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Our overall approach

Reference: SCR-1 Last Updated: 10/05/2021

In this guide

- The purpose of screening
- Our approach
- The role of employers
- Involving trade unions and professional bodies

The purpose of screening

The purpose of screening is to decide if a concern about a nurse, midwife or nursing associate's practice amounts to an allegation of impaired fitness to practise.

We'll carry out initial investigations to help us decide if the concern needs to be referred to our Case Examiners or the Fitness to Practise Committee and help us consider the nurse, midwife or nursing associate's fitness to practise.[1] If it does, we'll refer the case to either the Case Examiners or the Fitness to Practise Committee to consider the matter further.[2]

Our approach

Our approach to screening is based on our principles for fitness to practise. Our focus is on protecting the public by managing the risk that a nurse, midwife or nursing associate may pose to members of the public in the future. We'll also always consider whether a concern might undermine the public's trust in nurses, midwives and nursing associates or our professional standards generally.

It's not our role to punish people for past events. In line with our context commitments, unless evidence shows that a nurse, midwife or nursing associate deliberately caused harm or acted recklessly, our starting position will be to assume they are usually a safe and competent professional, but something got in the way of them being able to deliver safe care. We can best protect members of the public by making decisions on the concerns we receive swiftly and giving clear reasons for these decisions. We'll always take account of the context in which the person on our register was practising when deciding if there's a risk to public safety that may require us to take regulatory action.

This guidance sets out how we decide if a fitness to practise concern should be referred to our Case Examiners or the Fitness to Practise Committee.

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

The role of employers

Employers have an essential role in managing concerns about a nurse, midwife or nursing associate's practice. Most concerns can usually be addressed effectively by employers without requiring our involvement.

Our fitness to practise principles make it clear that local investigation and resolution are always the preferred way to deal with concerns, provided that approach does not leave the public at risk.

Employers are closer to the sources of risk to members of the public and can better recognise and manage them. If they need to, employers can intervene directly and quickly in a professional's practice and do so in a targeted way that deals with the risks.

We're further away from the sources of possible harm and have a limited range of options to prevent it. We only need to become involved if the nurse, midwife or nursing associate poses a serious risk of harm to the public or the public's trust and confidence in the professions.

Our Employer Link Service supports employers when deciding if we need to become involved in a concern. They provide advice to employers at the conclusion of a local investigation on whether or not regulatory action needs to be taken. Our employer resource aims to help employers conduct local investigations - you can read more here.

In some cases, it won't be possible for the employer to address the concern fully. This may be because the nurse, midwife or nursing associate practises in more than one setting, doesn't have an employer or has left the employer before an action plan could be put in place. We'll need to become involved in these cases where there's evidence of a serious concern that requires us to take regulatory action to protect the public.

Involving trade unions and professional bodies

Where a concern is received about a nurse, midwife or nursing associate who is a member of trade union or professional body, it can often be helpful for the person on our register to discuss the concern with their trade union or professional body at the earliest opportunity.

Trade union or professional body representatives can help us get information from the person on our register, which we need to make the right decision quickly and fairly. For example, they can help us get information about how a concern arose or any steps the professional has taken to strengthen their practice.

1 Rule 2A(4) of the Rules

2 Rule 2A(2) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004 ('the Rules')

The Three Questions we ask when making Screening Decisions

Reference: SCR-1a Last Updated: 27/03/2023

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

The process consists of us asking ourselves three questions.

This process is intended to be used flexibly to help us reach the right decision fairly and quickly.

For example, if an allegation could never amount to a serious concern (such as where an individual has received a fixed penalty notice for a parking offence), we won't spend our time and resources trying to establish whether the individual referred is on our register.

However, if an allegation could amount to a serious concern, we'll always make enquiries to check whether the individual is on our register to make sure there haven't been any similar concerns raised with us in the past.

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

Reference: SCR-1a-i Last Updated: 27/03/2023

In this guide

- Concerns we can consider
- Identifying nurses, midwives or nursing associates on our register
- In writing
- Supporting evidence

Concerns we can consider

We can only become involved in a concern where we:

- have sufficient detail about an individual to identify them on our register of nurses, midwives and nursing associates. We recognise that this is not always easy, but knowing a first name, the date, and the care setting in which the events took place is helpful.
- have a written account of the concern. We can assist people in providing us with a written account where this is needed.

Identifying nurses, midwives or nursing associates on our register

We can only consider allegations against an identified nurse, midwife or nursing associate who is currently on our register[1].

We must be confident that we have correctly identified the Personal Identification Number ('PIN') of the nurse, midwife or nursing associate who is the subject of a referral. Where a concern relates to someone who is not on our register, we won't consider the matter further (but may refer the matter to another organisation, such as another regulator, the police, an education provider or a Clinical Commissioning Group).

We often receive concerns about professionals delivering care on a certain ward, unit, or a particular setting rather than about identified nurses, midwives or nursing associates. If, after raising their concerns with the employer, a member of the public is unsure of the identity of those who delivered the care, we'll make inquiries to try to establish their identity.

We'll usually ask employers or healthcare providers to supply us with documents and information (such as rotas or timesheets) to help us identify individuals on our register. We'll treat cases involving a number of nurses, midwives or nursing associates from a particular healthcare setting (who we cannot immediately identify) as a single referral as we gather information to identify if any of the individuals are on our register.

If, after taking reasonable steps, we can't link the referral to an identified nurse, midwife or nursing associate on our register, we won't be able to investigate further.

In writing

To consider if a concern amounts to an allegation of impaired fitness to practise, we need to have a written account of the concern.

If someone first raises a concern with us over the phone, we'll ask them to put their concern in writing. If someone needs help with this, we'll provide them with the help they need. This is part of our wider commitment to support

people to communicate with us and stay involved in our processes.

We'll make enquiries at the screening stage to ensure we have an accurate and complete understanding of the concern to help us make our decision. We have broad powers to investigate any matters that will help us decide whether the concern can amount to an allegation of impaired fitness to practise.

If the scope of the concern is unclear, we'll contact the person raising the concern and ask them to clarify what their concern is about. If no clarification is provided, we may not be able to consider the matter any further.

Supporting evidence

It's helpful to provide supporting evidence when concerns are raised with us. This isn't essential, but it can take longer to resolve if the concern isn't accompanied by supporting evidence.

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

- a clear and logical narrative explaining the conduct which is being alleged
- dates of the incident(s) (including exact time and dates if possible)
- locations where the incident(s) took place (including name and address of the organisation, and specific wards or departments where possible)
- names and contact details of anyone present (including colleagues and members of the public)
- copies of notes made at the time or shortly after the event, and statements of anyone who witnessed the events alleged
- copies of medical records, medication administration record (MAR) charts, prescriptions
- local policies
- details or documentary records of any admissions made by the nurse, midwife or nursing associate
- details of other sources of evidence in support of the allegation
- any investigation report and appendices
- any disciplinary outcome letter.

1 Article 22(1) of the Nursing and Midwifery Order 2001 refers to allegations against 'a registrant', which is defined in Schedule 4 as 'a nurse, midwife or nursing associate who has been admitted to the register…'

Is there evidence of a serious concern that could require us to take regulatory action to protect the public

Reference: SCR-1a-ii Last Updated: 30/08/2024

In this guide

- Evidence of a concern
- Verifying the facts
- Allegations without any supporting evidence
- Anonymous referrals and people wishing to remain anonymous
- Context
- Seriousness
- Examples of concerns that are likely to be suitable for local investigation

Once we're confident that we understand what the complaint is about, we'll consider whether there's evidence of a serious concern that could require us to take regulatory action to protect the public.

We can carry out any investigations we consider are appropriate to help us with this consideration.

Evidence of a concern

Before we consider whether a concern is serious enough to refer to the Case Examiners or the Fitness to Practise Committee, we'll need some evidence to support the concern, or be confident that we'll be able to obtain evidence to support the concern.

In some cases, the written account setting out the complaint might provide us with enough evidence to decide if the concern is serious enough to refer to the Case Examiners or the Fitness to Practise Committee. However, in other cases, it may be appropriate to look into what the referrer has told us to make sure we have sufficient evidence to proceed.

Our Culture of curiosity guidance sets out our approach when we need to make enquiries.

Verifying the facts

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

Example 1

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

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

Example 2

A complaint is made about a nursing associate asking a member of the public for their personal telephone number. The nursing associate says they were instructed to do so by a doctor for medically justified reasons. We check the medical records made at the time, which confirms the nursing associate's account.

In this scenario we wouldn't have any evidence of a concern, and wouldn't need to consider the matter any further.

Allegations without any supporting evidence

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

Where someone makes an allegation without any supporting evidence, we'll make further enquiries to establish whether there's any evidence to support the concern. We'll usually ask the person raising the concern for more information. If this isn't possible, for example, where we don't know the identity of the person raising the concern, we'll make whatever reasonable and proportionate enquiries we can to verify it.

Where we've carried out appropriate investigations but are left with a bare allegation, we won't be able to take the matter further.

Example 1

We receive a complaint that a nurse didn't carry out an assessment of a patient properly. Our enquiries suggest that an appropriate assessment was carried out but that the person making the complaint disagreed with the assessment outcome.

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

Example 2

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

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

Anonymous referrals and people wishing to remain anonymous

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

When a referrer has asked us not to disclose their identity to the nurse, midwife or nursing associate who is the subject of the concern, we'll always seek to address any concerns they have about taking part in our fitness to practise process.

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

We'll use the information we've been given to investigate the concern without disclosing the identity of the referrer. We'll make whatever enquiries we can to see if there's any other evidence to support the concern. If we find any other evidence of the concern (and it meets the stages of our screening process) we'll refer the matter to the Case Examiners or Fitness to Practise Committee ourselves.[1]

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

Example 1

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

Example 2

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

Context

We'll take account of the context surrounding the concern to make sure we reach the right decision to protect the public.

We'll investigate the context of an incident where it helps us understand if there's evidence of a serious concern that could require us to take regulatory action.

If the evidence suggests that, in light of the context, there's no serious concern about the nurse, midwife or nursing associate's practice, then we won't need to refer the case to the Case Examiners or the Fitness to Practise Committee. However, we might need to take other steps, such as sharing information.

In other cases, it may be clear that based on the evidence we've received there's a serious concern that could require us to take regulatory action. For example, an allegation that someone on our register had a sexual relationship with a patient is unlikely to require us to investigate the incident's context. Provided the other stages of our screening test are met, this would amount to an allegation that should be referred to the Case Examiners or the Fitness to Practise Committee for further consideration of the context of the incident.

Example 1

A nurse is referred for repeatedly giving a patient the wrong dose of medication. Our enquiries show conclusively that a printing malfunction led to the wrong dose being written on the nurse's instructions.

The context in this scenario shows there's no evidence of a concern about the nurse's practice. While we don't need to take regulatory action, we would consider sharing this information with the employer and a system regulator to ensure such a mistake didn't happen again. We would do this in line with our Information Handling Guidance, which gives guidance on sharing information with employers and other outside agencies.

Example 2

We receive a referral that a nurse failed to respond to a medical emergency on a ward. There's clear evidence that the ward was short-staffed and the nurse escalated their concerns about this at the start of the shift. There's also evidence that there was another medical emergency that the nurse attended to at the same time. The nurse asked another member of staff to attend to the other emergency situation and made a clear record after the event explaining her decision-making.

In this scenario, the context suggests there's no evidence of a concern about the nurse's practice. However, we may need to take some other action to address the short-staffing issues, such as contacting the employer or a systems regulator.

Seriousness

Where there's evidence of a concern about a nurse, midwife or nursing associate's practice, this won't necessarily mean it needs to be referred to the Case Examiners or the Fitness to Practise Committee.

We'll consider whether the concern is serious enough that it could require us to take regulatory action to protect the public, uphold public confidence in the professions or uphold professional standards. We have broad powers to investigate the seriousness of concerns we receive. When assessing whether a concern is serious, we look at what risks are likely to arise if the nurse, midwife or nursing associates doesn't address or put the concern right. This could be risks to people receiving care or, in some cases, to the public's confidence in all nurses, midwives and nursing associates.

Regulatory action includes imposing restrictions on a nurse, midwife or nursing associate's right to practise, or

removing their right to practise entirely. It can also include issuing a warning. If a concern isn't of the kind that could require us to take regulatory action, it won't impact the professional's fitness to practise and won't need our involvement.

Many of the concerns we receive are not serious enough to require regulatory action to protect the public. But this doesn't mean that these concerns shouldn't be looked at. In line with our principles for fitness to practise, we consider that these cases are often suitable for local investigation and resolution by employers.

When we decide that concerns aren't so serious that we need to take action to protect the public, but a local resolution may be appropriate, we might contact the employer and tell the person who raised the concerns with us that we've done this. We'll follow our Information Handling Guidance when sharing information with employers.

In cases that aren't about professional practice, regulatory action is only likely to be needed if the concerns raise fundamental questions about the ability of a nurse, midwife or nursing associate to uphold the standards and values set out in the Code.

This may, for example, be the case where they've been convicted for a serious criminal offence or when their conduct demonstrates deep-seated attitudinal issues. An example of this could be displaying discriminatory views and behaviours or engaging in sexual harassment.

Our guidance on seriousness explains how we view the seriousness of different kinds of concerns.

Factors that we'll take into account when assessing seriousness at the screening stage include whether:

- the alleged conduct could have put a member of the public at serious risk of harm.
- the concern relates to an isolated incident or a pattern of behaviour over time. We're more likely to refer to the Case Examiners where we receive multiple concerns of a similar nature.
- the concern relates to dishonesty or breaches of the duty of candour. Allegations that a nurse, midwife or nursing associate has dishonestly sought to cover up clinical mistakes are particularly serious.
- the concern involves bullying, discrimination or harassment. We usually regard these cases as being serious.
- the alleged conduct could seriously damage public confidence in nurses, midwives or nursing associates or undermine professional standards - for example, sexual misconduct, serious violence, abuse of children or vulnerable adults or a conviction for a serious criminal offence.
- the alleged conduct involves serious leadership or management failings on the part of professionals on our register where the public have been put at risk as a consequence.

Examples of concerns that are likely to be suitable for local investigation

Here are some examples of concerns where local investigation and resolution is likely to be sufficient to protect the public. This is not intended to be an exhaustive list. Screening decisions will always need to be based on a careful consideration of each individual concern:

- concerns about the quality of treatment received where there is no indication of any serious risk to the public or that the nurse, midwife or nursing associate acted significantly below expected standards.
- one-off concerns about a nurse, midwife or nursing associate's poor attitude to patients or failing to take their preferences into account. These are more likely to be suitable for local investigation and resolution than allegations of a repeated pattern of behaviour suggestive of an underlying attitudinal concern placing members of the public at risk of harm. For example, a concern saying that a midwife was rude to a member of the public is likely to be suitable for local investigation. However, if we receive a series of concerns suggesting that a midwife has been rude to members of the public on numerous occasions, we are more likely to refer those concerns for investigation.
- concerns about conduct that may have been unprofessional but did not give rise to any risk of harm to the public. This could include concerns about the inappropriate use of social media.
- if our evidence of the context shows that the concern was caused by a problem with a system or process, rather than a problem with an individual nurse, midwife or nursing associate's practice, then the matter will usually be better dealt with locally (or by a systems regulator).

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

Screening

We won't usually refer concerns or incidents which took place before the nurse, midwife or nursing associate was registered with us to the Case Examiners or Fitness to Practise Committee. There may be exceptional cases of conduct that occurred before a nurse, midwife or nursing associate registered with us which are so serious as to appear to be incompatible with continued registration. In these cases, we may refer the matter for further consideration.

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

1 Using our powers under Article 22(6) of the Nursing and Midwifery Order 2001

Is there clear evidence to show that the nurse, midwife or nursing associate is currently fit to practise?

Reference: SCR-1a-iii Last Updated: 27/03/2023

We'll consider the evidence we have about the nurse, midwife or nursing associate's current practice.[1] Sometimes we receive evidence about the nurse, midwife or nursing associate's current practice which indicates that steps have already been taken to address any concerns about their fitness to practise since the incidents which led to the referral.

We always encourage nurses, midwives and nursing associates who have been the subject of concerns to consider what lessons they can learn from the incident and to strengthen their practice as a result. Full information about our approach to issues of strengthened practice, reflection and insight can be found here.

We'll consider whether the steps the nurse, midwife or nursing associate has taken to strengthen their practice satisfy us that there is no longer any risk to the public and the concern has been fully addressed.

For example, if there's clear evidence that the nurse, midwife or nursing associate has appropriately reflected on the issues raised in the concern, or, where appropriate, provided evidence of relevant retraining, we may decide that the case does not need to be referred to the Case Examiners or the Fitness to Practise Committee.

Where we receive information that health or personal circumstances may have played a part in the concern, we'll look for evidence from the nurse, midwife or nursing associate to demonstrate they've reflected on and addressed the issues they were experiencing at the time. Where we receive evidence that lack of training or support may have played a part in the concern, we'll need to be satisfied the gap in training or knowledge has been addressed. We'll also consider whether we need to share any information we receive about failures by employers to support nurses, midwives and nursing associates to stop similar concerns arising again, in line with our Information Handling Guidance on sharing information with outside agencies.

In some cases, the nature of the alleged conduct may be so serious that further investigation is required to promote and maintain public confidence in nurses, midwives and nursing associates generally, or to promote and maintain proper professional standards and conduct. In these circumstances, evidence about the nurse, midwife or nursing associate's current practice will be less relevant to our decision.

1 Sometimes nurses, midwives or nursing associates may provide us with reflective material in relation to an incident that isn't serious enough to require our involvement. While this won't usually be relevant to our screening decision, we encourage nurses, midwives and nursing associates to reflect on their practice and their reflections may be helpful when they go through Revalidation.

Clinical advice

Reference: SCR-1b Last Updated: 30/08/2024

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

Clinical advice at the screening stage should be aimed at assisting the decision-maker to understand the nature of the concern raised. This is so that they can assess whether it could require us to take regulatory action to protect the public. The clinical advisor may suggest further enquiries (provided these enquiries are limited to issues that can be conclusively determined at the screening stage, such as determining what policies, guidance or training were in place at the time). The clinical advisor may also suggest areas where the person raising the concern should be asked to provide further clarification.

It is not the role of the clinical advisor:

- to assist the decision-maker in resolving disputes of fact raised by the concern.
- to express any view as to the strength of the evidence presented or whether there is likely to be a case to answer following referral to the Case Examiners.

Referrals to other regulators

Reference: SCR-1c Last Updated: 10/05/2021

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

Similarly, where a referral does not raise concerns about the fitness to practise of a nurse, midwife or nursing associate, but appears to raise serious issues of public safety which should be investigated by another body (such as a systems regulator), we'll provide that body with the appropriate information and advice. This may include disclosure of the referral and any documents to assist with consideration of the case in line with our fitness to practise information handling guidance on sharing information with outside agencies.

In some cases, we might need to make a referral to another regulator, and conduct our own full investigation. For example, where a serious concern about someone on our register also raises issues that a systems regulator should consider.

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

Referrers that wish to remain anonymous

Reference: SCR-1d Last Updated: 10/05/2021

Sometimes referrers ask us not to disclose their identity to the nurse, midwife or nursing associate who is the subject of the concern.

In many cases, it won't be necessary for us to disclose the referrer's identity to refer a matter to the Case Examiners or the Fitness to Practise Committee. As long as the referral meets our screening requirements, then we have the power to investigate and refer a case for further consideration ourselves.[1]

We'll always seek to address any concerns that referrers have about taking part in our fitness to practise process. We'll engage our specialist Public Support Service for advice and support to help explain our process and the additional measures we can offer to help referrers and witnesses through it.

Our core function is to protect members of the public who rely on the services of nurses, midwives and nursing associates. For this reason, where a concern amounts to an allegation of impaired fitness to practise, we have to refer the concern to the Case Examiners or Fitness to Practise Committee.

We recognise that it is best practice to maintain confidentiality unless we are required by law to make a disclosure. Where the law requires us to make a disclosure, we don't require the referrer's consent to disclose their details. But disclosure without consent is an unusual step for us to take and we'll always give referrers the opportunity to explain to us any reasons why their details should not be shared, for example if they are a whistleblower.

1 Article 22(6) of the Nursing and Midwifery Order and Rule 2(A)(4) of the Fitness to Practise Rules.

Whistleblowing

Reference: SCR-1e Last Updated: 10/05/2021

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

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

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

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

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

A decision not to take any further action at this time

Reference: SCR-1f Last Updated: 01/04/2023

In this guide

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

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

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

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

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

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

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

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

Reviewing a screening decision

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

If someone requests a review

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

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

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

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

If we decide to carry out a review, we'll then tell the nurse, midwife or nursing associate that we're going to review

the decision and explain why. We'll also tell people who were told of the outcome at the screening stage, if they need to know. This could include employers, patients or other organisations.

What happens during a review

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

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

What we can decide

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

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

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

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

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

New information

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

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

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

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

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

When there is an error in the decision

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

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

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

New concerns

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

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

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

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

After we've reviewed the decision

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

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

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

Determining the regulatory concern

Reference: SCR-2 Last Updated: 29/11/2021

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

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

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

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

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

In this guide

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

Introduction

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

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

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

Identifying what causes us a regulatory concern

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

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

Analysing evidence of regulatory concerns

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

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

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

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

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

Regulatory concerns about motivation or intent

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

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

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

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

Statements of regulatory concern

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

It's important that the nurse, midwife or nursing associate is able to understand what we say happened, and why we say it means we may need to take regulatory action in their practice. The nurse, midwife or nursing associate needs to be able to tell us whether or not they accept that our concerns are well founded. Case examiners need enough detail for to make a clear and well reasoned decision about whether the nurse, midwife or nursing

associate has a case to answer, and also whether they should use their powers to dispose of cases by recommending undertakings, issuing warnings, or giving advice.

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

Regulatory concerns in health cases

Reference: SCR-2b Last Updated: 28/07/2017

In cases where the concern about the nurse, midwife or nursing associate's practice involves their physical or mental health, how we express the regulatory concern will depend on how their health condition has presented a risk to patients. It is important that we are able to provide detail of why we say the health condition is a source of concern, by referring to specific examples of risk. We will not leave the fact that the nurse, midwife or nursing associate has a health condition to speak for itself. Where, for example, the medical evidence makes clear that particular incidents or clinical concerns happened because the nurse, midwife or nursing associate has depression, making these incidents part of our regulatory concern shows the nurse, midwife or nursing associate why we say their depression could be a risk to patients.

For this reason, we will clearly set out any examples of the nurse, midwife or nursing associate having done something which put patients at risk of harm. This will be the case even where it would be possible to characterise the incidents as misconduct, if the medical evidence suggests that there is a link between what the nurse, midwife or nursing associate did, and the health condition they have.

Where there is sound medical evidence that the incidents would not have happened if the nurse, midwife or nursing associate did not have the health condition, our regulatory concern is about the way in which the health condition causes risks, rather than about the nurse, midwife or nursing associate's personal culpability.

Where there is no evidence of a link between what the nurse, midwife or nursing associate did and the health condition they have, there would be two different regulatory concerns based on two different factual backgrounds.

Cases that may involve incorrect or fraudulent entry

Reference: SCR-3 Last Updated: 13/01/2023

In this guide

- How we decide whether an allegation is about a register entry
- When we refer fraudulent or incorrect entry cases to the Investigating committee
- Agreed Removal

How we decide whether an allegation is about a register entry

When we receive an allegation, we will consider whether the facts alleged are capable of amounting to an allegation of an incorrect or fraudulent entry relating to a named nurse, midwife or nursing associate on our register.

If, following initial investigation, the facts are capable of amounting to an allegation of incorrect or fraudulent entry, we will refer the allegation for consideration by the Investigating Committee.

Sometimes, we receive allegations that could either be described as:

- allegations about a nurse, midwife or nursing associate's fitness to practise, or
- allegations about whether their entry on the register is fraudulent or incorrect.

For example, we may receive an allegation that a nurse, midwife or nursing associate gave us incorrect information as part of revalidation. This could amount to misconduct affecting their fitness to practise or give us grounds to investigate if their entry on our register is incorrect or fraudulent.

When this situation arises we usually prioritise the possible allegation of incorrect or fraudulent entry.

This is because we should investigate if someone is entitled to practise as a nurse, midwife or nursing associate we consider if their fitness to practise may be impaired.

It's important for public protection that members of the public can trust the information about who is listed as a nurse, midwife or nursing associate on our register. When there are issues relating to an applicant's health, in most cases, it will be more appropriate for the matter to be dealt with as a fitness to practise issue, not as an allegation of an incorrect or fraudulently procured entry on our Register.

When we refer fraudulent or incorrect entry cases to the Investigating committee

If we conclude that an allegation can amount to an allegation of fraudulently procured or incorrect entry, we'll refer the case to the Investigating Committee.

The Investigating Committee makes a final decision on whether or not the entry on the Register is incorrect or fraudulently procured.

In making this decision, the Investigating Committee will consider whether any of the information submitted, or information that the Registrar (or one of our Assistant Registrars who also make decisions on behalf of the Registrar) took account of during the application process, appears to be:

- wrong or inaccurate
- submitted with the deliberate intention to mislead the NMC
- obtained or created fraudulently.

The Investigating Committee will also assess whether it appears that the entry on the register was made in error

by the NMC.

We won’t refer the allegation to the Investigating Committee if, after an investigation, we consider the allegation isn’t capable of amounting to an allegation of incorrect or fraudulent entry.

This means that we are unlikely to refer to the Investigating Committee:

- cases where the evidence doesn’t support a finding of fraudulent or incorrect entry.
- incorrect entry cases where the error was not material (meaning that it either wouldn’t have made any difference to the entry in the Register or it has since been addressed).
- cases where, if we did make a referral to the Investigating Committee, our recommendation would be that no regulatory action was required.

Agreed Removal

Where a nurse, midwife or nursing associate is being investigated for an alleged fraudulent or incorrect entry, it won’t be appropriate for them to be granted Agreed Removal from the Register.