Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 13 November 2023 – Friday 24 November 2023
Tuesday 7 May 2024 – Thursday 9 May 2024
Monday 14 October 2024 – Thursday 17 October 2024

Virtual Hearing

Name of Registrant:	**Nicola Anne Diamond**
NMC PIN:	93J1180E
Part(s) of the register:	Community Practitioner Nurse Prescriber – (December 2010) Specialist Practitioner District Nursing – (November 2003) Registered Nurse – Sub Part 1 Adult Nursing – (October 1996)
Relevant Location:	Shropshire
Type of case:	Misconduct
Panel members:	Rich Youds (Chair, Lay member) Margaret Marshall (Registrant member) Anne Rice (Lay member)
Legal Assessor:	John Moir (13 – 24 November 2023, 7 – 9 May 2024) William Hoskins (14 – 17 October 2024)
Hearings Coordinator:	Hazel Ahmet
Nursing and Midwifery Council:	Represented by Alban Brahimi, Case Presenter
Mrs Diamond:	Not present and not represented at the hearing
Facts proved:	Charges 1a, 1b, 1c, 1d, 2a in part, 2b, 2c, 2e, 2g, 2h.i, 2h.ii, 2i.i, 2i.ii, 2j.i, 2j.ii, 4a, 4b, 4c

Facts not proved:	Charges 2d, 2f, 3
Fitness to practise:	Impaired
Sanction:	**Suspension order (12 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on application for hearing to be held in private

At the outset of the hearing, Mr Brahimi, on behalf of the Nursing and Midwifery Council, (NMC) made a request that this case be held in private on the basis that proper exploration of Mrs Diamond's case involves reference to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to go into private session in connection with matters regarding [PRIVATE], as and when such issues are raised in order to protect her privacy.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Diamond was not in attendance and that the Notice of Hearing letter had been sent to Mrs Diamond's registered email address by secure email on 12 October 2023.

Mr Brahimi submitted that the NMC had complied with the requirements of Rules 11 and 34.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs Diamond's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Mrs Diamond has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mrs Diamond

The panel next considered whether it should proceed in the absence of Mrs Diamond. It had regard to Rule 21 and heard the submissions of Mr Brahimi who invited the panel to continue in the absence of Mrs Diamond. He submitted that Mrs Diamond had voluntarily absented herself.

Mr Brahimi submitted that, closer to the time of this hearing, the NMC have been made aware of the difficulties Mrs Diamond is experiencing in attending not only this hearing, but also the case conference.

Mr Brahimi referred the panel to the documentation provided by Mrs Diamond, which contains [PRIVATE], which states that [PRIVATE], alongside an email provided on 13 November 2023, whereby Mrs Diamond stated the following:

'[PRIVATE]'

Mr Brahimi submitted that the previous substantive hearing in May 2023 was adjourned as Mrs Diamond was not present. On this previous occasion, two witnesses were warned to give evidence on the first day but were de-warned due to the adjournment of that hearing.

Mr Brahimi submitted that the NMC have been in constant contact with Mrs Diamond, through September, October, and November 2023. He submitted that the NMC cannot state definitively that Mrs Diamond is inviting the panel to adjourn this hearing, but one may think it is perhaps implied.

Mr Brahimi highlighted that not proceeding in the absence of Mrs Diamond would inconvenience the witnesses, who will once again, need to be de-warned.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel considered whether to proceed in the absence of Mrs Diamond. In reaching this decision, the panel has considered the submissions of Mr Brahimi, the communications from Mrs Diamond, the NMC Guidance on the fairness in proceeding in the absence of a registrant, and the advice of the legal assessor. [PRIVATE]

The panel paused the hearing temporarily and attempted to contact Mrs Diamond in order to provide the panel with more information surrounding [PRIVATE]. The panel considered the efforts made by Mr Brahimi, the Hearings Coordinator, and Mrs Diamonds' Case Officer in order to communicate and gain the documents the panel required. The panel also noted that Mrs Diamond did not respond to these attempts to contact her for this information.

It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- Mrs Diamond has informed the NMC that she has received the Notice of Hearing and confirmed she will not be attending the hearing;
- [PRIVATE]

- The panel noted that an email had been sent to Mrs Diamond by the NMC on 8 November 2023, clearly setting out the steps needed to be taken to request consideration of an adjournment;
- There is no reason to suppose that adjourning would definitively secure her attendance at some future date;
- A number of witnesses will be attending during the course of this hearing to give live evidence;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.
- This case has previously been adjourned, and therefore, the public would expect this hearing to be heard today.

[PRIVATE]

The panel also considered all of the efforts which were made to communicate with Mrs Diamond, including multiple phone calls, voicemails and emails, in regard to her attendance. The panel considered Mrs Diamond's lack of response, and therefore decided to proceed in her absence.

There is some disadvantage to Mrs Diamond in proceeding in her absence. She will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mrs Diamond's decisions to absent herself from the hearing, waive her rights to attend,

and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mrs Diamond. The panel will draw no adverse inference from Mrs Diamond's absence in its findings of fact.

The panel was provided with an email from Mrs Diamond which was sent to the NMC early the following morning, in which she stated that she could not attend the hearing and indicated her desire for an adjournment. The panel considered this email and gave Mrs Diamond a further opportunity to provide sufficient information which was not forthcoming. The panel determined that there was insufficient information before it to grant an adjournment at this stage. Accordingly, the panel determined to proceed in Mrs Diamond's absence.

Details of charge

That you, a registered nurse:

1. Between 2017 and 2018 whilst working as Head of Complex Care at Shropshire Clinical Commissioning Group ("SCCG"), abused your position in that you:

    a. Failed to disclose a potential conflict of interest in that you held a service agreement for work as a consultant with another company.

    b. Failed to disclose a potential conflict of interest in that you failed to declare that you had set up a business, NAD Healthcare limited.

    c. Coached and/or provided advice to external providers to assist them in applying for CCG contracts.

d. Undertook personal work/tasks for NAD healthcare during SCCG working hours.

2. Between 2016 and July 2018, demonstrated poor record keeping and management of patient records in that you:

   a. Failed to ratify care packages in a timely manner which led to a backlog of assessments to be completed.

   b. Approved care packages for one or more patients who did not exist ("Ghost patients") on the Broadcare system ("Broadcare"), or in the alternative failed to update Broadcare to reflect assessments were carried out.

   c. In respect of patient 9146, failed to add the patient and/or their healthcare package on to Broadcare until 9 August 2018, when the patient started receiving funding from 7 June 2018.

   d. Failed to approve or increase payment uplifts for one or more Section 117 patients in order to save SCCG costs.

   e. In July 2018, incorrectly inputted patient review assessment dates for one or more patients who had not had a review, or in the alternative you failed to upload any documentation to evidence an assessment had taken place.

   f. In July 2018, retrospectively amended one or more patient records, in that you ratified packages which were previously rejected for lack of information [excluding patient 3740 noted below].

   g. In respect of Patient 3740:
      i. On 21/22 June 2018, refused to ratify a care package as CHC (full funding) without following the correct procedures or recording a clear rationale in Broadcare.

ii. On 16 July 2018, ratified the care package without a new assessment or additional information being provided as requested by you on 21/22 June 2018.
iii. Failed to provide a clear rationale for your actions as described above at g(ii) in Broadcare.
iv. Backdated the date of the ratification of the care package to 23 March 2018, when you ratified the decision on 16 July 2018.
v. Did not ratify the care package within the 28 calendar days in accordance with the Framework's guidance.
vi. Amended the patient's records whilst on secondment to another role.

h. In respect of patient 809
    i. Failed to ratify the care package within 28 calendar days of 25 October 2017, or in the alternative did not update the records in Broadcare until 10 July 2018.
    ii. Did not attach any clinical documentation to support that a patient assessment was carried out on 25 October 2017.

i. In respect of patient 1575
    i. Failed to ratify the care package within 28 calendar days of 11 April 2018, or in the alternative, did not update the records in Broadcare until 10 July 2018.
    ii. Did not attach any clinical documentation to support that a patient assessment was carried out on 11 April 2018.

j. In respect of patient 357
    i. Failed to ratify the care package within 28 calendar days of 18 December 2017, or in the alternative did not record the decision in Broadcare until 10 July 2018.
    ii. Did not attach any clinical documentation to support that a patient assessment was carried out on 18 December 2017.

3. Your actions as set out in one or more charges 2(a) – 2(o) were dishonest in that you attempted to create a misleading impression that patient assessments were carried out when they were not.

4. Failed to adhere to NHS/CCG policies and procedures in recruitment and termination of staff members in that you:

    a. Employed staff without carrying out the necessary pre-employment checks.

    b. Authorised pay increases for your personal assistant without following the prescribed processes of the NHS and/or CCG.

    c. Did not process the resignation of Colleague A in a timely manner which led to Colleague A receiving overpayments.

AND in light of the above, your fitness to practise is impaired by reason of your misconduct.

Background

Mrs Diamond had been working for the Shropshire Clinical Commission Group (SCCG) when concerns were raised during her time within the organisation and her practice.

In 2018, Witness 2, a deputy director of performance and delivery, was asked to review the processes in the department managed by Mrs Diamond, and it was identified that there were a number of issues including a significant financial deficit. Witness 2 discovered various concerns regarding Mrs Diamond's practice, some of which included a failure to maintain record keeping standards. Mrs Diamond's alleged misconduct resulted in concerns of dishonesty as she allegedly amended patient care records. Mrs Diamond allegedly failed to complete patient assessments in a timely manner, impacting on the care that they received. There were further concerns as to whether Mrs Diamond had abused

her position for personal and or financial gain. Mrs Diamond further failed to approve care packages for patients in an attempt to cut costs or cost cutting; recruiting staff members without carrying out due diligence checks.

Mrs Diamond had commenced her role at the SCCG as head of department in 2013. Witness 2 discovered the various concerns in and around the middle of 2018 of Mrs Diamond's practice that eventually led to the internal investigation.

By September of 2018, Mrs Diamond was suspended pending the internal investigation, and in November 2018, the investigation was commenced.

The nature of these failures alleged, the NMC submit, are directly linked to Mrs Diamond's position at the time being head of a complex care department at the SCCG.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Brahimi to amend the contents of charge 3.

The proposed amendment was to change '*Your actions as set out in one or more charges 2(a) – **2(o)**'*, to *'Your actions as set out in one or more charges 2(a) – **2(j) (ii)**'*. It was submitted by Mr Brahimi that the proposed amendment would provide clarity, accurately reflect the evidence, and correct the typographical error within the charge.

The following removal will be made to charge 3:

*'3. Your actions as set out in one or more charges 2(a) - ~~**2(o)**~~'*

The panel accepted the advice of the legal assessor and had regard to Rule 28.

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Diamond and no injustice would be caused to either party by the proposed amendment being allowed. It

was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Mr Brahimi provided the following submissions:

> *'The NMC submit that witnesses were consistent, credible and were tested in their evidence. At times – fairness was extended to the Registrant in challenging why the records show inaccuracies and why the Registrant would be responsible. Ultimately, the responsibility returned to the Registrant as she was responsible for ratifying packages and her operation by instructing those below her […].*
>
> *This is a case where Mrs Diamond, of senior authority, has abused her position by demonstrating misconduct in a variety of areas. The NMC submit that the Registrant has not been ratifying packages for either or both of two reasons – the first is that she was seeking to improve the financial position of the SCCG and secondly is that she was seeking to use external agencies to conduct work. She has had conversations with external companies in respect of contracts and it is not unrealistic that she had some kind of vested interest in bringing these other companies in.*
>
> *The backlog of cases is not coincidental and there is concern as to why some patients were only coming to light when invoices came through. This may mean that activity took place in the background and only when payment was needed did these "ghost patients" become apparent. The NMC submitted that another reason why patients were not uploaded on the Broadcare system is because it would have flagged up necessary reviews. This would have triggered the need for more payments if the true health condition was revealed, such as further payment of care, some of which could have been more costly if it was upgraded to CHC.*

Mrs Diamond's responses to the questions asked of her during her investigation were vague, untruthful, and misleading in suggesting that her responsibilities don't extend as far as what she has or of being head of complex and CHC.

This case is a demonstration of misusing public money and insufficiently protecting public patients. SCCG worked with the NHS and was subject to NHS guidelines and policies. The impact of these actions had left a system that reflected poor record keeping and poor management of vulnerable patients.'

The panel heard and accepted the advice of the legal assessor.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Brahimi on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Mrs Diamond.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Interim Chief Nurse and Director of Quality;

- Witness 2: Deputy Director of Performance and Delivery;

- Witness 3: Medico Legal Nurse Specialist;
- Witness 4: Business and Operations Manager; and
- Witness 5: HR Business Partner.

The panel also considered the evidence within Mrs Diamond's Registrant's Response Bundle.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness and documentary evidence provided by the NMC.

The panel then considered each of the disputed charges and made the following findings.

Charge 1a

Between 2017 and 2018 whilst working as Head of Complex Care at Shropshire Clinical Commissioning Group ("SCCG"), abused your position in that you:

a. *Failed to disclose a potential conflict of interest in that you held a service agreement for work as a consultant with another company.*

This charge is found proved.

In reaching this decision, the panel took into account the fact that the failure comes from the need to comply with the SCCG Conflict-of-Interest Policy from 2016, particularly, Section 4.2. The panel further considered the Declaration of Interests form completed by Mrs Diamond on 3 January 2017 that did not report any conflicts of interest, and the service agreement for a position as a consultant with APEX, dated 7 December 2016. The

panel further considered the fact that when Mrs Diamond was asked about this charge during the SCCG investigation, she stated that her not having perceived this as a conflict of interest was a result of *'stupidity and naivety'*.

In light of the above, the panel determined that, on the balance of probabilities, this charge is proved.

Charge 1b

Between 2017 and 2018 whilst working as Head of Complex Care at Shropshire Clinical Commissioning Group ("SCCG"), abused your position in that you:

b. Failed to disclose a potential conflict of interest in that you failed to declare that you had set up a business, NAD Healthcare limited.

This charge is found proved.

In reaching this decision, the panel took into account section 4.2 of the Conflict-of-Interest policy, which states that you must declare your conflicts of interest; Mrs Diamond did not declare this on the form dated 3 January 2017, mentioned in charge 1a. The panel considered the Declaration of Interest form, and the evidence from Company's House which showed Mrs Diamond as director of NAD Healthcare limited, which was an active company until 2019. Witness 3 further confirmed that the work Mrs Diamond had completed was invoiced through NAD Healthcare Limited.

In light of the above, the panel determined that, on the balance of probabilities, this charge is proved.

Charge 1c

Between 2017 and 2018 whilst working as Head of Complex Care at Shropshire Clinical Commissioning Group ("SCCG"), abused your position in that you:

c. *Coached and/or provided advice to external providers to assist them in applying for CCG contracts.*

This charge is found proved in the second alternative.

In reaching this decision, the panel took into account the fact that APEX is an external provider, and that Mrs Diamond provided advice in assisting them in seeking work with the CCG. However, the panel concluded that Mrs Diamond did not coach any external providers regarding applying for CCG contracts, as there is limited evidence to support such an allegation. The panel considered the email sent by Mrs Diamond below:

> *'I have reviewed the document template you sent through which seems ok, I have some ideas on how it come be improved slightly. As discussed if you send a standard letter to the chc leads within all CCGS . I would suggest that you could pick up appeals rather than workload, as all teams have a backlog of work with both cohorts. CHS clinical lead is [Mr 6] not .... Examworks, CHS, Brayleino and CHC direct do seem to have the market regarding assessments. It doesn't look like there will be another pupoc lock down announced in the near future. As CCG leads QIPP is high on the agenda with NHSE and therefore any communication sent out to CCGS I would mention how Apex can benefit with QIPP targets. I have tried to call but think I have the wrong number [sic]'*

In light of the above, the panel determined that, on the balance of probabilities, this charge is proved.

Charge 1d

Between 2017 and 2018 whilst working as Head of Complex Care at Shropshire Clinical Commissioning Group ("SCCG"), abused your position in that you:

d. *Undertook personal work/tasks for NAD healthcare during SCCG working hours.*

This charge is found proved.

In reaching this decision, the panel took into account evidence in the form of emails and electronic diary entries that Mrs Diamond did undertake personal work/tasks for NAD healthcare during her SCCG working hours and did not disclose this to her employer at SCCG. The panel considered the fact that Mrs Diamond had received an email inviting her for training with the company she had a service agreement with on a normal workday within her expected working hours on 25 January 2017. Her SCCG diary entry showed *'Chat London'* for 08:00 that day. Email evidence showed that she had agreed to attend a day in training in Epping on that day in her role as a consultant as part of her work for NAD Healthcare Limited. Emails on 26 January 2017 confirmed that she did attend the training. The panel also considered the emails Mrs Diamond had sent from her NHS email account regarding her personal work.

In light of the above, the panel determined that, on the balance of probabilities, this charge is proved.

Charge 2a

Between 2016 and July 2018, demonstrated poor record keeping and management of patient records in that you:

a. Failed to ratify care packages in a timely manner which led to a backlog of assessments to be completed.

This charge is found proved, after deletion of the words '*which led to a backlog of assessments to be completed*'.

In reaching this decision, the panel found that there was a failure to ratify the care packages in a timely manner, as exhibited by the screenshots taken from the Broadcare Patient Record system. The panel heard evidence from Witness 4, that the dates that

entries are created are defaulted by the '*system*' and cannot be amended. The panel heard evidence that the National Service Framework for Continuing Health Care, stipulates packages should be ratified within 28 days of referral. The panel saw numerous examples within this evidence of where the 28-day target had not been met.

However, the panel did not find evidence that this led to a backlog in assessments themselves being completed, and could not within the evidence, find a causal link between that failure to ratify care packages in a timely manner and the backlog in assessments to be completed. The panel considered that new assessments would be done prior to ratifying new care packages. The panel also considered the fact that it heard evidence that Mrs Diamond was the only individual who could ratify the care packages, or provide the responsibility to another nurse manager, which she had been instructed not to do.

In light of the above, the panel determined that, on the balance of probabilities, this charge is proved.

Charge 2b

Between 2016 and July 2018, demonstrated poor record keeping and management of patient records in that you:

b. Approved care packages for one or more patients who did not exist ("Ghost patients") on the Broadcare system ("Broadcare"), or in the alternative failed to update Broadcare to reflect assessments were carried out.

This charge is found proved in the first alternative.

In reaching this decision, the panel took into account Mrs Diamond's admission of having failed to update Broadcare to reflect an assessment regarding one patient; this is supported by the witness evidence of Witness 2 and supported by evidence from Witness 4.

The panel determined that Mrs Diamond did approve a care package for two patients who did not exist on the Broadcare system, however concluded that there is insufficient evidence to determine that the assessments themselves were not carried out in respect of these patients. In concluding this, the panel considered the evidence from Witness 2 from 20 August 2018 where she stated that patient 9146 and patient 843 did not exist on the Broadcare system. They only came to light when invoices came in for payment for care of the patient, but they had not been entered on the Broadcare system.

In light of the above, the panel determined that, on the balance of probabilities, this charge is proved.

Charge 2c

Between 2016 and July 2018, demonstrated poor record keeping and management of patient records in that you:

c. *In respect of patient 9146, failed to add the patient and/or their healthcare package on to Broadcare until 9 August 2018, when the patient started receiving funding from 7 June 2018.*

This charge is found proved.

In reaching this decision, the panel took into account that the healthcare package and record were both created on 9 August 2018, when they were due to be created on 7 June 2018. The panel confirmed this through the screenshots provided by Witness 4.

In light of the above, the panel determined that, on the balance of probabilities, this charge is proved.

Charge 2d

Between 2016 and July 2018, demonstrated poor record keeping and management of patient records in that you:

d. Failed to approve or increase payment uplifts for one or more Section 117 patients in order to save SCCG costs.

This charge is found NOT proved.

The panel determined that Mrs Diamond in her email reply on 17 September 2018, referred to this decision being agreed by the complex care panel. In establishing where the duty comes from, to approve or increase payment uplifts, the NMC have not provided sufficient evidence in relation to the Section 117 of the Mental Health Act funding uplift that the duty was solely on Mrs Diamond. The panel have heard evidence from Witness 4 and Witness 1, that this was a decision that the Director of Finance would issue to the Head of Service to increase the relevant payments.

In light of the above, the panel determined that, on the balance of probabilities, this charge is not proved.

Charge 2e

Between 2016 and July 2018, demonstrated poor record keeping and management of patient records in that you:

e. In July 2018, incorrectly inputted patient review assessment dates for one or more patients who had not had a review, or in the alternative you failed to upload any documentation to evidence an assessment had taken place.

This charge is found proved in the second alternative.

In reaching this decision, the panel took into account the evidence from Witness 5 who produced a table, showing that on more than one occasion, patient review assessment dates were inputted, but there is no documentation on the system to evidence

assessments had taken place on those relevant dates. The panel noted that more than one patient record was updated on 10 July 2018. The panel considered the fact that Mrs Diamond, in her disciplinary interview, had stated that the nursing team had not been updating the record and that she was therefore picking up on missing information; adding it to the system. However, the panel was satisfied that part of Mrs Diamonds' role and responsibility was to ensure that accurate record keeping was maintained within the department.

In light of the above, the panel determined that, on the balance of probabilities, this charge is proved.

Charge 2f

Between 2016 and July 2018, demonstrated poor record keeping and management of patient records in that you:

f. In July 2018, retrospectively amended one or more patient records, in that you ratified packages which were previously rejected for lack of information [excluding patient 3740 noted below].

This charge is found NOT proved.

In reaching this decision, the panel took into account the evidence of Witness 5, who stated that Broadcare issues were identified for a number of patients and were retrospectively amended on 23 July 2018. The panel also heard from Witness 2 that patient records were retrospectively amended on 7/8 July 2018. The panel could not find documentary evidence that supported amendments being made on the dates stated by Witness 2 or Witness 4, other than in respect of Patient 3740, who is not part of this charge. There is insufficient evidence to find this charge proved.

In light of the above, the panel determined that, on the balance of probabilities, this charge is not proved.

Charge 2g

Between 2016 and July 2018, demonstrated poor record keeping and management of patient records in that you:

g. In respect of Patient 3740:

i. On 21/22 June 2018, refused to ratify a care package as CHC (full funding) without following the correct procedures or recording a clear rationale in Broadcare.

ii. On 16 July 2018, ratified the care package without a new assessment or additional information being provided as requested by you on 21/22 June 2018.

iii. Failed to provide a clear rationale for your actions as described above at g(ii) in Broadcare.

iv. Backdated the date of the ratification of the care package to 23 March 2018, when you ratified the decision on 16 July 2018.

v. Did not ratify the care package within the 28 calendar days in accordance with the Framework's guidance.

vi. Amended the patient's records whilst on secondment to another role.

The charge is found proved in its entirety.

Regarding charge 2g.i, the panel considered the statement made by Mrs Diamond in an email captured on Broadcare, whereby she said, *'I have not ratified this care package as CHC'*. The panel took into account the fact that Mrs Diamond did not provide any rationale for not ratifying this care package as CHC. The panel further considered the evidence from Witness 2 that the procedure, as set out in the National Service Framework for Continuing Health Care must be correctly followed, and without a clear rationale as to her refusal to ratify the package, Mrs Diamond had failed to follow the guidelines.

In light of the above, the panel determined that, on the balance of probabilities, this charge is proved.

Regarding charge 2g.ii, the panel considered that it has had no evidence that any additional information was provided by Mrs Diamond. The panel considered that the Broadcare record showed that there was a decision made on 16 July 2018 which made clear that the care package was ratified, but no record of any new assessment or other relevant information was included within the patient record.

In light of the above, the panel determined that, on the balance of probabilities, this charge is proved.

Regarding charge 2g.iii, the panel determined that there is no clear rationale or information on the Broadcare system to explain why Mrs Diamond had changed her mind. The panel highlighted that the duty to provide rationale comes from the National Service Framework for Continuing Healthcare.

In light of the above, the panel determined that, on the balance of probabilities, this charge is proved.

Regarding charge 2g.iv, the panel determined that the Broadcare record, and in particular the outcome box, shows that the decision date was 16 July 2018, which was backdated, as the eligibility date was shown as 23 March 2018. Consequently, the charge was found proved as Mrs Diamond had evidently backdated the decision.

In light of the above, the panel determined that, on the balance of probabilities, this charge is proved.

Regarding charge 2g.v, the panel considered the initial entry from 25 March 2018 whereby Mrs Diamond had stated that she was *'struggling to ratify the case'*. The panel also noted that the MDT assessment was completed on 22 March 2018. The panel further considered that there is no evidence of Mrs Diamond's rationale in having not ratified the care package within the 28 calendar days in accordance with the Frameworks guidance.

In light of the above, the panel determined that, on the balance of probabilities, this charge is proved.

Regarding charge 2g.vi, the panel determined that none of the witnesses in this case were able to confirm the dates in which Mrs Diamond went on secondment. The suggested dates from the witnesses varied from the end of June 2018 to 12 July 2018. Therefore, the amendment on 16 July 2018, was made after Mrs Diamond's secondment. However, the panel heard in evidence that, the approach of the organisation is that, whilst on secondment, an employee should not engage with any form of work relating to their substantive role. Therefore, the accessing of patient records whilst on secondment was inappropriate according to the rules of the organisation.

In light of the above, the panel determined that, on the balance of probabilities, this charge is proved.

Charge 2h.i

Between 2016 and July 2018, demonstrated poor record keeping and management of patient records in that you:

h. In respect of patient 809

i. Failed to ratify the care package within 28 calendar days of 25 October 2017, or in the alternative did not update the records in Broadcare until 10 July 2018.

This charge is found proved in the second alternative.

In reaching this decision, the panel took into account the fact that a duty to ratify a care package on review within 28 days would come from the Framework for Continuing Healthcare. However, the Framework does not specify any period in which a review should be ratified.

The panel considered, in relation to the second half of this charge, that the Broadcare record for patient 809 clearly shows that a decision was made on 16 October 2017, but that Mrs Diamond did not update the BC record until the 10 July 2018.

In light of the above, the panel determined that, on the balance of probabilities, this charge is proved in the second alternative.

Charge 2h.ii

Between 2016 and July 2018, demonstrated poor record keeping and management of patient records in that you:

h. In respect of patient 809

ii.Did not attach any clinical documentation to support that a patient assessment was carried out on 25 October 2017.

This charge is found proved.

In reaching this decision, the panel took into account the evidence heard by Witness 4, alongside the fact that the panel had sight of the record itself and concluded that there was no clinical documentation attached to support that a patient assessment was carried out on 25 October 2017.

In light of the above, the panel determined that, on the balance of probabilities, this charge is proved.

Charge 2i.i

Between 2016 and July 2018, demonstrated poor record keeping and management of patient records in that you:

i. In respect of patient 1575

i. Failed to ratify the care package within 28 calendar days of 11 April 2018, or in the alternative, did not update the records in Broadcare until 10 July 2018.

This charge is found proved in the second alternative.

The panel determined that the evidence of this charge leads it to determine that this is in relation to a review.

In reaching this decision, the panel took into account the fact that a duty to ratify a care package on review within 28 days would come from the Framework. However, the Framework does not specify any period in which a review should be ratified.

The panel determined that the charge is proved in the second alternative, as it is clear through the Broadcare record that the record entry states that it was made on the 10 July 2018 by Mrs Diamond.

Charge 2i.ii

Between 2016 and July 2018, demonstrated poor record keeping and management of patient records in that you:

i. In respect of patient 1575

ii. Did not attach any clinical documentation to support that a patient assessment was carried out on 11 April 2018.

This charge is found proved.

In reaching this decision, the panel took into account the fact that the Broadcare record does not show any clinical documentation attached to it relating to a patient assessment carried out on 11 April 2018; however, it does show records of other assessments carried out prior to this date.

In light of the above, the panel determined that, on the balance of probabilities, this charge is proved.

Charge 2j.i

Between 2016 and July 2018, demonstrated poor record keeping and management of patient records in that you:

j. In respect of patient 357

i. Failed to ratify the care package within 28 calendar days of 18 December 2017, or in the alternative did not record the decision in Broadcare until 10 July 2018.

This charge is found proved in the second alternative.

In reaching this decision, the panel took into account the fact that a duty to ratify a care package on review within 28 days came from the Framework. However, the Framework does not specify any period in which a review should be ratified.

The panel considered, in relation to the second half of this charge, that the Broadcare record for patient 357 clearly shows that a decision was not recorded by Mrs Diamond until 10 July 2018.

In light of the above, the panel determined that, on the balance of probabilities, this charge is proved in the second alternative.

Charge 2j.ii

Between 2016 and July 2018, demonstrated poor record keeping and management of patient records in that you:

j. In respect of patient 357

ii. Did not attach any clinical documentation to support that a patient assessment was carried out on 18 December 2017.

This charge is found proved.

In reaching this decision, the panel took into account that there is no evidence of clinical documentation to support that the above patient assessment was carried out. The panel highlighted that on Broadcare there is only a decision of the review, the event date, the creation date, and Mrs Diamond's name, however no evidence of an actual patient assessment date.

In light of the above, the panel determined that, on the balance of probabilities, this charge is proved.

Charge 3

Your actions as set out in one or more charges 2(a) – 2(j)(ii) were dishonest in that you attempted to create a misleading impression that patient assessments were carried out when they were not.

This charge is found NOT proved.

In reaching this decision, the panel took into account the legal advice which was provided to it in regard to dishonesty which referenced the case of *Ivey v Genting Casinos* [2018 AC391]. The panel determined that Mrs Diamond did not have dishonest intentions regarding her conduct in charge 2 and in any event that she did not attempt to create misleading impressions that patient assessments were carried out.

The panel considered the contextual factors in this case, and the fact that Mrs Diamond was working in an organisation which appeared to lack a clear governance structure at the time. For example, there was a lack of systems and processes in place to manage the flow of case referrals; this was supported by an external audit report. The organisation had

been placed under NHS directions by NHSE; audits reported a lack of assurance within the organisation.

The panel considered the lack of guidance or governance within Mrs Diamond's place of work, alongside the severe pressures and the level of scrutiny the employees were all under. The panel considered the fact that Mrs Diamond was [PRIVATE] and highlighted that the leadership of her place of work was questionable as it did not recognise the difficulty for one single person to undertake the entire financial packages responsibility for all patients and service users in the Complex Care Service.

The panel considered Mrs Diamond's email to her team, openly discussing her concern regarding saving money. The panel considered Mrs Diamond's statement that her actions were not intentional or dishonest, and that she was struggling with her work, which resulted in her secondment.

The panel determined that Mrs Diamond's mindset, on the balance of probabilities, was more likely than not, one of trying to correct errors and clear backlogs in her work. It would appear she had become overwhelmed with the volume of that work and leading her department. This is supported by Mrs Diamond raising the impact it was having with her line manager. As a result of highlighting this some coaching was arranged to try and assist Mrs Diamond.

Mrs Diamond's line manager, in the local investigation interview, stated that Mrs Diamond was managing a difficult situation and there was an awareness within the organisation of outstanding ratifications which once cleared would have had an impact on the financial forecast. The panel noted that Mrs Diamond felt under pressure to focus on the CCG's financial deficit.

The dishonesty charge relates to matters of timely and accurate record keeping as set out in charge 2, and the panel have determined that whilst there are clear errors, omissions and lack of oversight within her work, these resultant matters are more likely to have been

due to capability as a result of her state of mind at the time, rather than any dishonest intention.

The panel therefore determined that Mrs Diamond's actions did not reach the threshold for dishonesty.

In light of the above, the panel determined that, on the balance of probabilities, this charge is not proved.

Charge 4a

Failed to adhere to NHS/CCG policies and procedures in recruitment and termination of staff members in that you:
a. Employed staff without carrying out the necessary pre-employment checks.

This charge is found proved.

In reaching this decision, the panel took into account the fact that the staff were employed individually as they were invoiced personally rather than through an agency. Mrs Diamond was a senior nurse in charge of a large nursing team and the panel determined that it was her duty to ensure that the nurses working for her had pre-employment checks completed and no issues with their NMC registration. Had they been employed via an agency, or directly by CCG, in accordance with recruiting policies, then these checks would have been completed prior to commencing employment. The panel concluded that there is no evidence of Mrs Diamond having undertaken or instructed DBS checks and checks with the NMC, to establish whether the nurses were fit to work with vulnerable individuals. Therefore, Mrs Diamond did not comply with the policies and procedures required.

In light of the above, the panel determined that, on the balance of probabilities, this charge is proved.

Charge 4b

Failed to adhere to NHS/CCG policies and procedures in recruitment and termination of staff members in that you:

b. Authorised pay increases for your personal assistant without following the prescribed processes of the NHS and/or CCG.

This charge is found proved.

The panel took into account the duty of Mrs Diamond to comply with the Agenda for Change Policy.

In reaching this decision, the panel took into account the table produced by Witness 5 and explained within his oral evidence. This shows that on the 1 September 2017 Mrs Diamond's personal assistant was given a permanent contract. The panel heard that this was done without the required advertisement or selection procedure for such a post being undertaken and was therefore outside the rules set out in the NHS Agenda for Change policy.

Further the panel saw evidence that on the 1 April 2018 Mrs Diamond's personal assistant was moved into a permanent band 4 position, again without the necessary recruitment policies being followed as stipulated within the same policy. The panel noted that Mrs Diamond had authorised the increases which she herself had proposed.

In light of the above, the panel determined that, on the balance of probabilities, this charge is proved.

Charge 4c

Failed to adhere to NHS/CCG policies and procedures in recruitment and termination of staff members in that you:

c. *Did not process the resignation of Colleague A in a timely manner which led to Colleague A receiving overpayments.*

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's witness statement which had stated *'[…] left the CCG on 27 February 2018; however, Mrs Diamond processed her resignation only in June 2018, 3 months after she left'*. This witness stated that it was the duty of Mrs Diamond to have processed her resignation, as most of the resignation processes are completed by the line manager in charge.

The panel saw a timetable for events relating to this which showed that the matter only came to light when the previous member of staff raised it at the end of May having received three further salary payments since leaving.

Witness 5 clearly set out that the responsibility to comply with the CCG policy in notifying the relevant department of staff resignations, sat with Mrs Diamond and the panel therefore found this charge to be proved.

In light of the above, the panel determined that, on the balance of probabilities, this charge is proved.

Resuming proof of service and proceeding in the absence of Mrs Diamond

Mr Brahimi submitted that sufficient service has been sent to Mrs Diamond on 22 February 2024, in relation to the resuming of this substantive hearing, and in accordance with the Rules. Mr Brahimi invited the panel to proceed in the absence of Mrs Diamond, noting that she has not made an application for an adjournment.

The panel determined that there has been sufficient proof of service and decided to proceed in the absence of Mrs Diamond.

The panel determined that in the past, Mrs Diamond has been provided with the benefit of the doubt and time to attend the hearing; the hearings coordinator attempted to elicit a response from Mrs Diamond in regard to attendance but received no response.

The panel noted that Mrs Diamond has had the opportunity to engage and has done so by communicating with the Hearings Coordinator. The panel determined that Mrs Diamond understands the importance of the hearing and wants to contribute to it, having done so through a document sent on the morning of 7 May 2024, with submissions. The panel considered that these submissions did not affect the panels findings at the facts stage. Mrs Diamond stated that this document was sent to the NMC previously, in February, however, there is no evidence that this actually occurred. Therefore, the panel's first sight of the document provided by Mrs Diamond, was on 7 May 2024. Within this email, Mrs Diamond also stated that she was unable to attend the hearing due to [PRIVATE], however, the panel determined that there was insufficient information and there was no request for an adjournment.

The panel concluded that it is in Mrs Diamond's interest, fair to the NMC, and would be in the public interest to proceed with this hearing today in her absence.

Adjournment request from Mrs Diamond

On 7 May 2024, Mrs Diamond sent the Hearings Coordinator a letter which enclosed lengthy submissions, and her own account of the facts of this case, including details and context surrounding her previous employment.

On 8 May 2024, Mrs Diamond in the form of an email, informed the Hearings Coordinator that she was not aware that she could have requested an adjournment for her hearing, and further noted that if she were aware, she would have done so.

On the morning of 9 May 2024, Mrs Diamond confirmed to the Hearings Coordinator, once again in the form of an email, that she would like to make an application to adjourn the hearing as she would like to attend at a future date.

NMC submissions on adjournment

Mr Brahimi noted that the letter received by Mrs Diamond on 7 May 2024, whereby she made submissions, was undated and unsigned, but was sent through her own personal email. Mr Brahimi noted that, although this letter is a new document before the panel, the NMC submit that it does not provide any new information, and therefore should not impact the decisions at the facts stage of this substantive hearing.

Mr Brahimi highlighted each section of the letter sent through by Mrs Diamond on 7 May 2024; he cross referenced this document with other documents which were provided to the NMC previously, which the panel would have already had sight of. Mr Brahimi submitted that the panel has already had such information before it, and no new information has been proposed by Mrs Diamond in this extra letter.

Mr Brahimi confirmed that there are no further, or various documents sent by Mrs Diamond, as she had claimed, and that the panel now have in its view, all documents available in this case. Mr Brahimi submitted that the panel does not need to re-open the facts stage.

Mr Brahimi acknowledged the adjournment request from Mrs Diamond, however, submitted that it has previously been made clear to her that she had the ability to request for an adjournment as far back as November 2023, in the proof of service document.

Mr Brahimi nevertheless submitted that the NMC do not heavily oppose the application for an adjournment of this case but remain neutral. He submitted that it is not clear whether Mrs Diamond would like to attend at a future date in order to merely be present, or to provide verbal submissions.

Mr Brahimi submitted that adjourning would be at the expense of the public, if, the adjournment would not be found to amount to a fruitful delay.

The panel accepted the advice of the legal assessor.

Panel's decision on adjournment

The panel determined that, notwithstanding this further submission made by Mrs Diamond on 7 May 2024, it would not have changed its decision on facts, even had it been competent to do so. The panel considered that the further submission did provide more context in relation to Mrs Diamond's work circumstance which it could take into consideration at the next stages of the hearing.

The Hearings Coordinator received an email from Mrs Diamond confirming that she would address the panel on a certain number of questions they proposed and would like to be both present and communicative at any future hearing, if she were able to attend.

The panel also determined that due to the delays to the hearing, in resolving these issues, it was inevitable that matters would not have been concluded today in any event.

Whilst it acknowledged the public interest in expediting these proceedings, the panel determined that it would adjourn the hearing today, as it is in the interest of fairness to Mrs Diamond to be able to address the panel in this case prior to its determination on misconduct and impairment. [PRIVATE]

The panel also considered whether adjournment would cause any unnecessary inconvenience and determined that it would not as, other than Mrs Diamond, there are no other witnesses yet to give evidence.

The panel determined that it would adjourn the hearing today, as it is in the interest of fairness to Mrs Diamond and outweighs the public interest on this occasion. Therefore, in the interests of both Mrs Diamond and in the interest of justice, in gaining as much relevant information as possible, the panel would adjourn the hearing today, 9 May 2024.

When this panel reconvenes, and Mrs Diamond attends, the panel would be assisted by:

- For Mrs Diamond to have read all panel determinations so far, in full, noting that the panel have determined that their decisions on the facts of the case stand and will not be revisited;
- For Mrs Diamond to have read the NMC Guidance on misconduct and impairment in conjunction with the submissions made by the NMC in this regard in the knowledge that the NMC's current sanction bid is a striking-off order;
- For Mrs Diamond to be able to update the panel within her written and verbal submissions as to her reflections on the facts found proved, her current level of insight, any relevant testimonials in relation to any recent work as a nurse, and any relevant training and strengthening of practice;
- For Mrs Diamond provide further written or oral evidence in relation to the background and/or context of the events the charges arise from;
- For Mrs Diamond to provide her own submissions on misconduct and impairment;
- For Mrs Diamond to personally attend the adjourned hearing, in order to address the panel.

Resuming proof of service and proceeding in the absence of Mrs Diamond

Mr Brahimi submitted that sufficient service had been sent to Mrs Diamond on 20 August 2024 in the form of an email, in relation to the resumption of this substantive hearing, and in accordance with the Rules.

Mr Brahimi invited the panel to proceed in the absence of Mrs Diamond, noting that she has not made an application for an adjournment and is aware of this hearing occurring

today. Mr Brahimi highlighted that Mrs Diamond has explained her position and why she did not attend on 14 October 2024. He submitted that all reasonable methods have been attempted to secure the attendance of Mrs Diamond.

The panel heard and accepted the advice of the legal assessor.

The panel determined that there has been sufficient proof of service and decided to proceed in the absence of Mrs Diamond.

The panel determined that Mrs Diamond has, on multiple occasions, been provided with every opportunity to attend the hearing. She contacted the NMC by email on 11 October 2024 about [PRIVATE]. Mrs Diamond stated that she would contact the Hearings Coordinator with the time she would be able to attend the hearing after [PRIVATE]. No update was received from Mrs Diamond until the morning of 15 October 2024. On 14 October 2024, the panel deferred its further consideration of this case because it was hoped that Mrs Diamond would be in a position to update the panel as to her circumstances.

The panel noted that Mrs Diamond is aware of this hearing and has stated that she is unable to attend; providing written reflections on 15 October 2024. The panel further noted that it has previously adjourned for the purpose of allowing Mrs Diamond to attend, however, she has once again failed to do so at this resuming hearing.

The panel heard and accepted the advice of the legal assessor.

The panel recognised that the discretion to proceed in the absence of Mrs Diamond was a discretion which had to be exercised with the utmost care. However, the panel concluded that in light of all of the history of this matter, that the public interest and fairness to the NMC, meant that it was appropriate to continue in the absence of Mrs Diamond.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Diamond's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.
The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mrs Diamond's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (No. 2)* [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Mr Brahimi invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives [2015]' (the Code) in making its decision.

Mr Brahimi identified the specific, relevant standards where Mrs Diamond's actions amounted to misconduct.

Mr Brahimi submitted the following:

'Misconduct

1. Misconduct is a matter for the Panel's professional judgment. The leading case is Roylance v GMC [2000] 1 AC 311 which says:

"misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of proprietary may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances."

2. In Calhaem v GMC [2007] EWHC 2006 (Admin) Mr Justice Jackson commented on the definition of misconduct and he stated:
'it connotes a serious breach which indicates that the doctor's fitness to practise is impaired.'

3. Mr Justice Collins in Nandi v GMC [2004] EWHC 2317 (Admin) stated that:
"the adjective 'serious' must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners."

4. The NMC submit that the proven charges amount to misconduct. The following submissions are collectively made in respect of the Registrant's conduct:

a. To have held such a senior position and to have failed to disclose conflicts of interest creates a poor example to others, which easily filters down as a type of attitude that could be adopted by future employees. This is an omission which falls short of what would be proper in the circumstances.

b. The failure to ratify packages and demonstrate unacceptable record keeping clearly had an impact on the backlog of work, which would have affected patients. Failing to adhere to such an important task, which went to the heart of assisting patients connotes a serious breach regarding the Registrant's practice.
c. Refusing and/or failing to keep to correct procedure for a number of patients is a great concern. Procedure also became an issue regarding recruitment.

These wide-ranging failures are arguably deliberate and it is conduct which would be regarded as deplorable by fellow practitioners.

5. The NMC say that the following parts of The Code have been breached, but of course the Panel is able to consider any other parts as it sees fit (note that it is the Code of 2015 that applies in this case because the Code of 2018 reflects updates from October 2018):

1 Treat people as individuals and uphold their dignity;
4 Act in the best interests of people at all times;
5 Respect people's right to privacy and confidentiality;
10 Keep clear and accurate records relevant to your practice;
20 Uphold the reputation of your profession at all times;
21 Uphold your position as a registered nurse, midwife or nursing associate;
25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system.

6. Overall, the NMC further submits that the Registrant's actions as proven fall far short of what would be expected of a Registered Nurse. The public would expect that the profession will have staff that uphold a professional reputation. The Panel may find that most in breach are that of "20" and "25" above. The Registrant has put into question as to whether nurses can be trusted for the care of vulnerable patients and management of a complex organisation. Such behaviour will affect the

public's trust in the medical profession, particularly where misconduct came from such a senior individual.

7. The NMC therefore invite the Panel to find misconduct.

Registrant's latest position

8. The Registrant has not been on an interim order however she did not attend the hearing to provide any input to assist the Panel. It is therefore difficult to ascertain what reflection or insight she has developed to address the concerns of impairment below.
There is a limited Registrant's pack that the Panel have to consider regarding any working roles and training. The Panel will note that some of these documents are heavily outdated.'

Submissions on impairment

Mr Brahimi moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Brahimi submitted the following:

'Impairment

9. Current impairment is not defined in the Nursing and Midwifery Order of the Rules.

However, the NMC as of 27th March 2023, states the following on how to decide on impairment (reference DMA-1):

"The question that will help decide whether a professional's fitness to practise is impaired is: "Can the nurse, midwife or nursing associate practise kindly, safely and professionally?" If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired".

10. The Panel may be assisted by the questions posed by Dame Janet Smith in her Fifth Shipman Report, as endorsed by Mrs Justice Cox in the leading case of Council for Healthcare Regulatory Excellence v (1) NMC (2) Grant [2011] EWHC 927 (Admin):

"do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:

(i) Has in the past, and/or is liable in the future to act as so as to put a resident or residents at unwarranted risk of harm;
(ii) Has in the past, and/or is she liable in the future to bring the profession into disrepute;
(iii) Has in the past, and/or is she liable in the future to breach one of the fundamental tenets of the profession;
(iv) Has in the past, and/or is she liable in the future to act dishonestly."

11. As further stated at paragraph 74 of Grant, the Panel should:
"consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.

12. The NMC say that the Registrant is impaired and that the first 3 limbs of Grant are engaged in this case:

13. The first limb is engaged as a result of the Registrant putting patients in unwarranted risks of harm. The Panel have accepted the evidence in respect of the charges proven and it follows that individuals were put at risk of harm where (but not limited to):

a. The Registrant's behaviour put more multiple patients at risk of harm and this is made more significant where most required specific medication attention;
b. Some of the misconduct could have been avoided if the Registrant delegated some of the responsibilities but this was continuously repeated showing a liability to make mistakes in the future.

14. The second limb is engaged as a result of the Registrant's behaviour, as found proven, plainly brings the profession into disrepute:

a. It is clear that what took place, as per the proven charges, will bring the profession into disrepute. The Registrant was a key individual at a complex institution and was supposed to set an example to others and the public. The failures demonstrates by the Registrant range from concerns of patient treatment, record keeping, incorrect employment procedure and a conflict of interest. These wide-ranging issues reflect negatively upon the organisation and the medical profession.

15. The third limb is engaged, where the Registrant has plainly breached fundamental tenets of the profession in numerous areas of the Code of Conduct as referred to above, but in particular:

a. Act in the best interest of people at all times (4.2);

b. Uphold the reputation of your profession at all times (20.1 and 20.6);
c. Uphold your position as a registered nurse, midwife or nursing associate (21.3).

16. As further stated at paragraph 74 of Grant, the Panel should:
"consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances."

17. The NMC submit that there is a serious departure from the standards expected of a nurse and that the behaviour is incompatible with ongoing registration. The Panel should consider impairment on the following grounds:

18. Public protection

a. This case has demonstrated that there is a real risk of harm through the practice of this Registrant. Vulnerable patients relied on key packages to meet their treatment requirements and some packages were delayed and some not approved. When it comes to complex care, every moment counts and there are multiple examples where the Registrant failed to ratify packages. The failure to disclose potential conflicts of interest has an adverse effect on the Registrant's priorities, and arguably this can go on to affect the level of care provided while she focused on her own business. There is a risk of repetition as demonstrated by the multiple failings. It should be noted that there were multiple failings both in package ratifications and record keeping. It may be that this behaviour would have been ongoing until the Registrant was reported for her conduct.

19. Otherwise in the public interest

a. There is a high level of professionalism expected by individuals holding positions such as "head of complex care". Such a role is supposed set an excellent example to other colleagues and to promote confidence in the general public that the medical profession can be trusted. These expectations have been deeply set back and affected by the Registrant's conduct. It can be argued that a member of public may be less inclined to introduce a vulnerable family member or friend to complex care when they learn that their treatment could be delayed. They may also question as to whether individuals at such institutions are truly committed to their role when they learn that there are issues of conflict, therefore coming to a reasonable assumption that employees may be less committed to their role and rather, trying to expand their own business. There is a great deal of suspicion created when members of public learn about irregularities in employment such as hiring and paying individuals otherwise than in accordance with correct procedure. This may cause a member of public question whether funding is being appropriately used by the organisation looking after vulnerable patients.

These are wide-ranging issues and as a result of the Registrant's abuse of position, the NMC submit that the honesty and integrity of the medical profession has been challenged and evidently put into disrepute.

20. As such the NMC invite the Panel to find that the Registrant is currently impaired.'

The panel accepted the advice of the legal assessor which included reference to the principles contained within *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311.

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that Mrs Diamond's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Diamond's actions amounted to a breach of the Code. Specifically:

> '***1.2)*** *make sure you deliver the fundamentals of care effectively;*
> ***1.4)*** *make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay;*
> ***10.1)*** *complete records at the time or as soon as possible after an event, recording if the notes are written sometime after the event;*
> ***10.2)*** *identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need;*
> ***10.3)*** *complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements;*
> ***20.1)*** *keep to and uphold the standards and values set out in the Code;*
> ***25.1)*** *identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first.*'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Mrs Diamond's breaches of the code in this case, do amount to a finding of misconduct.

In relation to charge 1a, the panel determined that Mrs Diamond, as the Head of Complex Care, held a great amount of responsibility, including financial responsibility. The panel noted that Mrs Diamond breached the CCG's Conflict of Interest policy, in that she failed to disclose a potential conflict of interest whereby she worked at both the SCCG, and another company as a consultant. The panel found that it had sufficient evidence to determine that, Mrs Diamond, as a senior manager at SCCG, held a responsibility to

declare this potential conflict of interest, and should have allowed the SCCG to make the decision on how to proceed after considering this.

Mrs Diamond's actions in charge 1a, amount to serious misconduct.

In relation to charge 1b, the panel had sight of the letter sent from Mrs Diamond to the Hearings Coordinator on 7 May 2024. The letter set out Mrs Diamond's account of how and why things occurred in the manner in which they did at the SCCG. Whilst the panel acknowledged that Mrs Diamond said that she sought advice from the CEO and the director of nursing at the SCCG regarding the conflict of interest between NAD Healthcare limited and the SCCG, yet it recognised that it had no independent verification of this. The panel was conscious that it is unable to test Mrs Diamond's claims in her absence.

The panel concluded that the failure to inform the CCG of the potential conflict of interest constituted serious misconduct.

In relation to charge 1c, the panel determined that in the course of her role as Head of Complex Care, Mrs Diamond would be expected to share information about the type of services CCG required. The panel further determined that there is no evidence that Mrs Diamond was involved in making decisions about which external service providers the CCG would contract with. The panel noted that there is no evidence of Mrs Diamond having gained anything, in either a financial manner or otherwise.

Consequently, the panel found that charge 1c is not sufficiently serious to amount to serious misconduct.

In relation to charge 1d, the panel determined that Mrs Diamond's having undertaken private work during SCCG working hours, does not meet the standards normally expected of a professional nurse. The panel highlighted that a member of the public would be disappointed to hear of a nurse undertaking other personal tasks during their period of nursing duty. The panel further noted that Mrs Diamond had physically travelled a

considerable distance to undergo training for another role, on a normal working day in which she was being paid by the SCCG.

The panel determined that given the evidence before it, Mrs Diamond's actions in charge 1d do amount to serious professional misconduct.

In relation to charge 2a, the panel determined that Mrs Diamond's failure to ratify care packages in a timely manner, led to a real risk of harm to vulnerable patients, alongside causing the SCCG a problem financially. The panel considered the evidence of Witness 2, whereby she highlighted the impact of this failure on funding having been substantial, stating that the delays which were caused had led to costs of 1.2 million pounds, which the panel noted is a substantial amount of public money.

The panel noted that due to her failure to ratify care packages, the families of multiple patients may have been required to self-fund and self-care for their patients. Due to Mrs Diamond's actions, patients did not receive the timely care that they may have required. The panel noted that the ratification of care packages in a timely manner should have been a priority for Mrs Diamond, and although she provides reasons for her actions, and mentions the Broadcare system having been fairly new, the panel noted that she still held a responsibility to complete what was required of her.

The panel acknowledged that Mrs Diamond was told that she needed to ratify all cases, as she was the only one who could delegate these, [PRIVATE]. Mrs Diamond raised this issue she had with her line manager. However, the panel noted that she did not raise such an issue in a timely manner and that the impact of the failure to ratify the care packages in a timely manner was significant on finances, patients and their families.

The panel determined that Mrs Diamond's actions in charge 2a amounts to serious professional misconduct.

In relation to charge 2b, the panel took into consideration the written and oral witness evidence which confirmed that Mrs Diamond did approve the care packages of *'ghost patients.*' The panel noted that Mrs Diamond was the head of Complex Care and a registered nurse at the CCG and that she had a duty of care to provide the necessary leadership to ensure that care packages were recorded and ratified in a timely manner.

The panel concluded that Mrs Diamond's conduct in charge 2b is a breach of the NMC Code in relation to up-to-date record keeping and is sufficiently serious to amount to serious misconduct.

In relation to charge 2c, the panel noted that the patient had begun receiving funding 2 months before it was recorded onto the system by Mrs Diamond, which inevitably, caused complications in respect of CCG budgeting. The panel determined that this charge closely relates to the previous charge, charge 2b. It therefore determined that the same rationale can be considered in finding charge 2c to amount to serious professional misconduct.

In relation to charge 2e, the panel determined that it has evidence before it to show that Mrs Diamond's conduct and documentation practice fell below the expected standards of a senior nurse in her position. The panel noted that, fundamentally, charge 2e relates to record keeping, which is an extremely important part of nursing, as patient needs and requirements can change and must be updated.

Consequently, charge 2e can be found to amount to serious professional misconduct.

In relation to charge 2g, the panel considered the fact that Mrs Diamond refused to ratify the care packages as CHC, without following the correct procedures or recording a clear rationale in Broadcare. The panel highlighted that the package was refused with no clear evidence of reasoning, and then reversed in July with once again, no clear rationale having been recorded. The panel highlighted that Mrs Diamond's actions impacted the SCCG budgets and financial forecast and that this led to the risk of harm and financial loss to patients who did not receive the necessary care package in a timely manner. There was

no evidence to support the change in Mrs Diamond's original decision as required by the National Service Framework. The panel noted that Mrs Diamond failed to complete documentation in a timely manner; it determined that her conduct fell below those expected from a registered nurse.

Consequently, charge 2g can be found to amount to serious professional misconduct.

In relation to Charge 2h. i, 2h. ii, 2i. i, 2i. ii, 2j. i, 2j. ii, the panel decided to consider the misconduct of these charges all together.

The panel determined that there is evidence before it to show that Mrs Diamond did in fact fail to update patient records in a timely manner. The panel noted that Mrs Diamond did not follow the National Service Framework and did not evidence any documentation to support that a patient assessment was carried out in each case, which is fundamental to ratifying patient care packages. Mrs Diamond's conduct could have led to a potential impact on a patient's level of package and, whether it actually met their needs or not. Consequently, the panel determined that the above charges can be found to amount to serious professional misconduct.

In relation to charge 4a, the panel determined that Mrs Diamond did not ensure proper pre-employment checks and DBS checks were carried out when employing staff members. The panel noted that, the pre-employment checks of individuals before being hired is vitally important as nursing staff will often be working with vulnerable patients. The panel noted that Mrs Diamond had a duty of care as a nurse at her level, yet due to her conduct, caused a potential serious impact on patient safety and safeguarding. As a nurse in charge, the panel determined that it was Mrs Diamond's responsibility to ensure pre-employment checks were completed.

Consequently, charge 4a can be found to amount to serious professional misconduct.

In relation to charge 4b, the panel determined that Mrs Diamond failed to comply with the employment practices set out in the NHS Agenda for Change Policy. In failing to do so, charge 4b can be found to amount to serious professional misconduct.

In relation to charge 4c, the panel determined that Mrs Diamond had described the pressure in which she was working under in 2018, which contributed to her not having processed the resignation of Colleague A in a timely manner.

The panel felt that it was more likely than not, that Mrs Diamond's action was to have been a single oversight or omission, and as such, a mistake insufficient to amount to serious misconduct.

The panel found that Mrs Diamond's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Diamond's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*
>
> a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> b) *has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession;'*

The panel finds that patients were put at risk of physical and emotional harm as a result of Mrs Diamond's misconduct. Mrs Diamond's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

The panel considered that Mrs Diamond's misconduct has not yet been remediated but could be remediated at some stage in the future. Therefore, it was satisfied that the misconduct in this case is capable of being addressed.

The panel carefully considered the evidence before it in determining whether or not Mrs Diamond has taken steps to strengthen her practice. The panel took into account Mrs Diamond's submissions by email on 15 October 2024. In this she showed remorse, stating that:

'I *am extremely sorry for my conduct while working at Shropshire CCG and will in future ensure appropriate support is sourced.* '

'I deeply regret the lapse in judgement and the issues it may have caused'

Mrs Diamond has also focused on the matters surrounding the incidents she was involved in. There is no evidence that Mrs Diamond acknowledges, as Head of Complex Care, that she had a leadership role to ensure the quality of care provided by a complex care team was of expected standards. The panel further noted the email contains some limited reflection but that there is no recent independent evidence of safe practice since these incidents, nor is there any evidence of acknowledgement of Mrs Diamond's actions and the impact it had on patients, the reputation of nursing, her colleagues, and public finances.

The panel determined that there is currently a risk of repetition based on Mrs Diamond's lack of insight and remediation. The panel is also of the view that there remains a risk of harm to the public and to patients. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required because there has been a risk caused to patients and the public based Mrs Diamond's misconduct.

In addition, the panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds Mrs Diamond's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Mrs Diamond's fitness to practise is currently impaired.

Sanction

During the course of deliberations Mrs Diamond forwarded further material which she was concerned that the panel might not have seen. The panel reviewed this information and concluded that it had already seen almost all of the material which was forwarded. The only exception was a testimonial from Ms 7 relating to Mrs Diamond's clinical practice. The panel took this into account, but it did not materially affect the panel's conclusion. The panel had independently reached the view that Mrs Diamond's clinical practice was of an appropriate standard.

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the NMC register will show that Mrs Diamond's registration has been suspended.

Submissions on sanction

Mr Brahimi informed the panel that in the Notice of Hearing, the NMC had advised Mrs Diamond that it would seek the imposition of a striking-off order if it found Mrs Diamond's fitness to practise currently impaired.

Mr Brahimi submitted the following in relation to sanction:

> *'Sanction*
>
> *1. The Panel have now reached a stage of finding misconduct in respect of the Registrant's behaviour (save for charges 1c and 4c) and have concluded that fitness to practice is currently impaired. The Panel should therefore consider what sanction is appropriate to address the proven charges.*
>
> *2. The Panel should first take into account relevant factors before deciding on sanction, as set out by the NMC Fitness to Practice Library guidance SAN-1:*
>
> *3. Proportionality*
> *a. Finding a fair balance between Registrant's rights and the overarching objective of public protection;*
> *b. To not go further than it needs to, the Panel should think about what action it needs to take to tackle the reasons why the Registrant is not currently fit to practise;*
> *c. The Panel should consider whether the sanction with the least impact on the nurse practise would be enough to achieve public protection, looking at the reasons*

why the nurse isn't currently fit to practise and any aggravating or mitigating features.

4. Aggravating features
a. Breaching conflict of interest to pursue her own needs/wants;
b. Position of senior responsibility;
c. Patients seriously at risk of harm;
d. Further observations:
i. Record keeping affected vulnerable patients;
ii. Involved third parties.

5. Mitigating features
a. Registration effective from 1996;
b. Some reflection and (previous) training put forward;
c. Environmental factors that significantly contributed to errors and concerns;
d. The CCG was in disarray at the time.

6. Previous interim order and their effect on sanctions
a. No Interim Order in place.

7. Previous fitness to practice history
a. No previous findings.

Sanctions available

8. NMC submit that taking no action and a caution order are not suitable options for this case due to the variety of concerns. Guidance is found at SAN-3a and 3b.
a. Taking no action: this would not be an appropriate course of action as the combination of regulatory concerns of behaviour is serious. The public protection and public interest elements in this case are such that taking no action would not be the appropriate response;

b. Caution Order: similarly, a Caution Order is also not suitable as this is a sanction aimed at misconduct that is at the lower end of the spectrum. In this case the concerns involved conflicts of interest, poor record keeping, vulnerable patients and failure to adhere to policies.

9. With regards to a conditions of practice order (COPO), the NMC submit that this option does not adequately address and reflect upon the number of breaches in this case.
NMC guidance is found at reference SAN-3c.
a. The level of concern in this case would require a higher level of sanction than a COPO where there is a variety of issues. The guidelines refer to "When conditions of practice are appropriate" and the Panel may find that these conditions are not met.
b. Measurable, workable and appropriate conditions can be put into place to address instances such as specific clinical failures, however, a COPO would not suitably address the varied misconduct.
c. A COPO can be used even where impairment is found. Such an order is appropriate where there is no evidence of harmful deep-seated personality or attitudinal problems and there is a willingness on the part of the Registrant to engage. The NMC submit that with the multitude of patients and concerns, means that this would not be an appropriate sanction. There appears to still be an unclear position of whether the registrant accepts the proven facts, as she presents denial of certain conduct but accepts having a lapse in judgment and apologises for her conduct. Overall, this sanction would be insufficient to protect the public and would not meet the public interest test.

10. The NMC submit the Registrant's actions do warrant a suspension order (SO) but this would not be sufficient. Suspension guidance is found at reference SAN-3d, and includes some of the following (but not limited to):
a. "Key things to weigh up before imposing this order include:
• whether the seriousness of the case require temporary removal from the register?

b. "Use the checklist below as a guide to help decide whether it's appropriate or not. This list is not exhaustive:
• a single instance of misconduct but where a lesser sanction is not sufficient"
c. Seriousness of the case does require at least temporary removal from the case.

However, this is not a case where the areas of concern relate to clinical areas where a suspension would be appropriate. There are arguably attitudinal concerns on her abuse of position, her pursuit of private interests in conflict with her role, and her poor record keeping which impacted on care to patients of harm. There is also a significant risk of repetition of such behaviour, which poses a risk to the public and such an order would be insufficient to adequately protect the public in this case. A suspension order is not appropriate as the matters do raise fundamental questions about professionalism and affect public confidence if the registrant is not removed from the register.

11. The NMC submit that a striking-off order is appropriate when assessing the totality of concerns. The Panel may be assisted by guidance provided at reference SAN-3e.
a. This is the most serious sanction and is likely only appropriate when the conduct is fundamentally incompatible with remaining on the register. The number of concerns is serious. The failure to follow procedures and the Registrant's pursuit of private ventures (in conflict with her position) do raise issues tantamount to an abuse of position. Such abuse and failure to keep proper records poses a risk to patients and ultimately, the public confidence would be affected. When considering a striking-off, the NMC submit that this is the only sanction which will be sufficiently protect patients and maintain professional standards. In this case, there is a clear necessity to maintain professional standards. The Registrant's actions put patients at risk of significant harm where they were denied ratification of correct packages.

Sanction request:

12. The concerns in this case (when combined) may be described as being attitudinal in nature. For all the reasons previously argued, the NMC submit that the appropriate sanction is a:

Strike Off

13. The NMC have sought to assist the Panel by going through each of the possible sanctions and when weighing the evidence against the set guidance, it is justified that there be a strike off. Patients, colleagues and the public need to be able to trust those on the register and have no doubts that Registrants understand and respect of the limits within their role. This case has called into question whether registrants will uphold the proper professional standards of someone in such a trusted position. There has been a lack of demonstration in upholding the high standards expected of a senior position and a strike-off is the only order that would sufficiently protect the public, maintain trust and restore confidence in the medical profession. This sanction would reflect that the conduct of the Registrant has been properly addressed and maintain trust with the public that the NMC do take such allegations seriously and will take swift and appropriate action.

14. The NMC respect that the Panel is entirely at liberty to proceed as they deem most suitable for this case.

Interim order under Rule 24 (14) to cover possible appeal

15. Should the Panel make an order as to sanction beyond that of a caution, the NMC would invite that there be an interim suspension order for a period of 18 months. The Panel will appreciate that the decision on sanction will not take effect until at least 28 days. The period of 18 months would therefore be sufficient should an appeal be lodged by the Registrant. The request and grounds argued for why an interim order is required would be the same as those previously presented at the misconduct and impairment stage. The Panel may agree that having no interim

order would not be reflective of their finding that a sanction is required, beyond a caution.'

The panel heard and accepted the advice of the legal assessor.

Decision and reasons on sanction

Having found Mrs Diamond's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Mrs Diamond's misconduct was wide-ranging in nature and related to a number of decisions relating to her leadership role; occurring over a period of time;
- Mrs Diamond's conduct had the potential to put patients at risk of harm;
- Mrs Diamond's actions contributed to a loss of public funds;
- Mrs Diamond was in a position of leadership;
- Mrs Diamond has presented a lack of insight into her failings until very recently when the panel noted the development of a limited amount of insight;

The panel also took into account the following mitigating features:

- [PRIVATE]
- Organisational factors appear to have contributed to Mrs Diamonds decision making during the time set out in the charges, where she was working within a difficult and challenging environment;
- The CCG was in disarray at the time of Mrs Diamond's misconduct;

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Diamond's practice would not be appropriate in the circumstances. The panel noted that the concerns in this case are both wide ranging in nature and occurred over a lengthy period of time. The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Diamond's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Diamond's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*

- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Furthermore, the panel concluded that the placing of conditions on Mrs Diamond's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*
- *In cases where the only issue relates to the nurse or midwife's health, there is a risk to patient safety if they were allowed to continue to practise even with conditions; and*
- *In cases where the only issue relates to the nurse or midwife's lack of competence, there is a risk to patient safety if they were allowed to continue to practise even with conditions.*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register. It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. The panel

determined that the misconduct was in relation to failings in Mrs Diamond's leadership. No clinical concerns have been identified in the case, and there is the need to balance the public interest in not striking off an otherwise competent clinical nurse. The panel heard from witnesses that Mrs Diamond had a poor understanding of systems and processes in place during the time scale of the charges. The panel also heard evidence of the pressure placed on Mrs Diamond to address ongoing problems within the CCG including financial elements. The panel noted that there is evidence that Mrs Diamond's clinical practice remained at a competent standard when practising at clinical level after the period of time covered by the charges. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mrs Diamond's case to impose a striking-off order.

The panel noted that the misconduct identified in this case falls short of the standards expected from a registered nurse and that there remains at present a risk of repetition of the concerns raised, if Mrs Diamond were to secure a leadership role. The panel noted that the misconduct in this case occurred when Mrs Diamond occupied a role for which she was not suited. There is commonality between the charges found proved, in that they all relate to her position as a senior leader, rather than her clinical competencies. Prior to her occupying this role, her clinical practice as a nurse had been highly regarded.

Nonetheless, the panel recognised that Mrs Diamonds failings in the role that she occupied, were serious. Mrs Diamond was working in an organisation that was in some difficulty and [PRIVATE], however, her actions had the potential to impact on both patients and the CCG as an organisation, causing the risk of financial loss and harm to patient safety. The panel noted that Mrs Diamond worked for a private contractor during the working hours of her employed role at the NHS. This was a serious error of judgement which Mrs Diamond has since acknowledged in a reflective piece. The panel determined that, Mrs Diamond having employed staff without ensuring that the correct employment checks had been completed, and approving payment rises for her staff which were outside NHS policy, was both inappropriate and irresponsible.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the hardship such an order will inevitably cause Mrs Diamond. However, this is outweighed by the public interest in this case.

The panel considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

In making this decision, the panel carefully considered the submissions of Mr Brahimi in relation to the sanction that the NMC was seeking in this case. However, the panel considered that the misconduct in this case does not meet the required threshold for a striking-off order; it noted that this may be considered as disproportionate.

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Mrs Diamond's attendance at the next hearing;
- A further reflective piece on the impact of Mrs Diamond's actions, and how they impacted patients, colleagues and the reputation of the nursing profession;
- Any up-to-date testimonials/references from any employment or voluntary work;
- Evidence of keeping up to date with nursing.

This will be confirmed to Mrs Diamond in writing.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months in order to cover any potential appeal and the period to hear such an appeal.

If no appeal is made, then the interim suspension order will be replaced by the substantive suspension order 28 days after Mrs Diamond is sent the decision of this hearing in writing.

That concludes this determination.