

Fitness to Practise information handling guidance

Introduction

- 1 This guidance sets out our approach to the disclosure of information during each stage of our fitness to practise process.
- 2 The aims of this guidance are:
 - 2.1 To outline the routine disclosure of fitness to practise information we consider necessary to investigate and adjudicate on fitness to practise cases.
 - 2.2 To identify how we deal with specific requests from third parties for disclosure of fitness to practise information.
 - 2.3 To explain our approach to the use of confidential information during fitness to practise proceedings.

Legislative framework

- 3 We are subject to a range of statutory obligations in relation to how we handle information. These include:
 - 3.1 Duties under the Data Protection Act 1998 (DPA) to only process the personal data of individuals where that processing is necessary for us to carry out our statutory functions, and to process the data only in a way which is fair, lawful and in accordance with the data protection principles.
 - 3.2 Duties under the Freedom of Information Act 2000 (FOIA) to respond to requests for recorded information by considering whether an exemption applies to the information,¹ and if not, confirming whether or not the NMC holds the information, and to provide the information.²
- 4 We receive requests to share information about previous cases or current investigations with a range of public authorities and other regulatory bodies across the four countries of the UK. Such bodies include the police, the Crown Prosecution Service, the Care Quality Commission, other healthcare professional regulators, and the Disclosure and Barring Service.³
- 5 We have a general power to disclose information relating to a nurse or midwife's fitness to practise where we consider that disclosing the information would be in the public interest.⁴ For these purposes the public interest includes, but is not limited to, the protection of patients or others from harm, protecting public confidence in the professions and protecting the nurse or midwife in question.

Preliminary consideration of allegations

Disclosure to nurse or midwife

- 6 When a referral is made to us, we will ask the person making the referral whether they consent to us disclosing it to the nurse or midwife concerned. This consent is key for proper consideration of allegations against a nurse or midwife. Where the referrer does not agree to their complaint being disclosed to the nurse or midwife, we would only commence an investigation if there was a clear public interest reason, such as a risk of serious harm to patients.
- 7 Our normal course of action is to disclose to a nurse or midwife any referral that could involve an allegation which calls into question their fitness to practise. We have statutory duties to consider such allegations in order to protect members of the public who rely on the services of nurses or midwives. If a referral makes us aware of information which appears to call into question a nurse or midwife's fitness to practise, our duty to investigate properly and fairly will generally mean that the contents of any such referral will need to be disclosed to the nurse or midwife involved.

Disclosure to employers and healthcare settings

- 8 Our preliminary consideration of cases may require us to have contact with employers or healthcare settings so that we can confirm the identity of the nurse or midwife concerned. We may also need to contact such organisations to assist us with any early investigations we are carrying out as part of our preliminary consideration. We assess all cases to determine whether the referral is so serious that it affects the fitness to practise of a nurse or midwife on our register, which would mean that we need to refer the case for a full investigation.⁵
- 9 When we contact an employer or healthcare setting for this reason, it will often be the case that they were previously unaware that the nurse or midwife concerned had been referred to us. This disclosure is necessary for us to properly assess whether the case requires a full investigation.

Interim orders

- 10 Where it is necessary for an interim order to be sought in order to restrict the nurse or midwife's practice during the progress of our investigation, any hearing before the Investigating Committee will be in public. Details of any interim order made will be disclosable, although hearings (or sections of hearings) which relate solely to the nurse or midwife's health would always be held in private. Similarly, details of sections of hearings which were held in private for any other reason would not be disclosable to enquirers.

Redaction of interim order bundles

- 11 Due to the nature of our applications for interim orders, it is not possible for us to apply the same principles for redaction as those we use with substantive hearing bundles (which are set out later in this document).⁶

- 12 Interim orders necessarily involve an element of urgency. Fairness to the nurse or midwife means they should be provided with the material that we say suggests the need to restrict their practice. It is also necessary to provide this material in a form that enables the nurse to comment on the allegations. It follows that the nurse or midwife should be informed of the identity of any patients, colleagues or other witnesses concerned, where we rely on documents which identify them as part of the interim order application. Personal information which is not necessary to the interim order consideration, however, such as personal details of patients or witnesses or other people involved in the case, such as addresses, dates of birth or telephone numbers, will not be included in interim order bundles.
- 13 Sending the nurse or midwife materials that are free of redaction together with an anonymity key in advance, and providing the hearing panel with a different, anonymised version would be disproportionate in the interim order jurisdiction. This is due to:
 - 13.1 The need for us to refer to an interim order hearing nurses or midwives whose practice may present a risk of patient harm, as soon as the risk is identified.
 - 13.2 The volume of cases we send for interim order consideration.
 - 13.3 The complexity of carrying out the tailored redactions necessary to identify patients, colleagues or witnesses with separate aliases.
- 14 We recognise that patient records are by their confidential nature sensitive personal data. However, we consider that the processing of that data in an un-redacted form when applying for an interim order is necessary to protect the public from nurses or midwives who may pose a risk of harm. It is also necessary for reasons of fairness and transparency.

Disclosure during the investigation

- 15 The fact that a nurse or midwife is under investigation is generally treated as confidential information unless and until our case examiners decide there is a case to answer or issue a warning. We do not disclose details of any concerns involved to any enquirers (apart from those bodies with whom we share safeguarding information⁷) until the charges have been confirmed to the panel on the day of the hearing.
- 16 During the investigation we will frequently seek information from the nurse or midwife's past or current employers. We are required to take such steps as are reasonably practicable to obtain as much information as possible about the case.⁸ Where this would involve disclosure to a new employer who may previously have been unaware of the allegations, we would consider the nurse or midwife's interest in the confidentiality of the referral against the public interest in contacting the employer and disclosing the fact that a referral has been made.

- 17 In making this assessment, we consider that such disclosure to employers can be of particular importance to investigations into clinical incidents suggesting actual or potential harm to patients. The public interest factors weighing in favour of such disclosure to employers (whether or not the nurse or midwife has changed employers since the alleged incident) include:
 - 17.1 Determining whether any disciplinary proceedings have concluded, in order to ensure our investigation is proportionate.
 - 17.2 Considering evidence already gathered at a local level and the scope of further investigation required.
 - 17.3 Assessing whether the nurse or midwife in question has taken steps to remedy particular clinical concerns.
 - 17.4 Giving an opportunity for new employers to inform us of any details of the nurse or midwife's recruitment or interview process which may have raised fitness to practise concerns.
- 18 Disclosure of allegations without consent is less likely to be justified in cases based on non-clinical misconduct where there appears to be no imminent risk to patient safety.

Patient records

- 19 In order to properly investigate fitness to practise cases it is frequently necessary for us to ask healthcare providers for the disclosure of patient records relating to identifiable patients. We will only request patient records where to process them (which includes obtaining, recording, holding or disclosing the records) is in accordance with our obligations under the Data Protection Act 1998. We will seek to obtain the consent of the patients concerned, whether through the healthcare provider or directly from the patients themselves, where this is possible. It is not necessary for us to apply to the Court for an order for disclosure in order for us to use patient records.⁹
- 20 The processing of patient records where it has not been possible to obtain the informed consent of patients is lawful if it is necessary for us to fulfil our statutory function of safeguarding the health and wellbeing of people using the services of nurses or midwives.¹⁰
- 21 Obtaining and disclosing records without patient consent is likely to be necessary where without the records:
 - 21.1 The full seriousness of the allegations against the nurse or midwife could not be fully investigated or established.
 - 21.2 The nurse or midwife would not be able to have a fair hearing.
- 22 For example, in order to properly investigate fitness to practise concerns, we will need to see medication administration records where it is alleged that a nurse has made false entries, or clinical records where it is alleged that a midwife has failed to document clinical observations. In those examples, the

identity of the patients concerned would need to be disclosed in order for the nurse or midwife to have a full and fair opportunity to respond to the allegations.

- 23 Where it is both proportionate and possible to do so, we will inform patients of our use of their medical records. We will seek to do so when records that form part of our case are disclosed to the nurse or midwife at the conclusion of our investigation. Patient identities are anonymised during our substantive hearings process. If, in an exceptional case, it is necessary for us to use records belonging to identifiable patients or service users at a substantive hearing, we would inform them of this, if it is possible to contact them.

Disclosure of material gathered during investigation

- 24 When our investigation has been completed, the material we have gathered that relates to the allegation will be disclosed to the nurse or midwife and their representative, if they have one. It will also be sent to our Case Examiners as part of their consideration of whether or not there is a case to answer. This material may include (where it is relevant):
- 24.1 The identities of patients, colleagues or other witnesses involved in the events which gave rise to the investigation.
 - 24.2 Medical, clinical or other records relating to identified patients which record or are relevant to the matters alleged.
 - 24.3 Witness statements or other documents which identify the people involved in any alleged incidents, which will include any other nurses or midwives present or involved in the matters being considered, whether or not their fitness to practise has also been subject to investigation by us.
 - 24.4 Material we have gathered which is relied upon to show that the nurse or midwife concerned has a case to answer.
 - 24.5 Any disclosable 'unused' material. Unused material is material we have gathered throughout our investigation which is not part of the evidence against the nurse or midwife not seek to rely. Unused material is 'disclosable' if it could undermine the case against the nurse or midwife, or could support the nurse or midwife's case, or could raise a new issue for them. We will not inform the nurse or midwife of any material that is subject to legal privilege.
 - 24.6 A schedule of any other unused material which we have not sent to the nurse or midwife. This will be made up of material which is not evidence in support of our case, and is not material that undermines our case or supports the nurse or midwife's case. Routine correspondence, for example, would be included in this schedule. We will ensure that the schedule adequately describes each document so that the nurse or midwife is able to make an informed decision as to whether they feel they may need to request a copy of the document from us.

- 25 Disclosure of the material described above is necessary because it ensures both the full consideration of fitness to practise concerns and also that our processes are fair to nurses and midwives whose practice we have to investigate. In particular, fairness dictates that nurses and midwives are given sufficient material to enable them to properly respond to the allegations made against them.

Redaction of material at the end of the investigation

- 26 We will not redact information which we consider to fall within the categories set out in paragraph 23 above, because, as explained, we consider this information should be disclosed to nurses and midwives and the case examiners in order for them to properly carry out their statutory functions.
- 27 Material which we consider unnecessary to the case examiners' consideration of whether there is a case to answer, and will therefore not be disclosed, or will be redacted, includes:
- 27.1 Unnecessary personal details of patients or witnesses or other people involved in the case, such as addresses, dates of birth or telephone numbers.
- 27.2 The identities of any nurses or midwives involved in separate, unlinked incidents involving different nurses or midwives, but whose cases we have nevertheless investigated at the same time (this can happen where the incidents occurred at the same healthcare setting at around the same time).
- 28 The disclosure of this material would be disproportionate to most investigations into the fitness to practise of nurses or midwives. For example, in the circumstances explained above, the identity of other nurses or midwives being investigated would not make any difference to the individuals' cases. This would mean that it would not be necessary for the different nurses or midwives to be aware of the identity of the other(s) in order to prepare their defence. We would redact material, such as that outlined above from the documents put before the case examiners, because the disclosure of such personal information would not be justified by our statutory function.

Sharing the nurse or midwife's response with the person who made the complaint

- 29 When we disclose the material we have gathered during the investigation to the nurse or midwife, we will invite them to respond to the allegation about their fitness to practise or entry on our register. Their response will form part of the material the case examiners will consider.
- 30 We will usually only consider sharing the nurse or midwife's response with the person who referred the case to us (or the person who made the allegation, if they are different people) if the response from the nurse or midwife gives a significantly different factual account of what happened.

- 31 The reason for this is that our function is to protect members of the public by investigating the fitness to practise of nurse or midwives, rather than adjudicating on complaints or resolving disputes between individuals and nurses or midwives on our register. In each case, it is important that our factual investigations can be assisted by the involvement of people affected by the events, who will usually be in the best position to comment on the nurse or midwife's account.
- 32 We will not share information from the nurse or midwife's response where it:
- 32.1 contains comments of a personal nature not relevant to the case;
 - 32.2 identifies a whistleblower; or
 - 32.3 contains sensitive information personal to the registrant

Cases closed by the case examiners

- 33 If the case examiners have closed the case against the nurse or midwife, but issued a warning, we publish the warning, including a statement of regulatory concern, for a period of 12 months.
- 34 Following a case being closed by the case examiners, we sometimes receive requests for disclosure of the material gathered during our investigation from:
- 34.1 The nurse or midwife.¹¹
 - 34.2 The referrer or other interested parties.¹²
 - 34.3 Third party organisations that have been made aware of the case because of patient safety or other safeguarding concerns.¹³
- 35 In considering whether to confirm or deny the existence of the information, and whether to provide it,¹⁴ we will weigh up the following factors:
- 35.1 The nature of the concerns that lay behind the initial referral.
 - 35.2 The reasons given by the case examiners for finding there was no case to answer.
 - 35.3 The connection between the person making the request, the events in question and their involvement in the fitness to practise proceedings.
 - 35.4 Possible intended uses of the information.
 - 35.5 Whether there are other more proportionate methods or avenues available to the person seeking the information to gain access to it.
 - 35.6 The likelihood of damage or distress being caused to individuals identified within the case materials if disclosure is made.

- 36 We can share information about a nurse or midwife's fitness to practise if we think it is in the public interest.¹⁵ When we consider the public interest in this context, we will balance the nurse or midwife's right to a private life with fairness to the public and our own commitment to transparency.¹⁶
- 37 When a case is closed by the case examiners, we will send the referrer a copy (in full or edited) of the no case to answer decision. A decision may refer to material gathered during the investigation that the referrer has not seen. If a referrer requests a copy of this material, we will decide whether it would be in the public interest to disclose it. If the material directly relates to the no case to answer decision and the referrer needs this material to properly understand the decision, or to decide whether to request that the Registrar exercises their power to review a no case to answer decision,¹⁷ we will likely disclose the material.
- 38 We will only share the no case to answer decision or part of the no case to answer decision with other interested parties when they are connected to the allegation and when it is in the public interest to share the information.¹⁵

Disclosure at the adjudication stage

- 39 Any further material or evidence we gather between the referral to the Fitness to Practise Committee and the final disposal of the case will be served on the nurse or midwife, and any representative, if it is material we intend to rely on.
- 40 Equally, we remain subject to an ongoing duty to disclose material which may undermine the case against the nurse or midwife, or support the case of the nurse or midwife.
- 41 Where the nurse or midwife requests disclosure of material that is not in our possession, we will first seek to establish the relevance of that material. We will ask the nurse or midwife to tell us what steps, if any, they have taken to obtain the material directly from the person or organisation that holds it. Where we reasonably consider the material is relevant to the allegation of impaired fitness to practise, and the nurse or midwife has taken appropriate steps to obtain it directly, we will approach the person or organisation to seek disclosure of the material.

Evidence and redactions at hearings

- 42 At a final hearing, we will only place those documents before a panel that are required to prove the factual case against the nurse or midwife, or that may be necessary to the panel's consideration of impairment and sanction.
- 43 Hearing bundles will only contain material that is relevant and admissible in evidence. Irrelevant or excessive material will not be included and prejudicial material will be removed. Sections of documents or witness statements that give details of earlier allegations that are no longer pursued will be redacted where necessary.

- 44 We will also avoid placing irrelevant personal data such as addresses or contact details, or the identity of family members where they are not in issue, before panels. Where necessary, we will redact such material from documents.
- 45 In hearing bundles, patient medical records will be anonymised, with a form of anonymisation put in place that enables the nurse or midwife to identify the patient using an anonymity key together with the unanonymised material provided during the investigation.
- 46 Panellists, shorthand writers or other people who have access to hearing bundles do not need to know the identity of the patients named in records to be able to perform their function. Unless the nurse or midwife takes issue with the accuracy of the anonymisation, it is not necessary for panels to see the sensitive personal data of third parties, particularly the medical records of identified or identifiable patients, in order for them to properly consider the fitness to practise of the nurse or midwife concerned.
- 47 In advance of the hearing, legal assessors will be provided with the same material that was sent to the nurse or midwife at the conclusion of the investigation (in which any patient information will not have been anonymised). All legal assessors who attend NMC fitness to practise hearings are experienced legal professionals subject to professional duties of confidentiality.
- 48 As part of their preparation for the hearing, the legal assessors will be able to satisfy themselves that the redactions applied to the hearing bundle are correct. Legal assessors are independent of the NMC and can indicate to the parties if any problems with the continuity of the evidence appear to have been caused by incorrect redaction.

Panel determinations

- 49 The names of patients, patients' relatives, complainants in sexual cases, and children are anonymised throughout the hearing and in all hearing documents. The names of other witnesses and third parties who are not granted legal anonymity are not anonymised during the hearing, but will be anonymised in the decisions and reasons published on our website after the hearing.
- 50 The written document produced by the panel, setting out its decision and reasons, represents the formal and official determination in the case. This will be handed down when the panel's decision is announced. The nurse or midwife will be sent a copy of this decision, whether or not they were present at the hearing. Accordingly, the copy sent to the nurse or midwife will be identical to that handed down at the end of the hearing.
- 51 The panel members who have heard the case are in the best position to ensure that only personal data or sensitive personal data that is necessary to the decisions they have to make on the case is included in the document which contains the reasons for their decision. The key decisions in a substantive hearing include deciding the facts of the case, determining whether the nurse or midwife's fitness to practise is impaired and which sanction to impose, if any. After imposing a sanction (or at an interim orders hearing), the panel will

consider whether an interim order is necessary, or in the public interest, or in the interests of the nurse or midwife concerned.

- 52 The panel secretary assists the panel members in preparing the written record of the reasons for the decisions they make, and is able to advise them if it appears that personal data or sensitive personal data may be being processed unnecessarily. However, the final decision is that of the independent panel members.
- 53 We take steps, in accordance with our statutory obligation, to publish the decision, and the panel's reasons. We sometimes become aware, after a hearing decision has been made, that personal data which is not directly relevant to the panel's decisions on facts, impairment, sanction or interim order, has been included in the panel's reasons. Where such data is included in a panel's reasons, we may need to revise the document which captures the panel's reasoning before it is published on our website after the hearing.
- 54 We consider it is only appropriate for us to make changes to panel reasons we publish online where doing so would prevent such irrelevant personal data from being published. We will, however, ensure the nurse or midwife receives a copy of the panel's decision containing the reasons which is the same as the determination handed down at the end of the hearing.
- 55 The published decision of a Fitness to Practise Committee panel will take account of any time when the panel went into private session, and any details of those sessions will be excised from the published decision. A copy of any decision edited in this way will also be supplied to the nurse or midwife at the stage when the panel's decision is announced, and will be sent to the nurse or midwife's registered address.
- 56 In general, hearings before the Fitness to Practise Committee (and interim order hearings before the Investigating Committee) are held in public. Panels have the discretion to go into private session for all or part of the hearing. This will be considered when dealing with matters relating to the nurse or midwife's health, where issues are raised relating to the vulnerability of witnesses, the health of witnesses or other people who are identified but are not parties to the case, or to protect the anonymity of patients. The reasons published at the end of the case will mirror this approach.
- 57 Further information on how panels will decide when to go into private session can be found in our online [FtP Library](#).

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¹ For example under section 40(2) FOIA, where the information requested is the personal data of a person other than the person making the request, and disclosure of the information would be likely to cause damage or distress under s.10 DPA.

² The NMC is also subject to duties under the Environmental Information Regulations 2004 (EIR), but this document does not deal with those Regulations in any detail.

³ We have memoranda of understanding with many of these bodies addressing issues of exchange of information and we seek to cooperate with such requests for information where they are reasonable and where it is in the public interest to do so, particularly where it is justified to protect the safety of patients.

⁴ Nursing and Midwifery Order 2001 article 22(10).

⁵ Our Preliminary consideration of allegations guidance sets out the stages of our assessment.

⁶ Those same principles are set out in paragraphs 39–45. They involve anonymisation in a form which will allow panellists to distinguish between different patients whose identities remain protected.

⁷ As described at paragraph 4.

⁸ Article 25 of the Nursing and Midwifery Order 2001.

⁹ *GDC v Savery* [2011] EWHC 3011 (Admin).

¹⁰ Lawful by reference to s. 4 and Schedules 2 and 3 of the DPA.

¹¹ Material on which the NMC intends to rely, or which is legally disclosable to the nurse or midwife will already have been sent to the nurse or midwife before Case Examiner consideration of the case. This does not affect the right of nurses or midwives to make subject access requests under the DPA

¹² Disclosure to referrers under the FOIA is disclosure to the world at large. This requires us to consider whether the information would be exempt personal information under s. 40 (processing likely to cause damage or distress under s.10 DPA).

¹³ The NMC shares fitness to practise information with the police, the Disclosure and Barring Service, the CQC and other healthcare regulators.

¹⁴ Under s. 40(5) of the FOIA.

¹⁵ Article 22(10) of the Order

¹⁶ We will tell the nurse or midwife of our decision to share information in the public interest at the same time that we make the decision.

¹⁷ As contained in r. 7A of the NMC's Fitness to Practise Rules 2004.