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Aims and principles for fitness to practise

Reference: FTP-1 Last Updated: 14/04/2021

Our overarching objective as an organisation, is the protection of the public. It's central to everything we do.

In order to achieve our overarching objective, our legal framework[1] says we need to:

- protect, promote and maintain the health, safety and wellbeing of the public
- promote and maintain public confidence in the nursing and midwifery professions
- promote and maintain proper professional standards and conduct for members of the nursing and midwifery professions.

Our aims for fitness to practise

We have two clear aims for fitness to practise:

- A professional culture that values equality, diversity and inclusion, and prioritises openness and learning in the interests of patient safety
- Nurses, midwives and nursing associates who are fit to practise safely and professionally.

We designed a set of principles to help us deliver these aims.

Our principles for fitness to practise

We'll use these 12 principles to make sure we're consistent and transparent in the way we work and in the way we make decisions about nurses, midwives and nursing associates' fitness to practise.

Read about each principle below and how we apply it to what we do.

1. A person-centred approach to fitness to practise.

A person-centred approach helps us to put patients, families and the public at the heart of what we do.

It involves listening to what patients, their families and loved ones tell us about their experiences so that we can understand what the regulatory concerns about nurses, midwives and nursing associates might be and are better placed to act on those concerns. Sometimes, they provide vital information that shows we need to scrutinise the conclusions others have reached.

We want patients and members of the public to feel supported and listened to in our fitness to practise proceedings. Putting patients, families and the public at the centre of what we do helps us to make sure we are in the best place to protect the public.

2. Fitness to practise is about managing the risk that a nurse, midwife or nursing associate poses to patients or members of the public in the future. It isn't about punishing people for past events.

If professionals see us as being punitive, those professionals are more likely to hide things going wrong or act defensively. This will make it difficult to achieve the kind of open and learning culture that's most likely to keep patients and members of the public safe.

If we are seen by the people affected by unsafe care, as being there to discipline the nurses, midwives or nursing associates involved, those people may be distressed if we don't take action against nurses, midwives or nursing associates who are no longer a risk.

3. We can best protect patients and members of the public by making final fitness to practise decisions swiftly and publishing the reasons openly.

Transparency is crucial to an effective fitness to practise process. All the people involved in a case, including patients, members of the public, and nurses, midwives and nursing associates, expect fitness to practise processes to be efficient and joined up.

They need to understand clearly and as quickly as possible what we have done about the concerns, and the reasons for our decisions. Those reasons may help others in similar situations make decisions that will help keep patients and members of the public safe.

4. Employers should act first to deal with concerns about a nurse, midwife or nursing associate's practice, unless the risk to patients or the public is so serious that we need to take immediate action.

Employers are closer to the sources of risk to patients and members of the public, and better able to recognise and manage them. If they need to, they can intervene directly and quickly in a nurse, midwife or nursing associate's practice, and do so in a targeted way dealing specifically with the risks.

We are further away from the sources of possible harm, and have a more limited range of options to prevent it.

We only need to become involved early on if the nurse, midwife or nursing associate poses a risk of harm to patients or the public that the employer can't manage effectively (perhaps because the nurse, midwife or nursing associate has left), meaning the nurse, midwife or nursing associate's right to practise needs to be withdrawn or restricted immediately.

5. We always take regulatory action when there is a risk to patient safety that is not being effectively managed by an employer.

In the small number of cases where employers can't put the right controls in place to keep patients and members of the public safe, then we will need to become involved. This can often happen when the nurse, midwife or nursing associate practises in more than one setting, or doesn't have an employer, although these aren't the only examples. We may need to consider putting conditions on the nurse, midwife or nursing associate's ability to practise, or remove it.

6. We take account of the context in which the nurse, midwife or nursing associate was practising when deciding whether there is a risk to patient safety that requires us to take regulatory action.

When incidents of poor practice actually happen because of underlying system failures, taking regulatory action against a nurse, midwife or nursing associate may not stop similar incidents happening again in the future. Regulatory action against an individual nurse, midwife or nursing associate may give false assurance, direct focus away from a wider problem and cause a future public protection gap.

7. We may not need to take regulatory action for a clinical mistake, even where there has been serious harm to a patient or service-user, if there is no longer a risk to patient safety and the nurse, midwife or nursing associate has been open about what went wrong and can demonstrate that they have learned from it.

Encouraging nurses, midwives and nursing associates to learn from mistakes, including mistakes with serious consequences, is more likely to promote a learning culture that keeps patients and members of the public safe, than taking regulatory action to 'mark' the seriousness of the consequences.

Negative stories about regulation have a harmful effect on nurses, midwives and nursing associates. We want to assure nurses, midwives and nursing associates that they won't be punished if they admit to, and show they have learned from, past mistakes because this will support them in positively engaging with their professional duty of candour and help promote, rather than discourage, the kind of professional culture that's been shown to keep people safe.

8. Deliberately covering up when things go wrong seriously undermines patient safety and damages public trust in the professions. Restrictive regulatory action is likely to be required in such cases.

The duty of candour requires nurses, midwives and nursing associates to be open and honest when things go

wrong. It stops them from trying to prevent colleagues or former colleagues from raising concerns.

We know that if professionals don't speak up when things go wrong, significant numbers of people can suffer harm, and have done in the past. Nurses, midwives and nursing associates who try to cover up problems in their own practice deny patients and members of the public the honest explanation and apology they deserve when they have been put at risk of harm. It can also put other people at risk of suffering harm if organisations are prevented from investigating wider problems.

9. In cases about clinical practice, taking action solely to maintain public confidence or uphold standards is only likely to be needed if the regulatory concern can't be addressed.

If the nurse, midwife or nursing associate has fully addressed the problem in their practice that led to the incident, and already poses no further risk to patients, we won't usually need to take action to uphold public confidence or professional standards. Only those clinical concerns that are so serious that they can't be put right will prompt us to take regulatory action to promote public confidence or uphold standards.

10. In cases that aren't about clinical practice, taking action to maintain public confidence or uphold standards is only likely to be needed if the concerns raise fundamental questions about the trustworthiness of a nurse, midwife or nursing associate as a professional.

We know that the public take concerns which affect the trustworthiness of nurses, midwives and nursing associates particularly seriously. Our research told us that these cases are likely seen by the public as serious breaches of professional standards. Conduct that could affect trust in nurses, midwives and nursing associates and require action to uphold standards or public confidence include, where related to professional practice, dishonesty, bullying and harassment. Within a nurse, midwife or nursing associate's private life, convictions that relate to specified offences or result in custodial sentences are also likely to require regulatory action for the same reason.

11. Some regulatory concerns, particularly if they raise fundamental concerns about the nurse, midwife or nursing associate's professionalism, can't be addressed and require restrictive regulatory action.

Conduct that calls into question the basics of someone's professionalism raises concerns about whether they are a suitable person to remain on a register of professionals. It's more difficult for nurses, midwives or nursing associates to be able to address concerns of this kind, and where they cannot, it will be difficult to justify them keeping their registered status.

12. Hearings best protect patients and members of the public by resolving central aspects of a case that we and the nurse, midwife or nursing associate don't agree on.

Full public hearings are not always required to reach a decision that protects the public. Their adversarial nature often has a negative impact on people, and they are slow and resource intensive.

1 See article 3(4) and (4A) Nursing and Midwifery Order 2001

Allegations we consider

Reference: FTP-2 Last Updated: 28/07/2017

Our statutory powers to carry out investigations are limited to two kinds of allegation:

- Allegations of fraudulent or incorrect entry of an individual nurse, midwife or nursing associate to our register
- Allegations about the fitness to practise of nurses, midwives or nursing associates.

Allegations about fitness to practise can be based on:

- misconduct
- lack of competence
- criminal convictions and cautions
- health
- not having the necessary knowledge of English
- determinations by other health or social care organisations

Misconduct

Reference: FTP-2a Last Updated: 29/11/2021

The Code sets the professional standards of practice and behaviour for nurses, midwives and nursing associates, and the standards that patients and public tell us they expect from nurses, midwives and nursing associates. While the values and principles can be interpreted for particular practice settings, they are not negotiable.

If nurses, midwives or nursing associates fall short of the Code, what they did or failed to do may be serious professional misconduct. We'll need to investigate and take action if this is the case.

When does poor clinical practice become serious professional misconduct?

There are certain kinds of clinical concerns we think are the most serious because they may lead to patients or members of the public suffering harm.

Because fitness to practise is about keeping people safe, rather than punishing nurses, midwives and nursing associates for past mistakes, one-off clinical incidents won't usually be considered serious professional misconduct.

Even where there has been serious harm to a patient or service-user, provided there is no longer a risk to patient safety, and the nurse, midwife or nursing associate has been open about what went wrong and can demonstrate that they have learned from it, we will not usually need to take action.

However, some concerns about patient harm will be so serious that they can't be addressed and we will need to take action to protect public confidence or to uphold professional standards. In cases like this, we will usually only need to take action if it's clear that the nurse, midwife or nursing associate deliberately chose to take an unreasonable risk with the safety of patients or service users in their care.

When we are looking at patient safety incidents involving nurses, midwives or nursing associates, we will always look carefully at the context in which they were practising. Even poor practice by a nurse, midwife or nursing associate might actually have happened because of underlying system failures.

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

Our guidance about seriousness uses parts of the Code to explain what kinds of clinical concerns we think are the most serious.

What other kinds of misconduct are there?

Actions or failings which are related to clinical practice, but not a direct part of it, can be serious professional misconduct, as can issues about the nurse, midwife or nursing associate's role as a registered professional.

Bullying and harassment of colleagues, dishonesty about qualifications or employment history, are just some examples. A more extensive list is in our guidance about seriousness.

Sometimes, even the way a nurse, midwife or nursing associate conducts themselves in their private life could be serious professional misconduct.

This will usually only happen if the concerns raise fundamental questions about their trustworthiness as a registered professional or suggest a deep-seated attitudinal issue such as displaying discriminatory views and behaviours. This is a high threshold, because it means we may need to take action to protect public confidence in all nurses, midwives and nursing associates, or uphold professional standards.

Comparing misconduct in a nurse, midwife or nursing associate's private life, to our approach to criminal convictions, we would say that only convictions for specified offences or ending with a sentence of imprisonment would be serious enough to raise fundamental questions about a nurse, midwife or nursing associate's trustworthiness as a registered professional.

We don't need to become involved in issues like bad timekeeping, or minor breaches of a local disciplinary policy, because they won't put patients or members of the public at risk of suffering harm, and they don't raise fundamental questions about a nurse, midwife or nursing associate's trustworthiness as a registered professional.

Lack of competence

Reference: FTP-2b Last Updated: 14/04/2021

Lack of competence would usually involve an unacceptably low standard of professional performance, judged on a fair sample of their work, which could put patients at risk. For instance when a nurse, midwife or nursing associate also demonstrates a lack of knowledge, skill or judgement showing they are incapable of safe and effective practice.

Unless it was exceptionally serious, a single clinical incident would not indicate a general lack of competence on the part of a nurse, midwife or nursing associate.

We recognise that nurses, midwives and nursing associates sometimes make mistakes or errors of judgement. Our starting position is that the nurse, midwife or nursing associate is usually a safe and competent professional but something may have happened that got in the way of them delivering safe care.

If concerns are raised about the general competence of a nurse, midwife or nursing associate we'll seek to understand the circumstances at the time. We'll also look at their practising history and not just at the period of time when the concerns arose. This will help us understand if there is a particular area of practice where there may be concerns or whether they are more general in nature.

Where we identify a gap in the nurse, midwife or nursing associate's knowledge or training we'll try to help them understand what they can do to address this gap and demonstrate they're safe to practise.

It's important that we find out how this gap occurred and in particular if it raises a concern about the quality or availability of support and supervision at a particular setting or whether there's evidence of discrimination or victimisation. If there is such evidence we may need to take some additional action, such as sharing information with other regulators or employers.

Criminal convictions and cautions

Reference: FTP-2c Last Updated: 01/07/2022

In this guide

Overview

Criminal offending can affect the fitness to practise of nurses, midwives and nursing associates in a number of ways.

This page sets out when a nurse, midwife or nursing associate's criminal offending may be relevant to their registration or fitness to practise.

We also explain how we assess the seriousness of criminal convictions and what we do when possible criminal conduct does not end with a caution or conviction.

We have separate guidance on the types of criminal offending we can't investigate.

Considering criminal conviction or caution declarations

Nurses, midwives or nursing associates must declare any cautions or convictions, unless these are for a protected caution or conviction, when they apply to join our register or renew their registration with us.

They also need to let us know if they become involved in criminal offending while they're on our register.

Not telling us about a conviction or caution is a clear breach of the Code.

If there's evidence the nurse, midwife or nursing associate was dishonest about criminal offending when they applied to join our register or renew their registration, we'll have to carry out a full investigation into the circumstances to determine if this affects their registration.

If a nurse, midwife or nursing associate is involved in criminal offending after they joined the register, or renewed their registration, it won't affect their entry in the register, but it may affect their fitness to practise if they kept the fact they were charged, accepted a caution, or were convicted, from us.

This is because we have a clear expectation, as set out under the Code, that nurses, midwives or nursing associates should let us know if they are involved in criminal offending as soon as they can.

In all these cases we'll consider the possible effect on the nurse, midwife or nursing associate's registration, or their fitness to practise, even if the offending itself was not serious.

Assessing the seriousness of convictions and cautions

If the criminal offending was directly linked to the nurse, midwife or nursing associate's professional practice, it's very likely this would be serious enough to affect their fitness to practise.

For example, offences that involved neglecting, exploiting, assaulting or otherwise harming patients are so serious

that it may be harder for the nurse, midwife or nursing associate to address. In these cases it's more likely that we'll need to take regulatory action to maintain professional standards and public confidence in nurses, midwives or nursing associates.

If the criminal offending took place in the nurse, midwife or nursing associate's private life, and there's no clear risk to patients or members of the public, then it is unlikely that we'll need to take regulatory action to uphold confidence in nurses, midwives or nursing associates, or professional standards.

We'd only need to do that if the nurse, midwife or nursing associate was given a custodial sentence (this includes suspended sentences), or the conviction was for a specified offence.

Once we decide that the conviction, and any information we've gathered about the surrounding circumstances, would be serious enough to affect the nurse, midwife or nursing associate's fitness to practise, we'll seek police information to verify the details of the conviction or caution referred to us.

Find out more about how we determine seriousness.

Referring serious convictions directly to the Fitness to Practise Committee

We may pass the case directly to the Fitness to Practise Committee for their decision[1] if:

- a nurse, midwife or nursing associate has been sentenced to immediate imprisonment, or
- the conviction was for a 'specified offence'.

The nature of these convictions would raise fundamental questions about the nurse, midwife or nursing associate's trustworthiness as a professional, which means the Fitness to Practise Committee will probably need to take some action to restrict their registration as the possible outcomes imposed by case examiners are unlikely to be sufficient.

Police investigations that result in no conviction

Criminal investigations into possible offending by nurses, midwives or nursing associates can end with the police, prosecutors, or the courts taking no action.

The nurse, midwife or nursing associate may be found not guilty in court, or the investigation could end before the case gets to court.

For example, the court may give the nurse, midwife or nursing associate a conditional or absolute discharge.

Sometimes, the police may choose not to investigate following the findings of other organisations, such as safeguarding or social services, that the nurse, midwife or nursing associate has done something that is against the law.

We would only reinvestigate the facts of these cases if the concerns they raise put patients or members of the public at risk of being harmed, or could affect the public's trust in all nurses, midwives and nursing associates or their professional standards.

When we would reinvestigate

When deciding if we would need to reinvestigate, we would need to consider if the nurse, midwife or nursing associate's alleged actions could be serious professional misconduct.

We would reinvestigate the facts of a case if:

- the offence took place in a clinical or care setting or context,
- the alleged victims were patients, service users or people in the nurse, midwife or nursing associate's care, or
- there is a clear link to professional practice[2] (which includes respecting boundaries with patients and colleagues).

Before we reinvestigate alleged offending in a care, clinical or professional context we first carefully assess why there was not a conviction, or why the police decided not to investigate.

We will look carefully at whether, and if so why, the courts or the police rejected the accounts of people who would give evidence in any fitness to practise case.

We'll consider discussing any previous criminal trial with those people and assess very carefully how willing or able they would be to attend to give evidence in any future fitness to practise case.

When we wouldn't reinvestigate

If a nurse, midwife or nursing associate is accused of offending in their private life, based on incidents that have no connection with their practice as a registered professional, and they are not convicted, we are far less justified in reinvestigating the facts.

The allegations wouldn't really be connected with our role as a professional regulator, and the investigation would not need the specialist knowledge of our regulatory investigators or case examiners.

Nurses, midwives or nursing associate's fitness to practise can be affected by very serious offending in their private life for which they are convicted. But if they aren't convicted, it's not our role to fill in any perceived gaps in the criminal justice system by taking regulatory action against them if there isn't a clear link to patient safety, clinical practice, or professional standards.

For example, if a nurse, midwife or nursing associate is investigated for an alleged mortgage fraud against a bank, but the prosecution collapses, it wouldn't be our role to reinvestigate whether they acted dishonesty as part of a possible misconduct case.

When we may investigate matters not reported to the police

It isn't our role to fill any perceived gaps in the criminal justice system. When deciding whether to investigate concerns that could have been reported to the police, but have not, we will always consider the Code and the effect on patient safety. If the concerns could amount to a breach of the Code and could affect patient safety, we will look into them.

Concerns such as using discriminatory language or inciting racial hatred via social media are matters we are likely to look into even if they were not reported to the police as this behaviour is likely to amount to a breach of the Code and affect patient safety.

Equally, if we received a referral where it is alleged that a sexual assault against a patient had taken place, but the patient concerned did not wish to report it to the police, we are likely look into this.

By contrast, if we received concerns that nurse, midwife or nursing associate had committed a sexual offence in their private life and there was no evidence to suggest there was a risk to patient safety, we would usually say that the matter would be best investigated by the police in the first instance.

When considering these types of concerns we would want to establish why matters had not been reported to the police and if there is any evidence to support the allegation as concerns of this nature are serious. There may be situations where we need to share information with the police if we consider it is in the public interest to do so. This is explained in our fitness to practise information handling guidance.

1 Article 22(5)(b) requires us to refer allegations (as soon as reasonably practicable after they are received in the form required) to a Practice Committee. This includes referral directly to the Fitness to Practise Committee without consideration by our Case Examiners.

2 Ashraf v General Dental Council [2014] EWHC 2618 (Admin)

Directly referring specified offences to the Fitness to Practise Committee

Reference: FTP-2c-1 Last Updated: 29/11/2021

We'll usually refer the most serious cases of criminal offending straight to the Fitness to Practise Committee. We call this a direct referral. These cases include those where the courts gave the nurse, midwife or nursing associate a sentence of immediate imprisonment, or if the nature of their offending was particularly grave.

We call convictions of that level of seriousness 'specified offences'. We will always take into account how long ago the offending happened when we decide whether to send it directly to the Committee.

What are specified offences?

For us, specified offences include:

- hate crimes
- sexual offences
- other serious offences (listed below)

Hate crimes

We consider that a hate crime includes any criminal offence which is perceived by the victim or any other person, to be motivated by hostility or prejudice based on a person's race or perceived race; religion or perceived religion; sexual orientation or perceived sexual orientation; disability or perceived disability and any crime motivated by hostility or prejudice against a person who is transgender or perceived to be transgender.[1]

Sexual offences

Sexual offences include any offences which involve sexual activity or sexual motivation. They also include offences which relate to images or videos involving child sexual abuse.

Other serious offences

A direct referral is likely to be appropriate for the following categories of serious criminal offending:

- murder
- human trafficking
- slavery, servitude and forced or compulsory labour
- extortion
- blackmail
- manslaughter
- kidnapping
- causing an explosion likely to endanger life or property
- serious offences under the Firearms Act 1968
- causing death by dangerous driving
- hostage taking
- torture
- serious drug related offences
- hijacking offences
- offences that relate to:
    - serious harm to the security of the state or to public order
    - serious interference with the administration of justice or with the investigation of offences
    - the death or serious injury of any person, or a substantial financial gain or serious financial loss to any

person

1 This definition was used by the CPS and the former Association of Chief Police Officers.

Criminal offences we don't investigate

Reference: FTP-2c-2 Last Updated: 17/12/2021

In this guide

Protected cautions and convictions

Nurses, midwives and nursing associates need to let us know if they receive a caution or conviction, unless the caution or conviction is protected.

Protected cautions and convictions are defined differently across the UK.

Cautions

Cautions in **Scotland and Northern Ireland** are not protected.

A caution in England and Wales is protected if:

- the person was under 18 years at the time the caution was given; or
- the person was 18 years or older at the time the caution was given, it wasn't for a listed offence, and six years have passed since the date of the caution.

Convictions

A conviction in **England, Wales or Northern Ireland** is protected if all of the below bullet points apply:

- eleven years have passed since the date of conviction (or five and a half years if the person was under 18 at the date of conviction),
- it did not result in a custodial sentence (including a suspended sentence) or service detention, and
- it is not for a 'listed' offence.

There are separate groups of 'listed' offences (serious violent and sexual offences) in England and Wales, and in Northern Ireland.

A conviction in **Scotland** is protected if:

- it is spent, and
- appears in the list of offences to disclose subject to rules, and either:
- the sentence imposed by the court was an admonition or an absolute discharge, or
- fifteen years have passed since the date of conviction(or seven and a half years if the person was under 18 at the date of conviction).

Under Scots law, there is an additional list of convictions which cannot be protected because they are too serious.

Driving offences and penalty fares

We will not investigate referrals for motoring offences such as:

- parking and other penalty charge notices contraventions
- fixed penalty (and conditional offer fixed penalty) motoring offences
- penalty fares imposed under a public transport penalty fare scheme.

We'll assess other motoring offences on a case by case basis, but will only take regulatory action if this is closely

linked to the nurse, midwife or nursing associate’s professional practice, or it suggests there may be a concern about their health.

Drink-driving offences

Drink-driving offences will only call into question a nurse, midwife or nursing associate’s fitness to practise if:

- the offence occurred either in the course of a nurse, midwife or nursing associate’s professional duties, driving to or from those duties, or during on-call or standby arrangements
- there are aggravating circumstances connected with the offence, or
- it is a repeat offence.

If a nurse, midwife or nursing associate has been convicted of a drink-driving offence, decision makers should consider whether we need to explore any underlying alcohol issues that indicate the nurse, midwife or nursing associate’s fitness to practise is impaired because of their health.

In such cases the nurse, midwife or nursing associate’s employer, general practitioner or occupational health department should be contacted for additional information.

Conditional discharges, absolute discharges and admonitions

We can't argue that the nurse, midwife or nursing associate’s fitness to practise is impaired by reason of that conviction if a nurse, midwife or nursing associate has received the following:

- a conditional discharge
- an absolute discharge
- an admonition in Scotland.

However, we may investigate the underlying misconduct that led to the conviction where the facts suggest particularly serious misconduct, including dishonesty, violence, or sexual offending, especially if it relates to a nurse, midwife or nursing associate’s professional practice.

Health

Reference: FTP-2d Last Updated: 28/07/2017

We often receive referrals alleging that a nurse, midwife or nursing associate has a health condition. We will not normally need to intervene in a nurse, midwife or nursing associate's practice due to ill health unless there is a risk of harm to patients or a related risk to public confidence in the profession.

There are very few circumstances where we decide that a nurse, midwife or nursing associate who has (or used to have) a health condition, but is currently able to practise safely without any risk to patients, is impaired on the basis of public confidence in the professions alone.

A nurse, midwife or nursing associate may have a disability or long-term health condition but be able to practise with or without adjustments to support their practice. Equally, a nurse, midwife or nursing associate may be signed off as 'unfit for work' due to ill health, but this does not necessarily mean their fitness to practise is currently impaired.

Cases of ill-health are likely to be better managed with the support of an employer to safely reduce any risk to patients, and not require a regulatory investigation where:

- the nurse, midwife or nursing associate has demonstrated good insight into the extent and effect of their condition
- the nurse, midwife or nursing associate is taking appropriate steps to access treatment and is following any advice from the health professionals treating them
- occupational health (where available) is providing support through the employer
- the nurse, midwife or nursing associate is managing his or her practice appropriately, for example by taking sickness absence.

Referrals which indicate long-term, untreated (or unsuccessfully treated), or unacknowledged physical or mental health conditions will be of particular concern if they suggest a risk to public protection.

Even where a health condition appears to be well managed, the nurse, midwife or nursing associate may be at risk of relapse, which could affect their ability to practise safely. In such cases some form of restriction may be required to make sure there is no risk of harm to patients or others.

When we assess whether concern about a nurse, midwife or nursing associate's health is serious enough to become involved in their practice, we will consider the nature of the concern and whether there is sufficient evidence to justify seeking further information from third parties, such as the nurse, midwife or nursing associate's GP or occupational health department. We will balance the nurse, midwife or nursing associate's right to privacy with our overarching duty to protect the public.

Not having the necessary knowledge of English

Reference: FTP-2e Last Updated: 06/11/2017

In this guide

Knowledge of English and patient risk

When first assessing the seriousness of concerns about whether a nurse, midwife or nursing associate has the necessary knowledge of English, the first question will be whether patients are placed at potential or actual risk of harm.

Examples of language concerns that could place the public at risk of harm include:

- poor handover of essential information about patient treatment or care to other health professionals because of an inability to speak English
- serious record keeping errors or patterns of poor record keeping because of an inability to write English
- serious failure(s) to give appropriate care to patients because of an inability to understand verbal or written communications from other health professionals (or patients themselves).
- drug error(s) caused by a failure to understand or inability to read prescriptions.

Not every language concern raised will trigger the need for us to carry out an investigation. If decision makers are considering regulatory concerns that are only about spelling, difficulty in understanding regional slang or English colloquialisms without any suggestion of clinical impact, the case is unlikely to involve possible impairment of fitness to practise.

English language testing and fitness to practise decisions

In cases about a nurse, midwife or nursing associate's knowledge of English, decision makers will consider language testing results as the primary measure of whether the nurse, midwife or nursing associate has the necessary knowledge of English to practise safely. Both case examiners deciding whether a nurse, midwife or nursing associate has a case to answer, and panel members of the Fitness to Practise Committee, deciding whether the facts at a final hearing are proved, will base their decision on test results. A properly signed certificate from the test provider will be conclusive evidence of the test result the nurse, midwife or nursing associate achieved.[1]

If the nurse, midwife or nursing associate has not achieved the minimum scores we specify in each of the four language skills (reading, writing, listening and speaking), then decision makers are likely to find that the nurse, midwife or nursing associate does not have the necessary knowledge of English to practise safely. We explain our minimum scores and the kinds of language tests we will accept to demonstrate them in our guidance on accepted language tests.

If the nurse, midwife or nursing associate fails to comply with a direction to take a language test, decision makers can take this into account in assessing possible impairment of the nurse, midwife or nursing associate's fitness to practise through their knowledge of English.

In addition to language testing results, decision makers are also able to consider other evidence when assessing cases based on a nurse, midwife or nursing associate's knowledge of English. Such evidence will be particularly relevant if the nurse, midwife or nursing associate has averaged just below the minimum scores we require, because the Fitness to Practise Committee may be less likely to make a final finding of current impairment. Other evidence that can be taken into account includes:

- any written responses or evidence the nurse, midwife, nursing associate or employer has submitted which seems to demonstrate they have the necessary knowledge of English to practise safely
- any evidence that the nurse, midwife or nursing associate has trained or practised in an English speaking environment for a period of time
- any evidence that the nurse, midwife or nursing associate had previously completed a language assessment to the required standard (for example, as part of a previous application to the our register)
- any evidence that the nurse, midwife or nursing associate has recently obtained a qualification that has been taught and examined in English.

In all cases, decision makers should exercise their judgement and balance the individual features of the case and any actual harm or risk of harm to patients.

1 Rule 31(4A) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004

Determinations by other health or social care organisations

Reference: FTP-2f Last Updated: 14/04/2021

Nurses, midwives and nursing associates may be registered members of other health or social care professions, which are regulated by different legal bodies in the UK, or may be registered with licensing bodies overseas.

Decision makers sometimes receive referrals from these other organisations either in the UK or abroad, suggesting that a person also registered with us as a nurse, midwife or nursing associate has previously been impaired in their practice. When decision makers are looking at such referrals, they need to consider the potential impact on this person's nursing or midwifery practice in the UK or nursing associate practice in England.

We will consider the scope and nature of the other organisation's determination and the factual background.[1] We will assess how closely the issues relate to the practice of nursing or midwifery in the UK or nursing associate practice in England. We will also assess the underlying facts or issues, including any contextual factors and whether these have been considered by the other regulatory body when making their decision. We will consider if, in light of these facts, the nurse, midwife or nursing associate could present a risk to members of the public by continued nursing, midwifery or nursing associate practice, or if the other body's finding could affect public confidence in the nursing, midwifery or nursing associate professions

Cases about determinations of other regulators will generally need us to take regulatory action. The only exceptions to this are:

- where it is clear to us that the nurse, midwife or nursing associate presents no current risk of harm to patients
- the determination involves no potential impact on public confidence in the nursing, midwifery or nursing associate professions
- there is no need, in the particular case, to take action to maintain proper professional standards and conduct.

1 NMC (Fitness to Practise) Rules 2004 R 31 (4) states that a signed certificate is "admissible as prima facie evidence of the facts referred to in the determination"

Fraudulent or incorrect entry to the register

Reference: FTP-2g Last Updated: 06/09/2021

In this guide

Nurses, midwives and nursing associates are only entitled to practise if they are on our register. For this reason, allegations that a nurse, midwife or nursing associate entered the register incorrectly or by fraud are extremely serious. They also raise public protection concerns. For example, if someone enters the register without the required qualification, they may lack the skills needed to carry out their nursing or midwifery role. This means they pose a risk to patient safety.

It is in the public interest for us to investigate these allegations and take action where needed. Not doing this could affect public confidence in the integrity of the register and the nursing and midwifery professions.

When looking into an allegation that someone was entered on the register incorrectly or through fraud, we examine how the nurse, midwife or nursing associate entered the register, not their fitness to practise.

When we investigate if a person's entry onto our register was incorrect or fraudulent, we can consider applications for:

- first time registration
- registration renewal
- readmission to the register.

Incorrect entry

Someone's entry onto the register might be incorrect if our decision to register, renew or readmit them onto the register was based on wrong or inaccurate information about them meeting the relevant requirements.

For example, if someone wrongly declared that they had carried out the required number of hours of registered practice because they made a mistake when calculating them, their entry will be incorrect. The entry won't be incorrect if the error or inaccuracy doesn't make a significant difference to the registration decision or has subsequently been put right.

An entry could also be incorrect if we made a mistake during the application process. For example, if we entered the wrong person's name onto the register because of an administrative error.

If an entry was incorrectly made, it doesn't mean that there was any dishonesty involved. An incorrect entry may have come about because of a simple mistake by a nurse, midwife or nursing associate, by the NMC or another third party.

Where we consider an entry has been made incorrectly, we'll usually investigate whether there was any dishonesty involved, in other words, if the entry was fraudulently procured.

Fraudulent entry

An entry on the register is fraudulently procured if:

- any of the information submitted as part of the registration, readmission or revalidation process was submitted with the deliberate intention to mislead the NMC or an approved education institution or
- information provided to the NMC as part of an application was obtained or created by fraud.

An allegation that an entry has been fraudulently procured will always involve an element of dishonesty, either by the nurse, midwife or nursing associate, or a third party,

For example, if a person provides a falsified certificate to be registered, we'll have been deliberately misled. In this example, it doesn't matter who falsified the certificate. A nurse, midwife or nursing associate's entry on the register might be fraudulent even if they weren't aware that the information used was deliberately misleading.

This means the entry is still fraudulent, even though the evidence shows it was a third party who deliberately produced false documents or statements, and the person who registered with us didn't know or behave fraudulently or dishonestly.

This situation is likely to happen only in a small number of cases.

Decision makers should consider if the entry on our register was gained by fraud with the deliberate intention to mislead the NMC or another organisation. They shouldn't focus on whether the person on our register was directly at fault themselves.

For example, suppose someone steals another person's identity who was registered as a nurse, midwife or nursing associate and makes a false declaration. In this case, the entry is fraudulent, even though the former nurse, midwife or nursing associate is not aware of the fraud.

Another example would be if a nurse, midwife or nursing associate doesn't know whether they meet the requirements for renewing their registration but their employer tells them that they do. The employer then signs to confirm that the nurse, midwife or nursing associate meets the requirements even though they know this is not the case.

It doesn't matter whether or not the person whose name was entered on the register could meet the relevant criteria to be successfully registered or if they're currently able to practise safely. The key issue is if we made the entry based on information that was either submitted with the deliberate intention to mislead the NMC or was fraudulently obtained or created. However, whether the professional on our register had any knowledge or involvement in the fraud can be taken into account by the Investigating Committee when deciding what regulatory action, if any, needs to be taken.

Types of incorrect or fraudulent entry cases

Reference: FTP-2g-1 Last Updated: 06/09/2021

In this guide

Approved qualification

Everyone applying to join the register must prove to us that they hold an approved qualification and that the course was completed within five years of the application for registration.

If the qualification was not awarded within the five year period, the person applying must have done additional education, training and experience in order to be registered.

An entry on the register may be fraudulent or incorrect if there is evidence that the person concerned:

- didn't hold an approved qualification when they were registered
- didn't complete their course within five years of their application for registration and didn't do the required additional education, training and experience.

Indemnity arrangement

Everyone on the register must have appropriate cover under an indemnity arrangement or have an arrangement in place when they practise as a nurse, midwife or nursing associate. To meet this requirement, when someone applies to join or come back onto the register, or renew their registration, they must sign a self-declaration confirming that they have appropriate indemnity insurance. This can include insurance their employer holds on their behalf.

If we find that the declaration was wrong because the applicant didn't have cover in place when they applied or when they started practising, the entry is incorrect. If the declaration was deliberately misleading, the entry is fraudulent.

When we decide whether or not to carry out a full investigation in this kind of case, we look at the particular circumstances in which the declaration was made. If the nurse, midwife or nursing associate made reasonable enquiries and had no reason to doubt that their employer had appropriate cover in place when they applied, we may decide not to carry out a full investigation.

Health and Character Declarations

We consider that in most cases concerning the health of a professional on our register, a fitness to practise referral will be the most suitable method for dealing with the matter.

There may be cases where it will be appropriate for us to investigate whether an issue relating to a health and character declaration means that a register entry is either incorrect or fraudulently procured. We consider these types of cases will be relatively unusual.

The guidance that follows relates to the minority of cases where we consider that it is appropriate to use the

incorrect or fraudulently procured entry procedure in relation to a health and character declaration.

People will only be registered as nurses, midwives or nursing associates if they prove to us that they're capable of safe and effective practice. This includes showing that they meet our **health and character requirements.**

If any of the information about the applicant's health or character was wrong, their entry in the register may be incorrect. If the wrong information was provided with the deliberate intention to mislead, the entry may be fraudulently procured.

When deciding if the entry is fraudulent or incorrect, decision makers aren't looking at whether new information about the nurse, midwife or nursing associate's health or character shows they would've been capable of safe and effective practice when they entered the register. That is a registration decision for the Registrar and isn't relevant to whether the entry in the register was fraudulent or incorrect.

In our process, decision makers are only assessing if we were given wrong information about the health or character of that person when deciding whether they were capable of safe and effective practice, or whether any wrong information was provided with the deliberate intention to mislead the NMC.

Non-payment of fee

It's the professional responsibility of every nurse, midwife and nursing associate to ensure that they have paid the registration or renewal fee. If someone enters the register or stays on the register without paying the right fee, they would be incorrectly entered onto the register. If someone has deliberately misled the NMC about the payment of the fee, then the entry is fraudulent.

Other registration requirements

It's the professional responsibility of every nurse, midwife and nursing associate when applying to join the register, to make sure that they:

1. meet the qualification requirements required for registration
2. hold appropriate cover under a professional indemnity arrangement
3. meet our English language requirements.

If someone enters the register based on information relating to qualification, indemnity or language requirements that are incorrect, their entry on the register is likely to be incorrect.

If someone has deliberately misled the NMC about their qualifications, indemnity arrangements or language skills, then their entry will be fraudulent.

Registered practice hours

During revalidation, nurses, midwives and nursing associates must declare that they have done the required number of hours of registered practice.

A nurse, midwife or nursing associate is incorrectly entered onto the register if their declaration was wrong. If there is evidence that a wrong declaration was made with the deliberate intention to mislead us then the entry is fraudulent.

Continuing professional development

When renewing their registration a nurse, midwife or nursing associate must self-declare that they have done the required number of hours of continuing professional development (CPD).

A nurse, midwife or nursing associate is incorrectly entered onto the register if there is evidence that the CPD declaration was wrong. If there is evidence that a wrong declaration was made with the deliberate intention to mislead us, the entry is fraudulent.

Identity fraud

If the registration application contained deliberately misleading information about the identity of the applicant, the entry is fraudulent. This usually means that the person who applied and intended to practise using the registration deliberately made the application in the name of another person.

There is no need for the Investigating Committee to see evidence that the person who made the application has been convicted of a criminal offence in order to find the allegation proved.

Dual registration

Reference: FTP-2g-2 Last Updated: 15/12/2017

Nurses, midwives or nursing associates can apply to be on more than one part of the register as long as they meet the relevant entry requirements for each part. For example, they may be on the nursing part of the register and the midwifery part of the register.

Someone who entered one part of the register by fraud and was removed can still practise if they are on another part of the register.

Where someone has acted fraudulently there is likely to be public interest in making a fitness to practise referral. This is because the Investigating Committee's decision that a nurse, midwife or nursing associate fraudulently gained entry to one part of the register is likely to call into question their fitness to practise on the other part of the register. If the Investigating Committee decides it would be appropriate for such a referral to be made, it can say so as part of the reasons for its decision on what action to take.

How we determine seriousness

Reference: FTP-3 Last Updated: 01/07/2022

In this guide

What we mean by seriousness

Seriousness is an important concept which informs various stages of our regulatory processes.

When assessing whether a concern is serious, we look at what risks are likely to arise if the nurse, midwife or nursing associate doesn't address or put this concern right. This could be risks to patients or service users or, in some cases, to the public's trust and confidence in all nurses, midwives and nursing associates.

When considering seriousness, we will take into account evidence of any relevant contextual factors. For more information please see our guidance on taking account of context.

It's vitally important that we encourage nurses, midwives or nursing associates to try to put problems right where they can, because we want to promote a learning culture that keeps patients and members of the public safe.

By focusing on how risks could arise if concerns aren't put right, we can see what the nurse, midwife or nursing associate may need to do to address the problems in their practice, or what action we may need to take if they don't.

When our decision makers are looking at overall fitness to practise, they'll always consider what the nurse, midwife or nursing associate has done to address the concerns.

The guidance below helps us assess the seriousness of concerns by looking at how easy they are to put right, what could happen if they aren't, and what the role of public confidence and professional standards is.

Factors that indicate the seriousness of a case

Decision makers across our fitness to practise process look at factors of a case to identify the types of concern which, unless put right, will usually mean a nurse, midwife or nursing associate's right to practise needs to be restricted.

These factors indicate the seriousness of the case and we use these as a framework for the way we investigate cases and present cases before panels of the Fitness to Practise Committee.

The factors can be broken down into three broad categories:

- Serious concerns which are more difficult to put right
- Serious concerns which could result in harm to patients if not put right
- Serious concerns based on the need to promote public confidence in nurses, midwives and nursing associates

Discrimination, bullying, harassment and victimisation

The Code says that nurses, midwives and nursing associates must treat people fairly without discrimination,

bullying or harassment. It also states that individuals should be aware of how their behaviour can affect and influence the behaviour of others, be sure not to express personal beliefs inappropriately and use all forms of communication responsibly.[1]

The NMC takes concerns about bullying, harassment, discrimination and victimisation very seriously[2]. Although bullying is not included as a prohibited behaviour under the Equality Act, it can have a serious effect on workplace culture, and therefore patient safety, if it is not dealt with.

Not every finding of misconduct about these concerns will result in a finding of impaired fitness to practise, even though it will be likely with concerns relating to discrimination, such as racism.[3] Conduct of these types can be more difficult to address as they suggest an attitudinal problem.

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

Discrimination

A person **discriminates** against another person under the Equality Act 2010 if they treat them less favourably than they would treat others because of a protected characteristic.[4]

We've made clear that no form of discrimination including, for example, racism, should be tolerated within healthcare. Discriminatory behaviours of any kind can negatively impact public protection and the trust and confidence the public places in nurses, midwives, and nursing associates. We therefore take concerns of this nature seriously regardless of whether they occur in or out of the workplace. These concerns may suggest a deep-seated problem with the nurse, midwife or nursing associate's attitude, even when there's only one reported complaint.

When a professional on the register engages in these types of behaviours, the possible consequences are far-reaching. Members of the public may experience less favourable treatment, or they may feel reluctant to access health and care services in the first place. We know that experiences of discrimination can have a profound effect on those who experience it[5] and that fair treatment of staff is linked to better patient care.[6]

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

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

Bullying, harassment (including sexual harassment) and victimisation

The environment that all health and social care professionals work in should be safe and free from bullying, harassing and victimising behaviours. We take concerns about bullying, harassment (including sexual harassment) and victimisation relating to the professional context very seriously. When we consider whether concerns relate to the professional context we will consider whether the concerns could have an effect on patient safety. If they could, we will treat them as relating to the professional context.

The Code sets out that nurses, midwives and nursing associates must maintain effective communication with colleagues and act with honesty and integrity at all times, treating people fairly and without discrimination, bullying and harassment. The presence of bullying, harassment (including sexual harassment) and victimisation in the workplace can have an extremely negative effect on the work environment, performance and attendance.[7] This in turn can have an effect on the delivery of patient care and if not dealt with can affect trust and confidence in the professions.

Bullying and victimisation

Bullying can be described as unwanted behaviour from a person or a group of people that is either offensive,

intimidating, malicious or insulting. It can be an abuse or misuse of power that undermines, humiliates, or causes physical or emotional harm to someone. It can be a regular pattern of behaviour or a one-off incident and can happen face-to-face, on social media or over emails or telephone calls.[8] Usually bullying would be a pattern of behaviour, but an example of when it could be a one off incident could be if a member of the public felt that they had been bullied into agreeing to a do not resuscitate decision by a healthcare professional.

Victimisation is defined under the Equality Act 2010 as treating someone else less favourably because they have brought proceedings, given evidence in proceedings or done any other thing in relation to the Equality Act.[9] It will also be victimisation if someone is treated less favourably by a person for making an allegation that someone has broken the Equality Act. Giving false evidence or information or making a false allegation is not protected if it's done in bad faith.

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

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

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

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

Harassment (including sexual harassment)

Harassment is defined by the Equality Act 2010 as someone engaging in unwanted conduct that's related to a protected characteristic or is of a sexual nature.[10] The behaviour has the purpose or effect of violating an individual's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment. It's necessary to take the perception of the person who's the subject of the conduct and any other circumstances into account. As well as harassment linked to a protected characteristic as defined by the Equality Act, harassment can also be unwanted conduct that is unrelated to a protected characteristic which someone finds offensive or which makes someone feel intimidated or humiliated.

Where concerns of harassment or sexual harassment relate to the professional context we take them very seriously. We recognise that concerns of this nature can have a profound effect on the victims which could negatively affect public protection and the trust and confidence that the public places in nurses, midwives and nursing associates.

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

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

Our Public Sector Equality Duty (PSED)

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

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

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

1 The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates 20.2, 20.3, 20.7, 20.10.
2 The Equality Act 2010 states that harassment, discrimination and victimisation is prohibited in respect of the listed protected characteristics, age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion and belief; sex and sexual orientation.
3 PSA v HCPC and Roberts [2020] EWHC 1906 (Admin)
4 Equality Act 2010 s.13 - s.19.
5 Ross S, Jabbal J, Chauhan K, Maguire D, Randhawa M & Dahir S (2020) Workforce race inequalities and inclusion in NHS providers, The King's Fund.
6 West M, Dawson J, Admasachew L & Topakas A (2011) NHS Staff Management and Health Service Quality. Results from the NHS Staff Survey and Related Data.
7 Harassment at work. A Unison Guide, December 2016
8 ACAS bullying definition
9 Equality Act 2010 s.27.
10 Equality Act 2010 s.26.

Serious concerns which are more difficult to put right

Reference: FTP-3a Last Updated: 01/07/2022

A small number of concerns are so serious that it may be less easy for the nurse, midwife or nursing associate to put right the conduct, the problems in their practice, or the aspect of their attitude which led to the incidents happening.

In cases like this, we will be keen to hear from the nurse, midwife or nursing associate if they have reflected on the concerns and taken opportunities to show insight into what happened. Because concerns of this nature, when they aren't put right, are likely to lead to restrictive regulatory action, if we don't hear from the nurse, midwife or nursing associate we will usually focus on preparing the case for the Fitness to Practise Committee at the earliest possible opportunity.

We will need to do this where the evidence shows that the nurse, midwife or nursing associate is responsible for:

- breaching the professional duty of candour to be open and honest when things go wrong, including covering up, falsifying records, obstructing, victimising or hindering a colleague or member of staff or patient who wants to raise a concern, encouraging others not to tell the truth, or otherwise contributing to a culture which suppresses openness about the safety of care
- concerns that an individual has engaged in discriminatory behaviours that have taken place either inside or outside the workplace
- concerns relating to harassment, including sexual harassment, relating to the professional context
- sexual assault or relationships with patients in breach of guidance on clear sexual boundaries,
- criminal offending relating to accessing, viewing, or other involvement relating to images or videos involving child sexual abuse
- deliberately causing harm to patients
- deliberately using false qualifications or giving a false picture of employment history which hides clinical incidents in the past, not telling employers that their right to practise has been restricted or suspended, practising or trying to practise in breach of restrictions or suspension imposed by us
- exploiting patients or abusing the position of a registered nurse, midwife or nursing associate for financial or personal gain
- being directly responsible (such as through management of a service or setting) for exposing patients or service users to harm or neglect, especially where the evidence shows the nurse, midwife or nursing associate putting their own priorities, or those of the organisation they work for, before their professional duty to ensure patient safety and dignity.

Serious concerns which could result in harm to patients if not put right

Reference: FTP-3b Last Updated: 29/11/2021

Assessing the risks presented by an individual nurse, midwife or nursing associate's practice means carefully considering the evidence about those risks.

Our evidence will need to clearly explain whether patients were put at risk by the nurse, midwife or nursing associate's conduct or failings in the past, and what harm did or could have happened to patients because of those failings. When considering the risk of harm to patients, we'll always consider the possible consequences of the concerns, such as members of the public feeling reluctant to access health and care services, experiencing less favourable treatment or both.

We will need to assess how likely the nurse, midwife or nursing associate is to repeat similar conduct or failings in the future, and if they do, if it is likely that patients would come to harm, and in what way.

Conduct or failings that put patients or service users at risk of harm will usually involve a serious departure from standards. Standards, such as our Code, are intended to ensure that nurses, midwives or nursing associates practise safely and effectively.

We've used the Code to identify some examples below of the kinds of failings which are likely to cause risk to patients if they are not addressed.

We wouldn't usually need to take regulatory action for isolated incidents of these failings unless the incident suggests that there may be an attitudinal issue such as displaying discriminatory views and behaviours. This may indicate a deep-seated problem even if there is only one reported incident. A pattern of incidents is usually more likely to show risk to patients or service users, requiring us to act.

Prioritise people

The evidence shows that the nurse, midwife or nursing associate has failed to:

- uphold people's dignity, treat them with kindness, respect and compassion, deliver treatment care or assistance without undue delay, or deliver the fundamentals of care (including hydration, nutrition, bladder and bowel care and ensuring people receiving care are kept in clean and hygienic conditions).
- make sure the physical, social and psychological needs of patients are responded to.
- respect people's right to privacy and confidentiality.

Practise effectively

The evidence shows that the nurse, midwife or nursing associate:

- has not maintained the knowledge and skills for safe and effective practice.
- is unable to communicate clearly, work cooperatively, keep clear and accurate records, without falsification.
- failed to be accountable for decisions to delegate tasks and duties to other people and/or failed to ensure they are adequately supported.

Preserve safety

The evidence shows that the nurse, midwife or nursing associate has failed to:

- recognise and work within the limits of competence, accurately assess signs of normal or worsening physical

or mental health, or make timely and appropriate referrals where needed.
- be open and candid with all service users, or act immediately to put right, explain and apologise when any mistakes or harm have taken place.
- offer help if an emergency arises in practice.
- act without delay if they believe there is a risk to patient safety or public protection.
- raise or escalate concerns.
- advise, prescribe or administer medicines in line with training, law and guidance.
- be aware of, or reduce as far as possible, any potential for harm associated with practice, including controlling and preventing infection, taking precautions to avoid potential health risks to colleagues, patients and public.

Promote professionalism and trust

The evidence shows that the nurse, midwife or nursing associate has failed to:

- uphold the reputation of the profession, by not acting with honesty and integrity, treating people fairly, without discrimination, bullying or harassment, in a way that does not take advantage of their vulnerability or cause them upset or distress.
- maintain the level of health needed for safe and effective practice.
- avoid asking for or accepting loans.
- cooperate with investigations and audits, including requests to act as a witness.
- tell us as soon as they could have about cautions or charges, conditional discharges or convictions for criminal offences.

Serious concerns based on public confidence or professional standards

Reference: FTP-3c Last Updated: 29/11/2021

Sometimes we may need to take regulatory action against a nurse, midwife or nursing associate because of our objectives to promote and maintain professional standards and the public's trust and confidence in nurses, midwives and nursing associates.

This means we may need to take action even if the nurse, midwife or nursing associate has shown that they have put serious clinical failings right, if the past incidents themselves were so serious they could affect the public's trust in nurses, midwives and nursing associates.

We're more likely to need to do this if the clinical failings suggest an underlying issue with the nurse, midwife or nursing associate's attitude to people in their care.

We may also need to take action in cases where the concerns were not directly related to the care the nurse, midwife or nursing associate provided to people, but which call into question the basics of their professionalism. This may cover things that have happened in the nurse, midwife or nursing associate's private life. For example, if they've committed serious criminal offences, or there's evidence to suggest a deep-seated attitudinal problem such as displaying discriminatory views and behaviours.

A need to take action because the public may not feel able to trust nurses, midwives or nursing associates generally is a high threshold. It suggests that members of the public might take risks with their own health and wellbeing by avoiding treatment or care from nurses, midwives or nursing associates. Concerns that someone may have displayed discriminatory views and behaviours can have a particularly negative impact on public confidence, which may lead to members of the public avoiding using health and care services.

We may need to take restrictive regulatory action against nurses, midwives or nursing associates whose conduct has had this kind of impact on the public’s trust in their profession, who haven’t made any attempt to reflect on it, show insight, and haven’t taken any steps to put it right. This may mean they can’t stay on the register.

Why we screen cases

Reference: FTP-4 Last Updated: 31/08/2018

We screen cases to assess whether a case is for us or not. Screening cases helps us to identify risk, then understand how serious it is and think about whether regulation is the right way to address it.

First we check if the concern is about a nurse, midwife or nursing associates on our register. Then we check if the case could raise questions about their registration with us, or their fitness to practise as a registered professional.

If the case is for us, we need to decide, quickly, the seriousness of a case, and whether an interim order should be put in place.

We use thresholds to help us make these decisions.

This also ensures that we focus our resources on the right cases, where employers can't manage the risk effectively.

If regulatory action is required, we need to make sure we are proportionate and apply only the right amount of regulatory force to achieve our desired outcome of public protection.

Find out about the different stages of our screening process and more.

When we use interim orders

Reference: FTP-5 Last Updated: 31/08/2018

We use interim orders to protect the public from risk by restricting or suspending a nurse, midwife or nursing associate's practice. We use them:

- during our investigation,
- before the allegation against the nurse, midwife or nursing associate has been decided, and
- sometimes, after a panel makes an order against them, but before it takes effect.

Interim orders can have very restrictive effects on nurses, midwives or nursing associates, so we need to make sure we only use them when it's proportionate to do so.

We'll need good evidence of the possible harm to patients, or be able to explain why an order is otherwise in the public interest or the nurse, midwife or nursing associate's own interests.

Find out more about interim orders.

Our investigations

Reference: FTP-6 Last Updated: 19/09/2018

We investigate serious concerns about a nurse, midwife or nursing associates's fitness to practise which could place patients at risk, or negatively impact public confidence in the nursing and midwifery professions.

We also investigate concerns about whether the entry of an individual nurse, midwife or nursing associate on our register may be incorrect, or may have been made as a result of fraud.

Find out more about what we investigate and how, in our section on Investigations.

Examining cases

Reference: FTP-7 Last Updated: 31/08/2018

Once our investigations team has completed their investigation into the concerns about a nurse, midwife or nursing associate, our case examiners decide whether or not a nurse, a midwife or a nursing associate has a case to answer, and if they do, what should happen to the case.

They can recommend that we need to do further investigation before they can decide whether or not there is a case to answer.

In our fitness to practise process, case to answer has a precise meaning.

It means whether or not there is a realistic prospect that our Fitness to Practise Committee would find a nurse, midwife or nursing associate's fitness to practise to be currently impaired using the evidence we've gathered so far.

Decisions case examiners may reach

If case examiners decide there is **no case to answer**, they can:

- give the nurse, midwife or nursing associate advice,
- issue the nurse, midwife or nursing associate with a warning, or
- simply close the case.

If case examiners decide there is a **case to answer**, they can:

- recommend undertakings to be agreed with the nurse, midwife or nursing associate, or
- refer the case to the Fitness to Practise Committee.

Case examiners can also decide that the case should be referred to the Fitness to Practise Committee to consider whether an interim order should be imposed. If case examiners don't make this recommendation, the Investigating Committee can make an interim order at any point, until the Fitness to Practise Committee starts its consideration of the case.

Find out more about how we examine cases.

How we manage cases before a hearing

Reference: FTP-8 Last Updated: 26/11/2018

After the case examiners have made the decision to send the case to the Fitness to Practise Committee, our legal team will review it.

They may decide that there needs to be further investigation before it is passed to the committee.

Once the investigation is complete, we'll prepare for a hearing or meeting.

Where the nurse, midwife or nursing associate is represented, we'll consider whether to arrange a telephone conference with the representative to discuss the proposed hearing bundle and resolve any legal difficulties.

Find out more about how we manage cases before a hearing.

Meetings and hearings

Reference: FTP-9 Last Updated: 31/08/2018

The Fitness to Practise Committee holds meetings and hearings to consider fitness to practise matters.

About the committee

The committee is a three person panel, one of whom is a nurse, a midwife or a nursing associate. The panel can hear matters at a meeting or a hearing, and has the same powers whether the matter is considered at a hearing or a meeting.

Find out who sits on our panels.

Dealing with cases at meetings and hearings

Once the case examiners have sent a case to be dealt with by a committee, we'll write to the nurse, midwife or nursing associate and give them 28 days to tell us if they would like their case to be dealt with at a hearing or a meeting.

We'll arrange for the case to be heard at a meeting if the nurse, midwife or nursing associate requests this, or if they don't tell us what they would prefer, or has no contact with us.

We'll only arrange for a case to be heard at a hearing if a nurse, midwife or nursing associate has asked for one, or if we think there is a 'material dispute'. A material dispute is a disagreement between us and the nurse, midwife or nursing associate about an important issue in the case.

Resolving cases by agreement

Reference: FTP-10 Last Updated: 31/08/2018

We would much rather avoid unnecessary hearings for the sake of all involved. So when we can, we use consensual panel determination to resolve cases by agreement or consent.

If a nurse, midwife or nursing associate wants to resolve their case by consent, they must accept the facts of the allegation and they must also accept that their fitness to practise is impaired.

We will then agree an appropriate level of sanction with the nurse, midwife or nursing associate.

The panel makes the final decision about the outcome of the case.

What sanctions are and when we might use them

Reference: FTP-11 Last Updated: 31/08/2018

A Fitness to Practise Committee panel can impose sanctions (restrictions) if they decide that a nurse, midwife or nursing associate's fitness to practise is impaired.

They would do this to make sure we protect patients, maintain confidence in the nursing and midwifery professions, and uphold the standards we expect of nurses, midwives or nursing associates.

How we decide which sanction to impose

The panel will consider the seriousness of the concern and the facts of the case to find a sanction that is enough to achieve public protection.

The available sanction outcomes, starting from the least severe, are:

- taking no further action
- a caution order of between one and five years
- a conditions of practice order of up to three years
- a suspension order of up to twelve months
- a striking-off order.

Find out more about how we decide which sanction to impose.

Taking account of context

Reference: FTP-12 Last Updated: 29/03/2021

In this guide

Overview

We understand the importance of making sure our processes and decisions support a culture of fairness, openness and learning. Given the complexity of health and social care settings, sometimes concerns that appear to be the result of poor individual practice are actually caused by system pressures or other factors. They're not always due to someone's attitude, knowledge, skills or ability to provide safe and effective care.

When things go wrong, it can be easy to assign blame rather than take the time to understand why something happened and what can be done to prevent it from happening again.

This means we need to look beyond the actions of an individual and understand the role of other people, the culture and environment they were working in when something went wrong. Only then can we identify what needs to happen to keep people safe in the future - even if we're not the ones who can take that action.

Our approach

When people raise concerns about a nurse, midwife or nursing associate's fitness to practise, it's our responsibility to act in the way that best protects people from coming to harm in the future.

We don't seek to blame individuals or the system they work in. But where there's evidence of a serious concern about a nurse, midwife or nursing associate's fitness to practise, we need to take action to protect the public. This decision will always involve trying to understand the particular circumstances they were working in at the time. We'll also need to think about if we need to take any other steps to reduce the risk of something happening again, such as sharing information with other agencies.

We want to be systematic, methodical and consistent in our approach to taking account of context. When we look at concerns that have arisen in somebody's practice we need to ask:

- Is there evidence of a serious concern that requires us to take regulatory action to protect the public?
- If so, why did this happen and do we think it could happen again?
- If so, what action do we need to take to protect the public?

To help us make these decisions we want to hear from the people involved so that we have their perspective. This will include the nurse, midwife or nursing associate, and their employer. People who use services and members of the public involved in the process can also tell us their perspective of what happened which could give us important contextual information. We will then look at what these perspectives tell us about what happened, and what we need to do to keep the public safe.

We've developed a set of commitments we'll apply whenever we investigate and deal with concerns that have arisen in the professional practice of someone on our register.

These commitments must not be seen as separate from each other, and we recognise that the complexities of working in the health and social care sector mean it's inevitable that we might need to consider issues that span across different commitments.

Commitment 1: We'll approach cases on the basis that most people referred to us are normally safe

Reference: FTP-12a Last Updated: 29/03/2021

Unless evidence shows that someone deliberately caused harm or acted recklessly, our starting position will be to assume the nurse, midwife or nursing associate is usually a safe and competent professional, but something got in the way of them being able to deliver safe care. Examples of things that might get in someone's way include:

- gaps in their knowledge or training
- widespread practices or cultures
- issues in the working environment
- someone's personal context such as health issues or personal circumstances.

Our initial enquiries and investigations will seek to understand what got in the way of someone delivering safe care. To do this we'll routinely make enquiries about the contextual factors identified in our research to see if these could have played a part in what went wrong.

We'll take an objective approach to the cases we look into, and our decisions in respect of what action is required will be evidence based. This may mean taking action against the individual referred to us if the evidence suggests that there's a serious concern regarding their fitness to practise. However, the evidence may suggest that some other action is required instead of, or in addition to action against the individual, in order to protect the public.

Where there's evidence of deliberate harm or recklessness, we'll follow the approach in our list of 'serious concerns which may be more difficult to put right'. We'll need to ask questions about the culture of the team or setting, and what other people knew and did. However, causing deliberate harm or acting recklessly is more likely to call into question fundamental aspects of the individual's practice and require us to take regulatory action.

Commitment 2: We'll seek to build an accurate picture about the nurse, midwife or nursing associate's practising history

Reference: FTP-12b Last Updated: 29/03/2021

We'll always seek to build up, take account of and present an accurate picture of someone's practising history, rather than viewing an incident or concerns in a vacuum. A person-centred approach means looking at things that have gone well, not just the period of time when a concern has arisen.

Before deciding on someone's fitness to practise, it would be helpful to know if they'd encountered a similar situation before, knew the right thing to do and would usually do it. This could tell us if the incident we're looking at is out of character, part of a pattern or because of a gap in their knowledge or training.

Where our information shows what the nurse, midwife or nursing associate did was out of character, we'll focus our efforts on understanding what caused them to act differently on this occasion. The nature and extent of any further involvement by us will be informed by what that was.

We will aim to find out why the person did what they did and what prevented them from acting in the right way. This will help us decide if they represent a future risk to people who use services and the public (and if so, in what way) or whether something else was responsible for what went wrong.

If something else was responsible, we'll consider if we need to take other steps to stop it from happening again which don't involve taking regulatory action against the person.

Where the information shows a pattern of concerns, we'll look at why that might be the case. It's more likely that we'll need to take some kind of fitness to practise action if the concerns haven't been successfully addressed.

Commitment 3: We'll always carefully consider evidence of discrimination, victimisation, bullying or harassment

Reference: FTP-12c Last Updated: 01/07/2022

We value the diversity of the nurses, midwives and nursing associates on our register as an asset to the health and social care sector.

Data from the NHS staff survey in 2019 demonstrates that in England staff from an ethnic minority background are more likely to experience harassment, bullying or abuse both from members of the public and colleagues. When concerns are raised with us about people on our register, we'll take account of the links between these unacceptable behaviours, poor cultures and the safety of people who use services. We'll also recognise the impact discrimination, victimisation, bullying or harassment can have on someone's health and wellbeing and the significant part they can play in allegations of poor practice. We'll do this in the following ways.

Where we receive a complaint that a nurse, midwife or nursing associate may have been responsible for discriminating, victimising, bullying or harassing people and there's some evidence to support the complaint, we'll treat this as a potentially serious breach of the NMC Code. Our guidance on how we determine seriousness sets out why cases of this nature are so serious. We'll look to understand why the individual behaved in this way and concentrate on taking action to minimise the risk of the same thing happening again.

This may mean taking regulatory action against the nurse, midwife or nursing associate as well as against others where there's evidence they were involved in the same or similar conduct.

For those on our register, this means considering whether to open a referral about their fitness to practise. Where our enquiries show individuals not on our register were involved in the same or similar conduct, we'll consider sharing this information proactively with other regulators and employers. This is because other regulators and employers might be able to take action to address the issue and to help set clear expectations that the environment that all health and social care professionals work in is free from bullying, discrimination, victimisation and harassment and safe for everyone.

In all other cases, we'll ask at the beginning of our investigation whether discrimination, victimisation, bullying or harassment played a part in the referral. Where there's evidence the nurse, midwife or nursing associate referred to us was subjected to this kind of treatment, we'll need to decide whether this caused or contributed to what happened and if so, in what way. This could tell us if there's an issue with their practice that needs to be addressed or if what happened was purely the result of how they were treated and would be unlikely to happen again.

> Example
>
> A newly qualified nurse is referred to the NMC as their employer is concerned that they have a health condition that isn't being adequately managed. The nurse was found to be persistently crying whilst at work and had a high level of sickness absence. They refused to engage with occupational health because they said they had been bullied at work and were dismissed from their post. Upon investigation it is found that the senior nurse on the ward had been bullying a number of junior staff, which caused the sickness absence of the individual concerned.
>
> We would not need to look into the newly qualified nurse's fitness to practise as the issues came about as a direct result of an unacceptable working environment. We would however need to communicate the cultural issues we had uncovered to the Trust and see whether the bullying behaviour of the senior nurse was subsequently addressed. Unless the senior nurse has reflected and demonstrated that they would not act in this way again, we would need to start an investigation into the senior nurse's fitness to practise.

If we find evidence that a nurse, midwife or nursing associate who has been referred to us was discriminated against, victimised, bullied or harassed we'll also consider if we need to open any new referrals to look into the fitness to practise of those responsible. If those responsible are not on our register, we'll consider sharing information with other regulators and employers. This is because other regulators and employers might be able to take action to address the unacceptable behaviour and to help set clear expectations that the environment that all health and social care professionals work in is free from bullying, discrimination, victimisation and harassment, and safe for everyone.

Commitment 4: Where risks are caused by system and process failures, we'll concentrate on the action we can take to help resolve the underlying issues

Reference: FTP-12d Last Updated: 29/03/2021

The evidence is clear that even one-off events or errors are usually caused by multiple contributing factors coming together.[1] Wrongly blaming an individual won't change these factors, won't stop underlying issues happening again and ultimately won't help keep people safe.

Where systemic issues prevent nurses, midwives and nursing associates from delivering safe care, the system should be accountable. Taking action against an individual in these circumstances doesn't lead to a culture of openness and learning, may give false assurance, direct focus away from a wider problem, and cause a future public protection gap.

Genuine mistakes and errors caused by problems in the working environment are unlikely to be issues that call into question someone's fitness to practise. If the evidence shows that a similarly qualified nurse, midwife or nursing associate would have done the same thing this may indicate the root cause of the incident is not the person's fitness to practise. Examples of this could be not completing a task when staffing levels meant it would have been impossible for anyone to do it or giving out the wrong medication when the root cause was actually because of how the medication was stored or labelled.

If we know that problems in the working environment are the real source of risk, our safeguarding responsibilities may mean we'll need to work with other agencies or professionals that are better placed than us to put these problems right. This is likely to involve sharing information, which we'll always do in a proportionate way that allows us to meet our legal responsibilities and objectives.

Where the information shows system issues contributed to an incident but the actions of the nurse, midwife or nursing associate still raise serious concerns about their fitness to practise, we may need to share information as well as take action to address the fitness to practise concerns.

1 This is often explained in the 'Swiss Cheese' model developed by Professor James Reason. See Reason JT, Carthey J, de Leval MR. Diagnosing "vulnerable system syndrome": an essential prerequisite to effective risk management BMJ Quality & Safety 2001;10:ii21-ii25.

Commitment 5: In cases where a nurse, midwife or nursing associate was required to use their professional judgement we'll respond proportionately

Reference: FTP-12e Last Updated: 29/03/2021

Sometimes problems in the working environment will be outside the nurse, midwife or nursing associate's control. We'll take account of this. Examples include problems with systems, processes, equipment or staffing but could also involve issues about culture and leadership.

Where individuals are forced to make difficult choices, we'll focus on how they tried to escalate their concerns, if they did so before the incident or after, and how they exercised their professional judgement with reference to the Code.

Examples of such situations could be choosing to prioritise certain tasks or people over others due to short staffing or other kinds of problems in the working environment. We'll want to see any written records the nurse, midwife, or nursing associate made at the time (or after the event if they were acting in response to an emergency) as well as any relevant policies, documents on processes, or guidance documents in place at the time. We'll look for evidence that the professional was able to think critically and draw on their experience to make evidence-informed decisions, recognise and address any personal or external factors that influenced their decision-making, and explained the rationale for their choices.

We'll also ask questions about those in management positions to find out what their role was in the situation and how they acted on any concerns that were escalated to them. There may be issues relating to bullying and harassment that we need to consider. Where those in management positions have been required to make difficult decisions, we'll also look at what action they took to escalate concerns, and if they're also on our register, how they exercised their professional judgement with reference to the Code. If they're not on our register, we'd want to know if they took the steps they should have done as we might need to share that information with others.

When dealing with cases where someone has had to exercise their professional judgement, we won't apply an artificially high standard by judging what should have happened with the benefit of hindsight. Instead, we'll look at what the individual did in the context of the pressures they were working under at the time (which we know might involve life and death situations). We'll consider if recurring situations or a sense of perpetual challenge may have impacted on their professional judgement.

If there's evidence a nurse, midwife or nursing associate (either front line staff or those in management positions) didn't take the steps they clearly should have done under the Code, and this amounts to a serious concern, then they'll need to show us they've put the concern right. We would expect to see some evidence of the nurse, midwife or nursing associate's insight and steps they've taken to strengthen their practice to reassure us that they've learnt from the incident and they know how to balance the relevant requirements under the Code in the future.

Commitment 6: We'll look for evidence of steps the nurse, midwife or nursing associate has taken to address serious concerns caused by a gap in knowledge or training or personal context factors

Reference: FTP-12f Last Updated: 29/03/2021

Where we identify a gap in the nurse, midwife or nursing associate's knowledge or training, we'll try to help them understand what they can do to address this gap and demonstrate they're safe to practise.

It's important that we find out how this gap occurred and in particular if it raises a concern about the quality or availability of support and supervision at a particular setting or if there's evidence of discrimination or victimisation. If there is such evidence we may need to take some additional action, such as sharing information with other regulators or employers.

Where personal contextual factors, such as health issues or personal circumstances were the root cause of the concerns about someone's practice, our key consideration will be how they relate to the risk of harm to people who use services in the future. We'll need to look at the insight shown by the nurse, midwife or nursing associate into the extent and effect of the personal contextual factors on their practice and the steps they've taken to keep their practice safe in the future.

Commitment 7: We'll always look into whether group norms or culture influenced an individual's behaviour before taking action

Reference: FTP-12g Last Updated: 29/03/2021

When things go wrong there will usually be a number of people and different factors involved which contributed to some degree. Holding one individual to account where group norms or culture played a part in what happened may be unfair. It may also give false assurance and direct focus away from a wider problem.

Often incidents, errors or risks to safe care can happen through particular ways of doing things or because of a wider culture within an organisation. Workarounds can sometimes initially be developed because of problems in the working environment. Over time, these may become normalised and turn into a culture of this is how we do it here. Examples of this could be checking controlled drugs for multiple people at once, or pre-potting medication. Other norms can arise that result in unacceptable behaviour occurring in a working environment, such as inappropriate sexual banter.

Before deciding on someone's fitness to practise, we'll explore what role others played (including managers) to establish if there were any group norms or cultural issues that may have influenced their actions or behaviour. It will be important that we know how widespread the poor practice was in the setting (particularly if other health or social care professionals were routinely doing it), and how this came to be the case.

We'll also look at whether people felt safe to speak up, whether the person or others had attempted to raise concerns previously, and at any organisational pressure not to do so. If concerns were raised and dismissed or not responded to it might indicate that a working environment existed which prevented people from doing the right thing. Where there's evidence of this, we'll need to consider sharing information with others who also have a role in preventing future harm to people who use services.

Commitment 8: Where an incident has occurred because of cultural problems, we'll concentrate on taking action to minimise the risk of the same thing happening again

Reference: FTP-12h Last Updated: 01/07/2022

While we expect nurses, midwives and nursing associates to comply with the Code at all times, we recognise the psychological evidence about how hard it can be to speak up or to disobey group norms, even if that means people acted in a way that looks unacceptable with hindsight. If the evidence shows that an incident occurred because of a poor culture we'll take this into account when deciding what action we need to take.

As we explain in our guidance on seriousness, some concerns are so serious that they may be more difficult for the individual to put right. Such concerns include things like causing deliberate harm to people who use services, concerns of discrimination that have taken place either inside or outside the workplace, or a person breaching the professional duty of candour, for example by falsifying records or covering up their mistakes. For these concerns we'd follow the approach in our guidance "serious concerns which are more difficult to put right". We'd still look into the impact of poor culture or group norms, and evidence of these would be considered as part of our assessment of the case. However, concerns such as these are more likely to call into question fundamental aspects of the individual's fitness to practise, and require us to take regulatory action.

Where cultural problems are at the heart of the concern, we'd need to seek assurance that the individual has since reflected and demonstrated that they can act appropriately if they found themselves in a similar working environment. Without this evidence, regulatory action may be required to stop the problem from happening again.

Where there's evidence that other individuals on our register took part in the same poor practices as the person referred to us, we'd need to consider what other action to take to keep people safe. This might mean opening referrals against them. We are less likely to open a new referral if we're confident that the individual has reflected on the incident and demonstrated that they can act appropriately if they found themselves in a similar working environment. We'll also consider sharing information with other regulators and employers via our regulation advisors.

In these types of situations, the people leading or fostering poor cultures should be held accountable as well as and not instead of the people who carry the behaviours out. We'll need to consider whether we need to take any action against those in senior positions who were responsible for the poor culture and for ensuring correct processes were in place, known about, understood and adhered to.

If managers knew poor practices were happening and did nothing, it might call their management arrangements and the level of support they provided into question. It might also be a concern if managers didn't know of a widespread cultural issue. Again, we may need to consider opening referrals against people on our register or sharing information with other regulators or employers who also have a role in preventing future harm to people who use services.

What context factors we think are important to know about when considering a case

Reference: FTP-12i Last Updated: 14/04/2021

We carried out research to help us identify what factors we should take into account when we're thinking about the context an incident occurred in. We've listed these below. We've created specific context questions based on these factors to help people tell us their perspective.

During the investigation of our cases we'll routinely ask the nurse, midwife or nursing associate and their employer (if the incident happened at their place of work) these questions. We'll also think about who else can tell us about the context an incident happened in. This is particularly important if the employer and nurse, midwife or nursing associate have different views.

The factors we identified relate to three areas of context:

- The nurse, midwife or nursing associate themselves

We want to know whether there were any personal factors that may have impacted the nurse, midwife or nursing associate and how these may have affected them. Although sometimes these questions may be harder for an employer to answer, we want to give the employer the opportunity to tell us what they can.

- The working environment and culture

System pressures or the working environment can prevent nurses, midwives and nursing associates from delivering safe care. We need to understand what the environment was like and whether it was a contributing factor to an incident.

- Learning, insight and any steps the nurse, midwife or nursing associate's taken to strengthen their practice

This will help us understand how the nurse, midwife or nursing associate has responded and how this may affect our consideration of the referral. We also want to hear from the employer about what they have done to resolve any issues within a workplace. This will help us think about if we need to take wider regulatory action, such as making a referral to another regulator.

Not all context factors will be present in every case. There may also be other factors that contribute to an incident that aren't listed. If someone tells us about factors that aren't on this list, our decision makers will take them in to account by considering how these fit in with our context commitments.

We code each of the factors as this helps us analyse the information we get. We can then think about whether there are systemic issues that may need wider regulatory action.

NMC1
Past Performance
Understanding how someone has performed in the past will help us consider whether the concerns are 'out of character'.
NMC2
Health and Addiction
Physical or mental health issues could provide relevant context, and those affected may not always recognise the impact or effect.
NMC3
Protected characteristics

Discrimination, harassment or victimisation can affect people's behaviour, or be a factor in their referral.
NMC4
Communication problems
Communication problems between people can be barriers to providing the right level of care.
NMC5
Factors affecting attention
Distractions in the work environment or personal lives may mean people are unable to focus on what they are doing properly.
NMC6
Tiredness/Sleep deprivation
Excessive tiredness due to sleep deprivation can affect people's behaviour or ability to concentrate.
NMC7
Lack of breaks
Everyone needs to take breaks for their wellbeing and if they cannot, this may affect their ability to carry out tasks or concentrate.
NMC8
Emotions/Mood
Personal factors or stress can distract people from performing their roles.
PC9
Contributory factors
Sometimes a nurse, midwife or nursing associate may have to make a difficult decision or prioritise tasks or people in their care. They may feel that their actions were the only thing they could have done under the circumstances.
MA10
Analysis and impact
We want to know if the nurse, midwife or nursing associate understands what went wrong, the consequences and have taken steps to prevent this from reoccurring (if relevant).
PC11
Learning
Does the nurse, midwife or nursing associate understand what could and should have been done differently and/or how to act differently in the future to avoid similar problems happening? If so, this may reduce the risk of it happening again.
PC12
Insight and Remediation
If a nurse, midwife or nursing associate has reflected and taken steps to address any gaps in their skills, knowledge or training, they may be less likely to be an ongoing risk to people in their care.
N13
Workload
Workload or work pressures can sometimes get in the way of people providing the ideal level of care or stop them from doing the right thing.
N14

Distractions
What was the environment like at the time of the incidents? Was it particularly busy or loud compared to normal, and could this have been distracting?
N15
Substitution
Would another trained person have done the same thing? Ifso, this suggests the act may not be the fault of the nurse, midwife or nursing associate but the situation or environment.
N16
Training and supervision
Was the nurse, midwife or nursing associate adequately trained and supported for the job they had to do?
N17
Equipment
We need to know whether equipment or systems may have contributed to an incident. It may be that the right systems or equipment weren't available, or weren't in working order.
N18
Relationships
Were there poor relationships between professional groups and what impact did this have on how people acted
N19
Custom and practice
Was there a poor team culture or were poor practices or widespread workarounds part of the working environment.
N20
Raising concerns
Could concerns be raised by staff and were they appropriately responded to.

Insight and strengthened practice

Reference: FTP-13 Last Updated: 14/04/2021

Decision makers across our fitness to practise process will always need to consider the level of risk the nurse, midwife or nursing associate presents to members of the public, looking at the facts of the case.

Evidence of the nurse, midwife or nursing associate's insight and any steps they have taken to strengthen their practice will usually be central to deciding whether their fitness to practise is currently impaired. This is because whether fitness to practise is being considered at a final hearing, or at an earlier stage of our process, the events that led to the nurse, midwife or nursing associate being referred to us will usually have happened some time previously.

Before considering the nurse, midwife or nursing associate's insight and any steps they have taken to strengthen their practice, decision-makers should consider the context in which the incident occurred. This is because it may help them to understand what the concerns are with the nurse, midwife or nursing associate's fitness to practise and what sort of steps may be needed to address those concerns.

When assessing evidence of the nurse, midwife or nursing associate's insight and the steps they have taken to strengthen their practice, decision makers will need to take into account the following questions:

- Can the concern be addressed?
- Has the concern been addressed?
- Is it highly unlikely that the conduct will be repeated?

These factors are key points for decision makers to consider, but they are not a definitive test of whether a nurse, midwife or nursing associate's fitness to practise is currently impaired.

Can the concern be addressed?

Reference: FTP-13a Last Updated: 01/07/2022

Decision makers should always consider the full circumstances of the case in the round when assessing whether or not the concerns in the case can be addressed. This is true even where the incident itself is the sort of conduct which would normally be considered to be particularly serious.

The first question is whether the concerns can be addressed. That is, are there steps that the nurse, midwife or nursing associate can take to address the identified problem in their practice?

It can often be very difficult, if not impossible, to put right the outcome of the clinical failing or behaviour, especially where it has resulted in harm to a patient. However, rather than focusing on whether the outcome can be put right, decision makers should assess the conduct that led to the outcome, and consider whether the conduct itself, and the risks it could pose, can be addressed by taking steps, such as completing training courses or supervised practice.

Decision makers need to be aware of our role in maintaining confidence in the professions by declaring and upholding proper standards of professional conduct. Sometimes, the conduct of a particular nurse, midwife or nursing associate can fall so far short of the standards the public expect of professionals caring for them that public confidence in the nursing and midwifery professions could be undermined. In cases like this, and in cases where the behaviour suggests underlying problems with the nurse, midwife or nursing associate's attitude, it is less likely the nurse, midwife or nursing associate will be able to address their conduct by taking steps, such as completing training courses or supervised practice.

Examples of conduct which may not be possible to address, and where steps such as training courses or supervision at work are unlikely to address the concerns include:

- criminal convictions that led to custodial sentences
- inappropriate personal or sexual relationships with patients, service users or other vulnerable people
- incidents of discrimination that have taken place either inside or outside the workplace
- Incidents of harassment (including sexual harassment) that have taken place in a professional context
- dishonesty, particularly if it was serious and sustained over a period of time, or directly linked to the nurse, midwife or nursing associate's practice
- violence, neglect or abuse of patients.

Generally, issues about the safety of clinical practice are easier to address, particularly where they involve isolated incidents. Examples of such concerns include:

- medication administration errors
- poor record keeping
- failings in a discrete and easily identifiable area of clinical practice
- concerns about incidents that took place a significant period of time in the past, especially if the nurse, midwife or nursing associate has practised safely since they occurred.

Has the concern been addressed?

Reference: FTP-13b Last Updated: 29/11/2021

In this guide

Demonstrating insight

Before effective steps can be taken to address concerns, the nurse, midwife or nursing associate must recognise the problem that needs to be addressed. Therefore insight on the part of the nurse, midwife or nursing associate is crucially important.

A nurse, midwife or nursing associate who shows insight will usually be able to:

- step back from the situation and look at it objectively
- recognise what went wrong
- accept their role and responsibilities and how they are relevant to what happened
- appreciate what could and should have been done differently
- understand how to act differently in the future to avoid similar problems happening.

Decision makers do more than simply look at whether a nurse, midwife or nursing associate has shown ‘any’ insight or not. They need to assess the quality and nature of the insight. There may still be a public interest in restricting a nurse, midwife or nursing associate’s right to practise, even if they have shown ‘some’ insight into what happened.

Where a panel has found that a nurse, midwife or nursing associate was responsible for incidents that they denied (or continue to deny), this should not bar the nurse, midwife or nursing associate from being able to show insight. They may not have insight into the particular events that occurred, but they may be able to show insight by having an understanding of the need to minimise the risk of similar events occurring in the future, and the steps that might be taken to achieve this.

Assessing whether insight is sufficient

It is important to carefully assess whether the insight shown by the nurse, midwife or nursing associate is enough to address the specific concerns that arise from their past conduct, rather than simply identifying whether ‘any’ or ‘some’ evidence of insight is present. What is sufficient insight will depend on the circumstances of the case.

Decision makers must always consider each case on its own facts and circumstances. However, the following factors will be useful when considering whether the evidence of insight is sufficient to address the concerns in the case.

- If they had the opportunity to do so, did the nurse, midwife or nursing associate cooperate with their employer's or any other local investigation into the concerns?
- Did the nurse, midwife or nursing associate accept the concerns against them when first raised by their employer?
- Did the nurse, midwife or nursing associate, voluntarily or without prompting, draw any failings or inappropriate conduct to the attention of their employer?

- Did the nurse, midwife or nursing associate 'self-report' to the NMC, when a referral might otherwise not have been made by someone else?
- Does the nurse, midwife or nursing associate accept the substance of our regulatory concern, and accept responsibility for any failings or inappropriate conduct?
- Has the nurse, midwife or nursing associate done so since the early stages of our investigation?
- Does the nurse, midwife or nursing associate acknowledge:
  - any harm or risk of harm, to patients?
  - any damage to public confidence in the professions?
  - how far their conduct or practice fell short of professional standards?
  - their own responsibility for the problem, without seeking to blame others or excuse their actions?

If a nurse, midwife or nursing associate shows insight when they had previously not accepted responsibility for their actions , decision makers should consider this carefully. They should assess whether it was possible for the nurse, midwife or nursing associate to make admissions earlier on by considering the information that was given to the nurse, midwife or nursing associate during their employer's investigation, other earlier local investigations, or our own investigation.

The duty of candour

All registered nurses, midwives or nursing associates must comply with the duty of candour guidance which arises from the requirements set out in the Code and Raising concerns: Guidance for nurses and midwives.

To comply with this professional duty, nurses, midwives or nursing associates must:

- Be honest, open and truthful in all their dealings with patients and the public.
- Never allow organisational or personal interests to outweigh the duty to be honest, open and truthful.
- Act with integrity and give a constructive and honest response to anyone who complains about the care they have received.
- Act without delay and raise concerns if they experience problems that prevent them from working within the Code. Also act without delay and raise concerns if they or a colleague, or any other problems in the care environment, are putting patients at risk of harm. 'Doing nothing' and failing to report concerns is unacceptable.
- Apologise and explain fully and promptly what has happened and the likely effects if someone in their care has suffered harm for any reason. 'Near misses', where a nurse's, midwife's or nursing associate's act or omission puts a patient at risk of harm, must also be escalated as a point of concern.
- Cooperate with internal and external investigations.

Decision makers should take into account whether the nurse, midwife or nursing associate has complied with the duty of candour and the requirements it places on professional practice when they consider issues of current impairment.

Apologies and insight

Apologising for mistakes or failings should be encouraged. A decision maker may take an apology into account as evidence that the professional understands and has complied with the duty of candour.

However, there's no requirement for a nurse, midwife or nursing associate to make admissions to a regulatory concern at an early stage. An apology will not be viewed as an admission for what went wrong.

An apology may be expected in certain circumstances, such as when something goes wrong with a patient's treatment or care that causes or has the potential to cause harm or distress. However, there may be circumstances that prevent a nurse, midwife or nursing associate from offering an apology.

For instance, some may be discouraged from apologising by their employer or be encouraged to express the apology in a certain way. The employer may be concerned that an apology could be perceived as an admission of guilt and that this could have implications for any separate legal proceedings[1]

This can affect what a nurse, midwife or nursing associate feels able to do. We will consider our context principles when deciding how to approach the employer's actions in these circumstances.

Cultural differences or English being a second language may also affect the nurse, midwife or nursing associate's ability to provide a reflective statement and how they express insight, including whether they offer an apology.

Decision makers should consider whether these factors might be relevant when a nurse, midwife or nursing associate has not offered an apology.

Sufficient steps to address the concern

What is 'sufficient' to address the concern in a case will depend on the specific details, including the nature of the alleged failings or behaviour. The scale of the concerns will determine what steps are required. For example, the reassurance a decision maker will be looking for will be less for a single clinical incident in an otherwise unblemished career than it would be if a number of errors had taken place over a period of time, and they continued to happen after the nurse, midwife or nursing associate was made aware of the problem, or where other steps put in place to address the risks did not prevent problems from recurring.

Key considerations for decision makers in assessing the steps taken by a nurse, midwife or nursing associate to address concerns in their practice will be whether the steps taken are:

- relevant, in that they are directly linked to the nature of the concerns
- measurable (for example, where the nurse, midwife or nursing associate says they have been on a training course, information should be provided to help the decision maker understand the scope of the course, the topics covered and the results of any assessments)
- effective, addressing the concerns and clearly demonstrating that past failings have been objectively understood, appreciated and tackled.

Sufficient and appropriate steps may include the following.

- Attending a training course. Decision makers should assess whether the course content is relevant to the concerns in the case and whether the course was sufficiently comprehensive, ideally including a practical element and some form of assessment, with results available.
- Reflection. Reflective work by the nurse, midwife or nursing associates will be of more weight where they are able to give examples not only of what they have learned following the concerns being raised, but also how they have applied this learning in their practice.
- Developing and successfully completing an action plan.
- Successfully completing a period of supervised practice targeted at the concerns arising from the alleged behaviour.
- Periods of employment during which the nurse, midwife or nursing associate has practised in similar clinical fields, or carried out similar procedures to those where the original failings or concerns arose. Decision makers should look for clear evidence that the employer was aware of the areas of concern within the nurse, midwife or nursing associate's practice and what has been observed or assessed regarding these.
- Periods of unemployment (whether in the past or present) or periods working without having had the opportunity to demonstrate that the problematic task or tasks can be successfully completed without difficulty, will usually be of limited relevance.

Decision makers should only rely on the evidence that is actually available at the time they consider the case. They must not speculate about what other information might be available.

However, if a case is being considered before a final hearing or meeting, and the evidence of insight and the steps taken to address the concerns is insufficient, decision makers should consider whether further steps could be taken. For example, if a nurse, midwife or nursing associate has stated that they have attended a course or undertaken additional training, we could request evidence of this.

Assessing evidence

Decision makers must consider how much weight to place upon any evidence a nurse, midwife or nursing associate provides. In particular:

- A reflective piece can be considered 'evidence', although the decision maker should consider at what stage in the proceedings it was produced.
- Testimonials from a manager or supervisor should carry more weight than those from friends or colleagues.

References or testimonials should be signed by the author, dated, on letter-headed paper, and include contact details so we are able to verify the contents of the reference or testimonial.

- It should be clear that the author is aware of the full details of the allegations against the nurse, midwife or nursing associate, and of the nurse, midwife or nursing associate's acceptance of the charges.
- The content of the reference or testimonial should be relevant to the issues being considered by the decision maker.
- Evidence of training courses should be carefully considered. Decision makers should look at the duration of the course and the amount of time or focus placed on topics which address the relevant concerns. Courses with a practical element and formal assessment (with results available), can carry more weight than courses completed online or those without any means for the nurse, midwife or nursing associate to demonstrate understanding.
- Little, if any, weight should be placed on character references and testimonials that do not provide informed comment on the nurse, midwife or nursing associate's clinical practice, skills or competence.

1 The NMC and GMG guidance on duty of candour says the following: "Apologising to a patient does not mean that you are admitting legal liability for what has happened. This is set out in legislation in parts of the UK (Section 2 of the Compensation Act 2006 (England and Wales)) and NHS Resolution also advises that saying sorry is the right thing to do".

Is it highly unlikely that the conduct will be repeated?

Reference: FTP-13c Last Updated: 14/04/2021

When considering how likely it is that conduct will be repeated, decision makers will assess the extent of the nurse, midwife or nursing associate's insight into the concerns, and will also consider whether the steps taken to address concerns are sufficient.

Decision makers will consider whether the nurse, midwife or nursing associate is likely to repeat the conduct that caused the concerns. When doing this, they should take into account whether the nurse, midwife or nursing associate has been practising in a similar environment to where the conduct took place. If they have, and have therefore been exposed to occasions when there was a risk of past conduct being repeated, then the absence of repetition will be significant. If they have not been practising in a similar environment (whether because restrictions have been placed on their practice or for any other reason), the absence of repetition will be of little or no relevance.

Decision makers can also take into account the full circumstances of the case. The likelihood of the conduct being repeated in the future may be reduced where:

- The nurse, midwife or nursing associate has demonstrated sufficient insight and has taken appropriate steps to address any concerns arising from the allegations.
- The behaviour in question arose in unique circumstances. While this may not excuse the nurse, midwife or nursing associate's behaviour, this may suggest that the risk of repetition in the future is reduced.
- The nurse, midwife or nursing associate has an otherwise positive professional record, including an absence of any other concerns from past or current employers and of any previous action by us or another regulatory body.
- The nurse, midwife or nursing associate has engaged with us throughout our processes.

Engaging with your case

Reference: FtP-14 Last Updated: 06/09/2021

In this guide

Why it's important for nurses, midwives and nursing associates to engage early

We encourage nurses, midwives and nursing associates to engage with us as early as possible and at every stage of the process. This includes providing us with the following information:

- whether they're currently employed and any steps their employer may be taking to manage any risk
- information about the context in which the incident occurred
- evidence of any steps they've taken to address the concerns raised about their fitness to practise (such as completing courses or retraining)
- evidence of any insight they have or any reflection they've undertaken so far about the concerns raised (we recognise that insight and reflection can develop over time, and may also depend on how any investigation progresses).

The nurse, midwife, or nursing associate doesn't have to provide us with this information, but having it helps us make more informed decisions about the case early. Some examples of why early engagement can be important are:

- It may be in a nurse, midwife or nursing associate's interest to engage early, as having this information may mean we do not need to take action in relation to the case.
- If a nurse, midwife or nursing associate provides information early on to demonstrate that they've fully addressed the concerns raised, our decision makers may decide that they're currently fit to practise and no further regulatory action is required.
- Knowing about the context in which an incident happened may help our decision makers to better understand what went wrong.
- The nurse, midwife or nursing associate's early engagement may also help us to understand what we need to investigate. For example, it may help us understand which of the concerns raised they agree with, and which ones they dispute.
- If the case is at a later stage, then providing us with the information we ask for may help us to better plan for the final meeting or hearing, for example by avoiding spending time on issues that are not actually in dispute.

How not engaging early can affect the progression of the case

If a nurse, midwife or nursing associate doesn't provide the information we ask for early on, it can affect the case's progression. For example:

- It might mean that we proceeded with a case when we could have decided there wasn't a need for regulatory action if we'd had all the information. This is because our decision makers at the early stages might not have known what the nurse, midwife or nursing associate has done to address the concerns raised or the context in which the incidents happened.
- If the nurse, midwife, or nursing associate has information about the context in which the incident occurred but didn't share it with us until later, it may delay the case whilst we make further inquiries.
- If the case is at a later stage, then not having the information we've asked for may mean we're less able to

plan for the final meeting or hearing.
- If the nurse, midwife or nursing associate only engages with us at a late stage (for example, at the final meeting or hearing), it can cause delays to the case. For example, this can happen where an entirely new issue is raised at a hearing that then needs to be investigated.

What can happen if a nurse, midwife, or nursing associate doesn't engage, or engages at a late stage?

In some instances, not providing information or providing it at a later stage may have a particular impact on the final meeting or hearing.

There may be instances where the nurse, midwife or nursing associate can't engage with us for reasons such as ill health. We'll always take factors like these into account when making decisions on the case.

Nurses, midwives and nursing associates are required to co-operate with any investigation about their conduct in line with the Code[1]. If we regard a nurse, midwife or nursing associate's failure to cooperate with our investigation as particularly serious, we may raise this as an additional regulatory concern.

Raising issues at a late stage in proceedings

Suppose a nurse, midwife or nursing associate raises an issue at a late stage (such as the final hearing) that could reasonably have been raised at an earlier stage. In this case, the panel may consider whether there's a reasonable explanation for this and whether to adjourn the matter for further investigation.

For example, a nurse, midwife or nursing associate could raise for the first time at a final hearing that they were overloaded at the time of the incident due to staffing shortages. This may be something they could have reasonably raised with us earlier on in the fitness to practise process. (See our guidance on directing further investigation during a hearing.)

If the panel considers that there's no reasonable explanation for the issue being raised late, it may, subject to it being fair, decide to take that into account when assessing the nurse, midwife or nursing associate's credibility in relation to the matter raised.

Providing materially different accounts

If a nurse, midwife or nursing associate provides a materially different version of events in relation to the concerns raised than the version of events they provided at an earlier point in time, the panel may take this into account when considering their credibility. We may invite the panel to consider the nurse, midwife or nursing associate's credibility in relation to that issue.

Not giving evidence at the final hearing

A panel may consider whether to draw an adverse inference when a nurse, midwife or nursing associate chooses not to give evidence at the facts stage of a hearing[2]. This means that the panel may reach a conclusion based on the nurse, midwife or nursing associate's decision not to give evidence, that they have no good explanation for their alleged conduct or reasonable response to the case against them.

This principle applies where a nurse, midwife or nursing associate does not give evidence at all and where a professional refuses to give evidence about a particular issue or question.

A panel may also draw an adverse inference at a meeting where the nurse, midwife or nursing associate hasn't provided any written evidence in response to the case against them.

A panel's decision on whether to draw an adverse inference will depend on the circumstances of the particular case. Panels must always ensure that the nurse, midwife or nursing associate is treated fairly. The Courts have held that panels shouldn't draw an adverse inference based on the failure to give evidence unless:

1. We've put forward sufficient evidence that the nurse, midwife, or nursing associate has been involved in misconduct or that their fitness to practise is impaired for some other reason.[3]
2. The nurse, midwife or nursing associate has been given an appropriate warning that an adverse inference may be drawn if they do not give evidence. The nurse, midwife or nursing associate must be given an

opportunity to explain why it wouldn't be reasonable for them to give evidence and, if it is found that there is no reasonable explanation, be given an opportunity to give evidence.

3. There is no reasonable explanation for the nurse, midwife, or nursing associate not giving evidence (for example, not giving evidence due to illness may be reasonable).
4. There are no other circumstances that would make it unfair to draw an adverse inference. (For example, if the professional becomes upset whilst giving evidence and is unable to continue, it would be unfair for the panel to consider drawing an adverse inference without offering them time to recover and an opportunity to continue to give evidence.)

If a witness provides written evidence but doesn't attend the hearing to provide oral evidence and be cross-examined, the panel can take this into account when considering whether to admit the written evidence and what weight to attach to it. You can read about the panel's approach to a witness not providing oral evidence at a hearing by looking at our general guidance on evidence.

Health cases

Where the nurse, midwife or nursing associate's fitness to practise is alleged to be impaired because of health, the panel may also take into account any refusal by them to submit to an assessment of their current health.[4]

English language cases

Where the nurse, midwife or nursing associate is alleged to be impaired because of not having the necessary knowledge of English, the panel may take into account the fact that they have failed to take or failed to provide evidence of an English language test that we've required them to undertake[5].

1 Standard 23, The Code – Professional standards of practice and behaviour for nurses, midwives and nursing associates (2018)
2 See e.g. R (Kuzmin) v General Medical Council (GMC) [2019] EWHC 2129 (Admin)
3 The legal term for this is that a 'prima facie' case to answer has been established
4 Rule 31(5)(a) NMC Fitness to Practise Rules 2004
5 Rule 31 (6A) NMC Fitness to Practise Rules 2004