NHSE Midlands
NMC Best Practice

1.0 Introduction and background

Following on from the recent High profile legal cases surrounding NMC registrants, it has been deemed necessary to gain assurance that as a region, we are referring registrants as expected and in line with the NMC's fitness to practice guidance.

The NMC has one clear overarching objective in protecting the public. To achieve this in relation to fitness to practice there are two clear aims:

- A professional culture that values equality, diversity and inclusion and prioritises openness and learning in the interest of patient safety

And

- Nurses, midwives and Nursing associates who are fit to practice safely and professionally.

The NMC has twelve principles to make sure there is consistency and transparency in the waythey work, and, in the way, they make decisions about nurses, midwives and nursing associates' fitness to practice.

1. A person-centered approach to fitness to practice.
2. Fitness to practice is about managing the risk that a nurse, midwife or nursing associate poses to patients or members of the public in the future. It is not about punishing people for past events.
3. We can best protect patients and members of the public by making final fitness to practise decisions swiftly and publishing the reasons openly.
4. Employers should act first to deal with concerns about a nurse, midwife or nursing associate's practice unless the risk to patients or the public is so serious that we need to take immediate action.
5. We always take regulatory action when there is a risk to patient safety that an employer is not effectively managing.
6. We take account of the context in which the nurse, midwife or nursing associate was practicing when deciding whether there is a risk to patient safety that requires us to take regulatory action.
7. We may not need to take regulatory action for a clinical mistake, even where there has been serious harm to a patient or service-user if there's no longer a risk to patient safety and the nurse, midwife, or nursing associate has been open about what went wrong and can demonstrate that they've learned from it.
8. Deliberately covering up when things go wrong seriously undermines patient safety and damages public trust in the professions. Therefore, restrictive regulatory action is likely to be required in such cases.
9. In cases of clinical practice, taking action solely to maintain public confidence or uphold standards is only likely to be needed if the regulatory concern can't be addressed.

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

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

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

2.0 The NMC and Fitness to Practice

The NMC provides clear guidance of the role of an employer in managing concerns.
The fitness to practice principles makes it evident that local resolution and investigation is generally the best way to deal with concerns as long as it does not leave the public at risk.

The rationale is that employers are closer to the situation where a concern is raised and are often best placed to manage issues. If required, employers can intervene directly and quickly in a professional's practice and do so in a more targeted way. The NMC will need tobecome involved in these cases where there is evidence of a serious concern that requiresthem to take regulatory action to protect the public.

The NMC's legal powers allow them to investigate two kinds of concerns.

1. Allegations of fraudulent or incorrect entry of an individual nurse, midwife or nursing associate on the register
2. Allegations about the fitness to practice of nurses, midwives or nursing associates.

Allegations about fitness to practice can be based on:

Misconduct
The Code sets professional standards of practice and behaviour for nurses, midwives and nursing associates. If nurses, midwives or nursing associates' conduct falls seriously short of the expectations in the Code, what they did or failed to do could be professional misconduct.

Lack of competence
Lack of competence would usually involve an unacceptably low standard of professional performance. For instance, if a nurse, midwife or nursing associate demonstrates a lack of knowledge, skill or judgment, which shows they're incapable of safe and effective practice. NMC states, unless it is exceptionally serious, a single clinical incident would not usually indicate a general lack of competence.

Criminal convictions and cautions
Nurses, midwives or nursing associates have to declare any cautions or convictions unless these are protected cautions or convictions.

Health
NMC will not normally need to get involved in a nurse, midwife or nursing associate's practice because of ill health unless there is a risk of harm to patients or to the public's confidence and trust in nursing or midwifery professions.

The NMC do not need to look into health conditions if they are being effectively managed and that doesn't mean the registrant is unable to carry out their professional role. This is relevant if someone living with a condition but managing through medication or therapy, or if they have been given appropriate support or adjustments to help carry out their work.

Not having the necessary knowledge of English
Not every language concern raised will need the NMC to carry out an investigation. Language concerns that could place the public at risk of harm include serious failures to give appropriate care to patients because of an inability to understand verbal or written communications from other health professionals or patients.

Determinations by other health or social care organisations
Nurses, midwives, and nursing associates can be registered members of other health or social care professions regulated by different legal bodies in the UK or overseas. Sometimes the NMC receives referrals from these other organisations, which will be looked into.
Once the NMC has received a case they will take it through the screening process. In screening the concern is assessed to decide if it is serious enough to warrant taking regulatory action to protect the public and uphold confidence in the professions.

They have broad powers to look into the seriousness of concerns received. The focus is aimed at what the risks are if the nurse, midwife or nursing associate doesn't address or put right the concerns that have been raised.

Many of the concerns received by the NMC do not progress to regulatory action being taken and often recommend that the concerns are raised with the employer to investigate and resolve.

Risks we look at to decide if regulatory action is needed could include risks to patients, services or the public's confidence in the nursing, midwifery or nursing associate profession.

Some factors that are taken into account when looking at the seriousness at the screening stage include:

- if the alleged actions could have put a member of the public at serious risk of harm
- if the concern is about an isolated incident or a pattern of behaviour over time
- if the concern relates to dishonesty or breaches of the duty of candour
- concerns where there's evidence of bullying, discrimination or harassment of colleagues or members of the public
- if the situation could seriously damage public trust in nurses, midwives or nursing associates, or undermine professional standards
- if the concern involves serious leadership or management failings on the part of professionals on our register.

3.0 NMC Best Practice Guidance for Executive Chief Nurses

- Each Chief Nurse should have a nominated person who is the key conduit/nominated link between the NMC and the Trust for all registrant cases. This should be a registrant, and professional standards and registrations should be an integral part of their portfolio.

- The Chief Nurse should be an independent critical friend of the nominated link and provide constructive challenge and oversight of the process.

- The Trust link should have delegated responsibility from the Chief Nurse and the Chief Nurse should receive regular updates on all cases. Suggested roles to be part of this relationship could be Deputy Chief Nurse, Head of Nursing for workforce or Professional standards. This person should be a registrant and have responsibilityfor professional regulation and standards within their portfolio.

- Any Investigation to be conducted in line with an approved Trust policy.

- If case to answer, then hearing to be conducted in line with approved Trust policy.

- Key element of NMC fitness to practice principles breeched identified at hearing.

- If at the hearing stage the decision is made to remain employed at Trust, then for the key NMC F2P breached to be a clear objective within a developmental plan supportinglocal resolution.

- The developmental plan must be approved by two NMC registrants of sufficient seniorityto dismiss from the Trust. It would be best practice for at least one of these registrants to have been panel members of the disciplinary hearing.

- Achievement of development plan must be regularly reviewed for attainment by twoNMC registrants of sufficient seniority to dismiss from the Trust.

- It would be best practice for the developmental action plan reviews to be undertaken by the same registrants as the initial approval

- The person responsible for professional registration and standards must be made awareof this registrant and the developmental plan, receiving bimonthly updates. If this is not the Chief Nurse, then this person must ensure the Chief Nurse is updated on a quarterly basis of achievement and progress or any further concerns raised.

- If the registrant has been dismissed from the Trust, the registrant will have the right to appeal. Where possible a referral to the NMC should not be undertaken until the time has lapsed for an appeal to be made or if an appeal is made then the outcome of that appeal has been made.

- If the registrant is employed by an agency, the Chief Nurse or their deputy should contact the agency within 72 hours of the concerns being identified and have a conversation clearly stating the concerns raised and the principle's which they feel have been broken.

- If the Chief Nurse or their deputy do not feel that these concerns have been taken on board or that development will not be undertaken to support protecting the public safety, then to refer to the NMC. Clearly stating that contact has been made with the agency.

- Any contact with an external partner of this nature should be followed up in writing (email or formal letter) within 72hours of the contact being made.

- If the registrant is employed by another provider Trust, the Chief Nurse or their deputy should have contact with the other Trusts Chief Nurse with 72 hours of the concerns being identified and have a conversation clearly stating the concerns raised and the principles which they feel have been broken.

- It would be best practice for the Chief Nurse to take on board the concerns raised and commence their own investigation following their Trust guidance.

- If it was felt the receiving the Chief Nurse or Deputy were not taking on board the concerns or that development would not be undertaken to support protecting the public safety, then the chief nurse, can either raise with the Regional Chief Nurse or their deputy or raise a referral to the NMC.

- Any referral to the NMC from the Trust should be regularly reviewed with the NMC advisor for progress updates and to aid wider learning regarding the appropriateness of the referral and subsequent actions. This also allows for wider oversight of all cases which have been placed concerning current and previous registrants of the Trust.

- It is best practice that all referrals be made within 48hours of the decisionbeing made to refer.

- It is best practice that referrals from Trusts would be made using the NMC's online facility and a record of the referral is downloaded. A copy is to be stored in the registrants' personal file and a copy to be sent to the Trusts NMC link/nominated person maintaining the records on behalf of the Chief Nurse.

- It is best practice that any referral will be discussed with the Chief Nurse or their deputy before being made.

- It is best practice that a central record of referrals is kept, and regular updates are recorded.

- It is best practice that this record is only shared with a discrete group of registrants and/or HR professionals on a need-to-know basis.

- A dedicated senior person from within the Trust should be aligned to any registrant referred to the NMC for their ongoing wellbeing support and regular offerings made. Even if not within the Trusts employment.

- A dedicated senior person from within the trust should be aligned to any member of staff who have felt it necessary to refer to the NMC other registrants not within the employment providing they have been made aware

- Checklist/ Prompts:

Trusts will have Policy for professional registration, are there some common principles	☐
What are the processes for managing concerns?	☐
Where is the balance and checks?	☐
Where is the consistency across the region?	☐
What are the themes? How is that shared in region? What is the potential for learning	☐
What is the protected characteristic data telling us?	☐
How do we engage with HCPC (which is different to NMC)	☐
How do we prepare colleagues to prepare witness statements?	☐
What is the impact of police engagement which delays internal investigations and leaves registrants sitting at home on full pay? How do we support these individuals (duty of care)	☐
What assurance does the board / ICB/ Region have of the processes? What is reported to the board, so they are sighted? How is this shared with ICB/ region?What are the possible red flags?	☐

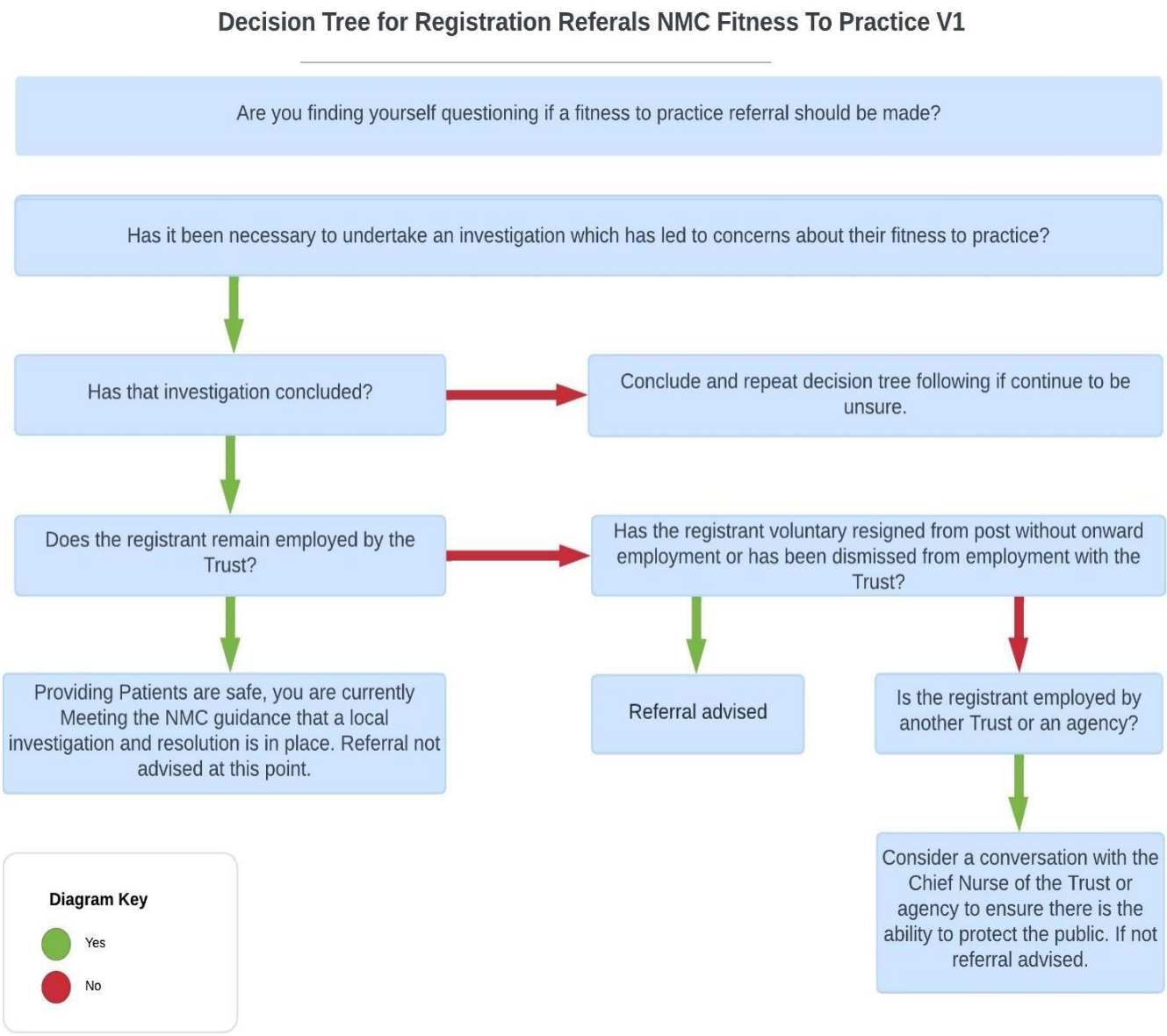
4.0 Examples to support Decision Making

Appendix 2 – Decision Making Rationale		**Date:**
In attendance:	**Name**	
Chief Operating Officer or nominated deputy		
Chief Nurse or nominated deputy		
Deputy Director of Workforce or nominated deputy		
Cultural Ambassador or EDI Representative		
Manager conducting the fact find		
HR representative (supporting the manager conducting the fact find)		

	Question/ Test	**Finding**	**Evidence (based on information from fact finding)**
1.	**Deliberate harm test:** Was there any intention to cause harm?	**Yes** Take action under formal investigation. **No** Go to question 2.	
2.	**Health test:** Are there indications of ill-health (physical/ mental/ substance abuse) that may have impacted on the incident/issue?	**Yes** Take action under Managing Attendance and Supporting Wellbeing Policy/ Substance Misuse Policy **No** Go to question 3.	
3.	**Foresight test:** a. Are there agreed SOPs/ policies/ accepted practice in place in relation to issue identified? b. Were the SOPs/ policies/ accepted practice workable and in general use? c. Did the individual knowingly depart from these SOPs/ policies/ practices?	**Yes** Go to question 4. **No** Take action to address the wider issues identified. Actions may include, but not be limited to, the individual. This may include under early resolution process.	

4.	**Substitution test:** a. Would others with comparable experience andqualifications behave in the same way in similar circumstances? b. Is the individual up to date with relevant training? c. 'Is the person receiving regular clinical or restorative supervision'? d. Have there been similar concerns of a similar nature in the past?	**Yes** Take action to address the wider issues identified. Actions may include but not be limited to, the individual. This may include actions for the individual under the Disciplinary Policy or other relevant Trust Policy e.g. Procedure for Dealing with Employee Capability. **No** Go to question 5.	
5.	**Mitigating circumstances:** Are there significant mitigating circumstances? (i.e. circumstances personal to individual and/or any protected characteristic (i.e. physical or mental health, neurodiversity, language barriers, acceptance of personal responsibility, remorse, and reflection).	**Yes** Take action in consideration of the mitigating circumstances and in line with Trust policy. **No** Take appropriate action in line with Trust policies. This could involve individual training, performance management, changes to role, increased supervision or appropriate disciplinary process.	
	Summary of decision and rationale:		

5.0 NMC Decision referral Tree



PROCESS for NMC and HCPC REFERRAL

Issue of concern regarding individuals' professional behaviour or clinical practice highlighted to manager or identified through internal investigation (awareness can come through PSI process or HR process)

If the concern raised is serious and particularly if there is a potential risk to patient safety the case should immediately (without waiting for the next meeting) presented to the Decision-Making Panel for review and consideration of immediate actions. This could include suspension.

Suspension is a neutral, no blame, action

Suspension is a last resort once any restrictions to practice have been considered and deemed inappropriate.

Suspension must be authorised through the Decision-Making Panel in accordance with the Trust Disciplinary Policy and Procedure

In hours: HR advice must be sought

On a weekend or night shift: if member of staff has to be removed from practice – either to restrict practice or through suspension, the registrant's manager or senior manager should speak to on call manager and notification to the Director on call prior to carrying out the restriction or suspension to agree staff member being removed from practice. E-mail to Chief Nurse and HR Business Partner to notify

Anonymous referral received by Chief Nurse passed to Deputy Director of Nursing, AHPs & Quality

Discussion with manager, HR business partner and Chief Nurse and Deputy Director of Nursing and AHP's Training re internal process and to identify next steps

Mapped against NMC/HCPC standards

No further action or local procedure put in place

Presented to Decision Making Group – Decision Made
If Chief Nurse is not present at DMG notify Chief Nurse
And local procedure put in place

Not enough information, not serious, risk to patients public mitigated. Potential to review at the end of the internal process and share lessons learned

Registrant is informed (advised to obtain Union support, Restorative supervisor Professional Nurse Advocate (PNA) support offered

Manager completes referral and cc's HR Business Partner and the Deputy Director of Nursing, AHPs and Quality (as single point of contact for the NMC and HCPC within NHFT)

Manager is provided with support from HR Business Partner and Deputy Director of Nursing, AHPs and Quality in order to inform the registrant

Information is provided to staff member and manager on wellbeing support available

Line Manager or agreed wellbeing contact to ensure wellbeing check ins are undertaken with the employee whilst external process is underway.

Occupational Health referral and psychological support offered too individual

Staff member resigns – NMC informed and if required, next employer

NMC/HCPC Decision
NHFT informed of outcome by the NMC/HCPC
Deputy Director of Nursing, AHPs and Quality informs manager and HR Business partner of outcome
Registrant informed outcome by the NMC/HCPC and NHFT

6.0 Acknowledgements

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