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Our screening approach

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The NMC has a statutory duty to set and ensure the maintenance of professional standards. Our over-arching objective when doing so is protection of the public. Our legislation outlines that we achieve this through:

- Protecting, promoting and maintaining the health, safety and wellbeing of the public
- Promoting and maintaining public confidence in the professions
- Promoting and maintaining proper professional standards and conduct of professionals.

This guidance sets out how we decide if a fitness to practise concern should be referred to our Case Examiners or to the Fitness to Practise Committee. They are responsible for determining whether or not regulatory action is required. By regulatory action we mean taking action to restrict the practice of a professional on our register by agreeing undertakings or through a substantive order made by the Fitness to Practise Committee.

We have separate guidance explaining how we consider concerns that a professional's entry on the register may have been incorrectly made or fraudulently procured.

The purpose of screening

Being fit to practise means that a professional on our register can practise as a nurse, midwife or nursing associate unsupervised, safely and effectively. The purpose of screening is to assess whether a concern about the professional suggests there's a risk that could require us to take action to stop them from working or put conditions on their practice. That could be because they've behaved or practised in a way which poses a continuing risk to public safety or to confidence in the professions generally, or because we need to act to maintain professional standards. In other words, we're assessing whether there's a risk that could require us to take regulatory action and intervene in a professional's practice.

Not every concern raised about a professional on our register will require regulatory action. In many cases concerns can be managed more quickly and appropriately by employers.

We have the power to make preliminary enquiries in Screening, where this will help us establish how to respond to the concerns raised. It is not the purpose of Screening to conduct a full investigation of the concern. Where we have information that indicates the professional's conduct may pose a risk either to public safety, public confidence or to professional standards and consider that a full investigation is required to assess the level of risk and decide whether regulatory action needs to be taken by us, the concern should be referred on to our Investigation team.

Our approach

Our approach to screening is based on our principles for fitness to practise. Thus, for example:

- It's not our role to punish people for past events (Principle 2)
- We'll always take account of the context in which the person on our register was practising when deciding if there's a risk to public safety that may require us to take regulatory action. (Principle 6)

The role of employers

Many concerns we receive can be addressed quickly and effectively by employers without requiring our involvement. They're better placed to understand whether any contextual or system issues were present which may have contributed to a concern related to care or treatment and to understand the professional's day-to-day practice. Employers also have responsibilities to manage concerns about employees and manage their performance and practice. This includes the investigation of safety events, responding to complaints, fair and unbiased performance and disciplinary processes and making referrals to the NMC where they believe it is appropriate to do so.

Our fitness to practise principles make it clear that local investigation and resolution are always the preferred way to respond to concerns unless there is a risk to public safety, public confidence or professional standards which employers can't manage.

In some cases, it won't be possible for the employer to address the concern fully. This may be because the professional practises in more than one setting, doesn't have an employer or has left the employer before an action plan could be put in place. We may need to become involved in these cases where there's evidence of a risk that could require us to take action to protect the public, uphold public confidence or maintain professional standards.

Where employers identify ongoing risks to the public that they are not able to manage effectively, we expect them to refer the concern to us. If the employer is unsure whether they should refer the matter to us, they should contact our Employer Advice Line. We also provide resources to help employers manage concerns locally.

We also recognise that we have different purposes and objectives to employers. While employers can and do deal with many issues that impact on public safety, where there are significant concerns about the acts or omissions of a professional, only the NMC has the overarching objective of protecting the public through promoting and maintaining the health, safety and wellbeing of the public, public confidence in the nursing and midwifery professions and standards in those professions. Deciding on whether a concern could require regulatory action based on one of these grounds is a matter for the NMC.

Making Screening Decisions

We use a screening process to decide if a concern about a professional's practice needs to be referred to Case Examiners or the Fitness to Practise Committee.

The process consists of us asking ourselves:

1. Do we have a concern in writing about someone on our register?
2. Is there evidence to suggest that there is an ongoing risk to public safety, public confidence or professional standards that could require us to take regulatory action?

This process is intended to be used flexibly to help us reach the right decision fairly and quickly. For example, if the information we've received does not suggest a risk requiring restrictions on practice, we'll keep a record of the concern raised, but won't take steps to establish whether the individual referred is on our register.

Do we have a written concern about a nurse, midwife or nursing associate on our register?

Concerns we can consider

We can only become involved in a concern where we:

- have sufficient detail about an individual to identify them on our register as a nurse, midwife or nursing associate. We recognise that this is not always easy, but knowing a first name, the date, and the care setting in which the

events took place is the minimum information we require to help us identify an individual.
- have a written account of the concern. If the scope of the concern is unclear, we may contact the person raising the concern and ask them to clarify what their concern is about. If no clarification is provided, we may not be able to consider the matter any further. We can assist people in providing us with a written account where this is needed.

We must be confident that we have correctly identified the Personal Identification Number ('PIN') of the professional who is the subject of a concern raised with us. Where a concern relates to someone who is not on our register, we won't consider the matter further (but may refer the matter to another organisation, such as another regulator, the police, safeguarding agency or healthcare body).

We often receive concerns about professionals delivering care on a certain ward, unit, or a particular setting rather than about identified nurses, midwives or nursing associates. In these cases, we will generally refer the concerns back to the employer to consider. There may be instances where the concerns identify risks about a particular setting that we will want to share with the systems regulator or those with system oversight, to decide on the best approach. If we think the concern is one where the concerns raise a potential risk to public safety, public confidence in the professions or to professional standards which could require regulatory action, and a member of the public is unsure of the identity of those who delivered the care, we'll make enquiries to try to establish their identity.

If we believe regulatory action may be required, we'll ask employers or healthcare providers to supply us with documents and information (such as rotas or timesheets) to help us identify individuals on our register. We'll treat cases involving a number of professionals from a particular healthcare setting (who we cannot immediately identify) as a single referral as we gather information to identify if any of the individuals are on our register.

If, after taking reasonable and proportionate steps, we can't link the referral to an identified professional on our register, we won't be able to investigate further.

If, after investigation, the employer has identified individuals on our register and they believe regulatory action by us is required, we would expect them to make that referral accompanied by all relevant supporting information and evidence.

Supporting evidence

When concerns are raised with us we need them to be supported by some evidence. If they are not, we'll make reasonable and proportionate enquiries to obtain the evidence we need, but this is likely to lead to delays.

Where an employer refers something to us, we expect it to be accompanied by full supporting evidence. Supporting evidence should usually include:

- a clear and logical narrative explaining the conduct which is being alleged
- details of the incident(s) (including exact times and dates if possible)
- locations where the incident(s) took place (including name and address of the organisation, and specific wards or departments where possible)
- names and contact details of anyone present (including colleagues and members of the public)
- copies of notes made at the time or shortly after the event, and the first accounts or statements of anyone who witnessed the events alleged
- copies of medical records, any relevant medication administration record (MAR)
- charts, prescriptions, local policies relevant to the concern being raised
- details or documentary records of any admissions made by the professional or copies of any professional reflection or training undertaken since the incident
- details of other sources of evidence in support of the allegation
- investigation reports and appendices including incident reports, complaint responses, system investigation outcomes, including any changes made as a result and any HR investigation reports with evidence of a fair and unbiased approach (for example, use of the NHS England Just Culture guide or similar).
- any disciplinary outcome letter
- any relevant contextual information about the concern (including any information about the health of the professional on our Register and any vulnerabilities we should be aware of).

s there evidence to suggest that there is an ongoing risk to public safety, public

confidence or professional standards that could require us to take regulatory action?

Our starting point to answer this question is whether the concern is one which could impair the fitness to practise of a professional on our register. In other words, is there an ongoing risk to public safety, public confidence or professional standards if that professional continues to practise without restrictions.

Our legislation sets out the types of concern that can impair the fitness to practise of a professional. These are set out in our guidance on allegations we consider. The most common concerns relate to:

- Misconduct
- Health
- Lack of competence
- Criminal convictions and cautions

We have broad powers to make enquiries to help us decide whether a concern raised with us suggests a risk that could require us to take action.

How we assess whether a concern suggests an ongoing risk either to public safety, public confidence in the professions, or professional standards that could require us to take action

Not every breach of the professional standards set out in the Code requires regulatory intervention by us and many issues can be more appropriately investigated and dealt with by an employer or contractor.

Where concerns relate to misconduct, we'll only take action where there's evidence the professional's behaviour represents such a serious departure from the standards set out in the Code that it poses an ongoing risk to either public safety, public confidence or professional standards.

Where professionals have been the subject of such concerns, we will expect them to consider what lessons they can learn from the incident and to strengthen their practice as a result. Read more about our approach to issues of strengthened practice, reflection and insight.

We'll consider evidence of strengthened practice provided to us at the screening stage, to see whether the professional could still pose a risk to either public safety, public confidence or professional standards. However, we won't hold cases in Screening specifically to obtain this information if we've judged the concerns raise risks that could require us to take action. If those risks are present we should refer the matter for a full investigation.

Where we receive information that the health or personal circumstances of a professional may have played a part in the concern, we'll consider evidence from the professional to see if it demonstrates that they've reflected on and addressed the issues they were experiencing at the time. Where we receive evidence that lack of training or support may have played a part in the concern, we'll need to be satisfied that the gap in training or knowledge has been addressed.

Incidents before the nurse, midwife or nursing associate was registered with us

We won't usually refer concerns or incidents which took place before the nurse, midwife or nursing associate was registered with us to the Case Examiners or Fitness to Practise Committee. There may be exceptional cases of conduct that occurred before a nurse, midwife or nursing associate registered with us where we consider that the conduct raises risks to public safety, public confidence or professional standards that could require removal from our register. In these cases, we may refer the matter for further consideration.

Where a nurse, midwife or nursing associate fails to declare a criminal conviction or caution to us prior to registration that may lead us to refer the matter as an allegation that an entry in the register has been incorrectly made or fraudulently procured.

Actions that we may take when we receive a concern

There are three decisions our Screening team can make when we receive concerns about a professional's fitness to practise. Concerns are assessed on a case by case basis and can result in:

- A decision that no action is required by us
- A decision that no action is required by us, but we should notify an employer or other outside agency of the concerns raised
- Referral for full investigation by the NMC, and determination by Case Examiners or direct referral of a case to the Fitness to Practise Committee

Sometimes our Screening colleagues will need to make some preliminary enquiries to decide which of the three decisions is most appropriate.

No action required by us

Some concerns raised with us do not require regulatory action because they won't affect the professional's ability to practise safely and pose a risk to public safety, the public's confidence in the professions or professional standards more generally.

Situations which are highly unlikely to require any actions by us (or consideration by a third party) include:

- Civil proceedings such as landlord and tenant disputes.
- neighbour disputes.
- motoring offences (unless they result in disqualification, involve drink-driving or specified offences, or suggest a serious health condition)
- Contractual disputes
- Communication issues such as being rude to colleagues or members of the public (unless we consider that the incident should be referred to an employer)
- Social media posts expressing controversial opinions that are unrelated to professional practice. Professionals are generally free to express their political and religious beliefs outside of work. We won't take action simply because something a professional has said or done has shocked, disturbed or caused offence to someone. More detailed information on this topic can be found in our guidance on freedom of expression.
- Some employment issues such as disputes about shift working, grievances about booking shifts or annual leave, or not turning up for a shift.
- Complaints about the quality of services provided by an organisation generally, (such as a care home, NHS Trust, primary healthcare provider), unless the evidence indicates that someone on our register in a senior leadership position should be held personally responsible for those failings (see below).

Examples

- We receive a referral from a member of the public telling us that their neighbour who is a nurse keeps parking their car across the referrer's driveway, thus blocking them in. They tell us that they need access to their driveway 24 hours a day and the nurse knows this. While this may be upsetting for the member of the public, this is not a concern which raises risks to either public safety or to the public's confidence in the professions generally or to professional standards.
- We receive a referral from a member of the public telling us a nursing associate rented a property from them and left it in disrepair owing hundreds of pounds for refurbishment.
- We receive a referral from a member of the public complaining about the length of time that it took them to be discharged from a ward.
- We receive a complaint from a member of the public telling us that they were at an outpatient clinic. When they complained to a nurse about the delay in being seen by a consultant, the nurse rolled her eyes and abruptly told them to sit down and just wait their turn. The referrer felt angry and upset by the nurse's response. While the behaviour is upsetting for the individual who made the referral to us, it doesn't demonstrate any deep seated attitudinal issues with the nurse's behaviour and in this instance doesn't raise any risks to either public safety, to the public's confidence in the professions generally or require us to take action to uphold and maintain professional standards.

These examples will not impair fitness to practise. While these incidents may be upsetting and significant for the individuals involved, they don't raise risks to public safety, the public's confidence in the professions or professional standards more generally which could require us to restrict the professional's practice.

No action required by the NMC; notifying others of the concern

Most of the referrals we receive don't require action by us to restrict the professional's practice. Unless we identify a potential risk to public safety or to public confidence and professional standards, which requires us to take regulatory action we will not refer the matter for full investigation.

Notifying the employer of concerns which they are better placed to deal with

Sometimes we may conclude that a concern doesn't require regulatory action by us, but because of the nature of the concern, we may decide that we need to bring it to the attention of the employer. This gives them the opportunity to assess the concern and decide themselves whether they need to take any action, using the range of options available to them.

We will only do this where we can identify the employer and where we believe that there is a public interest in us notifying the employer of the issues that have been raised with us. This will provide the employer with an opportunity to respond to the concerns raised and to manage any risks as necessary. For example, if the referrer has unanswered concerns which could be better and more quickly managed and responded to by the employer.

We'll tell the individual who raised a concern with us what we're doing, and why, as well as signposting them to the most appropriate route to raise a concern. Where we decide that it's in the public interest for us to refer a matter to the employer, we'll follow our Information Handling Guidance. If an employer subsequently identifies any concerns, or patterns of behaviour, that they consider require regulatory action by the NMC, they can contact the Employer Advice Line or make a referral themselves.

Situations where an employer may be better suited to deal with the concern include:

- Referral about a member of the public's experience of a clinical act or omission such as medication or record-keeping error, administering or ordering medications; leaving someone in soiled sheets or not providing timely personal care.
- Communication issues involving a colleague which don't suggest an underlying attitudinal concern that would place members of the public at risk of harm.
- Communication issues involving someone receiving care, for example where a patient perceives a nurse to have not listened to them or dismissed their concerns; Concern about a professional's poor attitude to someone receiving care or failing to take their preferences into account

Equally, there may also be some situations where we need to make our own enquiries before we can decide on the most appropriate action for us to take. In these cases we will make preliminary enquiries about the concern to assess whether there is any risk that could require us to take action, or any need for us to refer the matter to a systems regulator or other outside agency. One such situation would be where the referrer is a whistleblower who is raising patient safety concerns or where there is evidence to suggest that the employer may be covering up wrongdoing or failing to address patient safety concerns.

Examples

- A member of the public makes a referral to us alleging that a nurse on our register accessed their medical records without clinical justification. They tell us that the reason they believe this to have happened is because the nurse is married to their cousin and that their cousin is aware of their medical condition. They believe the only explanation for this is that the nurse accessed their records but they don't provide us with any other evidence to support their belief. In this situation the employer is better placed to investigate the concern. A single incident of this type does not raise risks that could require us to restrict the nurse's practice.
- An individual makes a referral to us about their colleague who is a professional on our register, telling us the professional acted unprofessionally by not providing relevant clinical information to them during a handover. A single incident of this kind is likely to be better dealt with by an employer. In isolation it doesn't suggest a risk that requires us to restrict the professional's practice and the employer is better placed to intervene and act quickly if necessary to resolve the situation. The employer can consider whether local action is required and if they believe it's part of a wider pattern of behaviour that places colleagues and patients at risk of harm we would expect them to refer the matter to us.
- An individual makes a referral to us, telling us they feel bullied by their line manager, a registered nurse. The information provided to us doesn't indicate the manager has acted in a way which has affected the workplace culture and the safety of people receiving care or that there are any deep-seated attitudinal concerns with the

manager's conduct. While the situation is distressing for the individual, we'd expect the employer to deal with the matter and for the individual to go through their employer's usual HR processes. If evidence comes to light indicating the manager's behaviour has had a negative effect on the workplace culture and therefore the safety of people receiving care, we would expect the employer to refer the manager to us.

- A member of the public makes a referral about a nurse working at a GP surgery. They tell us the nurse carried out a smear test which was painful and that the nurse was rude to them. The experience left them feeling upset and anxious. Although the concern raised may indicate a departure from the standards set out in our Code, a single incident of this type is unlikely to impair fitness to practise and is much better dealt with by the employer. A single incident of this type does not raise risks that could require us to restrict the nurse's practice.
- A member of the public makes a referral to us alleging that their father's catheter was wrongly placed by a nurse in a care home, leading to pain and bleeding. Such a single clinical incident is one that the employer is generally best placed to manage. They will be able to recognise more quickly than us, whether the incident was an isolated one or whether there is an underlying issue with the nurse's ability to catheterise patients safely.

Referring concerns to Regulators and other outside agencies

As well as employers, we may also refer concerns to Regulators and other outside agencies, where we consider that they are better placed to deal with the issues raised and that there is a public interest in us referring the matter to them.

Sometimes a referral does not relate to a professional who is currently on our register, but the person concerned appears to be registered with another healthcare regulator. We'll advise the person who referred the case to us that a referral to a different regulator may be appropriate. But we'll also disclose the referral to that regulator ourselves if we consider that this may be necessary to protect the public from harm.

Similarly, where a referral does not raise concerns about the fitness to practise of a professional but appears to raise serious issues of public safety which should be investigated by another body (such as a systems regulator), we'll provide that body with the appropriate information and advice. This may include disclosure of the referral to assist with consideration of the case in line with our fitness to practise information handling guidance on sharing information with outside agencies. An example would be where we have evidence that an employer is not providing appropriate training to professionals on our register.

We have Memorandums of Understanding with a number of regulators including the Care Quality Commission and the Care Inspectorate. You can find a full list here.

As well as regulators, we may need to share information with organisations who are responsible for safeguarding children or vulnerable adults, or who may be involved in patient safety investigations, or in preventing or detecting criminal activity.

Where we share information with third parties, we'll do so in line with our Information Handling Guidance on sharing information with outside agencies.

Matters requiring full investigation by the NMC

Some behaviours and conduct raise clear risks to public safety, public confidence and professional standards. As set out in our misconduct guidance it can involve either an act or an omission and it can be something that happened either within or outside the professional's practice. This is because either the conduct or omission is such a serious departure from expected standards that it poses a risk to the safety of those receiving care or it's so serious it could lead to a breakdown in the public's trust and confidence in the professions.

Where we're satisfied that we have a legal basis for taking action (because the conduct falls within one of our grounds for impairment) and that the act or omission poses a current or ongoing risk to public safety, public confidence or professional standards, we'll refer the matter for a full investigation, so we can consider whether we need to take regulatory action.

More information about concerns of this kind can be found in our Misconduct guidance.

We may also need to carry out a full investigation when we have evidence that a professional is unable to demonstrate the standards of knowledge, skill and judgment required to show that they are capable of safe and effective practice which has resulted in a risk to public safety.

Sometimes we receive concerns that indicate risks that are so serious that they require immediate action to restrict the professional's practice. This will usually be on grounds of public safety. Where this is the case, as well as referring the matter for full investigation, we will also apply for an interim order to restrict the professional's practice while we investigate the matter. Full information about the procedure for interim orders and our approach to applying for them can be found in our interim order guidance.

Examples of concerns where we're likely to refer for a full investigation (and may also apply for an interim order), can be found in our misconduct guidance. These include but are not limited to:

- Where the professional has either deliberately harmed those in their care or deliberately taken risks with the safety of those in their care
- Evidence that misconduct has caused death or serious harm to someone receiving care
- Breaches of the duty of candour (either professional or statutory). I.e. lack of openness and honesty about an incident related to the care or treatment of someone in their care.
- Attempts to cover up clinical incidents including falsifying records, victimising or hindering someone who wanted to raise a concern, or encouraging others not to tell the truth.
- Evidence suggesting a pattern of behaviour posing risks to public safety (for example making multiple medication errors, repeated concerns about the professional's ability to carry out basic nursing or midwifery practice or a failure to complete preceptorship, capability or supervision programme).
- Specified or serious criminal offences (or situations where a professional is suspected of such offences) including hate crimes, sexual offences and serious offences against children or vulnerable people (whether or not this relates to professional practice)
- Sexual misconduct whether or not it relates to professional practice.
- Deliberately causing harm to vulnerable people/children whether in or outside of professional practice. For example, using physical violence against a child or vulnerable adult
- Failing to safeguard children or vulnerable adults (whether or not this relates to professional practice)
- Fraud or theft linked to professional practice e.g. theft of money from people receiving care, or taking or asking for money/loans from people receiving care or theft of controlled medication (however we'll always look at the context, for example the reason why the controlled medication was taken)
- Serious dishonesty
- Sexual relationships with people receiving care (or those close to them) or failing to have clear professional boundaries with people receiving care or someone close to them.
- Violent or abusive behaviour
- Conduct involving an imbalance of power, cruelty, exploitation or predatory behaviour (whether or not this relates to professional practice and including for example behaviours such as domestic abuse or coercive and controlling behaviours, or participating in modern day slavery).
- Discriminatory behaviour (whether or not this relates to professional practice).
- Deliberately misleading employers or prospective employers to cover up previous or ongoing practice or behavioural concerns, or a lack of relevant qualifications.
- Having a health concern which poses a risk of harm to people receiving care or a related risk to public confidence in the profession.
- Attending work while unfit due to being under the influence of alcohol or drugs.
- Serious or multiple breaches of the confidentiality of people receiving care.
- Not having the necessary knowledge of English so that people receiving care are placed at potential or actual risk of harm.
- Bullying, victimisation and harassment that could raise risks to both colleagues and people receiving care. For example, where a ward manager's behaviour is so poor that junior colleagues are afraid to approach or raise issues with them or where a professional uses violence towards a colleague, intimidates them or behaves in a discriminatory manner or where a colleague has sexually harassed a colleague. Situations like these could affect the working environment to such a degree that patient safety is compromised.

Preliminary enquiries by our Screening team are necessary to establish whether a full NMC investigation is required

Sometimes we receive referrals where it's difficult to understand what the concern being raised is about and whether it

alls within one of the allegations we can investigate or whether it raises risks that might require us to take action. Sometimes this is because we've been provided with very little information.

Where the information we've received suggests that there may be a risk to public safety, public confidence or professional standards, which requires a full investigation, but the situation isn't entirely clear our Screening team may decide to make some preliminary enquiries.

Our culture of curiosity guidance sets out our approach when we need to make enquiries. Just because a professional doesn't have a current employer isn't a reason to make enquiries into their practice. We'll always assess the reason why a referral to us was made and whether it indicates a risk to either public safety or to public confidence/professional standards.

We should always be clear about the reasons why we're making additional enquiries about someone's practice in Screening. These enquiries should be proportionate and limited to those we need to decide whether or not there is a risk to public safety, public confidence or professional standards that requires full investigation by the NMC.

Preliminary enquiries may lead us to decide to take no further action, decide that the matter is better dealt with by an employer or outside agency or refer the matter for a full NMC investigation. As soon as we conclude that there is a risk that could require regulatory action by us, we should refer the matter for a full NMC investigation.

For example, where we receive concerns that social services are involved with a professional's children, we'll need to make some enquiries to fully understand what the professional is alleged to have done. We may decide to take no action if we receive information that the children were placed on the Child in Need Register because the professional is working with social services to improve their parenting skills. But if the professional's children have been removed because of serious neglect, harm or because of safeguarding concerns, then it's likely we'll refer for a full investigation because such behaviours raise fundamental questions about the professional's ability to uphold the values set out in the Code and could indicate that the professional poses a risk to people in their care or to public confidence/professional standards.

We may also make further enquiries where a referrer tells us that they've already shared their concerns with the employer but that employer has not responded, or where the referrer is unhappy with the response they've received from the employer. We'll make enquiries to assess why the referrer is unhappy with the employer's response and whether there's any risk to public safety, public confidence or professional standards that could require us to take action.

We may need to make further enquiries where we receive an allegation that a professional was placed on an action plan but has been dismissed or resigned before any action was taken to strengthen their practice, meaning that there is now no employer who is able effectively to manage the situation.

Examples of situations where preliminary enquiries may be needed

A member of the public makes a referral to us alleging that their father's catheter was wrongly placed by a nurse at a Care Home which led to pain, bleeding, complications and hospital admission. The incident followed several others where they had concerns about the poor care provided by the nurse - for example that medication/care plans weren't followed. We would need to make further enquiries to understand what the earlier concerns about care were and to assess whether there are any potential risks to patients or public safety.

We receive a brief complaint from a member of the public about a nursing associate asking a patient for their personal telephone number, and alleging they acted in a flirtatious manner. Breaching professional boundaries is a concern which, if supported by evidence, could pose significant risks to both public safety and public confidence. Given the lack of information we need to make some enquiries with the nursing associate's employer.

Allegations without any supporting evidence

Sometimes people can interpret events differently, particularly if a distressing or traumatic event has taken place. We'll always make an objective assessment of the evidence we've been given, rather than rely on an individual's interpretation of the evidence.

Where someone makes a serious allegation asserting the professional's behaviour is causing harm to the public or public confidence, but doesn't provide us with any supporting evidence, we'll decide whether to make further enquiries

o establish if there's some evidence to support the concern (this might be an account from the person who witnessed he professional's conduct, or a request for the relevant medical records). We'll usually ask the person raising the concern for more information. If this isn't possible, for example, where we don't know the identity of the person raising he concern, we'll assess the potential risks to decide whether it's reasonable and proportionate to make enquiries to erify it (or whether another body may be better placed to investigate the matter, for example the police).

Where we've carried out reasonable and proportionate enquiries but are left with a bare allegation, (one which is not supported by evidence), we won't be able to take the matter further.

Example
We receive a complaint that a midwife has given the referrer, a colleague who they manage, a negative appraisal report because of their race. We make enquiries to see whether there is any evidence to support the allegation that the midwife discriminated against the referrer. Other than the referrer's assertion, our enquiries don't identify any evidence hat could show there's a link between the appraisal and the referrer's race or any other evidence that could support a discrimination allegation.

n this case we would not have any evidence to support the concern, and wouldn't need to consider the matter further.

Professionals in senior leadership positions

We sometimes receive referrals about professionals on our register who are in senior leadership positions.

Our role is not to regulate healthcare organisations but the nurses, midwives and nursing associates who work within hem. When we receive concerns about serious systemic failings in an organisation we'll refer these to the appropriate systems regulator.

The professional standards set out in the Code apply to all professionals on the NMC register, in any nursing or midwifery role. A serious departure from those standards can amount to impairment and require us to take regulatory action if that departure demonstrates:

- a risk of harm to people in their care or the public or to public confidence, and/or;
- a fundamental question about the professional's ability to uphold the standards and values in the Code.

Simply being a senior leader within an organisation that has been criticised for institutional failings does not mean we'll need to take regulatory action against that individual. We will only do so if there is clear evidence of individual wrong-doing that indicates a fundamental departure from the standards and values set out in the Code. For example that a professional has:

- deliberately covered up failings in care.
- despite specific risks being drawn to their attention, wilfully ignored or failed to escalate these risks appropriately
- participated in or facilitated a culture of discrimination or bullying.

Senior nurses and midwives, such as Executive Directors of Nursing or Midwifery or Chief Nurses and Heads of Midwifery have strategic, board-level responsibilities. While they may not deliver direct patient care, they remain esponsible and accountable to the Trust's executive board and the public for the quality of nursing (and sometimes, depending on their organisation, for the care provided by Midwifery and Allied Health Professionals).

Professionals in senior leadership positions, as well as having responsibility for professional nursing and midwifery eadership, often also have a lead role in quality, safety, and safeguarding as well as patient experience and other corporate roles.

With such a broad scope of responsibility, it cannot be expected that any individual will have detailed knowledge of each clinical area for which they hold overall responsibility. However they are expected to have the knowledge, understanding and leadership skills to identify systemic or cultural issues that may impact on patient care or the safety of the public.

We recognise that such professionals can be perceived as being remote from issues. They should have appropriate systems for maintaining contact with their direct reports and satisfying themselves that they are being kept abreast of significant issues and changes. We'll take account of what information they were aware of and whether they exhibited sufficient professional curiosity to satisfy themselves of the risks involved in the matter.

Senior professionals may be limited in what they are able to do in practice by factors outside their control such as

financial or resourcing constraints or the political agenda of the day. We will take this context into account when assessing whether there's been a serious departure from the standards in the Code.

We may decide that regulatory action is not required where the professional has demonstrated that they have for example:

- recognised risks to people receiving care
- escalated those risks appropriately (for example, to their executive board and governance committees)
- taken steps to mitigate or manage the identified risks to the best of their ability in the circumstances of the matter
- Acted on technical advice for example from HR or safeguarding colleagues which they believed to be correct

Where we are dealing with concerns about someone in a senior leadership position, we will use a more senior contact in the organisation for any communication about the referral of that senior professional and any referrals linked to that specific case.

Verifying the facts

Sometimes we receive concerns where a referrer may have misunderstood or made a mistake about the underlying facts. We can check the facts contained in the written account to make sure the concern is well founded. If our enquiries show the concern isn't well founded, we won't consider the matter any further.

Example
It's alleged that a nurse was prescribing medication without the correct qualifications. We carry out enquiries to verify the allegation. Our investigation shows conclusively that the nurse did have the relevant prescribing rights at the time of the alleged incident.

In this scenario the referrer is mistaken about the nurse's qualifications, and we wouldn't need to consider the matter any further.

Anonymous referrals and people wishing to remain anonymous

In some cases, we won't know the identity of the person raising the concern. This usually means that we won't be able to rely on their written account as evidence supporting the concern.

When a referrer has asked us not to disclose their identity to the professional who is the subject of a concern which we've assessed as raising risks to either public safety or confidence, we'll always seek to address any concerns they have about taking part in our fitness to practise process.

We may engage our specialist Public Support Service for advice and support to help explain our processes and the additional measures we can offer to help witnesses through them.

If the information we've received indicates the professional's conduct may pose a risk to public safety, public confidence or to professional standards, we'll use the information we've been given to make preliminary enquiries about the concern without disclosing the identity of the referrer. We'll make whatever enquiries appear reasonable and proportionate to see if there's any other evidence to support the concern. If we find any other evidence of the concern and we've identified risks that could require us to take action) we'll refer the matter to the Case Examiners or Fitness to Practise Committee ourselves.

If we can't progress the concern without the referrer's evidence, then we won't be able to consider the matter any further.

While it is best practice to maintain confidentiality, we may sometimes be justified in disclosing information to third parties without an individual's agreement to do so. This may happen where we are required by law to make a disclosure, or in circumstances where we have identified a public interest reason justifying disclosure.

Example 1
We receive an anonymous letter that an agency nurse harassed a patient in a hospital car park. No further details are provided, such as the name of the hospital or the identity of the patient. Without further information, we can't make any enquiries to ascertain whether there's any other evidence to support the concern and we wouldn't be able to take the matter further.
Example 2

We receive a complaint that a midwife assaulted a patient during a medical procedure. There's no other evidence to suggest an assault took place and the patient wishes to remain anonymous. Without the evidence of the referrer who is the sole potential witness, we don't have any evidence to support the concern and wouldn't be able to take the matter further.

Clinical advice

Our decision-makers can ask for clinical advice from our internal clinical advisers at the Screening stage. Clinical advice can, in many cases, be very useful in helping us make fair, well-informed decisions.

Clinical advice at the Screening stage is aimed at assisting the decision-maker to understand the nature of the concern raised. This is so that the decision maker can assess whether it could require us to take regulatory action to protect the public. The clinical advisor may suggest preliminary enquiries, either with the person raising the concern or others, for example employers.

It is not the role of the clinical advisor:

- to decide whether we should investigate a matter further
- to express any view as to the strength of the evidence presented and on the likely outcome of an investigation

In cases where a concern raises clinical issues, and the Screening decision-maker is considering referring the matter to an employer or third party, it may be appropriate to seek clinical advice as to whether that would be an appropriate course of action, given the nature of the clinical issues raised.

Whistleblowing

Whistleblowers benefit from important legal protections. Although we've summarised some of the most important facts about whistleblowers, you can find more detail in our guidance (including the legal criteria for being a whistleblower).

Whistleblowing is when a worker, including a student nurse, student midwife or student nursing associate, raises a concern about wrongdoing in the public interest.

Whistleblowing can occur within an organisation or, if the worker feels they're unable to do this, to someone outside their organisation known as a 'prescribed person'. 'Prescribed person' is a legal term. The NMC is named as a prescribed person in the law.

Whistleblowing is not the same as raising a concern, but many workers who raise concerns with us will be whistleblowers. Examples of whistleblowing concerns are allegations relating to criminal offences or that an individual's health or safety is being endangered.

When considering whistleblowing concerns in Screening, we'll always act according to our legal obligations to whistleblowers. This will include giving very careful consideration to a whistleblower's request that their identity shouldn't be disclosed. The law does not compel us to protect the confidentiality of a whistleblower. However, we recognise that it is best practice to maintain confidentiality unless we identify a clear public interest reason to disclose the whistleblower's identity.

Use of Article 22 (6)

Reference: SCR-1b Last Updated: 23/07/2026

Article 22 (6) allows the NMC to refer concerns about a professional's practice for investigation and determination by the case examiners in the absence of any formal complaint or allegation having been received.

The NMC receives referrals from a variety of sources and usually these referrals come from individuals or organisations such as the police or employers.

Occasionally we may learn of information about a professional's fitness to practise that could mean they pose a risk to either public safety, the public's confidence in the professions and to professional standards e.g. via a media article or television report.

Our screening team is responsible for considering such concerns and they will do so in line with our screening guidance, making enquiries where appropriate.

Having done so, if they decide that the concern requires further investigation and consideration by the case examiners, screening will consider:

- whether the information in our possession relates to a professional on our Register
- whether the information in our possession indicates a risk to public safety, public confidence or professional standards that could require regulatory action by us
- whether it is necessary for us to conduct an investigation in order to fulfil our overarching objective of protecting the public

If all these factors are present they will refer the matter, under Article 22 (6), to our investigations colleagues to commence a formal investigation into the professional's fitness to practise.

A decision not to take any further action at this time

Reference: SCR-1a Last Updated: 06/05/2025

In this guide

- Reviewing a screening decision
- After we've reviewed the decision

Our screening team carefully considers the information available before making a decision. Sometimes, the team decides that we don't need to take any further action.

We take public protection extremely seriously when deciding that no further action is required.

Occasionally, we need to review a decision not to take any further action.
In very limited circumstances we can change a decision. That will only be where:

- There's new information that changes the decision and/or
- Something went so seriously wrong with how the decision was made that correcting the error would mean a different decision should have been made

We recognise the impact that a decision not to take further action has on the person who raised the concern with the NMC and anyone else affected by the issues that led to the referral to the NMC. We also recognise that when we review cases after a screening decision to take no further action, this has a serious impact on the professional involved. We recognise the impact that being subject to fitness to practise proceedings can have on the professional concerned, as well as the wider healthcare system.

We have support available to people affected by our fitness to practise processes. Further information about our processes and the support we can provide is available on our website:

- Information for registrants
- Information for patients, families, and the public

Reviewing a screening decision

We can only review decisions not to take further action – that is, a decision not to refer a concern to our case examiners or to the fitness to practise committee. We can't review a decision if the nurse, midwife or nursing associate has lapsed from the register. If the professional is readmitted to the register, we'll then consider the request to review our decision at that stage.

If someone requests a review

We'll ask the person who requested the review to explain:

- why they consider there's new information that changes the decision, and/or
- what they consider went wrong with how we made the original decision and why that means a different decision should be made

We won't usually carry out a review if the request is an expression of general unhappiness with the decision. We expect people who ask us to review a decision to explain why they consider there are reasons to carry out a review.

We may also decide to carry out a review if we consider that one of the reasons to review may apply.

If we decide to carry out a review, we'll then tell the nurse, midwife or nursing associate that we're going to review the decision and explain why. We'll also tell people who were told of the outcome at the screening stage, if they need to know. This could include employers, patients or other organisations.

What happens during a review

When we review a screening decision, we'll look at:

- the reasons for the decision
- the reasons for the request to review the decision
- any new information received and the reasons why someone says this means a different decision should be made
- any other information we consider relevant to our review.

What we can decide

When we carry out a review, we'll decide whether:

- There's new information that changes the decision and/or
- Something went so seriously wrong with how the decision was made that correcting the error would mean a different decision should have been made

If we decide that we should make a different decision, we can:

- send the case to the screening team for further enquiries and a new screening decision
- refer the case to the case examiners if the concern is about someone's fitness to practise
- refer the case to the Investigating Committee if the concern is about a fraudulent or incorrect entry to the register

If there's no reason why a different decision should be made, we'll write to the person who requested the review to confirm this.

New information

New information is information we didn't have when the original screening decision was made.

If someone tells us there's new information, we'll need to ask:

- Do we know what the new information is and has it been given to us?
- If the information had been available at the time of the decision, would we have made a different decision?

We expect people to give us all the relevant information they have when they make a referral. As part of the screening process, we also consider whether we should seek further information. It is therefore extremely rare that new information about the same matter will make a difference unless it fundamentally shows that the concern raises a risk to public protection that was not previously appreciated and/or where it provides evidence of something where we previously did not have any evidence.

Often, we're given new information and decide that it wouldn't change the decision.

When there is an error in the decision

We can only change a decision that we don't need to investigate a nurse, midwife or nursing associate in very limited circumstances. These circumstances include:

- we didn't follow our own legislation (sometimes called an 'error of law')
- it was so unreasonable that no reasonable regulator would make such a decision (sometimes called an 'irrational decision')
- reaching a conclusion that the available evidence does not support, relying on evidence which is not relevant, or failing to take account of relevant evidence.

We can only change our decision if correcting the error would change the outcome. This means that, even if there was an error in the decision, if the decision would be the same in any event, it won't impact on the outcome.

New concerns

Sometimes, we'll find information during our review that amounts to a new concern.

If that happens, and if we can, we'll decide whether the concern needs to be investigated further.

Screening

f we need more information to make a decision, we'll send it to our screening team to make enquiries. The screening eam will then decide whether the concern should be referred to the case examiners or Fitness to Practise Committee.

f we decide we don't need to make any further enquiries, we'll make that decision using our screening guidance. Read nore on our overall approach.

After we've reviewed the decision

We'll confirm the outcome of our review to the person who requested it. We'll also tell the nurse, midwife or nursing associate, and anyone else we told about the request to review the decision.

f we decide that no further action is needed, we won't look into the same concerns again unless there's new nformation that we've not considered before and which means a different decision should be made. If someone sends us more information after our review, we'll ask the person providing the information why they didn't provide it before and why it changes the decision.

f someone is unhappy about our customer service or is concerned that we did not follow the right process, our Corporate Complaints and Enquiries team can look into it. Their role is limited to reviewing how we've handled the case. They won't be able to change the decision.

Determining the regulatory concern

Reference: SCR-2 Last Updated: 06/05/2025

If our screening decision is to refer an allegation about a nurse, midwife or nursing associate's fitness to practise to the case examiners, we will clearly identify and articulate the issues that concern us as a regulator. We call these regulatory concerns. A regulatory concern allows us to focus on what it is about the nurse, midwife or nursing associate's practice or conduct which, unless regulatory action is taken, appears to be a risk to public safety or could affect the public's trust and confidence in nurses, midwives and nursing associates generally or to professional standards.

We should always be able to express the regulatory concern about a nurse, midwife or nursing associate's practice in clear terms at any stage in the life of a case. This allows the nurse, midwife or nursing associate to understand why we say there is such a risk with their practice as set out above, that it justifies us a) investigating it and b) possibly restricting their right to practise or imposing other outcomes against their registration.

We review the regulatory concern in every case on an ongoing basis. It will always be drafted in the right level of detail for the stage of our process the case has reached. The level of detail is likely to increase as we gather more information and the case progresses through our investigation towards consideration by case examiners.

Explaining how and why a nurse or midwife presents a regulatory concern

Reference: SCR-2a Last Updated: 14/04/2021

In this guide

- Introduction
- Identifying what causes us a regulatory concern
- Analysing evidence of regulatory concerns
- Regulatory concerns about motivation or intent
- Statements of regulatory concern

Introduction

As we explain earlier in this section, we use 'regulatory concerns' to identify and explain what it is about a nurse, midwife or nursing associate's conduct or practice that concerns us as a regulator. Because we may only have limited information when we are screening a case, or in the early part of our investigation, in those initial stages we usually explain regulatory concerns in fairly broad terms.

For example, if a nurse, midwife or nursing associate made a number of different kinds of dosing errors on different days, in the early stages of our fitness to practise process we would say our regulatory concern is that the nurse, midwife or nursing associate is unable to administer medication safely. We usually explain the concerns in more detail as we gather more information about what happened and how it could have put patients, members of the public, or public confidence in nurses, midwives or nursing associates at risk. Cases can be made up of more than one regulatory concern, and this can sometimes include concerns about the nurse, midwife or nursing associate's motivation, or reasons for doing or not doing something.

As the case passes through the further stages of our investigations process and is ready to be considered by case examiners, we prepare a formal statement of regulatory concern. This explains our concerns about the nurse, midwife or nursing associate's practice in more than detail than we will have given them when we were screening the case.

Identifying what causes us a regulatory concern

A regulatory concern will usually focus on one incident, or one series of closely related incidents. Often, problems in the nurse, midwife or nursing associate's practice that might seem quite separate from each other can actually be explained as one concern. For example, if the nurse who made the series of dosing errors also failed to observe patients who needed to be supervised when taking their medication, and didn't keep proper records of what medicines had and hadn't been administered, there is still likely to be one regulatory concern about whether the nurse can safely manage how they administer medicines.

An allegation about a nurse, midwife or nursing associate's overall fitness to practise can be made up of more than one regulatory concern. So one fitness to practise allegation could, for example, be based on three regulatory concerns: one about poor record-keeping, a second about neglecting patients, and a third concern about dishonesty based on false expense claims. If we uncover new and separate regulatory concerns as we are investigating a case, we will tell the nurse, midwife or nursing associate about this, and ask them to respond if they wish to. The latest we do this will be when we send them the information we've gathered at the end of the investigation.

Analysing evidence of regulatory concerns

Concerns about nurses, midwives and nursing associates need to be based on evidence. The way we describe the regulatory concern should always be informed by what the evidence we have tells us about possible risks to patients, or to the public's trust in nurses, midwives and nursing associates.

For example, if a nurse, midwife or nursing associate is alleged to have been sleeping on duty, we wouldn't simply assume doing this will automatically put patients at risk, or undermine public trust, and just describe the regulatory

concern as ‘sleeping on duty’.

Rather, to properly consider and explain what regulatory concern the nurse, midwife or nursing associate presents, and what decision or action we need to take to protect the public in any particular case, we will need to carefully review the evidence and what it says about:

- what happened
- the particular setting where the incident occurred
- whether it was an isolated incident
- whether it was a conscious decision or an accident
- whether the nurse, midwife or nursing associate failed in their duty
- whether any background context factors influenced what happened (see our guidance on taking account of context)
- whether there was a risk of patients or service users being harmed
- whether records were falsified or the nurse, midwife or nursing associate tried to cover up what happened

Each of these things will affect whether there is a regulatory concern about a nurse, midwife or nursing associate’s practice, whether there may actually be more than one concern, and how we explain or describe what causes us concern.

Regulatory concerns about motivation or intent

Sometimes, the reason why the nurse, midwife or nursing associate did or failed to do something might itself be a regulatory concern, because it could suggest a further risk to patients, or to the public’s trust in nurses, midwives or nursing associates, over and above the risks the conduct itself involves.

A nurse, midwife or nursing associate who personally contacts a patient in their care will usually present a regulatory concern, because doing so will probably mean a breach of professional boundaries. However, if the nurse, midwife or nursing associate tried to contact the patient because they wanted to pursue a sexual relationship with them, we would need to address this kind of motivation as a separate regulatory concern in itself.

We need a clear foundation to suggest concerns about a nurse, midwife or nursing associate’s motives. For example, if the nurse who made the series of medication administration errors also signed the records before they began the medication round, we would need clear evidence that they had a dishonest reason for doing this before we accused them of acting dishonestly. Otherwise the concern would really still be about the management of medicines administration.

In contrast, if a midwife administered a controlled drug without anyone to act as a second checker, and later asked another midwife to sign to say that they had checked the drugs, there would be two concerns. One about the failing in administering controlled drugs, and a second, separate concern about the dishonest attempt to cover up the failing. Unlike the pre-signing of records, there is no realistic possibility of an innocent explanation for this.

Statements of regulatory concern

At the end of our investigation we will produce a statement of regulatory concern. This is a concise explanation of what we say has happened in a particular case. The statement of regulatory concern won’t necessarily need to be broken down into specific episodes on specific individual dates, but it should explain what happened, and over how long.

It’s important that the nurse, midwife or nursing associate is able to understand what we say happened, and why we say it means we may need to take regulatory action in their practice. The nurse, midwife or nursing associate needs to be able to tell us whether or not they accept that our concerns are well founded. Case examiners need enough detail for to make a clear and well reasoned decision about whether the nurse, midwife or nursing associate has a case to answer, and also whether they should use their powers to dispose of cases by recommending undertakings, issuing warnings, or giving advice.

During the investigation we sometimes receive new information which forms the basis of a further area of regulatory concern, separate from those previously identified at the screening stage. When this happens we will tell the nurse, midwife or nursing associate and invite them to respond.

Cases that may involve incorrect or fraudulent entry

Reference: SCR-3 Last Updated: 04/09/2025

Please see our guidance on Incorrect and Fraudulent Entry (or "IEFE") for details of how we decide whether an allegation is about a register entry, and when we refer IEFE cases to the Investigating Committee. This guidance also provides details of our approach when we receive concerns about a nurse, midwife or nursing associate that involve both IEFE and fitness to practise allegations.