; and the **second digest** looked at dishonesty, retrospective amendment of allegations and offering no evidence. As ever, we would encourage regulators to share this digest with their panellists and trust that it provides you with a helpful overview of what we have identified during our scrutiny of final fitness to practise decisions.

OUR KEY CONCERNS:

1 Health

We had concerns about the approach taken by a number of regulators to cases where the registrant was suffering from a health condition. Problems arose particularly in cases where the regulator had separate health and conduct committees and the registrant was alleged to have committed misconduct and that misconduct was a result of a health condition. In some cases, the conduct is serious and might lead to erasure. However, we have been concerned that, where it became clear that erasure was not likely, panels or regulators did not follow this through and address the health condition (for example by referring to the health committee or seeking up-to-date information about the registrant's health). The effect of this, particularly where there is a finding of no impairment or a non-restrictive sanction is imposed, is that there remain questions about whether the registrant remains fit to practise.



We would encourage regulators and panels to transfer such cases to the health committee or seek up-to-date health information before reaching a final decision on sanction in such cases.

We have also fed back concerns regarding cases where there are health concerns which, in our view, should continue to be monitored, but panels have decided not to impose a review hearing.

We would encourage regulators and panels to ensure that all health concerns are fully investigated and that panels are provided with sufficient and up-to-date evidence regarding the registrant's current condition and that health assessments are conducted where necessary. This will not only continue to provide adequate patient protection but will provide the necessary support for registrants to address health concerns.

2 Failing to seek expert evidence and/or concerns with expert evidence

We have seen several cases where cases have failed because regulators have not provided expert evidence to show that a registrant's treatment was inappropriate. Instead we are seeing regulators and panels relying on employers' internal investigation notes or opinion that would appear to be heavily out-of-date.

Additionally, we are seeing cases where an expert witness has recommended seeking the view of a more specialised expert, but the regulator has not done so, leading to a particular charge not being found proved.

We have also identified cases in which expert witnesses have been appointed, but where panels have departed from the expert's opinion evidence, preferring their own opinion, without providing sufficient reasons or without putting these views to the witness.

Expert witnesses play a crucial role in assisting panels with often complex clinical issues. We encourage panels to provide thorough reasons as to why they have departed from the expert's opinion. Regulators need to ensure that experts with sufficient knowledge of the clinical issues of concern, are appointed.

3 Failing to bring full allegations

The Authority's appeal in *PSA v (1) NMC (2) Macleod [2014] EWHC 4354 (Admin)* highlighted the importance of all relevant allegations being put to a panel. This applied particularly where some motivation, such as dishonesty was involved.

We continue to see cases in which the allegations do not state the full extent of the misconduct involved and do not capture the seriousness of the failings. This can lead to panels reaching inadequate decisions in respect of misconduct or sanction because they do not have the full picture of the concerns.



Good practice

However, we are seeing cases in which panels are adopting the approach set out in *PSA v (1) NMC (2) Jozi [2015] EWHC 764 (Admin)* and are making decisions to adjourn a case to ensure that all relevant evidence was available and to ensure that a case is properly presented so that a panel are able to reach a fully informed decision.

Get in touch

The Authority's Scrutiny and Quality team has given presentations about our scrutiny work and what we look out for when reading determinations. If you are interested in asking us to deliver presentations to panel members, please contact [Georgina Devoy](mailto:Georgina.Devoy@professionalstandards.org.uk) by email (address as below).

Do let us know what you think about this digest. We would welcome any feedback. If you would like more information, please get in touch with Georgina by emailing: Georgina.Devoy@professionalstandards.org.uk



There is still time to respond to our consultation on the review of the Standards of Good Regulation, asking for feedback on the more detailed proposals we have set out, including the new proposed Standards and the evidence framework. The deadline for responses is **10 September 2018**. You can find out more from: www.professionalstandards.org.uk/standards-consultation

Key fitness to practise statistics 2017/18



4,095

DETERMINATIONS
RECEIVED



265

DETAILED CASE REVIEWS



35

CASE MEETINGS



8

CASES APPEALED



Useful links:



Latest issue of our [e-newsletter](#)



Our summer e-newsletter also includes [a case study](#) focusing on our scrutiny of the final fitness to practise decision in the case of Dr Valerie Murphy



Our [Lessons Learned Review](#) of the NMC



[Reviewing the regulators - key statistics](#) for the year taken from our annual report



[A highlights summary](#) for 2017/18



[Harry Cayton's blog](#) on the Williams Review