Misconduct

Reference: FTP-2a Last Updated: 20/05/2026

In this guide

When does poor practice become serious professional misconduct?

Concerns outside professional practice

The Code sets the professional standards of practice and behaviour for nurses, midwives and nursing associates, and the standards that the public tell us they expect from those professionals.

Nurses, midwives and nursing associates must act in line with the Code. If their conduct falls short of the requirements of the Code, what they did or failed to do could be serious enough for us to take action.

Where concerns are raised, we'll need to consider the allegation to identify whether there is a risk to the public, or whether the behaviour is likely to undermine our professional standards or public confidence in the professions we regulate.

When does poor practice become serious professional misconduct?

Back to top

Not all breaches of the Code or issues with practice will be a matter of regulatory concern. We should only take regulatory action where there is evidence of serious professional misconduct.[1]

Many instances of misconduct are better dealt with by employers in the first instance. Employers are closer to the sources of risk to people receiving care and members of the public, and better able to recognise and manage them. If they need to, they can intervene directly and quickly in a nurse, midwife or nursing associate's practice, and do so in a targeted way dealing specifically with the risks.

We only need to become involved if the nurse, midwife or nursing associate poses a risk of harm to people in their care or the public that the employer can't manage effectively (perhaps because the nurse, midwife or nursing associate has left), meaning the nurse, midwife or nursing associate's right to practise needs to be withdrawn or restricted immediately. For example, one-off clinical incidents won't usually require regulatory action if there is evidence that the professional has reflected and learned from their mistake and we consider that the risk of repetition is low.

Some concerns are more serious because they may lead to people receiving care or members of the public suffering harm or losing trust and confidence in the professionals we regulate.

Serious professional misconduct is more likely to occur in professional practice – that is, when a professional is:

- acting in the course of their professional practice, such as providing direct care to individuals, groups or communities, or
- undertaking activities closely related to their professional practice, such as leadership, education, or research.

To determine whether activity is closely related to professional practice, we will look to the nature and setting. For example, the exercise of specific clinical skills, such as infection control or administration of medication, is likely to be closely linked to professional practice, whether or not the professional was performing a nursing or midwifery role at the time.

There may also be other concerns which are related to professional practice or to the nurse, midwife or nursing associate's role as a registered professional. This includes bullying or harassing colleagues (including sexual

harassment), abusing their position as a registered nurse, midwife or nursing associate or other position of power to exploit, coerce or obtain a benefit, failing to maintain clear professional boundaries with people receiving care, and dishonesty about qualifications or employment history. A more extensive list can be found in our screening guidance.

Fitness to practise is about keeping people safe, rather than punishing nurses, midwives and nursing associates for past mistakes. Even where there has been serious harm to people receiving care as a result of a clinical error, provided there is no longer a risk to those receiving care, and the nurse, midwife or nursing associate has been open about what went wrong and can demonstrate that they have learned from it, we will not usually need to take action.

Some concerns about harm to people receiving care will be so serious that they can't be addressed. In cases like this, we will usually only need to take action if it's clear that the nurse, midwife or nursing associate deliberately chose to take an unreasonable risk with the safety of people in their care.

We may also need to take action if the incident suggests a deep-seated attitudinal issue that could put people receiving care at risk of harm or where the incident is so serious that it requires action on the grounds of maintaining professional standards or upholding public confidence in the professions we regulate. Where behaviour suggests deep-seated attitudinal issues that could put people receiving care at risk, it is less likely that the nurse, midwife or nursing associate will be able to remediate and take steps to address the underlying concerns. When we are looking at safety incidents which relate to people receiving care involving nurses, midwives or nursing associates, we will always look carefully at the context in which they were practising. Even poor practice by a nurse, midwife or nursing associate might actually have happened because of underlying system failures.

In these circumstances, taking regulatory action against a nurse, midwife or nursing associate may be unfair, and may not stop similar incidents happening again in the future or keep people safe.

Please see our screening guidance for more information.

Concerns outside professional practice

Back to top

Nurses, midwives and nursing associates should keep to the standards and values set out in the Code and consider the requirement to “uphold the reputation of [their] profession at all times” to help maintain the public’s trust and confidence.[2]

When considering their behaviour outside professional practice, nurses, midwives and nursing associates should be mindful, in particular, of the need to:

- act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment (20.2)
- be aware at all times of how their behaviour can affect and influence the behaviour of other people (20.3)
- keep to the laws of the country in which they are practising (20.4)
- treat people in a way that does not take advantage of their vulnerability or cause them upset or distress (20.5)

Sometimes the way a nurse, midwife or nursing associate conducts themselves outside their professional practice can be serious professional misconduct and will require us to act. We will take action when a professional’s conduct:

- either indicates deep-seated attitudinal issues which could pose a risk to the public in professional practice, or
- is capable of undermining public trust and confidence in the profession, raising fundamental questions about the nurse, midwife or nursing associate’s ability to uphold the values and standards set out in the Code.

As a professional regulator we would be unlikely to investigate if a nurse borrowed a small sum of money from a friend and subsequently failed to pay them back. However, if the scenario involved exploitation of someone in their care or the professional had committed a crime and received a sentence of imprisonment for such behaviour (for example, fraud), we are more likely to take action.

We recognise that our involvement in behaviour outside professional practice has the potential to engage a nurse, midwife or nursing associate’s right to respect for private and family life.[3] However, these rights are not absolute. Concerns outside professional practice can involve diverse situations, settings and relationships, including the

relationship between a professional and their partner or child. For example, domestic abuse could involve a range of behaviours, such as harassment and sexual misconduct, which could raise fundamental questions about a professional's ability to uphold the standards and values set out in the Code.

Guided by our statutory objectives and close attention to the seriousness of the case, we will always consider whether any regulatory action that may interfere with a professional's right to respect for private and family life is necessary and proportionate in the circumstances.

We will only interfere with disputes in someone's private or family life or make requests for information when it is necessary and proportionate to do so to protect the public, uphold professional standards or maintain public confidence in the professions we regulate.

Just because a matter is of concern to us, that does not mean that we will be able to progress the case. Such cases often involve evidential challenges. Our Case Examiners will only refer a concern to a panel hearing where the evidence available means that there is a realistic possibility the Fitness to Practise Committee would find the incidents did happen.

More information about the different evidential tests that we apply throughout our fitness to practise process can be found in our screening, case examiner and our decision making guidance. For more information on how we approach evidence, please refer to our guidance on evidence.

Risk of Harm

In some circumstances, the way a professional conducts themselves outside professional practice could indicate deep-seated attitudinal issues which could pose a risk to colleagues and people in the professional's care.

Professionals must be able to work with and care for the public, including those who are vulnerable. They exercise skills, have access to personal and sensitive information and materials, and undertake responsibilities that give them access to people who are vulnerable to abuse. Professionals need to be able to provide care for a diverse range of people and to work as part of diverse teams. Discriminatory attitudes can have a direct impact on the quality of care provided.[4]

To determine whether conduct outside professional practice could impair fitness to practise, we will consider all the facts involved. Examples of important factors include:

- the duration or frequency of the conduct in question
- the professional's relationship or position in relation to those involved
- the vulnerabilities of anyone subject to any alleged conduct.

Long-term or repeated misconduct is more likely to suggest risk of harm, together with conduct involving imbalances of power, cruelty, exploitation and predatory behaviour. We will assess how likely the nurse, midwife or nursing associate is to repeat similar conduct or failings in the future, and if they do, if it is likely that people in their care could come to harm, and in what way.

Broadly speaking, the following behaviours are *more likely* to suggest a risk of harm to the public and impaired fitness to practise, regardless of where they take place:

The Code says that nurses, midwives and nursing associates must treat people fairly without discrimination, bullying or harassment. It also states that individuals should be aware of how their behaviour can affect and influence the behaviour of others, be sure not to express personal beliefs inappropriately and use all forms of communication responsibly.[5]

The NMC takes concerns about bullying, harassment, discrimination and victimisation very seriously.[6] Although bullying is not included as a prohibited behaviour under the Equality Act, it can have a serious effect on workplace culture, and therefore the safety of people receiving care, if it is not dealt with.

If found proved, concerns relating to discriminatory behaviour, are likely to be regarded as misconduct, and will very often result in a finding of impaired fitness to practise.[7]

To be satisfied that discriminatory conduct has been addressed, we'd expect to see comprehensive insight,

remorse and strengthened practice from an early stage, which addresses the specific concerns that have been raised. In addition, we must be satisfied that discriminatory views and behaviours have been addressed and are not still present so that we and members of the public can be confident that there is no risk of repetition.

Not every finding of misconduct about these concerns will result in a finding of impaired fitness to practise, even though it will be likely with concerns relating to discrimination, such as racism, sexism, homophobia or other discriminatory behaviour. Conduct of these types can be more difficult to address as they suggest an attitudinal problem.

To be satisfied that conduct of this nature has been addressed, we'd expect to see comprehensive insight, remorse and strengthened practice from an early stage, which addresses the specific concerns that have been raised. In addition, we must be satisfied that discriminatory views and behaviours have been addressed and are not still present so that we and members of the public can be confident that there is no risk of repetition.

Both anti-Jewish hate and anti-Muslim hate are types of racism, as well as religious discrimination. This means that individuals who identify as Jewish or Muslim, or who are perceived as Jewish or Muslim, can be discriminated against for either their race or religion or both. As with all forms of discrimination, they may raise questions about the ability of the perpetrator to treat people in their care with kindness, respect and compassion, and also pose risks to public confidence in the professions we regulate.

The right to engage in public debate about political and religious matters is part of the fundamental right to freedom of expression; when considering whether any particular conduct constitutes anti-Jewish or anti-Muslim hate, we will always consider our freedom of expression guidance and ensure that our decisions to do not unduly restrict legitimate freedom of expression.

We consider anti-Jewish hate to be a serious matter and likely to be a breach of the Code. When considering concerns about anti-Jewish hate our starting point will be the International Holocaust Remembrance Alliance [IHRA]'s working definition of antisemitism, as adopted by the Government,[8] which states that:

> "Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities."

IHRA's working definition of antisemitism is supported by contemporary examples of antisemitism (included in the link above), which may, "taking into account the overall context", constitute antisemitism. In the case of *Husain v SRA*, the High Court made clear that when considering actions that may fall within the scope of the contemporary examples listed by the IHRA, the decision-maker should consider the language used and the context of what was said, informed by a reasonable understanding of the main historical and cultural manifestations of antisemitism.[9] The fact that conduct falls within the scope of one of the contemporary examples does not mean that the conduct will automatically and necessarily be deemed antisemitic.

Example 1

A nurse on a hospital ward identifies that one of the patients on the ward is wearing a Star of David. The nurse asks the patient if they are Jewish, and they confirm that they are. As a result, the nurse starts making comments loudly that are critical of the policies of the Israeli government, which are clearly directed at the Jewish patient. Targeting a Jewish patient in this way will clearly be antisemitic even if the actual comments made about the policies of the Israeli government might, in a different context, not be regarded as antisemitic. This is because the nurse is assuming that the Jewish person is in some way connected to or responsible for the actions and decisions of the State of Israel. This conduct falls squarely within one of the contemporary examples of antisemitism cited by the IHRA (namely "holding Jews collectively responsible for actions of the State of Israel").

The High Court's decision in Husain v SRA also emphasised that statements criticising the historic formation, existence or policies of the contemporary State of Israel will not, in and of themselves, be antisemitic. Whether or not such statements are antisemitic will depend on analysing the language used and the context in which the statement is made. For example, proposing a 'one-state solution' where Israelis and Palestinians share a unitary state is not necessarily antisemitic, because it does not necessarily imply hatred towards Jewish people.

Example 2

A nursing associate is socialising with colleagues after work. The conversation turns to the situation in the Middle East. The nursing associate is highly critical of the policies and actions of the Israeli Government, but at no point does she attack Judaism or the Jewish community generally, either within or outside Israel. This would not be deemed antisemitic and, on its own, would not raise fitness to practise concerns, because she is not discussing Israel any differently than another state might be discussed. Such comments are within her right to freedom of expression.

As with anti-Jewish hate, we consider anti-Muslim hate to be a serious matter and likely to be a breach of the Code. When considering concerns about anti-Muslim hate, our starting point will be the UK Government's definition of anti-Muslim hostility:

"Anti-Muslim hostility is intentionally engaging in, assisting or encouraging criminal acts – including acts of violence, vandalism, harassment, or intimidation, whether physical, verbal, written or electronically communicated – that are directed at Muslims because of their religion or at those who are perceived to be Muslim, including where that perception is based on assumptions about ethnicity, race or appearance.

"It is also the prejudicial stereotyping of Muslims, or people perceived to be Muslim including because of their ethnic or racial backgrounds or their appearance, and treating them as a collective group defined by fixed and negative characteristics, with the intention of encouraging hatred against them, irrespective of their actual opinions, beliefs or actions as individuals.

"It is engaging in unlawful discrimination where the relevant conduct – including the creation or use of practices and biases within institutions – is intended to disadvantage Muslims in public and economic life."

The accompanying text emphasises that the definition is not statutory, should not be confused with legislation and must not be used in any way that is inconsistent with the law. It also explains how this definition fits into the context of the right to freedom of expression[10], and in particular makes clear that criticism of any religion is, in and of itself, protected by law. We will also bear in mind any emerging caselaw relating to the new definition.

Example 1

A nurse posts on social media calling for the deportation of "anyone who undermines British values and the British way of life". The post includes an image depicting women with headscarves, men with long beards and a mosque in the background. We would be likely to regard this as an example of anti-Muslim hate that would impair fitness to practise. The images are a stereotypical depiction of Muslims and, when combined with the text of the post, treat Muslims as a collective group defined by fixed characteristics with the intention of encouraging hatred against them (i.e. that Muslims "undermine British values and the British way of life"). This would be in breach of paragraph 1.3 of the Code because the nurse has made assumptions and failed to recognise diversity.

Example 2

A community midwife complains that she is struggling to get to some appointments on Fridays because parking is difficult near the local mosque during prayer times. She is critical of the mosque for not having better provision in place for parking. However, her complaints are only about the parking and not the people praying, nor does she make any stereotypical or prejudicial comments about those attending the mosque.

This would not amount to anti-Muslim hate and, on its own, would not raise fitness to practise concerns.

To be satisfied that discriminatory conduct has been addressed, we'd expect to see comprehensive insight, remorse and strengthened practice from an early stage, which addresses the specific concerns that have been raised. In addition, we must be satisfied that discriminatory views and behaviours have been addressed and are not still present so that we and members of the public can be confident that there is no risk of repetition.

Not every finding of misconduct about these concerns will result in a finding of impaired fitness to practise, even though it will be likely with concerns relating to discrimination, such as racism,10 sexism, homophobia or other discriminatory behaviour. Conduct of these types can be more difficult to address as they suggest an attitudinal problem.

To be satisfied that conduct of this nature has been addressed, we'd expect to see comprehensive insight, remorse and strengthened practice from an early stage, which addresses the specific concerns that have been raised. In addition, we must be satisfied that discriminatory views and behaviours have been addressed and are not still present so that we and members of the public can be confident that there is no risk of repetition.

A person against another person under the Equality Act 2010 if they treat them less favourably than they would treat others because of a protected characteristic[11] that is:

- age
- gender reassignment
- being married or in a civil partnership
- being pregnant or on maternity leave
- disability
- race including colour, nationality, ethnic or national origin
- religion or belief
- sex
- sexual orientation

Discriminatory behaviours of any kind can negatively impact public protection and the trust and confidence the public places in nurses, midwives, and nursing associates. We therefore take concerns of this nature seriously regardless of whether they occur in or out of the workplace. These concerns may suggest a deep-seated problem with the nurse, midwife or nursing associate's attitude, even when there's only one reported complaint.

When a professional on the register engages in these types of behaviours, the possible consequences are far-reaching. Members of the public may experience less favourable treatment, or they may feel reluctant to access health and care services in the first place. We know that experiences of discrimination can have a profound effect on those who experience it[12] and that fair treatment of staff is linked to better care for people.[13]

Where a professional on our register displays discriminatory views and behaviours, this usually amounts to a serious departure from the NMC's professional standards.

In such cases where displaying discriminatory views and behaviours is proved, some level of sanction will likely be necessary unless there's been insight at the most fundamental level and the earliest stage. However, if a nurse, midwife or nursing associate denies the problem or fails to engage with the fitness to practise process, it's more likely that a significant sanction, such as removal from the register, will be necessary to maintain public trust and confidence.

The research conducted as part of our Ambitious for Change[14] work indicated that some groups with protected characteristics, such as black nurses and midwives, are more likely to be referred for fitness to practise concerns. As part of the work that we do to understand the wider context of a referral, we ask the person being referred whether they believe that a protected characteristic played a part in the referral. If someone who we are investigating tells us that they have been discriminated against, or discrimination has led to them being referred to us, we will take it very seriously. Where there is evidence to support this, we'll take this into account as set out in

our guidance on context.

The environment that all health and social care professionals work in should be safe and free from bullying, harassing (including sexual harassment) and victimising behaviours, as well as any abuses of power to exploit, coerce or obtain a benefit (for example sexual or monetary) from people receiving care, colleagues or students.[15]

The Code sets out that nurses, midwives and nursing associates must maintain effective communication with colleagues and act with honesty and integrity at all times, treating people fairly and without discrimination, bullying and harassment. The presence of bullying, harassment (including sexual harassment) and victimisation in the workplace can have an extremely negative effect on the work environment, performance and attendance.[16] This in turn can have an effect on the delivery of care and if not dealt with can affect trust and confidence in the professions.

Even when they occur outside professional practice, such concerns can raise fundamental questions about the ability of a nurse, midwife or nursing associate to uphold the standards and values set out in the Code.

can be described as unwanted behaviour from a person or a group of people that is either offensive, intimidating, malicious or insulting. It can be an abuse or misuse of power that undermines, humiliates, or causes physical or emotional harm to someone. It can be a regular pattern of behaviour or a one-off incident and can happen face-to-face, on social media or over emails or telephone calls.[17] Usually bullying would be a pattern of behaviour, but an example of when it could be a one off incident could be if a member of the public felt that they had been bullied into agreeing to a do not resuscitate decision by a healthcare professional.

is defined under the Equality Act 2010 as treating someone else less favourably because they have brought proceedings, given evidence in proceedings or done any other thing in relation to the Equality Act.[18] It will also be victimisation if someone is treated less favourably by a person for making an allegation that someone has broken the Equality Act. Giving false evidence or information or making a false allegation is not protected if it's done in bad faith.

Where bullying and victimisation has been raised as a concern in a professional context, in line with our principles for fitness to practise, we consider that employers should act first to deal with the issues, unless there is an immediate risk to public safety.

We will usually only get involved after there has been a local investigation into the nurse, midwife or nursing associate's behaviour and where we feel the nurse, midwife or nursing associate has not taken adequate steps to address the issues identified with their practice. This is more likely to be necessary where the individual has not reflected on their behaviour or taken steps to change their behaviours in the future.

Evidence of repeated poor behaviour which has not been adequately resolved following action at a local level is more likely to require regulatory action, than isolated instances of poor conduct which are unlikely to be repeated.

Example

A number of complaints are made about a midwife shouting and using offensive language towards more junior members of staff over the course of several months. These issues are raised with the midwife and a local investigation is started. The midwife resigns before the conclusion of the local investigation. We'd need to seek assurance that the midwife has reflected and demonstrated they would not act in the same way again if they found themselves in a similar working environment. Without this evidence, regulatory action is likely to be required to stop the concern from happening again.

- Sexual misconduct is unwelcome behaviour of a sexual nature, or behaviour that can reasonably be interpreted as sexual, that degrades, harms, humiliates or intimidates another. It can be physical, verbal or visual. It could be a pattern of behaviour or a single incident. As a healthcare regulator, it is not our role to pursue or punish potential criminal activity in place of the police. However, sexual misconduct outside professional practice could indicate deep-seated attitudinal issues which could put the public at risk, as well as raise fundamental

questions about the professional's ability to uphold the standards and values set out in the Code. Whether regulatory action is required will be considered on a case-by-case basis. In some circumstances we may need to investigate such concerns arising outside professional practice where there is no criminal conviction.

Example 1

> The conduct here falls within the definition of sexual misconduct. Even though it occurred outside professional practice, the nature of these acts, together with the reasons provided by the professional, could indicate deep-seated attitudinal issues capable of posing a risk to colleagues and people in the professional's care.

Example 2

> While the concerns relate to behaviour outside professional practice, sharing explicit messages with others about the sexual abuse of children suggests a sexual interest in children which could pose a risk to the public in the course of professional practice. Such expression could also seriously undermine public trust in the profession. This concern is capable of impairing fitness to practise and is likely to result in regulatory action.

- Safeguarding and protecting people from harm, abuse and neglect is an integral part of providing safe and effective care. It is also a key principle embedded throughout our Code.

  The Code says that nurses, midwives and nursing associates must 'take all reasonable steps to protect people who are vulnerable or at risk of harm, neglect or abuse'. Professionals are also expected to make sure that people's physical, social and psychological needs are assessed and responded to, which includes acting as advocates for the vulnerable and challenging poor practice and behaviour related to a person's care.

  Protecting people from harm, abuse and neglect goes to the heart of what nurses, midwives and nursing associates do. Failure to do so, or intentionally causing a person harm, will always be treated very seriously due to the high risk of harm to those receiving care, if the behaviour is not put right. Where professionals are shown to be involved in serious neglect or abuse outside their professional practice, there is likely to be a risk of harm to people receiving care. Such behaviour also has the potential to seriously undermine the public's trust and confidence in the professions we regulate.

  See our sanctions guidance for our approach to sanctions in cases involving abuse or neglect of children or vulnerable people.

  Example 1

  > The serious and repeated abuse of someone in the professional's care could indicate a risk to people

who receive care, whether through direct abuse or the failure to properly safeguard people in their care/children or vulnerable adults.

- Harassment is defined by the Equality Act 2010 as someone engaging in unwanted conduct that's related to a protected characteristic or is of a sexual nature.[19] The behaviour has the purpose or effect of violating an individual's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment. It's necessary to take the perception of the person who's the subject of the conduct and any other circumstances into account. As well as harassment linked to a protected characteristic as defined by the Equality Act, harassment can also be unwanted conduct that is unrelated to a protected characteristic which someone finds offensive or which makes someone feel intimidated or humiliated.

  We recognise that concerns of this nature can have a profound effect on those subjected to the behaviour and could negatively affect public protection and the trust and confidence that the public places in nurses, midwives and nursing associates, especially where it occurs within professional practice.

  We will always consider the seriousness of the individual concerns raised with us, but in circumstances where the concerns relate to sexual harassment we may need to take action when there has been just one reported incident.

Example

A nursing associate sends a number of abusive and harassing text messages to a colleague and makes inappropriate comments at work following the breakup of their relationship. A complaint is made and the matter is raised with the nursing associate by their employer. The nursing associate acknowledges their behaviour was inappropriate and stops immediately. They are issued with a formal warning and there are no other incidents. The matter has been dealt with locally and there's no need for us to become involved unless there are further incidents.

- Depending on the particular facts, violent behaviour can be serious enough to indicate a risk to the public and seriously undermine public confidence in the professions we regulate, irrespective of where it occurs. This includes in a domestic setting. Factors to consider include the nature of violence or abuse (for example, violence towards a child or vulnerable adult is likely to impair fitness to practise; discriminatory features or motivation will also be significant), the harm caused, and its frequency.

Example 1

> Whilst the conduct occurred in a domestic setting, the professional's treatment of their spouse involves serious violence and could suggest potential risk to those within their care, as well as seriously undermining public confidence in the profession. Healthcare professionals are entrusted to safeguard others and evidence demonstrates that people directly affected by domestic abuse will often seek their support. In addition, the discriminatory words could suggest a deep-seated attitudinal issue towards women and girls that could impact the standard of care provided.

Example 2

> Whilst this is not behaviour we would condone, it is not the kind of behaviour that is likely to require us to take action to restrict someone's ability to practise. The situation could be different, for example, if there was more serious violence, a link to discrimination, the professional received a sentence of imprisonment or, depending on the facts, was alleged to have conducted a prolonged campaign of violence or intimidation against a vulnerable neighbour.

Our Public Sector Equality Duty (PSED)

Alongside our professional standards, as a public authority, we have wider legal obligations which ensure equality is at the heart of what we do. The public sector equality duty (PSED) was created by the Equality Act 2010 and requires us to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

When a concern is raised with us, and there's evidence that a professional on the register has engaged in harassing, discriminatory or victimising behaviours, we'll always thoroughly investigate, taking into account our professional standards and the aims of the public sector equality duty.

Public confidence

Nurses, midwives and nursing associates hold an important position of trust. They are responsible for caring for and protecting people when they are at their most vulnerable, and for acting as an advocate on their behalf. Due to their unique position, members of the public expect nurses, midwives and nursing associates to uphold the rights of those they care for and to act in their best interests at all times. They must work, and be trusted to work, with and alongside diverse groups of people without discriminating unfairly against them or exploiting them. Failure to uphold these expectations could seriously undermine the public's trust and confidence in the profession and could make the public reluctant to access health and care services.

We are likely to take action to uphold public confidence where a nurse, midwife or nursing associate's conduct raises fundamental questions about their ability to uphold the standards and values set out in the Code.

Many behaviours which are likely to indicate a risk to people who use health and social care services are also likely to justify regulatory action on the grounds of upholding public confidence and maintaining professional standards. Examples include expressing discriminatory views or behaviours, sexual misconduct (including assault or harassment), serious violence (including in a domestic setting) and abuse or neglect of children and/or vulnerable adults.

Example 1

> Nurses midwives and nursing associates are expected to provide person-centred, non-discriminatory care to people of all backgrounds. While the concerns relate to behaviour outside professional practice, the underlying behaviours could indicate a risk to people in the professional's care. Discriminatory behaviours also raise fundamental questions about the professional's ability to uphold the values and standards set out in the Code. A failure to take any action is likely to impact the public's trust and confidence the profession.

Example 2

> Nurses, midwives and nursing associates are responsible for the care and protection of the vulnerable. Whilst the concerns relate to behaviour outside professional practice, the failure to safeguard and protect a child is serious enough to raise fundamental questions about the professional's ability to uphold the values and standards set out in the Code and undermine public trust and confidence in the profession.
>
> In situations such as this, we will always carefully consider the context to understand how it may have contributed towards the professional's behaviour – for example considering whether a professional was subject to coercive control by an abusive partner.

Example 3

> This serious and repeated violence raises fundamental questions about the ability of the nurse, midwife or nursing associate to uphold the standards and values set out in the Code. We are likely to consider these concerns further.
>
> Domestic abuse does not always involve violence. It can also take the form of controlling, coercive, threatening or degrading behaviour, including sexual misconduct. Depending on the facts, all of these behaviours are capable of undermining public confidence in the professions we regulate.

Misconduct that could also be a crime

If an allegation has not been reported to the police or relevant third party, this will not prevent us from investigating it, provided it could amount to serious professional misconduct.

We will exercise some caution when bringing cases of this kind, particularly when the conduct occurred outside professional practice. It is not our role to fill any perceived gaps in the criminal justice system. When deciding whether to investigate concerns that could have been reported to the police, but have not, we will carefully consider:

i) whether an investigation is necessary to fulfil our statutory duties; and
ii) whether it would be more appropriate for the concerns to be considered by the police or another third party organisation such as the Family Court.

For example, if we received a referral where it is alleged that a sexual assault against a person receiving care had taken place, but the person concerned did not wish to report it to the police, we would still look into this. Where a professional is alleged to have carried out a sexual assault outside their professional practice, but the person subject to the assault does not wish to report it to the police, we would carefully consider whether there was any proper basis for us to take any regulatory action.

Example

> As the behaviour here could constitute serious sexual misconduct and potentially involves serious and repeated violence, it is likely to suggest a risk of harm to the public or is likely to undermine public trust and confidence in the professions. We would be likely to refer this matter for investigation and will consider carefully whether there is a realistic prospect of the allegations being proved at a panel hearing.

If the information we receive about a nurse, midwife or nursing associate's conduct potentially discloses a criminal offence or suggests a safeguarding risk to children or vulnerable people, we may determine that it is in the public interest to share information with the police or relevant third parties.[20] This is discussed in more detail in our information handling guidance. If the police or third party organisations decide to investigate the relevant conduct, we will decide whether we need to delay our consideration of the matter pending the outcome of that investigation.

If we believe that another organisation is best placed to investigate the concern, we will always let the referrer know why we believe this to be the case. If the referrer does not wish to report the matter to the police or progress an investigation with another organisation, we will decide whether to open our own investigation applying our usual screening test. Where a matter is referred for investigation, our Case Examiners will, once our investigation is concluded, consider whether there is a realistic prospect of the allegations being proved at a panel hearing, taking into account all the available evidence.

We need to be kind and fair to everyone involved in our regulatory process. Even when we proceed to investigate, such concerns will not always progress to a final hearing. We don't have the same extensive powers or specialist expertise as the police to investigate behaviour and therefore there may be limits to the evidence we are able to obtain. For example, we do not have access to forensic testing and data regarding the geographic location of mobile phones, nor are we able to search, seize evidence or compel someone to be interviewed.

Where we feel we're able to progress with a case, we will explain to the referrer any potential issues we're likely to face taking the case forward. The referrer can then make an informed decision about whether they wish to continue assisting us. We will look at how we can support people through our processes which includes identifying and signposting to external agencies when needed.

1 Meadow v General Medical Council [2006] EWCA Civ 1390; Roylance v General Medical Council [2000] 1 A.C. 311

2 The NMC Code, Standard 20

3 See Article 8 of the Human Rights Act 1998

4 A person discriminates against another person under the Equality Act if they treat them less favourably than they would treat others because of one or more of a protected characteristic. It includes discrimination on the basis of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and / or sexual orientation. The Professional Standards Authority's September 2022 report Safer Care for All highlighted the impact that discrimination can have on the safety of people receiving care. In the PSA's report Perspectives on discriminatory Behaviours in health and care, members of the general public and health service users themselves highlighted the risk of mental and physical harm due to discrimination.

5 The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates 20.2, 20.3, 20.7, 20.10

6 The Equality Act 2010 states that harassment, discrimination and victimisation is prohibited in respect of the listed protected characteristics, age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion and belief; sex and sexual orientation.

7 See PSA v HCPC and Roberts [2020] EWHC 1906 (Admin) for a case where the use of racist language did not lead to a finding of impairment. However, the Court emphasised that cases of this type will be 'rare'.

8 Government leads the way in tackling anti-Semitism - GOV.UK

9 Husain v SRA Approved Judgment

10 PSA v HCPC and Roberts [2020] EWHC 1906 (Admin)

11 Equality Act 2010 s.13 - s.19.

12 Ross S, Jabbal J, Chauhan K, Maguire D, Randhawa M & Dahir S (2020) Workforce race inequalities and inclusion in NHS providers, The King's Fund.

13 West M, Dawson J, Admasachew L & Topakas A (2011) NHS Staff Management and Health Service Quality. Results from the NHS Staff Survey and Related Data.

14 Ambitious for change – research into NMC processes and people's protected characteristics, 20 October 2020

15 Harassment at work. A Unison Guide, December 2016

16 In addition to undermining public confidence, such concerns can also impact care. The Professional Standards Authority's September 2022 report Safer Care for All and its 2018 report Sexual behaviours between health and care practitioners: where does the boundary lie? highlight the impact that breaches of sexual boundaries between colleagues can have on the safety of people receiving care.

17 ACAS bullying definition

18 Equality Act 2010 s.27.

19 Equality Act 2010 s.26.

20 For example, other organisations who are responsible for safeguarding children or vulnerable adults, or who may be involved in safety investigations which relate to people receiving care, or in preventing or detecting criminal activity.